SIERRA VIEW
MEDICAL CENTER

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

AGENDA
December 20, 2022

OPEN SESSION (4:30 PM – 4:35 PM)

The Board of Directors will call the meeting to order at 4:30 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 4:35 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:00 P.M. In person attendance by the public during the open session(s) of this meeting are allowed in accordance with the Ralph M. Brown Act, Government Code Sections 54950 et seq.

Call to Order

I. **Oath of Office and Installation of newly elected/re-elected directors**

II. **Approval of Agendas**
Recommended Action: Approve/Disapprove the Agenda as Presented/Amended
The Board Chairman may limit each presentation so that the matter may be concluded in the time allotted. Upon request of any Board member to extend the time for a matter, either a Board vote will be taken as to whether to extend the time allotted or the chair may extend the time on his own motion without a vote.

III. **Adjourn Open Session and go into Closed Session**

CLOSED SESSION

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

IV. **Closed Session Business**

A. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report (Time Limit – 5 minutes)

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

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54956.9, Exposure to Litigation to subdivision (d) (2): Conference with Legal Counsel. BETA CLAIM No. 22-000947

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)

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

V. Adjourn Closed Session and go into Open Session

OPEN SESSION

VI. Closed Session Action Taken

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

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

B. Quality Review

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

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

C. Conference with Legal Counsel on BETA Claim No. 22-000947
Recommended Action: Approve/Reject BETA Claim No. 22-000947

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

E. Conference with Legal Counsel about recent work product
Recommended Action: Information only; no action taken

VII. Public Comments

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

VIII. Consent Agenda
Recommended Action: Approve Consent Agenda as presented

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

IX. Approval of Minutes

A. November 22, 2022 Minutes of the Regular Meeting of the Board of Directors

SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
December 20, 2022

Recommended Action: Approve/Disapprove November 22, 2022 Minutes of the Regular Meeting of the Board of Directors

X. CEO Report

XI. Appointment of Governing Board Director for Zone 3
Public review all applications; Public consideration of all applicants.
Recommended Action: Appoint Director for Zone 3 and Immediate Notification of the Appointment to be sent to the Tulare County Elections Official

XII. Business Items

A. **November 2022 Financials**
Recommended Action: Approve/Disapprove

B. **Retirement Planning Advisory Committee Report**
Recommended Action: Approve/Disapprove

C. **Election of Officers – Board Organization**
Recommended Action: Elect Board Chair, Vice Chair, and Secretary and appoint Treasurer

XIII. Announcements:

A. Regular Board of Directors Meeting – January 24, 2023 at 4:30pm

XIV. Adjournment

PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Mitchell, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 5:00 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

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

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MEDICAL EXECUTIVE COMMITTEE	12/7/2022
BOARD OF DIRECTORS APPROVAL	
	12/20/2022
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
December 20, 2022 BOARD APPROVAL

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

	Pages	Action
I. Policies:		APPROVE ↓
• Identification of Patient's Requests and Samples (Blood Bank)	1-3	
• Nutrition Assessment, Care Plans, Minimum Data Set and Documentation – DP/SNF	4-5	
• Performance Improvement Plan	6-11	
• Stroke Alert & Acute Care Stroke Management: Emergency Department and In Patient Units	12-24	
• Weight Variance – DP/SNF	25-27	
II. Diet Manual:		
• Sierra View Medical Center – *Diet and Nutrition Care Manual*	28-34	

SUBJECT: **IDENTIFICATION OF PATIENT'S REQUESTS AND SAMPLES (BLOOD BANK)**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide instructions on how to identify specimens for blood bank laboratory orders.

POLICY:

A. Request Forms: Done in order entry on the hospital computer system.

1. The electronic requisitions requesting blood bank (BBK) studies contain the following information to ensure positive identification of the patient and accurate processing of the blood bank orders in adherence to the American Association of Blood Bank (AABB) Standards and TJC Accreditation Requirements.

NOTE: All patients will be issued an ID wristband, which will include a unique BBK (Blood Bank) number for positive ID.

a. Patient's first and last name

b. Patient's medical record number

c. Patient's account number

d. Patient's date of birth (DOB)

e. Physician of record

f. Patient's location

g. Test(s) required

h. Blood products requested, if any

i. Date/time specimen draw

j. Two initials required on blood tubes labeled at bedside to validate witnessed phlebotomy with correct ID and correct BBK#.

(For Inpatient and Emergency Department (ED), any combination of phlebotomist, nurse, and/or physician initials are acceptable. For Outpatient, phlebotomist and lab clerk initials can be used.)

k. If tests are to be performed on newborns, the medical record number of the mother is also available on the baby's requisition.

l. Additional information, such as clinical diagnosis, ordering physician, medication, date and time blood products are needed for transfusions and the initials of the nursing personnel placing the order, are also required.

m. Incomplete orders will not be accepted by the blood bank for processing. This includes any sample missing a second set of initial's from witness, BBK number of the patient obtained from the wristband and time of collection.

B. Blood Samples:

1. The patient and the blood sample shall be positively identified at the time of collection by comparing the information on the blood bank specimen label with the information on the patient's ID wristband. The technician will verify the patient's name verbally with the patient, family member, or nurse when the patient is unable. In cases such as an ED emergency, a stat admit kit with temporary ID will be used. Blood specimens drawn will be labeled at the bedside with the computer generated or handwritten label containing the following:

a. Patient's first and last name

b. Patient's account number

c. Patient's DOB

d. BBK Number (handwritten by phlebotomist – found on patient's wristband) All specimens drawn for blood bank testing will be obtained and labeled by a certified/licensed lab personnel or licensed personnel in the presence of a second licensed personnel. All personnel involved in obtaining the specimen will each initial the specimen labels and/or additional forms as required, and confirm that the BBK# has been transcribed correctly from the patient's wrist band to the specimen label. The outpatient lab setting may use a lab clerk as the second personnel.

e. Date/time specimen drawn (handwritten by phlebotomist)

f. Initial of phlebotomist (handwritten by phlebotomist)

C. Identifying Information:

1. Before a specimen is used for blood bank test processing, the blood bank CLS shall confirm that all identifying information on the blood bank order is in agreement with that on the blood bank sample tube label.

2. A properly labeled BB specimen is defined as containing the above list of identification points. Any deviation from the above accurate identification will result in specimen rejection and another specimen must be obtained.

AFFECTED AREAS/PERSONNEL: *LABORATORY STAFF, NURSING, PHYSICIANS*

REFERENCES:

- American Association of Blood Banks (AABB) STDS, 33rd Ed, pgs. 38-39, 5.11.1 - 5.11.3, 2022.
- The Joint Commission (2022). Hospital accreditation standards (DC.01.01.01 and DC.01.03.01). Joint Commission Resources. Oak Brook, IL.

SUBJECT: **NUTRITION ASSESSMENT, CARE PLANS, MINIMUM DATA SET AND DOCUMENTATION - DP/SNF**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish the procedure for providing comprehensive nutritional care.

POLICY:

The Rregistered Ddietitian is responsible for providing a nutritional assessment/reassessment for comprehensive nutritional care in a timely, effective and efficient manner.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICES, DP/SNF*

PROCEDURE:

1. All residents will receive an initial comprehensive nutritional assessment by the rRegistered Ddietitian. Assessments should be initiated within 24 hours from admission, and completed within 48 hours of admission.

2. The comprehensive medical nutritional therapy assessment ~~should~~ shall include the following:

   a. Interview and observation to determine food tolerances, likes, dislikes and allergies as appropriate.

   b. Determination of eating ability including chewing or swallowing ability, need for self-help adaptive devices, mobility problems, etc. with observation at meal time if appropriate.

   c. Review of medical history from the resident's medical record to include laboratory tests, anthropometric measures, and clinical findings.

   d. Review of medications and food medication interactions if relevant to diet therapy or nutritional status.

   e. Review of physiological, sociological, behavioral and environmental data, which may affect nutritional status.

   f. Summary of findings including nutritional problems, assessment of estimated nutritional needs, recommendations and/or plan of care.

3. Nutritional assessment/review will be completed bi-monthly for the first month, monthly thereafter. ~~for the first quarter, quarterly thereafter.~~ and more often if clinically necessary.

4. Nutritional problems will be entered into the resident's interdisciplinary care plan.

5. Resident conditions requiring a weight loss/gain regimen will be presented at the DP/SNF team meeting.- If the team agrees with the recommendations, the physician will write an order for the weight loss/gain regimen and the Rregistered Ddietitian will secure a signed consent for weight loss/gain from the patient or patient family member prior to initiating the weight loss/gain regimen.

6. The facility will utilize an assessment form recommended by the Rregistered Ddietitian.

7. The Rregistered Ddietitian will complete the MDS nutrition section after admission within the appropriate timeframe. Information from the MDS observation period ~~should~~ shall be used to complete the assessment.

REFERENCES:

- Centers for Medicare and Medicaid Services, Conditions of Participation (~~2020~~2022). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html.

- Med Pass, Inc. (Updated February 6, 2015) Facility guide to OBRA Regulations, 483.25 (i). 483.20 (b)(1), 483.20(k), 483.75 (0).

SUBJECT: **PERFORMANCE IMPROVEMENT PLAN**	SECTION: ***Performance Improvement*** **Page 1 of 6**

PURPOSE:

Sierra View Medical Center (SVMC) is committed to providing quality health care services to all of our patients. As an organization, we realize that in order to provide this level of care, we must continually measure and assess systems and outcomes related to those services provided. This plan describes the organizational procedures to be utilized in performance measurement, performance assessment and performance improvement activities. It is the intent of the organization's leaders to develop a performance improvement program that allows all departments and services to collaboratively perform improvement activities utilizing the Plan, Do, Study, Act (PDSA) methodology. This plan describes the communication and coordination for all organizational activities directed toward improving patient care services.

POLICY:

A. Authority and Responsibility

1. The Board of Directors has the ultimate authority and responsibility to require and support a Performance Improvement program at Sierra View Medical Center. The Board of Directors has delegated the responsibility of implementing an organization-wide performance improvement program to Administration, the Medical Staff and the Performance Improvement/Patient Safety (PIPS) Committee.

B. Specific Performance Improvement Components

1. **Hospital Support Service**

Senior Leadership shall oversee the development and implementation of performance improvement activities for Nursing and other hospital support services, assuring the integration and coordination of service-specific activities into the organization-wide performance improvement program. The substantive results of support service performance improvement activities will be reported to the Performance Improvement/Patient Safety Committee. A summarized report will be presented to the Board of Directors at least quarterly. Relevant information from the support service performance improvement activities will be shared organizationally as needed.

2. **Medical Staff Peer Review Program**

The Medical Staff has empowered the Medical Executive Committee to develop and oversee the Medical Staff Peer Review Program. The Medical Executive Committee shall assure the integration and coordination of all Medical Staff peer review activities into the organization-wide Performance Improvement Program when indicated.

3. **Medical Staff Committees**

The Medical Staff Committees review quality data and determine necessary actions to make or sustain improvements. The Medical Staff coordinates their improvement activities with other Medical Staff and administrative committees as necessary to achieve

the desired outcome. Medical staff committee reports are submitted to the Medical Executive Committee by the designated chairperson.

4. **Patient Safety Program**

The organization has developed an integrated Patient Safety Program to collect data and investigate occurrences related to patient safety and risk reduction. Hospital occurrences which may be related to patient safety or medical errors are reported to Risk/Patient Safety Management. The Risk/Patient Safety Department assures timely integration of this Risk Management information into the Organizational Performance Improvement Program. Information related to sentinel events and error reduction is reviewed by the Performance Improvement/Patient Safety Committee (PIPS). The PIPS Committee has adopted the failure mode, effects, and analysis (FMEA) model for proactive process redesign.

5. **Performance Improvement/Patient Safety Committee (PIPS)**

The Performance Improvement/Patient Safety (PIPS) Committee has been empowered to develop and oversee the organization-wide performance improvement program with focus on the safe delivery of care. This program supports the integration and coordination of medical staff, nursing and support services in order to be successful in their improvement efforts. The PIPS Committee supports and follows the fundamental principles of performance improvement, collecting and analyzing data, and taking actions to make improvements and/or to sustain achievements. Emphasis is placed on patient outcomes and meeting regulatory requirements that support safe delivery of care.

6. **Process Improvement Teams**

The organization supports the development of process improvement teams to improve patient care and services. Prioritization of team activities are determined based on organization assessment and evaluation of organizational goals. Process Improvement teams are chartered through PIPS to avoid duplication of activities throughout the organization and to standardize the process. Teams will be further prioritized based on organization need with focus on improved patient outcomes, considering high volume and problem prone, high risk and low volume areas. Team activities will be tracked and reported through the Performance Improvement/Patient Safety Committee. Process improvement teams shall follow the PDSA model. Other Performance Improvement teams may be formed within the organization as needed and shall follow the performance improvement model most appropriate for the process which is being reviewed.

AFFECTED PERSONNEL/AREAS: *ALL HOSPITAL STAFF*

PROCEDURE:

A. Reporting and Coordination

1. *Hospital Support Services*: The following hospital support services shall analyze their scope of service and goals and recommend to the appropriate Executive and/or the Performance Improvement /Patient Safety Committee specific quality control and other measures for inclusion in the organization-wide performance improvement program. Hospital support services include:

   a. Care Management
   b. Population Health
   c. Risk/Patient Safety
   ~~d. Acute Dialysis~~
   ~~e.~~d. Donor Network West
   ~~f.~~e. Food and Nutrition
   ~~g.~~f. Infection Prevention
   ~~h.~~g. Laboratory
   ~~i.~~h. Pharmacy
   ~~j.~~i. Rescue/Resuscitation
   ~~k.~~j. Regulatory
   ~~l.~~k. Radiology
   l. Physical Therapy
   m. Graduate Medical Education

2. *Hospital Service Departments* – These departments shall analyze their scope of services and goals and recommend to the appropriate Executive and/or the Performance Improvement/Patient Safety Committee specific quality control and other measures for inclusion in the organization-wide performance improvement program. Hospital Service Departments include:

   a. *Critical Care*
   b. *Emergency Services*
   c. *Operative/Invasive Services*
   d. *Renal Services*
   e. *Cancer Treatment Center (CTC)*
   f. *Distinct Part Skilled Nursing Facility (DP/SNF)*
   g. *Wound Care*
   h. *Cardiac Cath Lab*
   i. *Urology Clinic*
   j. *Community Health Clinic*
   k. *Pediatrics*
   l. *Maternal Child Health*
   m. *Academic Health Center*
   n. ~~*General*~~ *Surgery Clinic*

3. *Nursing Care Units/Departments* –Nursing shall analyze their scope of service and goals and recommend to the Performance Improvement/Patient Safety Committee specific quality measures for inclusion in the organization-wide performance improvement program. Nursing participates in the National Database of Nursing Quality Indicators (NDNQI) program for submitting data for: Restraints, Pressure Ulcers, Falls, Patient Days, Nursing Care Hours, and Unplanned Post-Operative Transfers. Data is analyzed and actions taken to achieve desired goals.

4. *Contract Services* –Contracted services shall be monitored and evaluated yearly by the clinical leaders and medical staff. Improvement efforts will be implemented when contracted services do not meet their determined expectations as defined in their contract. This may include increased monitoring of services, training, and re-negotiation of terms. Applying penalties and termination would be considered as a last resort. Results of the yearly evaluation will be reported to the Governing Board. Oversight of Contract Services is shared with the Compliance Office.

5. *Medical Staff Department/Peer Review Committees* –The Medical Staff departments shall analyze their scope of service and goals and recommend to the Medical Executive Committee specific quality monitoring and other measures for inclusion in the organization-wide performance improvement program. Medical staff peer review committees include:

   a. *Emergency Medicine*
   b. *Family Medicine*
   c. *Pediatrics*
   d. *Radiology/Pathology*
   e. *Internal Medicine*
   f. *OB/GYN*
   g. *Surgery*
   h. *Anesthesia*

6. *Medical Staff Committees* – The following Medical Staff committees shall analyze their scope of monitoring and committee goals and recommend to the Medical Executive Committee specific quality measures for inclusion in the organization-wide performance improvement program by way of a designated Chairperson. Medical Staff Committees include:

   a. *Pharmacy and Therapeutics/Nutrition Care Committee/Infection Prevention*
   b. *Bioethics Committee*
   c. *Utilization Review Committee*
   d. *Performance Improvement/Patient Safety Committee*

B. Individual Practitioner Competence Issues

1. Issues related to the competence of individual physicians, other independent practitioners, or allied health practitioners will be referred to the appropriate Medical Staff peer review committee for review and will be reported on to the Medical Executive Committee and

Board of Directors as indicated by defined Medical Staff processes. Advanced practice nurses also fall under the auspice of the Chief Nurse Executive. This includes Certified Registered Nurse Anesthetists (CRNAs), nurse practitioners, and nurse midwives who are privileged through the medical staff.

2. Issues related to the performance of practitioners who are hospital employees or work under a hospital job description will be referred to the appropriate service director for evaluation and referred to hospital administration and the Board of Directors as indicated.

3. Written complaints or allegations regarding a provider's sexual misconduct or sexual abuse of a patient will be reported within 15 days to the provider's professional licensing board. Provider is defined to include any person with a license to practice in the healing arts.

C. Communication and Coordination of Results

1. The relevant results of Performance Improvement activities are used primarily to study and improve processes that affect patient outcomes and are related to patient safety. When relevant to the performance of an individual, performance improvement information will be utilized in the evaluation of individual capabilities as part of the human resources assessment or Medical Staff credentialing processes. The information will be communicated as may be necessary to achieve this goal.

2. The conclusions, recommendations, actions and results of the actions taken shall be documented and reported through established channels as noted in this plan.

3. Relevant information shall be communicated among departments, services and professional disciplines when opportunities to improve care involve more than one department or service in the organization. The purpose of reporting and communicating is to share information with those in the organization to whom the information is pertinent.

D. Annual Appraisal

1. The Performance Improvement / Patient Safety Committee shall report, on an on-going and periodic basis, and~~develop an annual~~ appraisal of the ~~overall~~ organizational Performance Improvement program. The appraisal should contain information regarding significant opportunities to improve care identified through the performance improvement process and the effectiveness of actions taken. The ~~annual~~ on-going and periodic appraisal should discuss both the strengths and weaknesses of the existing program, discuss the degree of overall integration and coordination of improvement activities, and contain recommendations for program improvement. The Performance Improvement/Patient Safety Committee shall submit on-going~~the annual~~ reports to the Medical Executive Committee and Board of Directors.

REFERENCES:

- Centers for Medicaid Services. (20210~~19~~). The CMS Compliance Crosswalk. § 482.21 Quality Assessment and Performance Improvement Program. Brentwood, TN.

- The Joint Commission. (20221~~0~~). Comprehensive Accreditation Manual. Performance Improvement Chapter. Oakbrook Terrace, IL.

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SUBJECT:	SECTION:
STROKE ALERT & ACUTE CARE STROKE MANAGEMENT: EMERGENCY DEPARTMENT & IN PATIENT UNITS	**Page 1 of 13**

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

PURPOSE:

To define the core stroke team as well as the roles and responsibilities of Sierra View Medical Center (SVMC) personnel responding to stroke alert notifications; to delineate the stroke alert process, and to assure timely and optimal care for all potential acute and non-acute strokes, as well as Transient Ischemic Attack (TIA) patients.

This policy will also outline the procedure for implementing current evidence-based practice for the management and care of the patient presenting with signs and symptoms of acute stroke and to implement clinical practice guidelines to further reduce the morbidity and mortality associated with stroke.

These guidelines support the primary principals and detailed aspects of successful stroke systems of care.

The scope of SVMC's stroke program is adult patients ages 18 and older who have suffered a stroke or TIA. This mission of the stroke program is to promote health through primary prevention and ensure access to the highest standard of stroke care through advanced medicine and collaborative partnerships, supported by evidence-based practice.

DEFINITIONS:

1. **Stroke Alert** – An overhead page or electronic notification announcing the presence and location of a potential stroke patient. Activated any time for any patient that displays the onset of stroke signs and symptoms, up to 24 hours after the Last Known Well Time (LKWT). Calling a Stroke alert is generally a nurse –driven process.

   - Patients with new or worsening neurological deficits (if National Institute of Health Stroke Scale (NIHSS) worsens by 3 or more points.)
   - Anyone with a positive BE FAST exam (Balance, Eyes, Face, Arms, Speech, Time).
   - Any other signs or symptoms concerning for stroke

   The alert activates members of the stroke team, who mobilize to the patient's location so that treatment of a potential acute stroke can begin as soon as possible.

2. **Stroke Team** – The Stroke Team members are based on the location of the stroke alert and includes, but is not limited to:

   - Emergency Department (ED) Attending Physician or midlevel provider**
   - Stroke & Sepsis Coordinator Ω,
   - CT Technologist **,± (remains at CT scanner)
   - ED Registered Nurse (RN)**
   - ICU RN ±
   - Phlebotomist**,, ±
   - Hospitalist √ (in-patient), OR
   - Intensivist §(in-patient)
   - Pharmacist §
   - Nursing Supervisor Ω,
   - Respiratory Therapy §
   - TeleNeurologist +

   ** denotes presence required upon stroke alert notification in the ED

± denotes presence required upon stroke alert notification in-house.
Ω denotes presence required when available for both ED & in-house stroke alerts
√ denotes presence required upon inpatient stroke alert notification
§ denotes required to be available in person or by phone

3. **BE FAST** – an acronym for symptoms of acute stroke, it stands for:

B - Balance – Is there a sudden loss of balance or coordination?

E - Eyes - Is there sudden blurred or double vision or sudden, persistent vision trouble?

F - Face - Ask the person to smile. Is one or both sides of the face drooping?

A - Arms - Ask the person to raise both arms. Does one side drift downward? Is there weakness or numbness on one side?

S - Speech - Does the person have slurred or garbled speech? Can he/she repeat simple phrases?

T - Time - Call 911 if you are outside the hospital, Call 55 if inside the hospital. Note the date and time the person was last known to be normal. Some clinical areas precede the stroke alert with a call to the Rapid Response Team (RRT).

4. **Clinical Practice Guidelines** – Recommendations for clinicians about the care of patients with certain conditions. SVMC follows clinical practice guidelines by the American Heart Association (AHA) / American Stroke Association (ASA).

5. **Last Known Well Time (LKWT)** – The time documented in an hour and minute format, that the patient was last known to be at their "baseline "- or "normal" – self.

6. **NIHSS**-National Institutes of Health Stroke Scale- a stroke severity assessment scale.

7. **Acute Ischemic Stroke (AIS)** – a disruption of blood flow to the brain that results in permanent damage to the brain. This disruption is usually caused by either:

- Cerebral Thrombosis: Blood supply to part of the brain is cut off because atherosclerosis or a blood clot has blocked a blood vessel.

- Cerebral Embolism: Generally, a blood clot that forms at another location in the circulatory system, usually the heart and large arteries of the upper chest and neck. A piece of the blood clot breaks loose, entering the bloodstream, and travels through the brain's blood vessels until it reaches vessels too small to let it pass, thereby blocking the vessel. A second important cause of embolism is an irregular heartbeat, known as **atrial fibrillation**. This creates a condition where clots can form in the heart, dislodge and travel to the brain.

Ischemic strokes account for 87% of all strokes. Time to reperfusion predicts clinical outcomes.

8. **Acute Hemorrhagic Stroke**: This results from a weakened blood vessel that ruptures and bleeds into the surrounding brain. The blood accumulates and compresses the surrounding brain tissue. There are two types of hemorrhagic strokes:

- Intracerebral Hemorrhage (ICH): Blood vessels within the brain bursts and leaks into the surrounding brain tissue. This is the most common hemorrhage.
- Subarachnoid Hemorrhage (SAH): Bleeding in the area between the brain and the tissue covering it, known as the subarachnoid space.
- Two types of weakened blood vessels usually cause hemorrhagic stroke:
  - Aneurysm: A ballooning of a weakened region of a blood vessel. If left untreated, the aneurysm continues to weaken until it ruptures and bleeds into the brain.
  - Arteriovenous Malformation (AVM): A cluster of abnormally formed blood vessels. Any one of these vessels can rupture, also causing bleeding into the brain.
- Acute Hemorrhagic Strokes account for about 13% of all strokes.

9. **Transient Ischemic Attacks (TIA):** Sometimes called a "mini-stroke." Blood flow to the brain stops for a short period of time (temporary blood clot) mimicking symptoms of stroke.
   - Most last less than 5 minutes; the average is about one minute
   - Approximately 40% of those experiencing a TIA will go on to develop an acute ischemic stroke
10. **Alteplase** – The only FDA-approved thrombolytic medication for AIS treatment
11. ~~**Tenecteplase** – A thrombolytic medication recommended in the 2019 AHA stroke guidelines, for specific treatment situations for acute ischemic stroke.~~

POLICY:

In recognition of the Stroke Chain of Survival, the SVMC stroke program strives to provide early recognition, and appropriate treatment throughout the patient's length of stay (LOS). To further the care continuum, referral to appropriate post-acute care takes place.

1. Detection: Early recognition
2. Dispatch: Early EMS Activation
3. Delivery: Transport & Management
4. Door: ED Triage
5. Data: ED Evaluation & Management, Activation of Stroke Alert
6. Decision: Neurology, Therapy Selection

7. Drug: Drug/Device, Reperfusion Approaches

8. Disposition: Admit or Transfer

AFFECTED PERSONNEL/AREAS: *OPERATORS (PBX), EMERGENCY DEPARTMENT (ED) PHYSICIANS, MIDLEVEL PROVIDERS AND STAFF, HOSPITALISTS, RADIOLOGY, IMAGING, INTENSIVE CARE UNIT (ICU), MEDICAL SURGICAL UNIT (MED-SURG), CLINICAL DECISION UNIT (CDU), MATERNAL CHILD HEALTH SERVICES, TELEMETRY, NURSING, RAPID RESPONSE TEAM, STROKE COORDINATOR, LABORATORY, RESPIRATORY THERAPY, NURSING SUPERVISORS, DIAGNOSTIC IMAGING.*

EQUIPMENT:

- Code Cart
- Cardiac Monitor / Transport Monitor
- Stroke Packet/Binder
- CT Scanner
- Tele-Neurology Cart, if needed

ROLES AND RESPONSIBILITIES

A. **Emergency Department Physician or Midlevel Provider**

- Leads the stroke alert team and assumes primary medical care for the patient in the ED. May perform and document the NIHSS.
- Utilizes order sets and clinical pathways, as needed. However, treatment decisions defer to treating provider's clinical judgment.
- Reviews and documents all diagnostic test results.
- Collaborates with Stroke Coordinator and ED registered nurses as needed.
- Considers and consults with Tele-neurologist or Neurologist.
- Evaluates inclusion / exclusion criteria for thrombolytic therapy or other treatment in collaboration with the neurologist/ tele-neurologist.
- If thrombolytics are not indicated, documents the reason.
- If thrombolytics are given, documents patient and/or family verbal consent.
- Participates in the thrombolytic time out process for rt-PA eligible patients.
- Implements the most appropriate treatment.
- Considers and updates the patient's family along the treatment continuum.
- Determines the need to transfer the patient to a tertiary stroke center (consultation with neurology will be considered).

B. **ED Registered Nurse (RN - ED) / Rapid Response RN (inpatient)**

- Performs & documents baseline NIHSS assessment, if not done by TeleNeurologist..
- Performs & documents initial blood sugar, if not done by EMS.
- May perform and document ongoing NIHSS assessments as needed, or at hours 2, 8, and 24 for the post thrombolytic patient.
- Reviews all test results in collaboration with the resident or attending provider.

- Performs neuro checks and vital signs (VS) as prescribed, or by unit standard, and is responsible for general nursing care of the stroke alert patient.
    - For the post-thrombolysis patient, VS and Neurological Checks will be performed:
        - Every 15 min x 2 hours (during infusion + one hour after)
        - Every 30 min x 6 hours
        - Every 1 hour x 16 hours
    - Hypertension Management for thrombolytic candidates
        - Pre-thrombolysis:
            - Must be less than 185/110
            - Post-thrombolysis, blood pressure must be maintained below 180/105.
- Considers and updates the patient's family along the treatment continuum.
- If thrombolytics are indicated & administered, patient ratio will be 1:1 until infusion is complete and for 1 hour after infusion.
- Consults with pharmacy as needed.

C. **ICU RN – (receiving nurse of patient post - thrombolytics)**

- Performs & documents baseline NIHSS assessment upon arrival to ICU.
- Performs and documents ongoing NIHSS assessments as needed, or at hours 2, 8, and 24 post thrombolytics.
- Reports any change of condition to the attending physician.
- Monitors the post thrombolytic patient for bleeding and angioedema, then reports to attending provider.
- Reviews all test results in collaboration with the resident or attending physician.
- Performs neuro checks and vital signs(VS) as prescribed, as needed, or by unit standard, and is responsible for general nursing care of the stroke alert patient.
    - For the post-thrombolytic patient, VS and Neurological Checks will be performed:
        - Every 15 min x 2 hours (during infusion + one hour after)
        - Every 30 min x 6 hours
        - Every 1 hour x 16 hours
    - Hypertension Management for thrombolytic candidates
        - Pre-thrombolysis:
        - Must be less than 185/110
        - Post-thrombolysis, blood pressure must be maintained below 180/105
- For Acute Ischemic Stroke that DOES NOT receive thrombolytics, or is not eligible for mechanical thrombectomy, and has hypertension - blood pressure greater than 220/120 mmHg – it might be easonable to lower the BP 15% in the first 24 hours.
- Considers and updates the patient's family along the treatment continuum.
- Documents patient and family education as needed on the Interdisciplinary Education Record (IER).

d

- Implements the stroke/CVA plan of care

D. **Stroke Unit (TELEMETRY) RN or Medical Surgical RN (receiving nurse of non-thrombolytic /non-acute patient)**

- Performs and documents the NIHSS upon admission to the unit, with any change in condition, or as prescribed.
- Reports any change in condition to the attending provider.
- Reviews all test results in collaboration with the attending provider.

- Performs neuro checks and vital signs as prescribed, and/or as needed.
- Is responsible for general nursing care of the stroke/TIA/stroke alert patient.
- Considers and updates the patient's family along the treatment continuum. Any patient or family education is documented on the Interdisciplinary Education Record (IER) and/or the plan of care
- Performs and documents the required discharge education, when appropriate.
- Institutes the plan of care for stroke / CVA patients, or TIA patients.

E. **Nursing Supervisor**

- Evaluates the need and provides the necessary staffing coverage for the affected units during the stroke alert, and/or to accommodate staffing needs of the patient receiving thrombolytics.
- Eliminates operational and administrative barriers

F. **Radiologist**

- Interprets CT scans for stroke alert patients with a time target of 25 minutes. Results will be called to the ordering provider when there are focal neurological findings on the scan. Interprets diagnostic imaging, including Magnetic Resonance Imaging (MRI) scans. Results are also available in the Electronic Medical Record (EMR).

G. **Diagnostic Imaging**

- Coordinates start time of patient's stat CT scan, Computed Tomography Angiography (CTA), and/or MRI exam.
- Will follow the stroke protocol for related diagnostic exams.
- Notifies the on duty Radiologist when imaging is complete.
- Obtains and processes the patient's chest x-ray (if ordered).

H. **Neurologist**

- Provides expert consultation.
- When consulted, responds by phone or in person, as needed or requested.
- Utilizes order sets and clinical pathways, as needed. However, treatment decisions defer to treating provider's clinical judgment.
- Reviews and documents relevant diagnostic test results.
- Collaborates with ED/ICU providers, ED /ICU/Telemetry nurses, pharmacy, and stroke coordinator as needed.
- When consulted, recommends a plan of action, and assists with treatment & transfer decisions
- In collaboration with the ED or ICU providers, evaluates inclusion/exclusion criteria for thrombolytic therapy or other treatment.
- May participate in the thrombolytic time out.

I. **Tele-Neurologist**

- Provides expert consultation in the neurologist role (as above), via a video and audio-enabled computer cart.
- Collaborates with the ED/ICU providers, ED/ICU nurses, and stroke coordinator as needed.
- ~~If~~ When consulted, ~~recommends a plan of action, assists with treatment decisions, and contributes a written report of recommendations to the unit and/or via integration with the EHR.~~ Assumes neurological care of the ED or inpatient, orders thrombolytic (if appropriate), and documents in the medical record.
- Updates the attending physician as needed

J. **Laboratory / Phlebotomist**

- Draws STAT labs per stroke orders and assures transport directly to lab for immediate processing.
- PT/PTT/INR results will be available as quickly as possible with a time target of 30 minutes, while the remainder of laboratory tests will result with a time target of 45 minutes from time specimen is received.

K. **Certified Nursing Assistant (CNA)**

- Assists the RN as needed / directed.
- May obtain & enter an accurate patient height and weight into the EHR.
- In the ED, obtains EKG and gives to the provider within a time target of 45 minutes from arrival (without delaying CT scan).

L. **Pharmacist**

- Available for consultation by phone and/ or in person during working hours, and by phone after hours.
- May assist with the evaluation of and administration of medications with specific emphasis on thrombolytic medication.
- Trained RNs will be responsible for mixing thrombolytics at the bedside, with the pharmacist available (as above) for consultation.

M. **Respiratory Care Practitioner (RCP)**

- As needed, will assist with the evaluation, management, and maintenance of a patent airway on the patient.
- As needed, will assist with the evaluation, management, and maintenance of oxygen therapy.

N. **Stroke Coordinator** – Available as a resource and for stroke process consultation.

O. **Intensivist or Hospitalist** – May provide primary patient management for inpatient stroke alerts:

- May assume care of suspected or confirmed stroke patients from the ED.
- Utilizes order sets and clinical pathways, as needed. However, treatment decisions defer to treating provider's clinical judgment.
- Reviews and documents all diagnostic test results.
- Collaborates with Stroke Coordinator and- registered nurses as needed.
- Considers and consults with Tele-neurology or neurology.
- Evaluates inclusion / exclusion criteria for thrombolytic therapy or other treatment.
- If thrombolytics are not indicated, documents the reason.
- Implements the most appropriate treatment.
- Considers and updates the patient's family along the treatment continuum.

- Determines need to transfer patient to a tertiary stroke center (consultation with neurology will be considered).

PROCEDURE:

In accordance with the stroke chain of survival:

1. Out of Hospital
   a. Activation of Emergency Medical Services (EMS)
   b. EMS will be assessing in the field for symptoms of stroke and intervene per EMS policy & procedure.
   c. Preferably, EMS alerts the Emergency Department of incoming suspected acute stroke arriving within 5 min, OR an acute stroke is identified upon arrival to the ED. An ED staff member will call Ext. 55 and have "STROKE ALERT" announced overhead with the location such as "Stroke Alert, ER, Bed 3" (repeated x 3).

2. Walk-Ins
   a. Rapid ED triage: B.E. F.A.S.T.
   b. Stroke Alert activation

3. In-Patient
   a. Rapid evaluation by RRT using B.E. F.A.S.T., if appropriate
   b. Stroke Alert activation

TIME TARGETS FOR STROKE

Activity	Time Targets
1. **Critical Assessment/Actions @ ED Arrival** • Support ABCs • Immediate general assessment and stabilization • Approximate NIHSS, if able • Activate Stroke Alert, if within 24 hrs of LKWT • Apply cardiac monitor and pulse ox prior to transport to CT • Initiate stroke alert order set, if desired by provider • Assess vital signs • Provide oxygen as ordered • Obtain IV access	Immediate Initiate stroke alert within 10 min of arrival **ED provider must see patient within 15 min of arrival**

• Point of Care glucose check (if not done by EMS) • Initial NIHSS performed – do not delay CT • Emergent non-contrast CT of the brain, followed by CTA, if ordered– labs per discretion of medical provider • Stat lab draws including CMP, CBC, Troponin, Coagulation studies, and beta-HCG in women of childbearing age, POC glucose (if not done prior)– **do not delay CT**. Delay CT only to treat low blood sugar. • EKG – **do not delay CT** • CXR – **do not delay CT**	**Within 20 min of ED arrival** **45-60 min for ancillary tests**
2. **CT of brain / CTA completed:** a. Neurological assessment b. Review patient history c. Establish Last Known Well Time d. NIHSS, if not done earlier e. Labs, if not done earlier f. CXR & EKG, if not done earlier	
3. ***Tele-Neuro / notification of neurologist (if not already done)** a. CT scan read – expert diagnosis b. Does CT show a hemorrhage? i. No -> possible ischemic stroke *see Acute Ischemic Stroke Treatment ii. Yes -> * see hemorrhagic stroke management	**Within 10 min of CT completion, if not already activated**
4. **STAT Labs resulted**	**45 min, 30 min for PT/PTT/INR**
5. **Acute Ischemic Stroke Treatment** a. IV Alteplase (rt-PA) – 0.9 mg/kg, max dose 90 mg, recommended for selected patients who are treated within 3 hrs of LKWT [class 1; level of evidence A] b. Alteplase may be used in time frame of 3-4.5 hrs from LKWT, with expert (neurologist) consultation, in select patients.(class I, level of evidence A) ~~c. Tenecteplase may be used for acute ischemic stroke prior to mechanical thrombectomy at a dose of 0.25 mg/kg, max 25 mg.(class IIb, level of evidence B-R)~~	Door to treatment time = less than 60 min in 50% of all eligible stroke patients receiving rt-PA: The Golden Hour of Acute Ischemic Stroke – from the TJC 2015: In patients eligible for IV rt-PA, betime dependent, and treatment should be initiated as quickly as possible. The

~~d. Tenecteplase may be used for suspected acute ischemic stroke, as an alternative to Alteplase, where there is minor neurological impairment and no major intracranial occlusion, at a dose of 0.4 mg/kg. (class IIb, level of evidence B-R)~~ c. d. If thrombolytics are given, no aspirin / anticoagulants to be given for 24 hours e. Complete a TPA time out with others in the room ~~e.~~f. Observe for orolingual angioedema ~~f.~~g. Blood pressure management **i. If patient is post-thrombolytics, blood pressure is maintained < 180/105 and post-thrombolytic VS & neuro check routine is maintained: VS & neuro checks Q 15 min x 2 hrs** **ii. VS & neuro checks Q 30 min x 6 hrs** **iii. VS & neuro checks Q 60 min x 16 hrs** Persistent hyperglycemia management within the first 24 hrs: Goal: 140-180 mg/dl*follow policy [class IIa; level of evidence C] ~~g.~~h. Repeat and document NIHSS post - thrombolytics, at hours 2, 8, and 24. ~~h.~~i. Admit to designated stroke bed. Admit to ICU, if thrombolytics were given – no exceptions. i. Nurse Swallow Screen done by RN prior to any oral intake	door to needle time (time of bolus administration) should be within 60 min of hospital arrival. [Class 1; level of evidence A]
6. **Acute Hemorrhagic Stroke Management** a. Physician to consult with neurology, as needed b. Consider Hemorrhagic stroke order set c. Consider transfer to higher level of care i. Physician to consult with outside neurosurgeon for acceptance of patient to stroke tertiary center d. Anticoagulation/ Thrombolytics are contraindicated	Immediate – seek expert consultation Transfer to neurosurgical capable facility as soon as possible. Time Target: 120 min.
7. **Non-acute Stroke or Transient Ischemic Attack (TIA)** a. Initiation of stroke alert if LKWT is within 24 hrs b. Establish whether stroke is acute or non-acute c. If patient is not eligible for thrombolytics, document reason and proceed based upon physician's orders / clinical pathway	

Nursing Bedside Swallow Screening (see attachment A) – If the patient needs to receive food, fluids, or medications orally, whether in the ED or in-patient unit, the attached evidence-based tool shall be utilized to screen the patient's swallow. The Nurse Swallow Screen must be completed by the RN to identify swallowing difficulties and potential aspiration risk. The Nurse Swallow Screen is documented in the EHR. Keep patient NPO until the patient passes the nurse swallow screen, and/or is evaluated by the Speech Language Pathologist. The Nurse Swallow Screen does not replace the evaluation by a Speech Language Pathologist.

If the patient has passed the screen, and then has a change in condition, mental status worsens, or the patient exhibits signs of poor swallowing, the swallow screen process should be repeated.

REFERENCES:

- (2020) American Heart Association. Advanced Cardiovascular Life Support, provider manual.
- (2017) American Stroke Association. Impact of stroke (stroke statistics). Retrieved 7/6/17 from http://www.strokeassociation.org/STROKEORG/AboutStroke/Impact-of-Stroke-Stroke-statistics_UCM_310728_Article.jsp#.WW1NsxXythF.
- (2017) American Stroke Association. "Target: Stroke, Phase II." Retrieved 7/7/17 from http://www.strokeassociation.org/STROKEORG/Professionals/TargetStroke_UCM_314495_SubHomePage.jsp.
- (2019) Guidelines for the Early Management of Patients with Acute Ischemic Stroke: 2019 Update to the 2108 Guidelines for the Early Management of Acute Ischemic Stroke: A guidelines for healthcare professionals from the American Heart Association / American Stroke Association, *Stroke,* 2019;50:e344-e418. 55248F2D31984959BE25687599A4E3AA2
- Demaerschalk, B.M., Kleindorfer, D.O., and Adeoye, O.M. et al (2016). Scientific rationale for 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,*47, p. 1-61.
- (20220) The Joint Commission. Advanced disease-specific care certification requirements for primary stroke center. *Comprehensive Certification Manual for Disease-Specific Care,*PSC 1-48.
- Adapted from and Referenced: Lin, Y. T.; Yu, J. L.; Wang, W. H.; Sung, H. C.; Wang, Y. Y (2014) Nurses' performance of using a screening tool to screen swallowing functions among hospitalized patients with acute stroke. *International Journal of Evidence-Based Healthcare. September, 2014.* doi: 10.1097/01.XEB.0000455242.14367.85 & Massey, R & Jedlicka, D. (2002) The Massey Bedside Swallowing Screen. *Journal of Neuroscience Nursing, 34*(5), 252- 260

CROSS REFERENCE:

- Thrombolytic Therapy in Acute Ischemic Stroke Policy – Sierra View Medical Center

ATTACHMENT A: Swallow Screen Tool

SIERRA VIEW MEDICAL CENTER — NURSING SWALLOW SCREEN

DOES PATIENT HAVE ABDOMINAL FEEDING TUBE OR TRACHEOSTOMY PRESENT?

☐ Yes ☐ No **(If yes, stop screen, document result as Fail, make NPO, notify MD and request SLP)**

PART 1

Patient:

• Awake and alert 15 minutes	☐ Yes	☐ No
• Responds to speech and makes eye contact	☐ Yes	☐ No
• Able to be positioned upright with head control	☐ Yes	☐ No
• Face symmetrical, tongue protrusion midline	☐ Yes	☐ No
• Demonstrates rotary chewing motion	☐ Yes	☐ No

If answer is No to any of the questions above, go no further. Keep patient NPO and notify MD.

PART 2

Patient:

• Coughs when asked to	☐ Yes	☐ No
• Able to breathe freely and / or able to maintain SpO2	☐ Yes	☐ No
• Able to control saliva, can close lips	☐ Yes	☐ No
• Has a dry/clear sounding voice	☐ Yes	☐ No

If answer is No to any of the questions above, STOP, notify MD and obtain MD order for ST Swallow Evaluation.
If Yes, proceed to Water Swallow Screen.

PART 3

Instructions:

1) Sit patient up as close to 90 degrees as possible,

2) give a teaspoonful (5 mls) of water. MAKE SURE THE WATER IS SWALLOWED (total of 3 trials)

If any of the following identified:

• no attempt to swallow	☐ Yes	☐ No
• water leaks out of mouth	☐ Yes	☐ No
• coughing, choking or breathlessness	☐ Yes	☐ No
• wet / gurgly voice	☐ Yes	☐ No

-->-->-> Stop the screen, FAIL the patient, notify the MD for SLP referral order

Repeat 2nd and 3rd teaspoonful of water. If there are still NO PROBLEMS EVIDENT (from list above), give 2 oz (60 mls) of water.

If there is NO PROBLEM, notify physician for a diet order.
Make sure patient is **upright** and **supervised** when eating the **test meal**.

Nursing Bedside Swallow Screen Result:

Pass: ☐ Fail: ☐ (Notify MD and refer to SLP, if not notified above)

Adapted from and Referenced: **Lin, Y. T.; Yu, J. L.; Wang, W. H.; Sung, H. C.; Wang, Y. Y** (2014) Nurses' performance of using a screening tool to screen swallowing functions among hospitalized patients with acute stroke. *International Journal of Evidence-Based Healthcare*: September, 2014. doi: 10.1097/01.XEB.0000455242.14367.55. **Massey, R & Jedlicka, D.** (2002) The Massey Bedside Swallowing Screen. *Journal of Neuroscience Nursing, 34*(5), 252-260.

Date	Time	Evaluated by Signature	Title

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
NURSING SWALLOW SCREEN
Form # 020901 REV 11/17

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

SUBJECT: **WEIGHT VARIANCE - DP/SNF**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish guidelines for treatment of residents with unusual or significant weight variance.

POLICY:

Monitoring and treatment for unusual or significant weight variances will be based on best practice. The weekly disciplinary team will discuss treatment options. Treatment will proceed once a physician's order and consent is secured and on record.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, DP/SNF*

PROCEDURE:

1. Each resident will have their weight and length measured on admission. The facility will establish a schedule to obtain each resident's weight. A new resident will be weighed weekly for four (4) weeks and then monthly, unless ordered otherwise. Weights will be recorded in pounds. Increased frequency of weight monitoring will be determined by the resident need at the discretion of the physician, clinical director, dietitian, or registered nurse.

2. The facility will adhere to the guidelines for obtaining accurate weights to ensure accuracy.

3. Staff members obtaining residents' weight will be in-serviced on procedures for obtaining accurate weights and for reporting unusual or significant weight variances to the licensed nurse.

4. Scales will be re-balanced by staff prior to obtaining each resident's weight.

5. Unusual or significant weight variance includes the following:

   a. Gain or loss of five (5) pounds or more or 5% of ~~weighs~~ weight (whichever is greater) in one month when the resident weighs over 100 pounds.

   b. Gain or loss of three (3) pounds in one month when the resident weighs 100 pounds or less.

   c. Gain or loss of three (3) pounds or more in one week if the resident is on weekly weights.

   d. Consistent weight gain or loss of 7.5% in 3 months or 10% of weight in 6 months.

6. Significant weight losses/gains, (both planned and unplanned) will be reported to the physician and the dietitian.

7. When a weight loss or gain trend has been identified as undesirable, an entry will be included on the resident care plan and reported to the dietitian.

8. Residents requiring a weight loss/gain regimen will be presented at the weekly interdisciplinary meeting. If the team agrees with the recommendation, the Rregistered Dietitian will secure consent for weight loss/gain from the resident or patient family member. A physician order will be placed in the medical record.

9. All obtained weights will be recorded in the resident's permanent record.

10. All physician notifications will be documented in the nurse's notes.

11. If a patient refuses to be weighed, reattempt in three (3) days. After two refusals, the physician and dietitian will be notified and refusals documented in the medical record.

GUIDELINES FOR OBTAINING ACCURATE WEIGHTS:

1. Locate the scale in a convenient place and avoid moving it if at all possible.

2. Try to weigh residents within time frames as consistent as possible.

3. Try to maintain consistency in staff performing weights. This increases accuracy.

4. Validate weight discrepancies by re-weighing prior to notification of the physician.

5. The contracted bio-med company will calibrate scales routinely (according to policy) and document the calibration.

"Consent for Weight Gain / Loss Regimen" Form Attached

REFERENCES:

- Centers for Medicare and Medicaid Services, Conditions of Participation (~~20202~~2022). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html.

- Med Pass, Inc. (Updated February 6, 2015), Facility Guide to OBRA Regulations,483.35 (1),483.25 (i).

SIERRA VIEW MEDICAL CENTER
DISTINCT PART SKILLED NURSING FACILITY
CONSENT FOR WEIGHT GAIN/LOSS REGIMEN

INFORMED CONSENT FOR DIET REGIMEN

CIRCLE ONE : **WEIGHT LOSS** **WEIGHT GAIN**

NAME OF RESIDENT_____

ADVANTAGE: To allow the dietitian and physician to adjust calories in the diet as needed to maintain a healthy weight.

SIDE EFFECTS: If a resident chooses not to follow dietary regimen recommended by the dietitian and physician, subsequent clinical manifestations may arise over time (i.e. obesity, cardiovascular disease, skin and respiratory issues).

The above information has been explained to me. I consent and agree with the treatment recommended by the physician and dietitian to change the diet when needed for a healthy nutrition status.

CHECK A BOX : Telephone conversation ☐ In person ☐

_____ _____
(Resident Name or Representative) Date
If signed by other than resident, indicate relationship.

_____ _____
Registered Dietitian Date

_____ _____
Physician Date

_____ _____
Registered Nurse (Witness) Date

rev 01/2019 cj

SIERRA VIEW
MEDICAL CENTER

SVMC INTERPRETATION OF DIET ORDERS

SVMC menu plans are developed using best evidenced based practice guidelines. The **Diet & Nutrition Care Manual by Becky Dorner** is the basis for our menu planning and patient education materials. Listed below is a brief summary of the menu plans provided by SVMC and any specifics that may differ from the Diet & Nutrition Care Manual. These diets are orderable in Meditech EMR. Our regular non select menu serves as the basis for all our menu plans and follows the Dietary Reference Intake (DRI's/RDA's) for our population of Women 31-50 years old. Menus are designed to meet nutritional requirements specified by the 2011 update of the DRI's from the Food and Nutrition Board, Institute of Medicine, National Academies of Science's guidelines. This menu is then further modified to meet the specific needs of each patient based on diet order, nutritional status, food allergies, age, cultural preferences and food likes and dislikes. Current Dietary Reference Intakes recommend that Sodium intake remain less than 2300 mg per day. In order to meet their preferences and maintain intake, most diets that do not indicate a sodium restriction will exceed this value. A sodium restriction should be ordered if needed. Diets with Nutrient Goals are based on weekly averages.

Due to limitations within our nutrient database (CBORD) we do not have values available to us for all nutrients. Currently our database is incomplete for: biotin, choline, chromium, molybdenum, fluoride, iodine, chloride, linoleic acid and alpha-linolenic acid and sometimes other micronutrients.

Thin liquids are a default for all diets. Mildly Thick Level 2, Moderately Thick Level 3, Extreme Thick Level 4 fluid consistency or fluid restriction needs to be ordered under "DIET CATEGORY".

Diets with nutrient goals and no House diets are identified with *
House Diets with nutrient goals built into CBORD are identified with **
House Diets built on compliancy only with no nutrient goals***

If oral nutrition supplements (ONS) are ordered BID with meals, i.e. Ensure, they will be given at breakfast and lunch. All diet orders include the option of an ONS. An RD, may modify the frequency, delivery time and flavor of existing ONS orders by physician but may only discontinue ONS ordered by another RD. Patients who refuse the foods served will be offered substitutes of equal nutritional value. This may include oral nutrition supplements. For a list of supplements that are approved to be offered with diets without a physician's separate order, please see the ONS policy which includes the crosswalk.

Call Dietitian Office at 788-6110 or Clinical Nutrition Manager 788-6112 for questions.

Care order: Advanced Diet as Tolerated/Diet of Choice *This is for communication only. It does not place the patient on a starting diet. Place an order for a starting diet and a goal diet in addition to this communication.*

SIERRA VIEW
MEDICAL CENTER

1. 6 Small Meals: For the patient who experience early satiety, anorexia or control/stablilize overweight residents. 3-4 items at a meal, 2-4 at snack. Some items from tray are removed and sent as snack. Resembles small portion of regular diet with snack TID in between meals. Has no diet restrictions or diet goals.

2. *Calorie Controlled Diet Intended for the patient with adequate po intake but requires calorie restriction. Calories available are: 1200, 1500-1600, 1800 (standard), 2000-2200, 2400 + 50-100kcal maximum per meal.

3.* BRATT (Adult):** To initiate oral feeding subsequent to gastrointestinal dysfunction, normally ordered for adults. The diet is inadequate and does not meet recommended daily allowances for any nutrients. The diet is only temporary and may not benefit every person. Only the following foods are used: (B) Banana (R) Rice - steamed or boiled, or rice cereal (A) Applesauce (T) Toast white (T) Tea hot. More restricted than Gastro Pediatric Diet.

4. **Consistent Carbohydrate Diet: Indicated as dietary management and treatment of diabetes and blood sugar control. Adequacy is based on a weekly average. House diet goals: minimum 180g-240g (maximum) carbs/day or 70g +/-10g/meal. Other nutrient goals recommended include:1800- 2000 calories, 45-50% of total calories coming from carbs, 25-35g fiber, protein 10-35% of calories. **Limit/Avoid foods that**: are high in sugar, and avoid eating too many high carbohydrates or starchy foods at one time. **Snacks are not routinely included as part of this diet. If more carbs are needed, snacks rotation can be ordered. A Consistent Carbohydrate Low Diet can be ordered if 4 servings of CHO per meal is excessive.

5. **Consistent Carbohydrate Low: Reflects standard Consistent Carbohydrate Diet. House diet provides 30-45g carbs per meal, and meal goal when selecting items is 40g/meal +5g, -10g. Minimum of 90g carb-135g/day maximum per day is allowed. A comment should be entered in diet order: Add 2-3 oz protein per meal for extra nutrition (if pt making meal selections and not receiving house diet)

6.Cardiac Diet** Indicated for patients with heart disease. It is a combination of total fat, sodium, and caffeine restriction. House diet nutrient goals: <75g Total Fat and < 3000mg Sodium per day. Other goals considered include: fiber 20-25g/d, minimum of 1800kcal/d, <20g saturated fat. **Limit Foods/Avoid**: most café entrees, low sodium/fat cheese, whole milk, <3 eggs yolks/week.

7. *Clear Liquid Diet (CLD) Indicated for transition from NPO to a liquid or solid diet and used for the pre and post-surgical patient, which is nutritionally inadequate. It contains minimal residue and can be easily digested and absorbed. Foods allowed include: coffee, tea, carbonated beverages, broth, clear juices (apple, cranberry, grape), gelatin, sugar, sugar candies, and popsicle. The diet should contain a high protein, ***clear*** liquid oral nutritional supplement if used longer than 3 days. Regular soda is not automatically served on this diet. A 2gm low sodium or cardiac modifier will offer low sodium broth.

HOUSE CLD: 1 juice (15 g CHO), icee (20g), broth, regular Jello (20g), coffee/hot tea/ice tea, regular sugar = ≤60 g/meal and is diabetic friendly

8. *Clear liquid Diet (CLD) with Supplement: Intended for patients that require extra nutrition while on extended CLD. Non clear oral nutrition supplement (ONS) Ensure Plus High Protein, Boost Glucerna, etc. can be added to increase nutrition. Supplement order needs to be entered.

9. **Diabetic Clear Liquid Diet (CLD): Intended for patients that require less carbohydrate. Menu provides: 1 juice (15-18g), 1 icee (20 g) broth (1g) , diet jello (1g), coffee/tea (0), sugar free packets (1g)= <40g carb/meal. THIS DIET IS NOT SUGAR FREE!

10. *(Dr. Mohan) Clear Liquid Diet- No Red foods, no soda, no juice- physician requested diet for gastrointestinal issues.

11. Diabetic Full Liquid:** Diet is restricted in carbohydrates but not sugar free
House diet provides 60g +/-10g (50-70g/meal). Sugar-free ice cream, sugar-free pudding are provided.

12. *Full Liquid Diet: is usually transitional post-op diet. It includes mostly liquids (including milk) and some foods with small amounts of fiber. It can provide many nutrients but may not give enough vitamins, minerals and fiber. Foods allowed include: all beverages, broth, bouillon, strained cream soups, cream of wheat, strained oatmeal, farina, fruit juices, ice cream, sherbet, gelatin, custards, puddings, tapioca, yogurt without fruit, margarine, butter, cream, all spices. It tends to be poorly tolerated secondary to high fat and dairy content. *Contraindications*: lactose intolerance, low fat diet, pancreatitis. For patients with chewing or swallowing difficulties that may benefit from a liquid diet, dysphagia diets are recommended.

13. *Dysphagia Diets: Uses foods off regular diet menu. The **IDDSI** (International Dysphagia Diet Standardization Initiative) framework consists of a continuum of 8 levels (0-7), where drinks are measured from Levels 0 – 4, while foods are measured from Levels 3 – 7. The IDDSI Framework provides a common terminology to describe food textures and drink thickness. SVMC did not adopt Level 1 Slightly Thick liquid (infant formulas, naturally thick supplements) or Level 7 Easy to Chew.

Current NDD (National Dysphagia Diet) Standards—>IDDSI

FOODS:

Blenderized Puree→ Level 3 Liquidized. Can be eaten with a spoon or drunk from a cup. Cannot be eaten with a fork because it slowly drips through. Effort needed to drink this through a wide straw. Foods and Fluids can be different texture. Some foods may require thickening. Very thin in consistency and homogenous. Can be used for patients with wired jaw fracture. It is often a patient preference or recommendation per Speech Language Pathologist

Dysphagia Puree Level I→ Level 4 Pureed. Smooth with no lumps, not sticky, no chewing ability needed. Can be eaten with a spoon.

Dysphagia Mechanically Altered Level II→ Level 5 Minced and Moist. Very soft, small moist lumps, minimal chewing ability needed.

Dysphagia Advanced Level III→ Level 6 Soft & Bite Sized. Soft + Bite-sized, tender and moist throughout, with no thin liquid leaking or dripping from the food. Chewing ability needed.

Regular→ Level 7 Regular. Normal everyday foods of various textures that are developmentally and age appropriate. Biting and chewing ability needed.

LIQUIDS:

Spoon/pudding thick→ Level 4 Extremely Thick
Honey thick→ Level 3 Moderately thick

30

Nectar thick→ Level 2 Mildly thick
Thin→ Level 0 Thin

14. **Gestational Diabetes: Intended for patients with diabetes during pregnancy. Small, frequent meals help to minimize heartburn, nausea, blood sugar levels after eating (postprandial) and ketones. The diet consists of 3 meals and 3 snacks per day. Minimum of 150-200g/day is usually required. Use 2 or less artificial sweeteners/day, <2 cups caffeine drinks/day. GDM diet is 30-60 g CHO/meals (2-4 CHO servings), 15-30 g CHO (1-2 CHO servings) at snack and provides 2000-2200 calories per day. Each exchange is 15 g CHO. No fruit or fruit juice in AM and only ½ c milk in AM due to risk of hyperglycemia. Order a MISC diet and specify grams per meal and snacks in comments for a specialized meal pattern. See GDM snack rotation for allowed items.

15. ***Gluten Free Diet: intended for patients who needs to eliminate wheat, rye, oats, barley or its derivatives such as malt from barley from their diet, i.e. patients with Celiac Disease. Foods which contain these grains as a base, stabilizer, emulsifier or thickening agent are also eliminated.

16. **Hepatic: Used when patient has hepatic encephalopathy, reduce fluid retention and is usually refractory to medical treatment. Ammonia levels are high and patient may be confused. These restrictions ***are not*** for patients with cirrhosis. ESLD/Cirrhosis pts may require more nutrients. Fluid restriction may be considered if ascites is present**.** Nutrient goals: < 2100g sodium, <60 g protein per day. Less than 40 g protein per day will not meet DRI's.

17. **High Calorie/ High Protein Diet: Intended to prepare a malnourished patient for surgery, have suspected protein calorie malnutrition, long bone fracture, post op recovery, AIDS, cancer. Nutrient goals >3,350 calories, > 125g protein/day and is entered. House diet provides ~3100kcal, 150 g protein so oral supplement. i.e. Ensure Plus High Protein, Pro Pass Protein powder **OR** snack rotation either TID or BID between meals *order needs to be generated.* In CBORD, supplements are not tallied for nutrients but will add extra nutrition in addition to diet. Automatic snack rotation TID can be generated to meet requirements. Information will be kept in department Standards of Practice binder.

18. ***High Iron: provides 18-27 mg of iron daily for the anemia. Limits caffeine (interacts with iron absorption). Increase amounts of meats, vitamin C foods and fortified cereals.

19. ***Hyperemesis Gravidarum: is usually given to expecting mothers who are experiencing nausea and vomiting. Eating high carbohydrate foods (simple starches), such as crackers, bread, or dry cereal, rice may help. Drinking liquids between meals should be encouraged. Six small meals should be provided each day. **Foods to avoid:** high fat, fried, highly seasoned, and strong smelling foods. Avoid eating large meals.

20. ***Kosher Diet: intended for patients who observe Jewish Dietary laws. Unfortunately, we do not have a kosher kitchen, but we do offer TV dinners that are Kosher and individual items that are considered Kosher.

21. ***Low Lactose: Less than 8-10 g daily is encouraged so milk and most foods containing milk are omitted.

SIERRA VIEW
MEDICAL CENTER

22. *Low Fat: Intended for patients with difficulty digesting fats (gall bladder removal, bowel resection, and pancreatitis). Provides <60 g of total fat per day and <215 g of cholesterol daily. **Foods allowed include**: broiled, baked, or boiled trimmed meats/fish, chicken/turkey without skin, nonfat and low fat milk products, fruits and vegetables, most breads, pastas, rice, caffeine and salt is allowed. **Foods not allowed**: butter, cream sauces/soups, gravies, desserts, and baked goods such as cakes, cookies, muffins, biscuits.

23. **Low Fiber/Residue: Provides 4 or less grams of fiber per meal or <12g per day those who are unable to tolerate a regular diet. It is usually ordered as a progressive diet after lower bowel surgery, Crohn's disease, ulcerative colitis, irritable bowel disease, diverticulitis, colostomy/ileostomy to reduce the frequency and volume of fecal output while prolonging intestinal transit time. This diet is soft in texture and may be appropriate for people needing soft foods but not chopped or pureed. **Foods allowed include:** most beverages (no alcohol), most breads and cereals (except those containing coarse whole grains, bran, nuts or seeds), most desserts (except those with dried fruit, nut, seeds, etc.), most fruits (no dried, or any with skins or seeds), lightly seasoned salad dressing, all fruit juices, cooked vegetables, all vegetable juices, lettuce (as tolerated), soups made with allowed foods, lean and tender meats, poultry, fish, and shellfish, eggs, mild cheeses, creamy peanut butter, plain or flavored yogurt (without seeds), potatoes, spaghetti, macaroni, and other pastas. **Foods NOT allowed include:** chili pepper, fatty foods, prune juice, lactose. These may aggravate bowel problems by increasing the number of bowel movements or by exacerbating malabsorption.

24. ***Low Microbial (aka Neutropenic): Is used when a patient's immune system is compromised. There is limited evidence supporting this diet in the hospital setting. **Foods not allowed:** raw and fresh fruit/vegetables and undercooked meats. Wrapped fruits that need to be peeled (orange and bananas) can be offered to patient, as long as staff can peel for the patient with gloves or the patient can peel it themselves.

25. *Low Potassium: Contains less than 2 g of potassium a day. High potassium containing foods are omitted. This diet is commonly ordered along with protein, sodium and fluid restrictions in acute or chronic renal failure

26. *Low Protein Diet: intended for patients who needs to control protein intake. This diet contains <60 grams protein daily. Maybe appropriate for the pre-renal or hepatic patient who does not require a sodium restriction.

27. Low Sodium Diet (2 g Sodium)**: Nutrient goal is set at 2300mg Na+ /day and is used for those with congestive heart failure, liver and kidney failure, high blood pressure, edema or ascites. Limiting the amount of sodium or salt in a diet may ease or eliminate the problems. **Foods allowed** include: all foods cooked with little or no salt, fruits, vegetables, breads, and cereals. Lemon juice, onion, red pepper, and garlic are excellent substitute seasonings. Minimal salt will be added to the meal and processed foods should be avoided. Mrs. Dash substitute is provided for flavorings. A salt substitute (Nu salt) is not allowed without the discretion of the physician and Dietitian.

28. *Low Sodium Diet (3-4gm Sodium): Nutrient goal is set at <4000mg/d. Pt cannot select >4gm/day. Salt packets are non-compliant.

29. ***Low Vitamin K: intended for patients who need to reduce intake of vitamin k foods

30. ***NPO Except Supplements: No trays are sent. Oral supplement will have to be ordered. Created for patients who may have respiratory issues and wears Bipap which can only be removed for short time and liquid nutrition is temporary.

31. ***No Caffeine: Only decaf items provided, no chocolate items.

32. Pediatric Diets:

BREASTFED INFANT: No food tray is sent for patient, parent can receive a tray.
FORMULA-FED INFANT: No food tray is sent for patient; parent can receive tray. Enfamil bottle formula is stocked on the floors. If a special formula is requested, consult RD.
INFANT BABY FOOD: Baby food in jars (Gerber) will be sent; one meat, one vegetables and one fruit.
TODDLER (AGE 1-2): Foods appropriate for the age will be sent. Smaller portion of regular house diet offered. Mostly chopped/ground texture items given. High risk choking foods avoided.
PEDIATRIC (AGE 2-12): Foods on the adult menu are sent, but juice is offered instead of tea. Amounts will vary dependent on age.
***GASTRO (PEDIATRIC)**: this diet was created by Dr. Gheysar which treats gastroenteritis and may be prescribed for children who have diarrhea. The diet repeats with chicken or beef patty, noodles or mashed potatoes, milk, plain yogurt for gut health, sugar free jello and diet 7 up.

33. ***PUD/GERD/Bland Diet (Peptic Ulcer Disease/Gastro-esophageal Reflux Disease): Also known as a bland diet. Used for those who suffer from hiatal hernia, reflux, esophageal ulcers or strictures, or increased abdominal pressure caused by obesity or ascites. **Foods to avoid:** alcohol, citrus, chocolate, mint, fatty or fried foods, high caffeine and decaffeinated drinks, and spices that may cause discomfort. This diet is very individual. Patient should maintain upright posture during and 1 hour after eating, and elevate head of bed to help prevent reflux.

34. *Regular: This diet is unrestricted and is expected to meet the needs of adult patients using the DRI (Dietary Reference Intake) for SVMC population. Goal to provide ~ 2200-2400 calories, 3-4g sodium, **25 g** dietary fiber. Sodium content exceeds DRI's for 2300 mg/d and a 2gm sodium diet restriction may be warranted. The 2020-2025 Dietary Guidelines for Americans are referenced.

35. **Renal: Intended for patients with stage 5 kidney failure. House Diet Goals: Protein 60-120g/day, <2400mg Sodium, <2400mg potassium, < 1125 mg phosphorous per day. Liquids may be limited by physician.

36. *Renal High Protein: Intended for the PD or kidney transplant patient. House Diet goals: Protein 90-130g protein daily, <2400mg Na+, <2600mg K+, Phosphorus <1000mg/day

37. *Renal Low Protein: Provides <65g protein daily, <2400mg Sodium and <2400mg potassium, Phosphorus <1000mg/day. This may be used for patients with chronic kidney disease that are not on dialysis, or AKI with CKD.

38. ***Vegan Diet: Does not include meat, fish, poultry, eggs, milk, cheese, or other dairy products.

33

 33

39. ***Vegetarian Diet: Does not include meat, fish, or poultry, but will include eggs, milk, cheese, and other dairy products. If alternative vegetarian options are requested, a miscellaneous diet can be ordered with specifications.

40. Dietary Misc: This order is usually used for enteral feeds that are brought from home and are off formulary. Comments will be entered for formula regimen

Y:\RD files/CLINICAL/DIET & DEPT MANUAL
Revised 11/4/2022

Senior Leadership Team	12/20/2022
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	12/20/2022

SIERRA VIEW MEDICAL CENTER-
CONSENT AGENDA
December 20, 2022
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. Criteria for Transfusion Review	1-3	
2. HIM Coding Compliance Plan	4-8	
3. Mercury Handling and Spills	9-11	
Forms:		
1. PHQ2 English and Spanish	12	
2. Flu Screening English	13-14	
3. Flu Screening Spanish	15-16	
4. Health Screening Form	17	
5. Protective Custody for a Hospitalized Minor	18	
Reports:		
1. Annual Nursing Report		
2. Annual Quality Division Report		

SUBJECT: **CRITERIA FOR TRANSFUSION REVIEW**	SECTION: **Page 1 of 3**

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

PURPOSE:

Transfusion audits provide reviews of policies and practices to ensure safe and appropriate transfusions

CRITERIA FOR TRANSFUSION REVIEW:

Appropriate Use of Red Blood Cells:

- Hypovolemia due to blood loss evidenced by significant change in blood pressure or pulse, or orthostatic change in blood pressure.
- Symptomatic anemia whatever the cause if no other therapy is likely to correct the anemia.
- Anemia requiring correction perioperatively (hematocrit < 24% or hemoglobin less than 8 gm/d).
- Non-trauma or non-cardiac surgical patient receiving red blood cells when blood loss does NOT exceed 15% - 20% of the total blood volume. (Review criteria, refer record to Radiology-Pathology Committee)

Appropriate Use of Fresh Frozen Plasma:

- History or clinical course suggestive of a coagulopathy due to deficiencies of soluble coagulation factors, and prothrombin time (PT) > 18 seconds, partial thromboplastin time (PTT) > 45 seconds or studies pending, in a patient with significant bleeding.
- Intravascular volume depletion due to active bleeding documented by replacement of blood volume once within several hours.
- Antithrombin III deficiency state for patients about to undergo surgery or who require heparin for treatment of thrombosis.
- Immediate reversal of warfarin effect in patients who are actively bleeding or who are about to undergo emergency surgery.
- Inpatients with thrombotic thrombocytopenic purpura.
- Protime and PTT or specific coagulation factor assay to be obtained immediately prior to and within four (4) hours post transfusion.
- Transfusion of fresh frozen plasma units without confirmation of a clotting factor deficiency. (Review criteria - refer record to Rad-Path committee)

Appropriate Use of Platelets:

- Platelet count < 20,000/ul with or without active bleeding.
- Platelet count < 50,000/ul with active bleeding consistent with platelet deficit or when patient is receiving chemotherapy with or without active bleeding.
- Platelet count < 50,000/ul in patients undergoing major surgery.
- Transfusion of platelets without first obtaining a platelet count indicating a thrombocytopenia that warrants transfusion. (Review criteria - refer to Rad-Path committee)
- Transfusion of platelets in numbers that do not correspond, over a 24 hour period, to the appropriate amount to maintain at least a minimum platelet count. (Review criteria - refer record to physician peer review/committee)

Appropriate Use of Cryoprecipitate:

- Decreased Factor VIII level documented by appropriate laboratory data.
- von Willebrand's disease documented by a positive or suggestive history and appropriate laboratory testing.
- Hypofibrinogenemia <150 documented by history or clinical course suggestive of decreased fibrinogen or history of active bleeding and laboratory documentation of low fibrinogen.

Appropriate Use of Whole Blood:

- Same as for packed cells, see above, when reasons are documented in the clinical record.

Appropriate Use of Autologous Blood:

- Same as for packed cells, see above, when reasons are documented in the clinical record.
- Transfusion back to patient if Hgb is 11 gm or lower, at the discretion of the ordering physician.
- Last phlebotomy at least 72 hours before procedure.
- Documentation that the patient has been placed on oral iron supplement.
- Transfusion of autologous blood resulting in post transfusion CHF. (Review criteria - refer record to Rad-Path committee)

Directed Donor Blood Criteria:

- ABO and Rh grouping

- Antibody screening
- Antibody screening for Hepatitis B antigen
- Screening for HIV Antibody

* ***Directed donor blood collection is not performed at this facility. All directed donor collection is performed through the Central California Blood Bank, with criteria met as stated above.***

Specific Blood Use Requiring Review:

1. All transfusions are reviewed with special emphasis on:
   a. Transfusions of more than one (1) platelet aphoresis or 12 single platelet concentrates in a 24-hour period.
   b. Mortality associated with transfusion.
   c. Adverse effects associated with transfusion.
   d. Appropriateness and necessity of transfusion.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

REFERENCES

- Fung, Mark E (2020). American Association of Blood Banks Technical Manual (20th Edition).
- American Association of Blood Banks (2018). Standards for Blood Banks and Transfusion Services (31st Edition).
- The Joint Commission (2021). Laboratory Accreditation. PI.01.01.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **HIM CODING COMPLIANCE PLAN**	SECTION:

SCOPE:

This policy applies to all Sierra View Medical Center (SVMC) personnel responsible for performing, supervising or monitoring of inpatient and outpatient coding services. This policy applies to diagnosis and procedure code assignment by Health Information Management (HIM) Coders for all inpatient and outpatient services.

PURPOSE:

The purpose of this policy is to affirm SVMC's commitment to ethical, complete, accurate and consistent HIM coding and documentation improvement.

POLICY:

This policy outlines the requirements for validating coding accuracy (e.g., ICD-10-CM, CPT, modifiers) and various types of inpatient reimbursement methodologies (e.g., MSDRG, APRDRG, etc.) for hospital inpatient and outpatient services.

DEFINITIONS:

A. **"AHIMA"** means the American Health Information Management Association. AHIMA is the national organization for HIM professionals. AHIMA is one of four parties that are responsible for establishing national ICD-10-CM coding guidelines.

B. **"HIM coding"** means short-term, DPSNF, or other affiliated departments based on coding and abstracting services on behalf of SVMC for the purpose of claim submission. SVMC HIM coding function includes assignment of any ICD-10-CM diagnosis (including present on admission (POA) indicator) or procedure code, assignment of any CPT procedure code to represent the "technical component" between 10020 and 69990 (excluding 36415), designated HCPCS Level II codes, designated HCPCS modifiers, and designated CPT Category III Codes.

C. **"HIM Coder" or "Coder"** means a SVMC, telework employee, contractor, subcontractor, agent or other person who performs SVMC HIM coding. It also includes those employees or contractors involved indirectly, such as in a supervising or monitoring role, with the HIM coding.

D. **"Clinical Documentation Improvement" or "CDI"** means the entity-based process of reviewing patient records at the point of care and, as needed, working with treating physicians to assure that the clinical documentation in the medical record most accurately reflects the patient's clinical condition and treatment provided.

E. **"Clinical Documentation Improvement Specialist" or "CDIS"** means a SVMC, telework employee, contractor, subcontractor, agent or other person who performs clinical documentation improvement duties. It also includes those employees or contractors involved indirectly, such as in a supervising, assisting or monitoring role, with clinical documentation improvement.

F. **"Office Guidelines"** means applicable portions of the following publications:

1. International Classification of Diseases, 10th revision, Clinical Modification, including addenda, conventions and instructions, (ICD-10-CM)
2. Current Procedural Terminology, including addenda, conventions and instructions, (CPT)
3. ICD-10-CM Office Guidelines for Coding and Reporting
4. Coding Clinic for ICD-10-CM
5. Coding Clinic for HCPCS
6. Online CMS manual system.

Each of the above publications is a CMS-approved reference for hospital inpatient and outpatient coding and reporting. CPT Assistant, while not an official CMS reference, provides additional nationally recognized guidance regarding CPT codes and shall be included as an "official guideline" by HIM Coders in areas not addressed by CMS-approved references.

G. **"Outpatient Procedure"** as used in this policy means any account with a HIM assigned CPT procedure code to represent the "technical component" between 10020 and 69990 (excluding 36415, collection of venous blood by venipuncture), designated HCPCS Level II codes, designated HCPCS Modifiers, and designated CPT Category III codes. Note: Accounts in this group are not limited to those procedures performed in the operating room.

POLICY:

A. HIM coding is to be complete, consistent, accurate and compliant. SVMC must strive to code every patient's claim correctly and take reasonable and necessary efforts to achieve this outcome.

B. Any individual involved in HIM coding and CDI must adhere to the AHIMA Standards of Ethical Coding, Official Coding Guidelines as well as applicable SVMC policies, and Coding Compliance procedures, processes and guidelines.

C. Each patient's account is to be released, or re-released, for billing only when all of the following are met:

1. All ICD-10-CM diagnoses and outpatient procedures CPT/HCPCS codes (including select modifiers) that are submitted for billing purposes under a SVMC provider number must be assigned by a HIM coder
2. All ICD-10-CM diagnoses and outpatient procedure (CPT/HCPCS) codes reported on the patient's claim are supported by legible, complete, clear, and consistent provider documentation.

3. A sufficient clinical documentation set exists in the patient record from which to assign a complete set of codes.

4. Diagnosis and procedure codes are assigned and sequenced appropriately according to Office Coding Guidelines.

5. Other claim elements, including the discharge disposition code, admission status (inpatient or outpatient) and admit/discharge dates as recorded in the patient accounting system, correlate with documentation in the patient's medical record.

Accounts with identified discrepancies in one or more of the above areas must not be released for billing until the discrepancy is resolved and the account can be billed with an accurate and complete code set.

D. When a discrepancy is detected with the HIM coding on a previously submitted claim, SVMC must undertake reasonable efforts to correct the deficiency and prevent the defect from reoccurring on future claims. Overpayments must be corrected and resubmitted to the payer.

Each HIM coding staff shall have and maintain coding accuracy rates of 95% or as measured by periodic coding compliance audits. Coding staff who do not achieve the accuracy rate are subject to appropriate corrective action.

E. General Coding Compliance Policies

1. SVMC adopts the AHIMA Standards of Ethical Coding as the foundation of its Coding Compliance Program. All employees directly or indirectly involved in coding, clinical documentation and/or revenue cycle processes are required to abide by the AHIMA Standards of Ethical Coding. In addition, all CDI initiatives are to be guided by the AHIMA Ethical Standards of Clinical Documentation Improvement Specialists and the ACDIS Code of Ethics.

2. Physician Queries and Clinical Documentation Improvement Program. Refer to the *REVIEW AND QUERY PROCESS FOR CLINICAL DOCUMENTATION IMPROVEMENT (CDI) PROGRAM Policy and Procedure*.

3. HIM Coder Education and Training

   a. HIM Coders (and other pertinent staff as indicated) are required to complete training activities as assigned

   b. HIM coders are required to complete the required CEU's to maintain their coding certification. SVMC may provide some educational resources such as audio conferences, which include CEUs. Coders are responsible for the maintenance of their credential as required by their position.

4. Coding audits for coding accuracy will be conducted periodically. At the conclusion of the audit, investigation as to the causes of any coding discrepancies, remediation of potential claims made in error, education regarding trends identified, if any, and appropriate disciplinary action are to occur under the direction of the HIM Director.

5. The HIM Director and Manager must assure all new HIM coders (including newly hired and new contract coders) are provided orientation and training. Additionally, pre-bill coding reviews must be conducted until acceptable coding quality can be demonstrated.

6. SVMC permits final coding of inpatient accounts without a discharge summary. When the patient's payer reimburses based on DRG methodology (including APR-DRG), an account originally coded without the discharge summary (where one is required by hospital/medical staff policy) must be returned to the coder to determine whether the summary supports a change to the final ICD-10-CM code set.

7. Contract Coding Arrangements

   a. Approval by the SVMC Chief Financial Officer (CFO) is required before engaging a new consultant/vendor in the area of coding.

   b. HIM is ultimately responsible for the accuracy of work produced by a contract coder. It is recommended that the contract have provisions to reduce payment or terminate the contract if any contract coder's individual coding error rate is less than 4.5%.

8. External Coding Consultants and External Clinical Documentation Consultants

   a. Engaging an external consultant/vendor to review patient accounts with the goal of assessing the quality/completeness of coding and/or clinical documentation, requires written approval of the Chief Financial Officer (CFO).

PROCEDURE:

A. Responsible Person

1. The hospital HIM Director is responsible for assuring that all individuals adhere to the requirements of this policy and that all applicable procedures and processes are implemented and followed.

2. Auditing and monitoring

   a. All audits will adhere to this policy as part of its coding compliance audits

3. Enforcement

   a. All employees whose responsibility is affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination.

REFERENCES:

- AHIMA. Code of Ethics, 1957, 1977, 1988, 1998, 2004, 2011, and 2019. Retrieved from http://www.ahima.org/downloads/AHIMACodeofEthicsPrinciplesFINALApprovedApril292019.pdf.

- AHIMA House of Delegates. "American Health Information Management Association Standards of Ethical Coding [2016 version]" (AHIMA, December 2016).

SUBJECT: **MERCURY HANDLING AND SPILLS**	SECTION: ***Hazardous Materials & Waste Mgt*** **Page 1 of 3**

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

PURPOSE:

To provide all employees with information regarding the potential hazards of mercury.

GENERAL:

Mercury is a heavy silver-white metallic element that produces a poisonous vapor and may cause birth defects.

The following equipment may include mercury:

- Thermometers
- Sphygmomanometers
- Barometers
- Maintenance measuring devices
- Specialized medical devices

Symptoms of exposure include:

- Severe respiratory irritation, digestive disturbances and kidney damage in excessive acute exposures.
- Severe nervous system impairment, weight loss and allergic skin reactions in chronic exposures.
- Mercury may also be absorbed through intact skin leading to systemic toxicity.

Mercury Spills:

- Spill Kit:
  - Mercury vacuum hand pump
  - Mercury sponge
  - Stainless steel adapted tube
  - Rubber gloves
  - Face mask
  - Mercury absorbing powder
  - Impervious disposable container

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

PROCEDURE:

Notify Engineering Staff to respond immediately to a mercury spill.

Large Spills:

- Mercury droplets will be picked up with the mercury vacuum.
- To pick up mercury droplets in small cracks use the stainless steel adaptor tool.

Small Droplet Spills:

- Use a damp mercury sponge to wipe the contaminated area.
- When the sponge is nearly saturated with mercury, rub it into the mercury absorbing powder, dampen it with water again and continue the process.
- When clean-up with the sponge has been completed, put the sponge back in a plastic storage bag, label it as hazardous material and dispose of it according to federal and state law.

Mercury in deep cracks:

- Sprinkle mercury absorbing powder directly over the mercury and then wet the powder.
- Allow the mercury to react with the powder and water so that an amalgam is produced. This will reduce the vapor level.
- Pick up amalgam with a vacuum cleaner (use of mercury vacuum hand pump is not necessary).

Mercury Spill on Carpets:

- Pour mercury absorbing powder in a small container and add water until powder is covered.
- Stir and let stand for five minutes.
- Drain off solution.
- Moisten the mercury absorbing powder with additional water and spread on the contaminated area. Wash the powder into the rug so it can react with mercury.
- After the mercury has been converted into an amalgam, pick it up with a vacuum cleaner (use of mercury vacuum hand pump is not necessary).
- Pour mercury amalgam into the impervious container for disposal.

Following Spill Clean-up:

- Contact the Director of Environmental Services for proper disposal of the mercury and clean-up supplies.

- Order replacement mercury spill kit.
- Complete an incident report

REFERENCES:

- The Joint Commission, (2022) Hospital Accreditation Standards EC.02.02.01 EP4. Joint Commission Resources, Oak Brook, IL.

SIERRA VIEW MEDICAL CENTER **PHQ-2 ENGLISH**

Name: _____ Date: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: _____0_____+_____+_____+_____

*= Total Score*_____

Durante las *últimas 2 semanas,* ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Poco interés o placer en hacer cosas	0	1	2	3
2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	0	1	2	3

For office coding: _____0_____+_____+_____+_____

*= Total Score*_____

Patients scoring 3 or greater are to be referred to their Primay Care Provider

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

PHQ_2 ENGLISH

Form # 025083 REV 10/22

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

12

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Inactivated Injectable Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	☐	☐	☐
3. Has Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Technical content reviewed by the Centers for Disease Control and Prevention, August 2010.

www.immunize.org/catg.d/p4066.pdf • Item#P4066 (8/10)

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

FLU SCREENING

Form # 025091 REV 10/22

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

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Information for Health Professionals about the Screening Questionnaire for Inactivated Injectable Influenza Vaccination

Are you interested in knowing why we included a certain question on the Screening Questionnaire? If so, read the information below. If you want to find out even more, consult the sources listed at the bottom of this page.

1. Is the person to be vaccinated sick today?
There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. Persons with an acute febrile illness usually should not be vaccinated until their symptoms have improved. Minor illnesses with or without fever do not contraindicate use of influenza vaccine. Do not withhold vaccination if a person is taking antibiotics.

2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?
Allergic reactions to any vaccine component can occur. The majority of reactions probably are caused by residual egg protein. Although current influenza vaccines contain only a limited quantity of egg protein, this protein can induce immediate allergic reactions among persons who have severe egg allergy. If a person can eat eggs, they can receive inactivated influenza vaccine. However, persons who have experienced an anaphylactic reaction (e.g., hives, swelling of the lips or tongue, acute respiratory distress, or collapse) after eating eggs should consult a physician for appropriate evaluation to help determine if vaccine should be administered. Persons who have documented immunoglobulin E (IgE)-mediated hypersensitivity to eggs, including those who have had occupational asthma or other allergic responses to egg protein, might also be at increased risk for allergic reactions to influenza vaccine. Consultation with a physician should be considered. Protocols have been published for safely administering influenza vaccine to persons with egg allergies (see source 3).

Fluzone (sanofi pasteur) contains gelatin as a stabilizer; therefore a history of anaphylactic reaction to gelatin is a contraindication. Some inactivated influenza vaccines contain thimerosal as a preservative. Most persons who had sensitivity to thimerosal when it was used in contact lens solution do not have reactions to thimerosal when it is used in vaccines. Check the package insert at www.immunize.org/packageinserts for a list of the vaccine components (i.e., excipients and culture media) used in the production of the vaccine, or go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.

3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?
Patients reporting a serious reaction to a previous dose of inactivated influenza vaccine should be asked to describe their symptoms. Immediate—presumably allergic—reactions are usually a contraindication to further vaccination against influenza.

Fever, malaise, myalgia, and other systemic symptoms most often affect persons who are first-time vaccinees. These mild-to-moderate local reactions are not a contraindication to future vaccination. Also, red eyes or mild upper facial swelling following vaccination with inactivated injectable influenza vaccine is most likely a coincidental event and not related to the vaccine; these persons can receive injectable vaccine without further evaluation.

4. Has the person to be vaccinated ever had Guillain-Barré syndrome?
It is prudent to avoid vaccinating persons who are not at high risk for severe influenza complications (see source 3) but who are known to have developed Guillain-Barré syndrome (GBS) within 6 weeks after receiving a previous influenza vaccination. As an alternative, physicians might consider using influenza antiviral chemoprophylaxis for these persons. Although data are limited, the established benefits of influenza vaccination for the majority of persons who have a history of GBS, and who are at high risk for severe complications from influenza, justify yearly vaccination.

Sources:

1. CDC. *Epidemiology & Prevention of Vaccine-Preventable Diseases*. WL Atkinson et al., editors, at www.cdc.gov/vaccines/pubs/pinkbook.
2. CDC. "General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP)" at www.cdc.gov/vaccines/pubs/ACIP-list.htm.
3. CDC. "Prevention and Control of Influenza—Recommendations of ACIP" at www.cdc.gov/flu/professionals/vaccination.

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Cuestionario de contraindicaciones para la vacuna inyectable contra la gripe

NOMBRE DEL PACIENTE _____

FECHA DE NACIMIENTO ____/____/____
mes día año

Para pacientes adultos y para los padres de niños a los que se van a vacunar: Las siguientes preguntas nos ayudarán a determinar si hay algún motivo por el cual no deberíamos aplicar hoy la vacuna inyectable contra la influenza (la gripe) a usted o a su hijo. Si contesta "sí" a alguna de las preguntas, eso no siempre quiere decir que usted (o su hijo) no se debe vacunar. Simplemente quiere decir que hay que hacerles más preguntas. Si alguna pregunta no está clara, pida a su profesional de la salud que se la explique.

	sí	no	no sabé
1. La persona que se va a vacunar, ¿está enferma hoy?	☐	☐	☐
2. La persona que se va a vacunar, ¿es alérgica a algún componente de la vacuna?	☐	☐	☐
3. La persona que se va a vacunar, ¿tuvo alguna vez una reacción seria a la vacuna contra la influenza (gripe)?	☐	☐	☐
4. La persona que se va a vacunar, ¿tuvo alguna vez el síndrome de Guillain-Barré?	☐	☐	☐

FORMULARIO LLENADO POR _____ FECHA _____

FORMULARIO REVISADO POR _____ FECHA _____

"Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination"

Immunize.org

FOR PROFESSIONALS www.immunize.org / **FOR THE PUBLIC** www.vaccineinformation.org

www.immunize.org/catg.d/p4066-01.pdf
Item #P4066-01 Spanish (9/2022)

escanear para PDF

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

FLU SCREENING

Form # 025092 REV 10/22

PATIENT'S LABEL

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Information for Healthcare Professionals about the Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination (IIV4 or RIV4)

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the "Note" below.

NOTE : **For supporting documentation on the answers given below, go to the ACIP vaccine recommendation found at the following website: www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html**

1. **Is the person to be vaccinated sick today?**

   There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. People with a moderate or severe illness usually should not be vaccinated until their symptoms have improved. Minor illnesses with or without fever do not contraindicate use of influenza vaccine. Do not withhold vaccination if a person is taking antibiotics.

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2. **Does the person to be vaccinated have an allergy to an ingredient of the vaccine?**

   All vaccines, including influenza vaccines, contain various components that might cause allergic reactions, including anaphylaxis. Not all such reactions are related to residual egg protein; however, the possibility of a reaction to influenza vaccines in egg-allergic people might be of concern to both these people and vaccine providers.

   An egg-free recombinant influenza vaccine (RIV4, Flublok; Sanofi) is available for people age 18 years and older and an egg-free cell culture-based IIV (ccIIV4, Flucelvax; Seqirus) is approved for people age 6 months and older. ACIP does not state a preference for the use of RIV4 or ccIIV4 for people with egg allergy although some providers may choose to administer RIV4 or ccIIV4 to their patients with a history of severe egg allergy.

   Reviews of studies of egg-culture based IIV and live attenuated influenza vaccine (LAIV) indicate that severe allergic reactions to egg-based influenza vaccines in people with egg allergy are unlikely. ACIP recommends that people with a history of egg allergy who have experienced only hives after exposure to egg may receive any recommended influenza vaccine (inactivated influenza vaccine [IIV4], RIV4, LAIV4) appropriate for their age and health status.

   In people with a history of severe egg allergy who report symptoms other than hives (e.g. angioedema, respiratory distress, recurrent vomiting) or who required emergent medical intervention (e.g., epinephrine) may also receive any recommended influenza vaccine appropriate for their age and health status. If a vaccine other than ccIIV4 or RIV4 is used, it should be administered in a medical setting (e.g., a hospital, clinic, health department or physician office). Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic reactions. Providers should consider observing all patients for 15 minutes after vaccination to decrease the risk for injury should they experience syncope.

   Inactivated influenza vaccines provided in multidose vials contain thimerosal as a preservative. Most people who had sensitivity to thimerosal when it was used in contact lens solution do not have reactions to thimerosal when it is used in vaccines.

   Check the package insert at www.immunize.org/fda for a list of the vaccine components (i.e., excipients and culture media) used in the production of the vaccine, or go to www.fda.gov/vaccines-blood-biologics/vaccines/vaccines-licensed-use-united-states.

   For the 2022–2023 influenza season, no vaccine or packaging contains latex.

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3. **Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?**

   Patients reporting a serious reaction to a previous dose of influenza vaccine should be asked to describe their symptoms. Immediate – presumably allergic – reactions are usually a contraindication to further vaccination against influenza. Do not give any egg-based IIV to a person who has experienced a serious systemic or anaphylactic reaction to a prior dose of any influenza vaccine (i.e., egg-based IIV, ccIIV, RIV, or LAIV). For ccIIV4, history of a severe allergic reaction (e.g., anaphylaxis) to any ccIIV or any component of ccIIV4 is a contraindication to future use of ccIIV4. For RIV4, history of a severe allergic reaction (e.g., anaphylaxis) to any RIV or any component of RIV4 is a contraindication to future use of RIV4.

   Fever, malaise, myalgia, and other systemic symptoms most often affect people who are first-time vaccinees. These local reactions are not a contraindication to future vaccination. These people can receive injectable vaccine without further evaluation.

   A history of a severe allergic reaction to a previous dose of any egg-based IIV, LAIV, or RIV is a precaution to use of ccIIV4. A history of a severe allergic reaction to a previous dose of any egg-based IIV, ccIIV, or LAIV is a precaution to use of RIV4. Use of ccIIV4 and RIV4 in such instances should occur in an inpatient or outpatient medical setting under supervision of a provider who can recognize and manage a severe allergic reaction; providers can also consider consulting with an allergist to help identify the vaccine component responsible for the reaction.

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4. **Has the person to be vaccinated ever had Guillain-Barré syndrome?**

   People who are not at high risk for severe influenza complications and who are known to have developed Guillain-Barré syndrome (GBS) within 6 weeks after receiving a previous influenza vaccination should not be vaccinated. As an alternative, clinicians might consider using influenza antiviral chemoprophylaxis for these people. However, the benefits of influenza vaccination might outweigh the possible risks for certain people who have a history of GBS within 6 weeks after receipt of influenza vaccine and who are at higher risk for severe complications from influenza.

SIERRA VIEW MEDICAL CENTER **Health Screening Form**

Name:		
Date of Birth:		
Phone #:		
Blood Glucose Result:	Last Time I ate:	
Hemoglobin Result:		
Blood Pressure Reading:		
Body Mass Index (BMI)	Height:	Weight:
Flu Vaccine		
Site of injection:	□ Left Deltoid	□ Right Deltoid
	□ Left Thigh	□ Right Thigh
Signature of Vaccine Administrator:		Date:

Disclaimer: I understand that my participation in this health fair is voluntary. Signing this form will indicate that I have been informed of the screenings offered at this event, and that I hereby consent to provide a blood sample via finger stick for the purpose of measuring my blood glucose and/or hemoglobin level. In consideration of having my blood glucose and/or hemoglobin measured, I hereby release Sierra View, its affiliates, respective employees, directors, officers, board of directors, and agents from any liability other than as a direct result of actual services rendered. By signing this form I also acknowledge I have read and fully understand this document and if I have questions, I had the opportunity to have them answered by the Nurse. If you have any results that are out of range, please seek the advice of a healthcare professional for further evaluation. If you do not have a doctor, please call us and we will make an appointment for you to see a medical provider for further testing.

Aviso Legal: Entiendo que mi participación en esta feria de la salud es voluntaria. Firmando este formulario indica que he sido informado de las proyecciones ofrecidas en este evento, y que consiento proporcionar una muestra de sangre mediante palillo del dedo con el fin de medir mi nivel de glucosa o hemoglobina de la sangre. En consideración de medir mi glucosa en la sangre o hemoglobina, desligo a Sierra View, sus filiales y empleados respectivos, directores, funcionarios, y agentes de cualquier responsabilidad que como un resultado directo de los reales servicios prestados. Al firmar este formulario reconozco también que he leído y entiendo este documento y que si tengo dudas he tenido la oportunidad de que sean contestadas por la enfermera. Si tienes cualquier resultado que está fuera de norma, por favor busque el asesoramiento de un profesional para la evaluación adicional de la salud. Si no tiene un médico, por favor llamenos y le proporcionaremos una cita para que vea un médico para exámenes adicionales.

Signature/Firma:	Date/Fecha:

For an appointment, please call us at (559)544-6815

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

Health Screening Form

025112 REV 11/23

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

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SIERRA VIEW MEDICAL CENTER

PROTECTIVE CUSTODY FOR HOSPITALIZED MINOR

This child is under protective custody under California Welfare and institution Code 300

Patient _____ is currently hospitalized at Sierra View Medical Center (SVMC) and is not to be released to the parent or guardian without prior consent of an authorized representative of the County Department of Child Welfare Services.

RESTRICTIONS {As per discussion with county social worker):

_____

_____

_____

Child's Name:_____ Unit:_____ DOB:_____

Parent/Guardian Name:_____

Address:_____ Phone:_____

Date/Time custody was removed:_____ CWS Worker:_____

Phone:_____ Cell:_____ Fax:_____

Law Enforcement Agency:_____ Incident #:_____

Officer's Name:_____ Badge #:_____ Phone:_____

Signature of CWS Worker / Date

_____ /

Signature of Law Enforcement Officer / Date

_____ /

COMPLETE UPON DISCHARGE

The child will be discharged to:_____

Phone:_____ Address:_____

CWS Social Worker:_____ Signature:_____

Phone:_____ Agency/Country:_____ Date:_____

SVMC Social Worker:_____ Signature:_____

Form is valid through this current admission. Date of admission:_____

Form is to be completed by SVMC social worker in collaboration with County Child Welfare Services social worker. Place copy of CWS social worker's photo ID and Business card in chart at time of discharge. White original copy of this form is to be placed in patient's medical record in the consent section, Yellow copy is given to CWS social worker, and Pink copy is for the social service log located in the social service office.

PROTECTIVE HOLD FOR HOSPITALIZED MINOR CVBF# 1546

WHITE - CHART YELLOW - CWS PINK - Social Services

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

PROTECTIVE CUSTODY FOR HOSPITALIZED MINOR

Form # 025080 REV 10/22

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

ANNUAL NURSING REPORT
FISCAL YEAR 2022

Presented By:

Jeffery Hudson, DNP, RN, NEA-BC, FACHE
Vice President of Patient Care Services
Chief Nurse Executive

Top challenges

1. Nearly 3 years of experience in operating a “clean” and “dirty” hospital regarding Covid, Flu and RSV management.
2. Resignations continue (National Trend)
3. Fatigue
4. “Not heroes anymore”
5. Filling vacancies
6. Maintaining a safe patient-care and work environment

Staffing shortages

R.N. vacancies	23.7%

Open positions:

Charge R.N.	3
L.V.N.	2
R.N.	58
R.N. Nursing Supervisor	2
Seasonal R.N.	4
Seasonal R.N.F.A	1
	70

New staffing models, nurse recognition makes gains

- Using Team and Functional models of nursing at times to accommodate surge volumes.
- LVNs and RNs with competence in other specialties used in these models.
- DAISY Award ceremonies
- Nurses featured in print and social media stories and campaigns.

Emotional health and well-being support

- RISE Program
- Resilience activities
  - Special activities held on day and night shifts
- Frequency of Chaplain rounding increased

Intent to leave nursing grows

- The Great Resignations Period is occurring nationally.
- Raised competitive market salaries at SVMC
- Incentive pay provided to fill vacant shift
- Responded with continuing 48-hour club and other incentive based staffing programs.

Post-pandemic staffing shortages experienced

- Seasonal Per Diem (Internal Agency) R.N. program intiated
- Tapping into decreasing national pool of travel nurses.
- Travel R.N. wages have decreased, but still significantly higher than pre-pandemic rates.

Addressing staff shortages

- Special recruiting events
  - RNs
  - LVNs and CNAs
- Staff incentives for referral of new staff being hired
- SVMC Nursing school partnership with Unitek College – first cohort, Spring 2023
- University on SVMC campus. Expect up to 36 students per year

Summary

1. Resignations and movement away from hospital based care to other specialties.
2. Resilience and well-being activities
3. Competitive market place for salaries and benefits
4. Surges are anticipated for Covid periodically
5. Safety

Quality Report
FY 2022

SIERRA VIEW
MEDICAL CENTER

NOVEMBER 2022

Sierra View Medical Center
Prepared by Dr. Melissa Mitchell, VP of Quality and Regulatory Affairs

Annual Evaluation:

- **Quality Priorities**
- **Patient Experience**
- **Patient Safety/Risk**
- **Population Health**
- **Care Integration**
- **Infection Prevention**
- **Employee Health Services**
- **Stroke/Sepsis**

Sierra View Medical Center

Mission

Sierra View Medical Center promotes health and ensures access to high quality health care services. This will be achieved:

- Through partnership and collaborations
- By being a good steward of resources to ensure it can contribute to meet the needs of the community

Vision

Strengthen the quality of life through the delivery of integrated health care programs and services that promote access, care coordination and patient care experience.

Values

Compassion: Caring from the heart

Collaboration: Partnering for a common purpose

Accountability: Accepting ownership of our actions

Integrity: Inspiring trust and honesty

Respect: Embracing and appreciating others

Table of Contents

Quality Division Updates

FY 2022 Quality and Patient Safety Priorities

Management of Suicidal Patients
The focus was to improve documentation around suicide assessment completion, providing safe envirnment, and providing the required 1:1 sitter.

While this continues to be a struggle for our ED department, we are making conscious strides to ensure the proper resources and audits are being completed to ensure compliance. The biggest challenge is staffing the required 1:1 sitter for patients who present with complaints or actions indicating suicidal behavior.

Medication Titration
This project focused on the consistentcy between the documented medication order and documented administration.

Pharmacy worked with critical care services to review the fall-outs indicated in our mock survey. Together they created a way to block chart, eliminating much of the opportunity for error. Education and ongoing chart audits continue to ensure sustained change. The biggest challenge is the high volume of verbal orders by providers – indicating the on-going demand for CPOE rates above 90%.

MIFU Management
MIFU (Manufacturer's Instruction For Use) management focuses on the need to centralize and standardize the process for obtaining updated MIFUs for the District's equipment and ensuring it is properly applied and documented.

Infection Control took lead on this project, working with the various stakeholders within the organization. They created an inventory of equipment requiring MIFU log books to document required maintence performed. A subscription was purchased and leadership was trained on how to review, download, and apply updated MIFUs to the equipment they have oversight of. Ongoing checks for sustainment are completed during the weekly environment of care rounds.

Patient Experience

Like other hospitals across the country, COVID continued to present challenges in the area of patient satisfaction. We continued the practice of using iPads and zoom to keep our patient and families connected. As guidelines permitted, we gradually opened up in person visitation to our non-Covid patients. Having family and friends at the bedside of our patients is always a key part of the healing process.
Despite these challenges, the areas we focused on improving, Hospitalist Physician Communication and Ambulatory Surgery showed improvement.
The Maternal Child Health unit, along with Patient Experience, created a discharge check list for their patients. This project was highly successful, and has created near perfect scores for the unit around their discharge communication score.

Hospitalist Physician Communication

- Overall Physician Communication improved 4.2 points
- Courtesy and Respect shown to the patient improved 3.4 points
- Listen carefully to the patient improved 3.1 points
- My doctor explained things to me in a way I could understand improved 6.1 points
- My doctor treated me with loving kindness improved 2.8 points
- My doctor created helping and trusting relationship improved 2.9 points

Ambulatory Surgery

- 16 metrics trended up
- 6 metrics declined
- 2 metrics were flat

This year Patient Experience worked with our survey partner Press Ganey to begin using e-mail and text messaging to survey our patients in the Emergency Department, Cancer Treatment Center (CTC) and Outpatient Imaging and Lab services. The new method of surveying gives us the ability to reach more patients and therefore gather more data and patient comments. We can then use the data and comments gathered to focus on those areas our patients tell us matters the most to them.

The MyRounding platform continues to be a great resource as several new patient experience and quality-related applications were created. These include:

- 32 new Accreditation and Tracer audits
- Patient Satisfaction at the Rural Health Clinic

Some applications that had been added the previous year showed great benefit.

- 1060 Ambulatory Surgery discharge phone calls made
- 8683 Hand Hygiene audits performed.

Patient Safety/Risk

The Patient Safety/Risk programs continued to make strides in the identification of preventable medical error with a focus on near misses and system vulnerabilities. Some of the ongoing work done to maintain focus on patient safety include:

- Risk/Pt. Safety/and Just Culture education to: Resident Physicians, New Graduate Registered Nurses, and New Hire Orientation.
- Focused Special Topic Classes: Falls and Care for the Caregiver education programs for new graduate nurses; Informed Consent educational program specific to physicians as well as a program tailored to non-physicians implemented this year
- Risk and Patient Safety Departments chair two multi-disciplinary committees focused on harm prevention and risk mitigation: Patient Safety Committee and Threat Assessment Team

In March of 2022, SVMC took the annual Culture of Safety Survey (SCOR). This year's response rate was 71%. We have continued focused work surrounding our Culture of Safety, improving staff burnout, and increasing resilience. In regards to BETA hearts Principles we continue to excel in our Culture of Safety work and our Care for the Caregiver program. Efforts in the two areas were recognized with awards in recognition of HEART validation from BETA Healthcare Group. This brings cost savings to the District in the form of a reduced insurance rate.

Care Integration

Advance Care Plan

Purpose: to increase documentation of patients aged 65 and older who have an advance care plan or surrogate decision maker in the medical record.

In collaboration with Performance Improvement, Registration and ACS a new contact tab was created to capture the information.

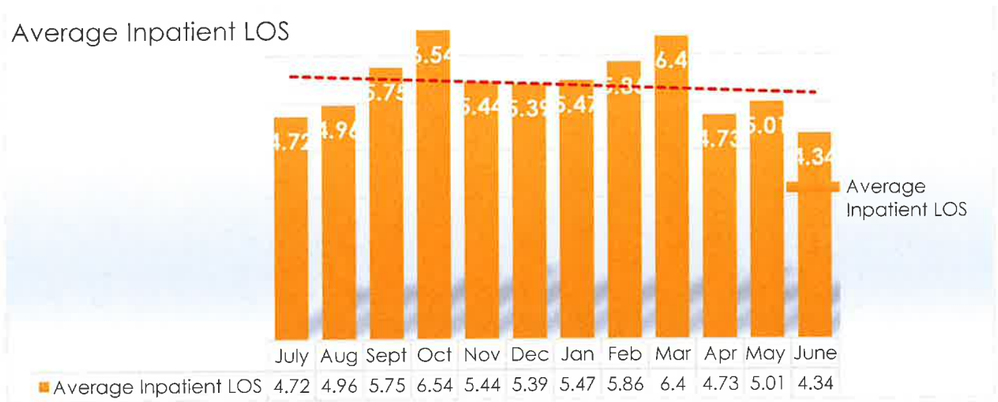
- Target: Move from 75.2% to ≥ 91.02%
- On 6/16/2022 data indicated 72.1% compliance
- On 8/15/2022 registration began to obtain information in all outpatient areas: PT,ST, Urology, RHC and all other OP clinic areas
- On 8/16/22 registration implemented process for all other areas within the hospital: Lab, IP, ED, OB

- On 8/15/2022 data indicated 100% compliance

Length of Stay

Reducing length of stay by targeting several areas that directly impact this metric:

- Discharge plan
  - Initiating early on during admission
- Streamlining SNF placement/Post-Acute Services
  - Obtaining insurance authorization early on
- Leveraging service lines appropriately
  - Proving residents information about post-acute service lines available to transition patient into
  - Bringing service lines into SVMC to provide information to the care integration team about the community services available
- Highlights
  - Despite COVID still having an impact on admissions and causing discharge barriers there has been a decrease overall in LOS
  - In the beginning of July of this year there were several days that it was observed that there were only 5-6 patients in the hospital greater than 5 days.
  - For two days in July, the hospital did not have any patients that were greater than 5 days in the hospital. There is no previous data that indicates this has been achieved before.
  - Average length of stay for the month of July was 3.46.



Infection Prevention

During FY 2022, the world entered year 2 of the Covid-19 Pandemic. And, like most other health care organizations in the U.S., SVMC did more with less. Through diligent work, open communication and collaboration, the Infection Prevention Department has contributed to SVMC's survey readiness in numerous ways. Below is a brief summary of just some of the IP Department's accomplishments for FY 2022:

- An IP Manager was brought on board in August 2021 and has now completed a full year at SVMC.
- The IP staff, in collaboration with Performance Improvement, Engineering, EVS and Materials Management, played a crucial role in the Environment of Care/Infection Prevention surveillance rounds. Among improvements noted:
    - A great reduction in the number of expired items found within each clinical department
    - MIFU Log books for high-risk items have been created and kept current – this is important in our efforts to stay survey ready
- Important health care updates were reviewed and shared with SVMC staff as FAQs, 5-minute Huddles, etc., in a timely fashion. Some of the important topics included:
    - New Sars-CoV2 variants – symptoms, treatments and the ongoing changes in the Emergency Temporary Standards
    - The Monkeypox outbreak and other emerging infectious diseases in the U.S.
    - Changes in the COVID-19 Prevention Emergency Temporary Standards (ETS)
- Professional Development Activities
    - All IP Dept. members were able to attend the AHA National Conference in March, 2022 through a scholarship provided by AHA/CDC Frontline.
    - Two IP Department members were awarded scholarships to virtually attend the 2022 APIC National Conference in Indianapolis during June.
    - Professional Development - Hold IP Monthly meetings where CIC topics are discussed based on the APIC Infection Preventionist Competency Model and CBIC Core Competencies.
- Below are the summary points for this year's HAI surveillance activities based on NHSN standards:
    - SSIs – Three of the last 4 quarters SVMC has fewer SSIs than predicted
    - CLABSI – There were 0 (zero) CLABSI in the last two quarters of FY 2022 and the overall trend has been a reduction of infections over the last FY.
    - CAUTI – There were zero (0) infections in 3 of the last 4 quarters, which means SVMC performed better than predicted.
    - CDI – SVMC performed better than predicted with respect to CDIs for all 4 quarters
    - MRSA – Two of the last 4 quarters SVMC performed better than predicted, but there is definitely room for improvement. The IP Department plans to continue reporting MRSA Discrepancies to each department as this has seem to have had a positive effect in the reduction of MRSA infections.

- Hand Hygiene (HH) Surveillance – Over 97% of those observed were compliant for proper hand hygiene. During the last quarter of FY 2022, over 73% of all departments submitted HH surveillance data, but only 20% meet their HH observation quota. There is room for improvement in HH surveillance.
- Conduct surveillance on blood culture draws for 1 month in order to offer recommendations on how to reduce SVMC blood culture contamination rates. The results of the surveillance and the subsequent recommendations were written up in a report and distributed to stakeholders in the Laboratory and the Emergency Department.

Employee Health Services

COVID related activity continued to occupy a large amount of Employee Health Service's time. We continued on to a second year with no identified conversions after work-related COVID exposures throughout the pandemic. This year Employee Health has started work to prevent employee injury and harm. Focus areas have included preventing sharp related injuries, reinforcing our existing ergonomics program, supporting safe patient handling education and supporting workplace violence initiatives.

Specific departmental highlights for the year include:

- Continued management of mandatory masking/social distancing guidelines
- Employee screening protocols and Vaccine compliance.
- Education/training of proper fitting of N95 mask to protect from exposure
- Effective contact tracing methods for positive employees and identifying exposures and follow up monitoring
- Daily screening for symptomatic employees and non-employees for all sick calls to determine need for testing
- Working with TCPH as necessary to continue using crisis level staffing protocols to reduce staffing shortages
- Implementing employee voluntary and mandatory testing process
- Keeping up to date with changing AFL's, county guidelines, state mandates and regulatory requirements

Roll-out of a comprehensive ergonomics program to help prevent workplace injury

Bridge Services

Bridge Services is a revamp and rework of the existing PRIME team members in December, 2021. This team was restructured and workflows put into place to support 2 separate service lines: Palliative Care and PACT Services.

Palliative Care:

Palliative care services are not new to SVMC, but did benefit from new workflows and dedicated FTEs. The program started with 32 patients, and closed the fiscal year with 40, consistently. Their number of days from referral to initial assessment dropped from 42 down to 30. Finally their number of patient contacts dramatically increased from 29 to over 50, per month.

Palliative Care Program		Quarter 1				Quarter 2				
		January	February	March	Q1	April	May	June	Q2	
Average Weekly Case Load	<36, 36-38.5, 38.6>	36.75	36.50	37.40	36.88	40.00	40.20	40.00	40.07	
Number of referrals per month		7	2	10	6	1	5	5		
Average number of days to complete initial	<30, 31-40, >41	42	33	33	36	15	21	25	20	
Percent of patients that have initial within 30 days of referral.		29%	50%	60%	46%	100%	100%	100%	100%	
Number of patient contacts per month	>50, 49-36, 35<	NA	NA	29	29	55	47	58	53	
# DC/Graduated due to improved/declining S/S		4	8	3		1	4	3		
#DC/Graduated due to lack of participation		1	0	1		0	1	2		
Average days patient in program		253	263	219	245	243	227	227	232	

PACT Services:

This program was designed to bridge the gap between the inpatient admission and successful discharge for those that have chronic conditions; specifically COPD, CHF, and Pneumonia. Data shows these cohorts are high utilizers and costly to the hospital to care for if they are not managing well at home. Those enrolled in the program showed decreased readmission rates. The most used feature of this program was the medication reconciliation and counseling provided by our Bridge Pharmacist.

Quality Key Performance Indicators

PACT Program		Quarter 3 January	February	March	Q3		Quarter 4 April	May	June	Q4
Total number of qualifying patients identified		44	70	94	69		72	75	77	75
Number of Patients who agree to participate in program		14	20	32	22		28	24	34	25
Percentage of patients presented program who accept (Engagement Rate)	100-75, 74-50, 49-0	not tracked	77%	65%	71%		61%	61%	60%	61%
Loss Rate = Percent Not Contacted of those meeting criteria and not DQ	0-10, 11-20, 20-100	33%	19%	15%	17%		4%	9%	6%	6%
participating vs accepted		9/14	19/20	30/32			24/28	19/24	19/24	
Percent of accepting patients that participate in Medication Reconciliation	<75, 76-89, >90	64%	95%	91%	94%		86%	79%	79%	81%
Average # of days from DC to 7 Day IDT Meeting	<10, 11-14, 15>	not tracked	11	9	11		11	13	8	10
Percent of those accepting program who complete program	<25, 26-39, 40>	not tracked	40%	25%	33%		32%	29%	66%	42%
Percentage of accepting patients who readmit w/in 30 days	<10, 17-30, 31>	33%	26%	20%	24%		21%	16%	13%	17%
ED ONLY visits within 30 days	<15, 16-25, >25	11%	28%	27%	24%		13%	11%	13%	12%
Percentage of participating patients ED or Readmit 31-90 days.	<20, 21-35, >35	22%	17%	17%	24%		4%	15%	21%	13%

Stroke & Sepsis Program

Stroke:

In 2021, SVMC became an Advanced Primary Stroke Center – a certification by the Joint Commission. This recognized us for the quality stroke care we deliver. Since certification, our stroke program has continued to improve patient quality, safety, and thrombolytic treatment times (the "clot-busting" medication used to treat stroke). Additionally, the stroke program once again gained recognition from the American Heart Association (AHA). This time, for 2021, we received the Gold Plus award along with recognition for our diabetes care. The Gold Plus is the highest award given for stroke care from the AHA.

Sepsis:

SVMC performance around sepsis bundled care has consistently been greater than ninety-percent, while our SEP-1 score has had peaks and valleys. The sepsis program has been impacted by the COVID pandemic, as many of these patients present to our Emergency Department with sepsis. For CY2021, we saw 469 patients with sepsis. Eleven out of twelve months we consistently scored better than our peer group, on sepsis metrics, measured through Press Ganey reports. We will begin looking toward sepsis certification through the Joint Commission in FY23.

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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 **November 22, 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 4:35 p.m.

Directors Present: BEHL, LOMELI, REDDY, PANDYA, SORRELLS

Others Present: Blazar, Dan, Patient Experience Officer, Canales, Tracy, VP of Human Resources, Marketing and Public Relations, Cartwright, Susan, Director of Medial Staff Services, Dickson, Doug, Chief Financial Officer, Eckhoff, Richard, Community Member, Franer Julie, Admin Director of Patient Financial Services, Gilman, Robin, Community Member, Gomez, Cindy, Director of Compliance, Hefner, Donna, President/Chief Executive Officer, Hibbert, Morton, MD, Hirte, Todd, Contracts Administrator, Hurtado-Ziola, Nancy, Infection Prevention Manager, Johns, Karen, Sierra View Foundation Parsons, Malynda, Senior Marketing and Community Relations Specialist, Pryor-De-Shazo, Kimberley, Director of Marketing and Commnity Relations, Reed-Krase, Alex, Legal Counsel, Sandhu, Harpreet, MD, Chief of Staff, Shelton, Greg, Community Member Sorrells Bennie, Community Member, Urquizu, Iris, Community Member, 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, Zeboskey, Debbie, Director of HIM and Privacy Officer

I. Approval of Agenda:

Director SORRELLS 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
SORRELLS	Yes
BEHL	Absent
PANDYA	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 4:37 p.m. to discuss the following items:

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update

Director BEHL presented at 4:55 p.m.

3. Compliance Report – Quarter 1

Chairman REDDY out at 5:02 p.m. and returning 5:03 p.m.

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

III. Open Session: Chairman REDDY adjourned Closed Session at 5:05 p.m., reconvening in Open Session at 5:05 p.m.

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

A. Chief of Staff Report provided by Chief of Staff, Harpreet Sandhu, 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 Chairman REDDY, 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
SORRELLS	Yes
BEHL	Abstain
PANDYA	Yes

2. Quality Division Report

Following review and discussion, it was moved by Chairman REDDY, seconded by Vice Chairman LOMELI, and carried to approve the Quality Division Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Abstain
PANDYA	Yes

3. Compliance Report – Quarter 1

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by, Chairman REDDY and carried to approve the Compliance Report – Quarter 1 as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

IV. Public Comments

A written public comment was delivered by Richard Eckhoff, Community Member. A copy of the public comment is attached to the hard copy file of these minutes.

V. Consent Agenda

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

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Vice Chairman LOMELI and seconded by Chairman REDDY to approve the October 25, 2022 Minutes of the Regular Meeting of the Board of Directors with the changes as discussed. The motioned carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

VII. Hospital CEO Report

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

In the District:

- $10,000 raised for the Roger S. Good Cancer Treatment Center with the Pink Patch Project, Porterville Police Department and Porterville Peace Officers Association.
- District 3 Seat Open
- Health Insights Winter Edition released

VIII. Recognition of Service of Director Kent Sorrells and Director Ashok Behl

IX. Business Action Items

A. October 2022 Financials

Doug Dickson, CFO presented the Financials for October 2022. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $12,197,876. Supplemental Funds were $1,048,709. Total Operating Expenses were $13,586,708. Loss from operations were $1,388,832.

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

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

B. Investment Report

Doug Dickson, CFO presented the Financials for October 2022. A copy of this presentation is attached to the file copy of these minutes.

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

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

C. Quarterly Foundation Report

The Quarterly Foundation Report was presented by Karen Johns, Sierra View Foundation member. The Golf Tournament raised $41,000 which will be allotted to the purchase of new Workstations on Wheels. The first ever Dueling Pianos event raised $25,000.

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

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

X. Announcements:

Zoom will no longer be available as a platform to view the Board meeting.

XI. Closed Session: Board adjourned Open Session at 6:11 p.m. and went into Closed Session at 6:21 p.m. to discuss the following items:

C. Pursuant to Gov. Code Section 54956.9 Exposure to Litigation to subdivision (d)(2): Conference with Legal Counsel. BETA Claim No. 22-001812

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 7:00 p.m. and went into Open Session at 7:01 p.m. to discuss the following items:

C. Following review and discussion, it was moved by Director SORRELLS and seconded by Director PANDYA and carried to Reject BETA Claim No. 22-001812 as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

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

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

XII. Announcements:

A. Regular Board of Directors Meeting – December 20, 2022

B. Adjournment: There being no further business, a motion to adjourn brought by Director BEHL and seconded by Director SORRELLS. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

The motion having carried, the meeting was adjourned 7:15 p.m.

Respectfully submitted,

Kent Sorrells
Secretary
SVLHCD Board of Directors
KS: ww