SIERRA VIEW
MEDICAL CENTER

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

AGENDA
February 27, 2024

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

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

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

2. Quality Division Update –Quality Report

3. Compliance Report – Quarter 2

C. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation: Conference with Legal Counsel. BETA Claim No. 24-000264

D. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation: Conference with Legal Counsel. Bond Reporting.

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

F. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter.

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

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

B. Quality Review

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

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

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

C. Conference with Legal Counsel Re: BETA Claim No. 24-0000264
Recommended Action: Approve/Deny BETA Claim No. 24-000264

D. Discussion Regarding Significant Exposure to Litigation
Recommended Action: Information Only; No Action Taken

E. Discussion Regarding Trade Secret and Strategic Planning
Recommended Action: Information Only; No Action Taken

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

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

VI. Public Comments

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

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
February 27, 2024

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

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

VIII. Approval of Minutes

A. **January 23, 2024 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove January 23, 2024 Minutes of the Regular Meeting of the Board of Directors

IX. CEO Report

X. Business Items

A. **January 2024 Financials**
Recommended Action: Approve/Disapprove January 2024 Financials

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

C. **Capital Budget Report – Quarter 2**
Recommended Action: Approve/Disapprove Capital Budget Report

D. **Board Self Evaluation and Goals**
Recommended Action: Information only; No Action Taken

XI. Announcements:

A. Regular Board of Directors Meeting – March 26, 2024 at 5:00 p.m.

B. Form 700 due April 1, 2024. Disclosure forms must be on file with the Board Administrator by that date.

XII. Adjournment

PUBLIC NOTICE

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

PUBLIC NOTICE ABOUT COPIES

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

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MEDICAL EXECUTIVE COMMITTEE	02/07/2024
BOARD OF DIRECTORS APPROVAL	
	02/27/2024
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
February 27, 2024 BOARD APPROVAL

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

	Pages	Action
I. Policies:		**APPROVE**
• Blood & Blood Components, Administration of	1-8	↓
• Domestic Violence Assessment and Reporting	9-12	
• Endoscopes-Use and Care	13-19	
• Fluid Restrictions	20-21	
• Infection Control Guideline for People with Head Lice (Pediculus Humanus Carpitis)	22-26	
• Prisoners/Wards of Legal System – Care of	27-30	
• Solutions, Monitoring Temperature of Solutions	31-32	

SUBJECT: **BLOOD & BLOOD COMPONENTS, ADMINISTRATION OF**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 8**

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

PURPOSE:

- Provide guidelines for preparation, administration and monitoring of the patient receiving a blood transfusion.
- To ensure that the treating physician has obtained an informed consent from the patient.
- To provide the patient with the opportunity to exercise the right to give an informed consent or refusal for the transfusion recommended by the physician.
- To provide the patient with the opportunity to acknowledge that the physician adequately explained the benefits, risks, complications, alternatives to transfusion and discussed all information concerning the transfusion to the patient's satisfaction.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to verify, by means of the Blood & Blood Component Transfusion Record, that the patient's informed consent has been obtained by the treating/attending physician, before the patient receives a blood/blood component transfusion.

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

EQUIPMENT:

1. IV pole and infusion pump
2. Solution of 0.9% Normal Saline IV bag
3. IV #18 or #20 gauge needle/catheter and accompanying equipment per IV Start Procedure
4. Blood administration set (Y-tubing with specific filter)
5. Prepared transfusion administration form / "pick-up slip"
6. Blood warmer (physician order is required for non-emergent use)
7. Pressure Infusion Cuff (physician order required)
8. Gloves

PROCEDURE:

PHYSICIAN RESPONSIBILITIES:

1. It is the exclusive duty and responsibility of the attending and/or treating physician to obtain informed consent.

2. It is the responsibility of the attending and/or treating physician to document in the medical record that a discussion was held with the patient, and that an informed consent was given. Any special circumstances should also be documented. The physician may also place into the record a copy of any written material he/she gave to the patient.

HOSPITAL PERSONNEL RESPONSIBLITIES:

1. If, at the time the Transfusion Consent Form is presented to the patient, the patient voluntarily indicates doubt or confusion about the blood/blood component transfusion and consequently there is a question raised as to whether or not informed consent has been obtained, the physician will be contacted immediately. Under no circumstances should the healthcare provider (e.g. Registered Nurse) attempt to obtain the patient's informed consent in such a situation.

2. Although the hospital personnel cannot and should not be responsible for securing the patient's informed consent and for giving the patient the information that is required in order to secure the patient's informed consent, it can be expected that patients will ask hospital staff who are performing a procedure pursuant to the physician's orders, questions about what they will be or are doing. Hospital personnel generally may answer such questions.

3. If it appears that the patient has significant questions about the nature of the procedure and its benefits or risks, which indicate that he/she may not have been given sufficient information about the transfusion or does not understand the information he/she was given, the hospital personnel should contact the patient's physician in order to allow him/her to answer the questions and thereby help to ensure that the patient has given an informed consent to the transfusion procedure.

COMPLETING THE HOSPITAL'S CONSENT FORM:

1. ***Time and Date of Signature***: The time and the date on the form should be the time and date the form is signed by the patient or the patient's legal representative.

2. ***Witness***: One person should serve as a witness, then the patient or the patient's legal representative signs the form. The witness should be a responsible staff member of SVMC who, according to licensure or experience, understands the information provided.

PACKED RED BLOOD CELLS (PRBC) AND FRESH FROZEN PLASMA (FFP)

A. Ordering and Obtaining Blood Products

1. A physician order will include the component requested and number of units to be infused.

2. Explain the procedure to the patient and obtain written authorization.

3. The laboratory will draw a second sample of blood for T&C at a separate phlebotomy to reduce the risk of error in transfusion for non-emergent red cell transfusions, when patients have been ordered to receive packed cells and have no prior history of blood type. In the event of an emergent need for blood, the emergency release protocol will be followed (See Lab policy on comparison of past blood bank records).

B. Obtain blood product(s) from the lab.

1. Ascertain from the electronic record that the blood product is ready for use. Take the request for blood component slip, or "pick-up slip," to the lab. *This must be signed by the blood bank technologist and the clinical representative. This slip becomes part of the medical record.*

2. A clinical representative, defined as an employee in a clinical service and designated by the Charge Nurse, can pick up the blood and will double check the following with the blood bank technologist: If any of the information is missing or does not match, the blood cannot be released (Exception: type compatible but not type specific units).

   a. Patient's name

   b. Identification number

   c. Blood group, Rh type and antibody screen,

   d. Donor number

   e. Donor blood group and Rh type

   f. Expiration date and time

   g. Blood product ordered

3. Blood Bank Technologist, clinical representative, RN/LVN will sign the Blood Bank computer-generated Unit Issue Card, which becomes a part of the medical record. The record will be printed with all the pertinent patient blood bank information. There must be exact verification of all information before the unit leaves the blood bank.

NOTE: No more than 1 unit is to be removed from the Blood Bank at a time with the exception of a massive bleed, transfusion during dialysis or surgical patient with monitored refrigeration available for storage.

C. Preparing the patient

1. Provide transfusion reading material to the patient and/or family member(s) and allow for questions.

2. Obtain transfusion informed consent after the physician has spoken to the patient.

   a. Patient must agree and sign consent to the administration of blood/blood product(s) prior to the transfusion and prior to staff picking up the blood from the Blood Bank. If the patient refuses the transfusion, the refusal form must be completed.

3. Established IV access with #18 gauge catheter (preferred) prior to obtaining blood from Blood Bank. A #20 gauge catheter may be used in the event that a larger vein is not accessible. A #23 gauge catheter may be used for pediatric patients. ***(See pediatric policy: "Pediatric Blood Transfusion")***

4. Vital signs, including temperature, will be taken and recorded in the Transfusion Administration Record prior to start of transfusion.

D. At the bedside

1. The blood product will be verified by the transfusionist and scanned as the second verification. Scanning should include all indicators as listed below in order to qualify as the second verification. If unable to scan, the blood product can be verified with two (2) qualified licensed staff against the "Transfusion Administration Record" at the bedside. The one individual conducting the identification verification must be the qualified transfusionist who will administer the blood or blood component to the patient. At least two unique identifiers are used in the verification process and will be conducted after the blood or blood component matching the order has been issued or dispensed. The following information will be verified:

   a. Patient's name

   b. DOB

   c. Patient Account Number

   d. BBK#

   e. Blood unit number

f. Donor blood group and Rh type

2. The patient's identification is verified by checking the name, date of birth and BBK.

3. The two (2) licensed staff sign in the space provided on the "Transfusion Record" if scanning is not used.

E. Preparation for Transfusion

1. Wash hands thoroughly. Put on gloves.

2. Run 0.9% Normal Saline solution through the "Y" tubing to remove air and clamp tubing. Make sure the fluid level in the drip chamber is above the entire filter.

3. Gently agitate the unit of blood to distribute all the cells.

4. Gently open either outlet of the plastic blood container.

5. Insert the "Y" tubing into the blood container.

F. Administration

1. Check the patient's vital signs and record on the Blood Administration Record.

2. Check to make sure that the IV site is patent. Apply arm board, if necessary, and then begin transfusion.

3. Check IV insertion site, rate of flow, and monitor for side effects. Vital signs are taken every 15 minutes times two, then PRN and at the completion of the transfusion.

4. Observe the patient closely for signs of reaction, e.g. fever (2 degrees F above the baseline), chills, rash, flank or back pain, hypotension (30mmHg below baseleine), dypnea, or uticaria (hives). ***Stop the transfusion if a reaction is suspected.*** Review "Blood & Blood Components, Transfusion Reaction" Policy.

***NOTE**: If a hemolytic reaction or anaphylactic reaction is going to occur, it usually will happen after a very small volume of blood enters the patient's circulation. A febrile reaction (2 degrees F above the baseline) may occur at any point during the transfusion or even after the transfusion.*

G. Completion of Transfusion

1. Clamp blood component bag.

2. If another unit of blood is to be transfused, obtain from the laboratory and repeat above steps. If transfusion is completed, flush the line with solution of 0.9% Normal Saline and resume parenteral infusion or maintain IV lock.
NOTE: The filter within the "Y" tubing can be used for a maximum of four hours or two units of packed red blood cells. If maximum time or number of units has been reached, the tubing must be changed prior to the administration of additional units of blood.

3. Remove blood products and tubing

   a. Dispose of blood bag and tubing in appropriate biohazard container.

   b. Return blood bags to the lab only when a reaction is suspected.

   c. The Unit Issue Card is affixed to the patient's lab sheet in the medical record.

4. Document the patient's response to the transfusion.

PLATELETS

A. Platelets should be infused rapidly due to loss of viability (1.5 to 2 hours, but less than 4 hours).

B. Use the same procedure as when ordering and verifying PRBC's.

FRESH FROZEN PLASMA (FFP)

A. Use same procedure as when ordering and verifying PRBCs.

NOTE: Laboratory will need 30 minutes advance notification to thaw the unit.

B. Administration rate for adult infusion of FFP should be at 200ml/hr. Give slowly if circulatory overload is a potential problem.

SPECIAL CONSIDERATIONS

A. Blood components must be started within 30 minutes after being signed out from Blood Bank, and should be completely infused within 4 hours.

   1. Unused blood should be returned immediately to the Blood Bank within 30 minutes of issue.

   2. If the blood is returned after 30 minutes, it may not be re-issued and must be discarded by the Blood Bank.

3. Blood should not be laid in the sunlight, on top of microwave units, or near a heat source that could result in prolonged warming.

4. No drugs or fluids other than 0.9% NaCl should be given through the IV port where the blood is infusing.

B. Informed consent must be signed prior to administration of blood component(s).

C. Reading material must be provided to the patient and/or family. A "Patient's Guide to Blood Transfusions" by the California Department of Health Services will be provided in English. Pamphlets will also be available in Spanish.

D. The patient has the right to refuse the transfusion.

E. Type and screen is good for 72 hours but still requires a cross match before blood is made available.

F. Massive Bleed Protocol and initiation of process to obtain large amounts of blood rapidly:

1. In the event of a Massive Bleed (e.g. gun shot in the ED, DIC in the OR or OB), the provider will direct the RN to contact blood bank and state "Emergency release of uncross matched blood for a massive bleed in _____."

2. Blood bank will issue 2-4 units of PRBCs and 1 unit of FFP upon request, per specific situation and will work closely with nursing services to provide continued blood products as needed. Cross matched blood will be utilized upon availability.

3. Responsible physician will sign for release of uncross matched blood upon completion of the procedure.

DOCUMENTATION

A. Complete all information on the "Transfusion Administration Record"

REFERENCES:

- Kelly, William (2022). Health and Willness. Blood transfusion reactions: a comprehensive nursing guide. obtained from https://healthandwillness.org/blood-transfusion-reactions/

- Nettina, S. (2019). Manual of Nursing Practice, 11th edition. Ambler, PA. Lippincott Williams and Wilkins. pp 777-789.

- The Joint Commission (2023). Laboratory & Point-of-Care accreditation standards. QSA 05.18.01 EP1, EP 2, & EP3 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- *Pediatric Blood Transfusion* – SVMC Policies and Procedures
- *Blood and Blood Components, Transfusion Reaction* – SVMC Policies and Procedures

SUBJECT: **DOMESTIC VIOLENCE ASSESSMENT AND REPORTING**	SECTION: ***Ethics, Rights & Responsibilities (RI)*** **Page 1 of 4**

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

PURPOSE:

To provide guidelines for assessing and interviewing suspected victims of domestic abuse.

POLICY:

Sierra View Medical Center (SVMC), in accordance with the State Domestic Violence Reporting Law, will assess patients who exhibit signs of spousal or partner abuse and, when appropriate, make an oral and written report.

AFFECTED AREAS/ PERSONNEL: *ALL PERSONNEL*

PROCEDURE:

Responsibility:

- Any health care practitioner employed in a health facility or clinic who has knowledge of or observes a patient whom he/she suspects has suffered an injury as the result of an abusive relationship, must report this to the local law enforcement agency.
- It is the responsibility of the health practitioner who observes the suspected abuse to initiate the reporting process by contacting the local law enforcement agency. A referral will be given to the Social Service Department, who will ensure that sufficient follow-up has taken place.

Abuse Assessment:

1. When assessing for abuse, some persons may be uncomfortable with the topic and may exhibit some of the following behaviors. For some women, these behaviors may be suggestive of abuse and disclosure of battering may follow at a later date:
    a. Laughing or inappropriate gesturing
    b. Lack of eye contact (Use caution as this may be cultural)
    c. Crying
    d. Incongruent mood/affect
    e. Minimizing statements
    f. Searching or engaging eye contact, expressive of fear
    g. Anxious body language: standing to leave, dropped shoulders, depressed
    h. Anger, defensiveness

i. Comments about emotional abuse, evidence of low self esteem

j. Comments about a "friend" who is abused

2. When one or more of the following circumstances exist, consider possible domestic violence:

a. Patient admits to abuse

b. Unexplained bruises, lacerations, fractures or multiple injuries in various stages of healing

c. Presence of injuries to head, neck, chest, breasts, abdomen, or genital area

d. Extent or type of injury is inconsistent with explanation given

e. Patient describes in a hesitant, embarrassed or evasive manner surrounding the alleged "accident"

f. Substantial delay occurs between time of injury and presentation for treatment

g. Frequent use of Emergency Department or other medical services

h. Untreated old injuries

i. A history of prior physical abuse

j. Psychiatric, alcohol or drug abuse history in patient or spouse

k. Depression regarding family situation, i.e., not wanting to return home, fear of safety of children, flat affect

l. Vague complaints or unexplained symptoms. Complaints of tension, stress, anxiety or insomnia, fatigue, chronic headaches, dizziness or gastrointestinal complaints

m. Previous suicide gestures or attempts

n. The presence of an overly controlling or solicitous partner, who may insist on joining the victim while being examined. The partner may even answer questions for the victim. The partner should not be allowed in or near the area where the victim is being examined or questioned.

Assessment and Interventions to be considered, as applicable:

1. Support network
2. Financial concerns/dependent on partner
3. Cultural considerations
4. Presence of children
5. Provide education and information on alternatives.
6. Determine the victim's wishes; encourage decision-making, whatever direction it may take, through supportive efforts and open communication.
7. Inform victim of the need for photographs for evidence in the event of future prosecution.
8. Facilitate communications with agencies that victim has specified a desire to interact with, and advocate on his/her behalf (i.e., finding available shelter beds).
9. Utilize local law enforcement, as necessary, for safe transport of victim to shelter or family/friend's home.
10. If patient is to be hospitalized, arrange for continued attention to his/her psychosocial needs and safety concerns while hospitalized.
11. Coordinate appropriate referrals, including legal counseling and law enforcement follow-up for emergency protective orders.

Reporting Requirements for Domestic Violence/Abuse:

Any health practitioner suspecting spousal or partner abuse of any patient coming into the Emergency Department or being admitted to the hospital must call the local law enforcement agency at (559) 782-7400. This report must be given immediately and must include information regarding the patient's name, whereabouts, injuries, and the identity of the person that the patient alleges assaulted him/her. Keep in mind that you need to share that you are making this report with the victim as this may place him/her in greater harm if law enforcement contacts the abuser. The victim may choose not to give the abuser's specific information. Accept this, as it may be his/her way of protecting themselves.

1. All patients with visible injuries should be offered photography. The victim should be informed that this is a routine, but important procedure, since the photographs will become a part of the medical record and therefore may be used for evidence if the perpetrator is prosecuted.

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2. Social Service Worker will follow up with written documentation to the law enforcement agency that day or the next business day, except in the case of patients seen in the Emergency Department. Emergency Department staff will complete their own documentation and forward this to the Social Service Department. The report will be completed on the designated form.

3. Mail Domestic Violence Reports to:
Porterville Police Department, 350 North D St, Porterville, CA 93257 (559) 782-7400

Liaison with Law Enforcement Personnel:

1. A law enforcement officer should be involved for the following reasons:

   a. At the request of the victim to make a report of the incident;

   b. As required by law;

   c. At the request of either hospital personnel or the victim, to restrain or escort the perpetrator away from the premises;

   d. As contacted for the safety of the children.

2. The law enforcement officer can be expected to inform the victim of their rights under California State Law. The officer should also answer any questions regarding law enforcement and court actions that follow from a report.

3. Community Resources: National Domestic Abuse Hotline: 800-799-7233 and Tulare County Domestic Violence Hotline 559-732-5941

REFERENCE:

- CHA Consent Manual (2023) Chapter 17. Retrieved 10/4/23 from www.calhospital.org.

SUBJECT: **ENDOSCOPES-USE AND CARE**	SECTION: **Page 1 of 7**

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

PURPOSE:

To provide guidelines to assist personnel in the decontamination, cleaning, maintenance, handling, storage, and disinfection of endoscopes and related accessories to prevent cross contamination of patients when using the endoscope for multiple procedures.

POLICY:

Prior to using endoscopes, personnel will be knowledgeable regarding appropriate endoscope selection, proper handling, inspection, testing, use, and processing. Universal precautions are employed during endoscopic procedures, and when handling and processing contaminated endoscopes, endoscopic accessories, or related equipment. Proper disinfection of endoscopes ensures infection control standards are achieved and provides a safe environment for the patient. Endoscopes must be disinfected before each procedure. Endoscopes that come in contact with mucous membranes are considered semi-critical and should receive a high level disinfection.

AFFECTED AREAS/ PERSONNEL: *OPERATING ROOMS/ENDOSCOPY/ RN, LVN/ ORT/ENDO TECH*

EQUIPMENT NEEDED:

Non -Enzymatic Detergent, High Level Disinfectant, Leak tester, Air/water channel adapter, Scope buddy, Disposable Cleaning Brush, Contoured Enzymatic Sponge, Auxiliary tube, Personal Protective Equipment, Airtime Instrument Channel Dryer.

PROCEDURE:

General Information

1. Inspect endoscope, endoscopic accessories, and related equipment prior to use for cleanliness.
2. Scopes will be inspected in like manner at the following intervals:
   a. During the procedure
   b. Immediately after use
   c. Prior to cleaning and after rinsing
   d. After drying and prior to disinfection
3. Defective/damaged scopes are sent to a scope company for repair. A loaner scope is received via overnight mail if available.

4. Processing of all endoscopes is done immediately following use. The procedure is completed using the same sequence with each cleaning and disinfection.

5. Documentation of endoscopic procedures will be done in the EMR. A permanent log of aspects of care is kept in the Surgical Services computer system.

6. The information recorded is:

   a. Patient name, medical record number

   b. Date and time of procedure

   c. Diagnosis, physician, staff providing care

   d. Medications and irrigations

   e. Specimens and culture

   f. Scope ID

CLEANING/DISINFECTION (Colonoscopes and EGD scopes) – per manufacturers guidelines

1. At bedside, attach ETO cap to all camera scopes. If scope is immersed in water without cap, rinse with sterile water.

2. All endoscopes shall receive mechanical cleaning prior to high level disinfection. Flexible endoscopes shall be cleaned with manufacturer approved cleaner immediately following use.

3. Turn the video system center and light source OFF.

4. Adjust the flexibility ring to the most flexible condition.

5. Attach the cap to the scopes that need cap.

6. Turn the light source on, remove air/water valve, and attach air/water cleaning adapter. Immerse the distal end of insertion section in water. Depress button on AW adapter for ten seconds, release, and flush with air for ten seconds. Turn light source off. Immerse distal tip in water and aspirate (500 ml for colon scope and 250 ml for EGD scope).

7. Wipe insertion tube with enzymatic sponge.

8. Flush all scopes that have an auxiliary water channel. Flush channel by using water pump and flush for ten seconds, followed by 10 seconds of air. Detach suction tubing and all other attachments from scope and transport scope to decontamination room.

9. Attach scope to leak tester, scan serial number of scope and push start button.. Once leak test is complete, detach the scope from leak tester and print results (put printed results in log)

10. .Attach scope to Scope Burddy, connect all attachements and run all five cycles.

11. Immerse scope into water and wipe with sponge.

12. Insert cleaning brush at a 45 degree angle into the air channel using short strokes, feed brush until it immerges at distal end, and repeat until debris is removed. Next, insert cleaning brush at a 90 degree angle into the air channel using short strokes feed brush through until it immerges out the suction connector. Pull brush out completely and repeat until debris is removed. (All channels must be brushed a minimum of 2 times or until clean).

13. Discard cleaning brush, sponge, and buttons. Discard detergent water (Discard all detergent solutions after each use).

14. Once scope has been manually cleaned , place scope in covered bin and transport to AER for disinfecting process.

15. All reusable accessories (i.e., cytology brushes, biopsy forceps) which penetrate mucosal barriers will be mechanically cleaned and sterilized between each patient..

16. When High Level Disinfecting is complete. Remove scope from AER and use the Airtime Instrument Channel Dryer (follow manufacture guidelines).

17. Ensure that any time an instrument, brush, forcep, etc. is introduced into a scope, that it is fully intact upon removal.

ERCP SCOPES TJF-Q190V

1. Immediately after, wipe off endoscope with lint free sponge & non-enzymatic detergent (wipe entire insertion section from boot to distal end).

2. Remove single use distal cover and discard. Then confirm that the instrument channel outlet of the distal end is open by turning the elevator control lever (forceps elevator should be up). Wipe distal end of the endoscope with wet sponge.

3. Turn on suction pump and close the biopsy valve cap.,
4. Immerse the distal end of the endoscope (insertion section) in water.

5. Depress the suction valve and aspirate water into the channel for 30 seconds or more.

6. While continuing the immersion and aspiration, close and open the instrument channel outlet (3 times), by turning the elevator control lever.

7. Remove distal tip from water.

8. Depress suction valve and aspirate air for 10 seconds or more.

9. Turn off suction pump.

10. Turn light source on .

11. Switch off the air flow regulator on the light source, detach air/water valve from the endoscope and place in detergent solution.

12. Attach the air/water channel cleaning adapter and immerse the distal end in the clean water.

13. Turn on the light source and switch the airflow to "High."

14. Depress the air/water channel cleaning adapter to flush the air channel with water for 30 seconds or more.

15. Release the button to flush the air/water channel with air for 10 seconds or more and Turn off light source.

16. Disconnect and remove reusable parts from the endoscope.

Once scope has been manually cleaned at bedside, place scope in covered bin and transport to decontamination room.

17. Place air/water channel cleaning adaptor and any other reusable parts in detergent solution, and clean per manufacture guidelines.

18. Prepare basin with clean water and detergent solution, to the appropriate level and concentration recommended by the manufacture.

19. Attach scope to leak tester, scan serial number of scope, ensure it has automatically changed to manual settings, push start button, and follow the directions.,,. Once leak test is complete, detach the scope from leak tester and print results (put printed results in log).

20. Immerse scope into rthe detergent solution and wipe entire endocscope with sponge, until no debris is observed.

21. Confirm that the instrument channel outlet of the distal end is opened (by turning the elevator control). Immerse distal end in the detergent solution and insert brush into the instrument channel along the forceps elevator. Completely pull brush out and repeat 2 more times.

22. Keep distal end immersed and rotate brush one full rotation in each direction to clean guidewire-locking groove. Remove brush and then remove distal end from detergent solution. Inspect for any debris on the forceps elevator. Repeat if debris is observed.

23. Move the elevator control to close the instrument channel outlet. Immerse scope in detergent solution and insert brush to the back of the forceps elevator. Brush bottom of the forceps elevator, the groove, the forceps elevator recess, and the lens. Remove brush and then remove distal end from detergent solution. Inspect for any debris on the back of the forceps elevator. Repeat if debris is observed.

While immersing the endoscope completely in the detergent solution, insert cleaning brush at a 45 degree angle into the suction channel using short strokes, feed brush until it emerges at distal end, repeat until debris is removed. Next insert cleaning brush at a 90 degree angle into the suction channel using short strokes, feed brush through until it emerges out the suction connector. Pull brush completely out and repeat until debris is removed (All channels must be brushed a minimum of 2 times for each task or until clean).

24. Brush all ports (suction cylinder and instrument channel port).

25. Confirm instrument channel outlet of the distal end is open.

26. Lower the forceps elevator by turning the elevator control lever in the opposite direction of the "U" direction until it stops, and brush thoroughly. Straighten distal end of scope..

27. Insert brush into the forceps elevator recess along the forceps elevator until the brush handle touches the distal end of the endoscope, and pull the brush out of the forceps elevator recess.

28. Raise the forceps elevator by turning the elevator control lever in the "U" direction until the operator feels heavy.

29. Attach distal flushing adapter (MAJ-2319), then attach green cover clip to the shaft of the white cover until secured.

30. Use 30ml syringe with detergent solution to flush the distal end with 180ml of detergent solution through the white flushing port. Detach syringe.

31. Flush the green flushing port with 180ml of detergent solution.

32. Remove distal end flushing adapter, while keeping scope submerged in detergent solution.

33. While keeping scope submerged in detergent solution, close and open channel outlet. Confirm channel outlet remains open.

34. Attach scope buddy to endoscope then turn on scope buddy.

35. Once scope has been manually cleaned, place scope in covered bin and transport to AER for disinfecting process.

36. When High Level Disinfecting is complete. Remove scope from AER and use the Airtime Instrument Channel Dryer (follow manufacture guidelines).

37. All reusable accessories (i.e., air/water channel cleaning adapter) will be mechanically cleaned and sterilized between each patient,per manufacture guidelines..

STORAGE & ACCESSORIES

- Scopes are vertically stored in a protective area without ETO cap or buttons. Do not store the endoscope coiled.
- All accessories used with the endoscope are cleaned and disinfected in the same manner.
- Scopes are rotated and reprocessed every 7days, if not in use.

REFERENCES:

- Society of Gastroenterology Nurses and Associates, Inc. (2016). Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes. Retrieved from http://www.sgna.org.
- Olympus. (2012). Reprocessing Manual. Japan: Olympus Medical Systems Corp.

SUBJECT: **FLUID RESTRICTIONS**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 2**

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

PURPOSE:

To ensure that patients with a fluid restriction receive the appropriate amount of fluid to meet the physician's orders.

POLICY:

Patients/residents requiring fluid restrictions will receive a determined amount of fluid from Food and Nutrition Service (FNS) on the meal trays and a determined amount from the nursing staff each day.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, PATIENT CARE AREAS*

PROCEDURE:

1. Nursing will notify FNS of patients/residents requiring fluid restrictions via the electronic medical record (EMR). Fluid restrictions shall be ordered under diet modifications within the diet order, which will include the total daily amount of fluid to be given. *For example: 2 gram low sodium diet, 2000 cc fluid restriction.*

2. FNS will limit fluid on trays as specified by the guideline listed below.

3. Nursing limits the total fluid as specified by the guideline listed below, with extra fluid allowed if intake fluid from the trays is refused.

4. Nursing staff will record the amount of fluids taken in the electronic medical record (EMR) per policy.

5. The following items will be considered as fluids:

    a. Hot and cold beverages
    b. Soups
    c. Ice cream and sherbet
    d. Fruit ices
    e. Gelatin
    f. Water, juice
    g. Milk, coffee, tea
    h. Mighty shakes, Ensure, Glucerna, etc.

6. The following items will NOT be considered as fluids

    a. Custard, pudding
    b. Hot cereal
    c. Sauces, gravy, au jus
    d. Jelly

7. Fluid restriction schedule for FNS and Nursing in a 24 hour period:

FLUIDS RESTRICTION	NURSING	FNS	B	L	D
500 cc or less	500 cc	Dry Tray	0	0	0
1000 cc	600 cc	Dry Tray	0	0	0
1200 cc	700 cc	500 cc	240	120	120
1500 cc	900 cc	600 cc	240	180	180
1800 cc	900 cc	900 cc	360	300	240
2000 cc	1000 cc	1000 cc	400	300	300

8. Fluid amounts for standard containers and foods:

   a. Water Pitcher *(plastic insert filled to bottom of indentation)* – 900 cc
   b. Tumbler - 240 cc
   c. Thermal Cup - 180 cc
   d. Soup Bowl - 180 cc
   e. Milk - 8 oz. or 1 cup - 240 cc / 4 oz. or ½ cup –120 cc
   f. Carbonated Beverages - 12 oz. - 360 cc
   g. Ice Cream/Sherbet/Italian Ice 120cc, Popsicle - 90 cc
   h. Fruit Juice - 120 cc
   i. Ensure (1 carton) - 240 cc
   j. Gelatin - 120cc
   k. Fruited Gelatin – 60 cc
   l. Coffee - 8 oz. or 1 cup -240 cc / ½ cup Coffee – 120 cc

9. Standard Calculation for ounces to cc.

   a. 1 oz. = 30 cc
   b. 2 oz. = 60 cc
   c. 3 oz. = 90 cc
   d. 4 oz. = 120 cc
   e. 6 oz. = 180 cc
   f. 8 oz. = 240 cc

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. PC.02.02.03, EP 7
- CMS Title 42 Regulations: Chapter 4 § 482.28(b)(1)

SUBJECT: **INFECTION CONTROL GUIDELINE FOR PEOPLE WITH HEAD LICE (PEDICULUS HUMANUS CARPITIS)**	SECTION: **Page 1 of 5**

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

INTRODUCTION

Pediculosis (head lice infestation) is caused by a parasitic insect *Pediculus humanus capitis* that feeds on human blood. Although they are found throughout the world *P. humanus capitis* is not known to spread disease. Head lice move by crawling and do no jump, hop or fly, thus requiring close contact to spread. Infestation is most likely to occur among children attending day care, elementary school and the family members of those children. This policy covers information to prevent the transmission of like within the healthcare setting.

PURPOSE

To prevent the transmission of lice within the healthcare setting.

AFFECTED PERSONNEL AND AREAS

All staff in clinical areas, all employees and all patients.

GENERAL INFORMATION, DEFINITIONS AND IDENTIFICATION

Head lice are small insects 2-3 mm long that inhabit and infest the head and hairy parts of the body. They attach their eggs (nits) to the base of the hair shaft, most commonly behind the ears and back of the head.

Types of lice:

- Pediculus capitis – Head lice are attached to the individual hair shafts, eyebrows, or eyelashes.
- Pediculosis corporis – Body lice are found on the skin and/or clothing
- Phthisis pubis – Crab lice usually found in the pubic area, but can been seen in eyelashes and axillary hair.

Pediculosis is the infestation of the head and hairy parts of the body with adult lice.

Lice have an incubation period of 7 – 14 days from the time of exposure to the causative agent until the first symptoms develop.

Lice life cycle

- The eggs of body lice are called nits, which are difficult to see and are often mistaken for dandruff. Nits are oval in shape and are about 0.8 mm by 0.3 mm, and are usually yellow to white in color. Nits take about one week to hatch.
- A nymph is released when the nit hatches. The nymph looks like an adult louse but is about the size of a pin head. A nymph will molt 3 times within a 7 day period at which point it becomes a mature adult louse.
- The adult louse is approximately the size of a sesame seed and has 6 legs. Its color may run from tan to grayish-white. Female lice may lay up to 8 nits per day and an actively feeding adult lice can live up to 30 days on the body.

The mode of transition requires direct person-to-person contact or contact with infected combs, brushes, towels, bedding or furniture. Transmission may occur as long as the nits are viable and/or the lice are alive on the infested person or object

The symptoms of infestation include severe itching and excoriating of the scalp and body. Infestation must also be present to initiate treatment. There is minimal risk of an employee to contract lice from a patient, because close, prolonged contact must occur.

PROCEDURE

PATIENT PRECAUTIONS

1. Place patient in Contact Isolation:
    a. Gown and gloves for contact with patient, patient's clothing and bed linens (long hair should be pulled back and placed in a disposable hair bonnet).
    b. All bed linens must be bagged in a plastic bag. Tie bag closed; change into a clean pair of gloves and take to laundry bag.
    c. Place patient's clothing and headwear in a plastic bag and send home.
2. Notify Physician and get an order for head lice treatment.
3. DURATION OF PRECAUTIONS: Until 24 hours after therapy has been given. Check with Pharmacy to see what is available (i.e., Permethrin 1%, Malathion).
4. Examine patient 48 hours after therapy administered to verify effectiveness. Usually only one treatment with permethrin is required because residual activity on the hair is effective in killing any lice that hatch from still viable eggs.

TREATMENT

- Both over-the-counter and prescription medications may be used for treatment
- Retreatment of head lice is recommended because no approved pediculicide is completely ovicidal
- Before applying treatment, it may be helpful to remove clothing that can become wet or stained during treatment
- Apply lice medicine, according to the instructions contained in the box or printed label. Patients with long hair, may need a second bottle
- Follow instructions on label or in the box regarding how long the medication should be left on the hair and how it should be washed out
- Have patient put on clean gown after treatment
- Apply clean linen to patient's bed
- Retreat as recommended

When treating head lice:

- Do not use extra amounts of any lice medication unless instructed to do so by the physician and pharmacist
- Medications should be kept out of the eyes. If medication gets in the eyes, flush eyes immediately with water
- Do not treat patient more than 2 – 3 times with the same medication if it does not seem to be working. Notify the MD.
- Do not use different head lice drugs at the same time unless instructed to do so my MD.

Treatment for Pediculosis corporis (body lice):

- Improving hygiene and access to regular changes of clean clothes is the only treatment needed for body lice infestations

Treatment for public lice

- Both over-the-counter and prescription medications are available for treatment
- Wash the infested area: towel dry

- Follow the instructions in the package or on the label
- Thoroughly saturate the pubic hair (infested area) with lice medication.
    - **Warning**: See special instructions for treatment of lice and nits on eyebrows or eyelashes
- Leave medication on hair for the time recommended in the instructions
- Remove the medication by carefully following the instructions on the label or box
- Following treatment, most nits will still be attached to hair shafts. Nits may be removed with fingernails or by using a fine-toothed comb
- Put on clean underwear and clothing after treatment
- Repeat treatment in 9-10 days if live lice are still found

REPORTING

Report all inpatient cases to the Infection Prevention Department (IP RN or IP Manager)

ENVIRONMENTAL CLEANING

Routine cleaning by Housekeeping/EVS

EMPLOYEE

When a patient with lice is identified, Infection Prevention must be notified by the department where the patient is located. Both Infection Prevention and employee(s) will notify Employee Health.

1. Employee must report to EHS if there is evidence of skin/hair infestation with lice or nits
2. Employee Health Services will:
    a. Identify the type of exposure
    b. Refer employee(s) to a private physician for consultation and treatment
3. Treatment Plan
    a. The employee is to follow the physician's treatment recommendations

REFERENCES

- Parasites: Lice/Head Lice, Centers for Disease Control and Prevention. Retrieved December 20, 2023 from https://www.cdc.gov/parasites/lice/head/index.html, last Reviewed: June 15, 2023.
- Parasites: Lice/Head Lice, Resources for Health Professionals, Centers for Disease Control and Prevention. Retrieved December 20, 2023 from https://www.cdc.gov/parasites/lice/head/health_professionals/index.html, last reviewed: September 26, 2019.
- Parasites: Lice/Head Lice, Treatment, Centers for Disease Control and Prevention. Retrieved December 20, 2023 from https://www.cdc.gov/parasites/lice/head/treatment.html, last reviewed: October 15, 2019.
- California Code Regulations, Title 22, § 70723 - Employee Health Examinations and Health Records. Retrieved December 20, 2023 from Legal Information Institute, https://www.law.cornell.edu/regulations/california/22-CCR-70723

SUBJECT:	SECTION:
PRISONERS / WARDS OF LEGAL SYSTEM -- CARE OF	***Leadership (LD)*** **Page 1 of 3**

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

PURPOSE:

To define the duties and responsibilities of staff responsible for caring for patients in police or protective custody.

POLICY:

It is not the policy of Sierra View Medical Center (SVMC) to routinely provide care to patients in police custody; however, such patients may be admitted from time to time because they are not transferable. In that event, the appropriate level of care will be provided by Sierra View Medical Center until the patient may be transferred to an appropriate facility, pursuant to policies and procedures governing interfacility transfers.

In the case of the admission of a patient in police custody, the law enforcement agency involved shall be responsible for ensuring the security of such patient while he/she is on the premises of Sierra View Medical Center.

Whenever a law enforcement agency is involved in the supervision of a patient under treatment or observation at the Hospital, such patient shall be considered to be in police custody until Hospital personnel are informed otherwise. Upon conclusion of treatment and/or observation, the involved law enforcement agency shall be responsible for escorting the patient from the facility.

AFFECTEDAREAS/PERSONNEL: *ALL HOSPITAL PERSONNEL*

PROCEDURE:

The following procedures are to be followed whenever a "custody patient" is treated at Sierra View Medical Center:

RESPONSIBILITIES OF NURSING SERVICES/UNIT STAFF:

1. In the event that an individual in police custody is brought to the Hospital for treatment and/or observation, it shall be the responsibility of the staff of the Nursing Services Department to notify the Hospital's Security Department personnel.

2. Unit staff shall immediately notify the Charge Nurse of the Unit and the Nursing Supervisor that such a patient has been admitted.

3. In the event that a patient under legal or correctional restriction refuses to cooperate with the staff of the Nursing Services Department, becomes combative, displays any other unacceptable behavior, and/or elopes from the treatment area, the staff of the Nursing Services Department shall immediately notify the Hospital's Security Department.

4. In the event that such patient decides to leave the Hospital, nursing personnel are NOT to attempt to physically restrain the patient; rather, they are to immediately contact the Security Department,

at which time they are to provide the patient's last known direction of travel and time of departure.

UNDER NO CIRCUMSTANCES SHALL NURSING PERSONNEL RISK PERSONAL PHYSICAL INJURY IN ORDER TO HOLD A PATIENT FOR TREATMENT.

RESPONSIBILITIES OF THE SECURITY DEPARTMENT

1. Whenever a patient is brought to the Hospital by a law enforcement agency or is admitted under legal or correctional restriction, the Hospital's Security Department is to be notified.

2. When so notified, the Security Department will obtain information to include but not be limited to:

   a. The patient's name, gender and age;

   b. The reason why the patient is being monitored (e.g., because he/she is in police custody, is a danger to himself/herself and/or others, etc.);

   c. The name of the responsible party (police officer);

   d. A full physical description of the patient.

3. In the event that the Security Department is notified about any security-related issue/problem involving a patient in police custody, such will be considered a priority call for assistance, to which Security Officers will respond immediately.

4. Should a patient in police custody attempt to leave the facility, the police officer assigned to guard the patient should be assisted in obtaining back-up assistance from his/her agency. Security Officers should not attempt to physically detain such a patient unless the patient commits another crime, becomes violent, or engages in behavior that endangers himself/herself or others. Leaving against medical advice shall not be considered justification for a Security Officer to use any physical force whatsoever.

RESPONSIBILITIES OF LAW ENFORCEMENT AGENCY

1. Those persons assigned the responsibility of guarding patients in police custody are expected to conduct themselves in a professional manner at all times while on Hospital premises.

2. No arresting agency shall be permitted to leave a charged or convicted individual unguarded on Hospital premises.

3. All such law enforcement agency staff will be dressed in appropriate uniforms displaying agency affiliation and bearing name badges.

4. Unless a sworn law enforcement officer, staff members supervising patients in custody are not to be permitted to carry a weapon on Hospital premises.

5. Coffee, soft drinks, etc., are not to be provided by the nursing unit.

6. If the law enforcement officer must vacate his/her assigned post for any reason, relief must be arranged through the appropriate law enforcement agency, as applicable.

7. The law enforcement officer or sitter, as applicable, is to remain in the room with the patient; he/she shall not stand in the doorway or hallway except at the specific request of the patient care staff to ensure patient privacy.

SAFETY CONSIDERATIONS:

1. Prisoners shall not be permitted to have telephones in their rooms.

2. Prisoners are not allowed visitors, nor will any patient in police custody be permitted to receive packages from outside the Hospital.

3. Nourishment ordered by a physician will be served, as will, if indicated, a bedtime snack. Additional snacks and refreshments will not be served by Hospital staff. Prior to trays being given to the patient, nursing should ensure that only paper or plastic products are provided.

4. If more than one patient in police custody is admitted, up to two (2) may be placed in a semi-private room with one officer serving as guard, unless contraindicated by the involved law enforcement agency or mitigated by either patient's medical condition.

5. If a patient requires an assisted shower, an employee of SVMC should provide such assistance with the officer present.

6. Any inappropriate behavior on the part of a patient in police custody shall be reported immediately to the Unit Director, House Supervisor and law enforcement officer.

7. If the use of handcuffs or leg shackles is deemed necessary by the law enforcement agency, the nurse assigned to the patient must be made aware of the location of the key in the event of an emergency, and a sign should be placed at the head of the patient's bed, stating, "Metal restraints in use; remove prior to defibrillation." All other behavioral or medical restraints shall be implemented in accordance with Hospital policy.

GENERAL CONSENT AND PRIVACY FOR FORENSIC PATIENTS

A forensic patient with the capacity to make health care decisions has the right to consent (or withhold consent) to medical examinations, treatment, or procedures before they may be performed. If the patient lacks the capacity to make health care decisions or is a minor, an appropriate legal representative should be found, if possible. For state prisoners, the California Department of Corrections and Rehabilitation (CDCR) medical director or CDCR case manager will contact any next of kin or surrogate decision maker, if available. If there is no surrogate decision maker available, the hospital should use the same process as it does for unrepresented patients while gathering information from available sources about the patient's values and best interests.

Although law enforcement officers may not consent for the patient, in narrowly defined circumstances law

enforcement officers may request limited medical examinations and tests pursuant to their authority to make constitutionally permissible searches. In addition, specific rules govern drug and alcohol tests performed pursuant to Vehicle Code Section 23612.

The hospital may disclose medical information to jail or prison physicians or nurses as needed to provide follow-up care to the forensic patient. Guards should be told only the information they need to guard the patient; they should not have access to the patient's medical record. Of course, officers who stay in the room to maintain security may overhear medical information because of the need for them to be in close physical proximity to the patient during treatment. These disclosures are incidental to a lawful use of the patient's medical information and do not constitute a privacy breach.

EMTALA CONSIDERATIONS

If a person is brought to a hospital and a request is made for emergency services by or on behalf of the patient, whether by a law enforcement officer or anyone else, the patient must be given a medical screening exam pursuant to the Emergency Medical Treatment and Labor Act (EMTALA). If the patient has an emergency medical condition, he or she must be provided stabilizing treatment to the extent possible, and/or transferred to an appropriate facility.

REQUESTS FOR EVALUATION OR TREATMENT

Physicians and other hospital personnel should not perform medical evaluations or procedures requested by law enforcement officers except in the following circumstances:

1. The patient or legal representative consents
2. A medical emergency exists and the patient does not object to the treatment
3. The officer requests a noninvasive medical evaluation to determine if it is medically safe to incarcerate the person
4. The officer requests a blood test pursuant to Vehicle Code Section 23612 and the patient does not forcibly resist
5. The officer requests the medical evaluation or procedure to be performed pursuant to his or her authority to conduct constitutionally permissible searches
6. The officer requests the medical evaluation or procedure to be performed pursuant to a valid court order; or
7. The request involves the collection and release of evidence of rape or other sexual assault from an alleged victim

For additional information pertaining to blood draws requested by law enforcement, see the 2023 CHA Consent Manuel; chapter 9.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- California Hospital Association; Consent Manuel e-dition (2023). Referenced Chapter 9 and 20. https://publications.calhospital.org/issues/consent/quick-reference

SUBJECT:	SECTION:
SOLUTIONS, MONITORING TEMPERATURE OF SOLUTIONS	***Provision of Care, Treatment & Services (PC)***

PURPOSE:

To establish guidelines for the safe storage of warmed solutions, parenteral and irrigation, used in the Operating Room and Post Anesthesia Care Unit (PACU) / Flex Care.

POLICY:

1) All solutions, parenteral or irrigation, in plastic containers will be stored according to conditions specified on the individual product label.

2) Warming cabinets used for solutions:

- Will be monitored for temperature, the temperature of the cabinet will be maintained at the recommended temperature for the solutions.
- Maintained in accordance with manufacturer's recommendations.
- Loaded correctly and not exceed the level or quantity specified by the manufacturer's instructions for use (over-loading can be a source of fire).
- Only contain items that the warming cabinet was designed for. Blankets and fluids are not to be commingled in a warming cabinet unless specifically designed for that purpose.

3) A daily log will be maintained for the temperatures of the cabinets.

PROCEDURE:

Warming recommendations:

1. Large Volume Parenterals:

   a. Solutions of volumes 150ml or greater can be warmed in their plastic over-pouches to temperatures not exceeding 40 degrees C or 104 degrees F and not longer than 14 days.

2. Irrigation Solutions Plastic Pour Bottles

   a. Solutions can be warmed to temperatures not exceeding 50 degrees C or 122 degrees F and not longer than 60 days.

3. Irrigation Solutions (urology and arthroscopy)

   a. Solutions in their over-pouches can be warmed to temperatures not exceeding:

      - 45 degrees C or 113 degrees F not longer than 14 days

- 66 degrees C or 150 degrees F not longer than 72 hours

Solutions that have been warmed for the maximum time will be removed from the cabinet and can be used at room temperature until the expiration date on the bottle. **DO NOT RE-WARM SOLUTIONS.**

REFERENCES:

- Baxter Health Care Corporation, Product Information Center (2017).

- AORN. Environment of Care. Warming Cabinets. (2018). https://aornguidelines.org/guidelines/content?sectionid=173720645&view=book#200100611.

Senior Leadership Team	2/27/2024
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	2/27/2024

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
February 27, 2024
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	Action
Policies:		Approve ↓
1. Attendance and Punctuality	1-5	
2. Competency Assessment Process	6-14	
3. Compliance Education and Training	15-17	
4. Compliance Issue Reporting	18-20	
5. Compliance Quarterly Report	21-22	
6. Simulation Lab Program	23-31	
7. Solicitation and Distribution of Literature	32-33	

SUBJECT: **ATTENDANCE AND PUNCTUALITY**	SECTION: **Page 1 of 5**

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

PURPOSE:

To establish a standardized procedure for the reporting and handling of absences in order to ensure the consistent and equitable treatment of employees.

POLICY:

In order to ensure quality patient care and to fulfill your job responsibilities, it is important that all employees are present at work at scheduled times and are able to perform the duties required of their job(s). In declared emergencies/disasters at the local, State, and National levels, healthcare providers are considered disaster service workers and are required to report to work. Exceptions must be approved by Human Resources.

DEFINITIONS:

1. ***Absence Occurrence*** is a failure to report to work on a scheduled day and time due to personal reasons, illness and/or family matter. Absences related to protected sick leave, bereavement leave, family or medical leave of absence, disability leave of absence or worker's compensation will not be counted as an absence occurrence. Extra shifts are considered part of the regular schedule and will have the same attendance expectations under this policy.

   If the absence is not to be considered an absence occurrence, employees must have prior written/verbal supervisory approval within a consistent time frame as determined by each Department. Approval is granted by the Department Director and is based on factors such as staffing needs, workload and the employee's attendance history.

   During times of declared emergencies/disasters or other extenuating circumstances involving emergency situations exceptions will be considered and reviewed on a case-by-case basis by Human Resources to determine if the absence(s) will be considered an absence occurrence.

2. ***Partial Absence Occurrence (arriving late/leaving early)*** – is arriving at work late or leaving work early without written or verbal supervisory approval.

   Tardy is defined as clocking in eight (8) or more minutes after the employee's scheduled start of shift and/or after the employee's 30 minute meal break, are considered a partial absence occurrence. Leaving work early is defined as clocking out eight (8) or more minutes before the end of the employee's scheduled shift and is considered a partial absence occurrence. Employees are expected to be at their workstation at the start/end time of their shift. Continued patterns of clocking in after the start time of a scheduled shift (one or more minutes late) and/or not remaining in their workstation until the end of the employee's scheduled shift (one or more minutes early)may result in disciplinary action.

   Two (2) partial absences (arriving late/leaving early) will be counted as one absence occurrence.

3. ***Consecutive Days*** – is an absence occurrence of one or more consecutively scheduled workdays missed due to the same illness.

   In a declared emergency/disaster related to a medical situation like a pandemic, a physician's note will be required after the third day of work missed.

4. ***Non-Consecutive Days*** – Non-consecutive days are considered separate and unrelated absence occurrences, except for interrupted workdays missed due to the same illness, i.e. staff who are absent two (2) days of work, return to work and are still too sick to work and go home mid-shift.

5. ***Catastrophic Injury or Illness*** – (Heart attack, trauma, stroke, major broken bones, etc.) A catastrophic injury or illness will not be considered as an absence occurrence in this policy

PROTECTED TIME OFF:

1. ***Sick Leave -*** An employee may be absent by use of available sick leave hours for the purposes noted in the Sick Leave policy and not have it count as an absence occurrence. If an employee's available sick leave hours do not cover the full time absence, the remainder of such time not covered by available sick leave will be considered a partial absence occurrence. If an employee does not have any available sick leave hours for their absence, the absence is not considered a sick leave absence and will count as a full absence occurrence.

   If the employee believes that any of the absences should not be counted as an occurrence because the absence is protected by law governing time off from work, the employee must provide information at that time, prior to the implementation of the corrective plan of action.

2. ***Chronic Medical Condition*** – If an employee has been identified as having a chronic medical condition as exemplified by the federal Americans with Disability Act (ADA) or the California Fair Employment Housing Act (FEHA) that at intermittent times keeps the employee from work, these times may not count toward an absence occurrence. It is required that an employee with a chronic illness work with both Human Resources and their health care provider to minimize, as much as possible, the impact the absences may have on the department. The employee is required to provide reasonable advance notice when she or he is able, but not when the absence is emergent. The employee is required to comply with the Hospital's normal attendance call-in and notification procedures. Human Resources, in collaboration with Department leadership, will be responsible for determining if any modifications to the employee's work schedule or duties need to be made. Where appropriate, Sierra View Medical Center shall grant the employee intermittent leave under the provisions of the applicable statutory family/medical leave acts.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

GUIDELINES FOR CORRECTIVE ACTION

The following guidelines are to be followed for absence occurrences excluding Sick Leave and other absences protected by law governing time off from work:

3 occurrences	Employee receives a Verbal, Documented
4 occurrences	Employee receives a Written Warning.
5 occurrences	Employee receives a Final Written Warning with possible demotion and reduction in pay if in a lead position or above
6 occurrences	Employee is Terminated.

To be considered for disciplinary action, the absence occurrence must have occurred during the last rolling 12-month period. Any occurrences prior to this time frame will not be considered.

In a declared emergency/disaster, Human Resources will assess occurrences on a case-by-case basis. Any employee requiring written corrective action will meet with their department head and a corrective plan of action will be determined, i.e. not allowed to sign-up for extra shifts or call time, change in status to part-time, leave of absence, etc.

Pattern Absenteeism:

Employees will be considered to have a pattern of unscheduled absences if their absences tend to occur immediately before or after previously approved scheduled days off, immediately before or after a holiday(s), the weekend, occur at regular intervals or on consistent days, occur immediately following disciplinary action, or occur on days previously requested off but not approved/or denied such request. Patterns of absences will be considered misconduct and maybe subject to disciplinary action.

Where there are parallel or overlapping incidents of absenteeism, tardiness and/or no call/no shows, the disciplinary action may be accelerated.

During the introductory period of a new employee, absenteeism or incidents of tardiness may result in disciplinary action up to and including separation of employment.

However, nothing in this policy alters the employee's at-will employment status and SVMC's ability to terminate an employee's at-will employment with or without cause at any time.

When employees are unable to report to work for the beginning of their shift, they must call their supervisor (2) two-hours before their scheduled shift. Exceptions will be considered based on how emergent the situation was that prevented the 2-hour notification.

It is the responsibility of the Department Director or Designee to track and review absence patterns of all employees in his/her department(s). Prior to final corrective action, the appropriate Vice-President and Human Resources Department must review attendance history and performance.

Directors/Managers must notify Human Resources when employees are absent for more than 3 days, as they may qualify for a protected Leave of Absence.

MAKE-UP POLICY

If the employee called off on their scheduled weekend days, they will automatically be scheduled to work the following weekend, one or both days, depending upon which one(s) they called off. *The employee may be required to work a number of weekends in a row if the employee has missed more than one weekend commitment. Exception: Those employees who regularly work every weekend and call in sick will be required to complete their "make-up day" at the discretion of the Department Director.*

If the absence is covered with the Sick leave bank or Intermittent FMLA, the employee will not be required to make up the shift.

Failure to actually work on the following scheduled weekend will result in disciplinary action. Exceptions may be pre-authorized only by the appropriate Vice-President.

REPETITIVE WRITTEN WARNINGS

Upon receiving the third corrective action for attendance within a rolling twelve (12) month period, the employee will be subject to termination of employment.

NO CALL/NO SHOW - FAILURE TO REPORT TO WORK AS SCHEDULED

It is the employee's responsibility to follow the notification procedure as designated by his/her department when reporting an unscheduled absence. Failure to report to work as scheduled is a serious offense.

A No Call/No Show will result when one of the following occurs:

- Employee fails to call in within the first fifteen (15) minutes of the start of an assigned shift
- Employee fails to call and reports to work fifteen (15) minutes or more after the start of an assigned shift
- Employee fails to report to work for assigned shift.
- First No Call/No Show is a Final Written Warning
- Second No Call/No Show is termination.

A single incident of a No/Call/No Show may escalate the disciplinary process up to and including termination when there is a documented record of occurrences for attendance. When reviewing action to be taken as a result of an employee's failure to report to work or provide appropriate notification, consideration will be given to the length of time between occurrences, as well as the number of occurrences within the rolling twelve month calendar for attendance occurrences purposes.

UNAUTHORIZED LEAVE DURING A SHIFT

Employees who report to work and leave the facility early without communication and authorization from their supervisor will receive a final written notice for leaving their shift early without prior notification and/or approval. If a second incident occurs within the rolling twelve month calendar, it would result in separation of employment.

A single incident of an incomplete shift due to an unauthorized leave may escalate the disciplinary process up to and including termination when there is a documented record of occurrences for attendance. When reviewing action to be taken consideration will be given to the length of time between occurrences and the number of occurrences.

ABANDONMENT OF POSITION

Three (3) Consecutive Days of failure to report to work without notification to the hospital will be considered job abandonment and a voluntary resignation.

CROSS REFERENCES:

- Recording Hours Worked policy
- Sick Leave Policy

SUBJECT: **COMPETENCY ASSESSMENT PROCESS**	SECTION: **Page 1 of 9**

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

PURPOSE:

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

DEFINITION:

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

POLICY:

Methods utilized for competency assessment will be based on job title.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

The following assessment methods will be utilized for all job titles in the organization:

1. Pre-Employment Assessment: Competence begins with the evaluation of the individual's qualification for the particular position based on the position's scope and requirements. Pre-employment competency assessment will include, but is not limited to, validation of the following:

    a. Licensure, registration, cards of completion and certification (where applicable)

    b. Previous experience and current skills and abilities through the interview process, reference checking, résumés and applications

2. Performance Appraisals: During the initial and annual performance appraisal process, competency is evaluated to determine ability to meet job requirements and to identify opportunities for improvement. In response to the appraisal, the manager/director may develop an action plan to improve performance. Some factors that may be considered during the appraisal process are the individual's:

    a. Ability to exercise independent judgment as appropriate

    b. Ability to competently carry out specific components of patient care or support services

    c. Understanding of their role in the organization

d. Success in meeting customer needs

Additional methods of competency assessment are required for specific job titles within the organization as listed in Appendix A. This process is outlined below:

1. Initial Competency Assessment: Within the first 90 days of employment, an initial competency assessment will be completed. This assessment may include validation of the following:

   a. Core job functions

   b. Frequently used functions and accountabilities

   c. High-risk, low-volume job functions and accountabilities

2. Annual Competency Assessment: Competency assessment will continue on an ongoing, annual basis. Annual competency assessment may include validation of the following:

   a. New policies, procedures, equipment, technologies, service lines and initiatives

   b. Changing policies, procedures, technologies and initiatives

   c. High-risk, low-volume functions and accountabilities

   d. Problematic job aspects identified through performance improvement data, incident reports, customer surveys, review of aggregate competency data, etc.

3. Competencies will reflect the employee's job description, focuses on performance standards and behaviors necessary to perform core job functions.

4. Each department is responsible for identifying competencies to meet the job performance standards and behaviors, and for determining the appropriate methods for validating those competencies.

5. Methods of validating competencies include direct observation of work, return demonstration /teach back, simulation, written testing, exemplars, presentations, case studies and performance improvement monitors.

6. Competency validation is documented and kept accessible in staff competency folders in each department and/or in the facility electronic Learning Management System (LMS). A standardized hospital-wide format will be utilized for documenting competency validation.

7. Employees will function under the supervision of a preceptor/resource person until designated competencies have been validated.

a. The preceptor/resource person will have documented competency validation in the specific knowledge, skills and technologies necessary to orient and validate competency in others.

b. The employee and assigned preceptor/resource person share responsibility for completing competency assessment and submitting documentation within the established time frames

PROCEDURE:

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

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

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

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

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

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

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

   e. Providing education to employees on the competency process

   f. Monitoring employees progress

   g. Participating in evaluation of the competency process

3. The employee is responsible for:

   a. Completing competencies as indicated

   b. Participating in competency development

Validation of Individual Competencies

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

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

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

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

REFERENCES:

- Bruce, S., (Ed). (2017). Core Curriculum for Nursing Professional Development. (5th Ed.) Chicago, IL: Association for Nursing Professional Development. Chapter 26: Competency Management.
- The Joint Commission (2020). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- OMH CLAS Standards – Standards 2 and 6
- California Code of Regulations (2020). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCES:

- Human Resources Management Plan
- Performance Review Process

APPENDIX A

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

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

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

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

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

SUBJECT: **COMPLIANCE EDUCATION AND TRAINING**	SECTION: **Page 1 of 3**

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

PURPOSE:

To identify the process for the development and implementation of regular, effective compliance education and training for employees of Sierra View Medical Center (SVMC).

POLICY:

Compliance education is divided into two general components. First, all employees must receive an introduction to the implementation and maintenance of the compliance program, with an emphasis on the employee's responsibility to report suspected misconduct. Second, employees whose work is linked to identified risk areas will receive specialized compliance education pertaining to their particular job function and responsibilities.

All employees will receive education related to SVMC's overall compliance program at new hire orientation and annually thereafter.

Employees in identified risk areas, such as Patient Accounting and Health Information Management, will receive more detailed education related to their job function and responsibilities provided by department leadership and Compliance.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

1. The Compliance/Privacy Officer (CPO) is responsible for developing the compliance education curriculum, and for monitoring the effectiveness of compliance training and orientation.

2. Compliance education must include an explanation of the structure and operation of the compliance program. Employees will be introduced to the CPO during new hire orientation and other compliance education.

3. Compliance education, at a minimum, will include information on the following aspects of the compliance program:

    a. Definition and reasons for a Compliance Program;

    b. Code of Conduct and other related written guidance;

    c. Communication and reporting mechanisms for direct and anonymous reporting;

    d. Employee reporting obligations; and

    e. SVMC's Non-Retaliation policy.

4. Comprehensive education materials will be developed to facilitate compliance education and ensure that a consistent message is delivered to all employees.

5. All newly hired employees will be assigned Compliance training modules including the SVMC Code of Conduct, as well as other pertinent policies. Employees will be instructed to read the information and sign an electronic attestation stating that he/she has received, read, and understands that should they have questions, they should seek answers from their department leadership or the Compliance Office.

6. During compliance education, employees will be given the opportunity to seek clarification or more information on any aspect of the compliance program.

7. In conjunction with Human Resources and Education, the Compliance/Privacy Office will maintain new hire and annual orientation compliance education attendance logs.

8. Only properly trained individuals will be used to provide compliance education and training seminars. Compliance program trainers must be knowledgeable of the:

   a. compliance program;

   b. applicable federal laws and regulations;

   c. requirements of the Sentencing Commission Guidelines;

   d. relevant organization policies/procedures;

   e. operations of the compliance program;

   f. content of the Code of Conduct.

9. The CPO is responsible for coordinating with department leadership to ensure that specialized compliance education occurs in identified risk areas as needed.

10. The CPO is also responsible for submitting periodic reports to the Chief Executive Officer (CEO) and/or Board of Directors on all education seminars related to the compliance program.

REFERENCE:

- U.S. Department of Health and Human Services. Office of Inspector General, General Compliance Program Guidance2023.

CROSS REFERENCE:

- Compliance Program/Plan
- Code of Conduct
- Compliance Issue Reporting
- Compliance Hotline
- Non Retaliation- Compliance Issue Reporting

SUBJECT: **COMPLIANCE ISSUE REPORTING**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide structure and mechanisms for Sierra View Medical Center (SVMC) employees, contingent work force, medical staff and agents to report suspected violations of federal and state laws, regulations, SVMC policies and procedures and any compliance-related concerns without fear of retaliation, retribution or harassment.

POLICY:

SVMC recognizes that a critical aspect of its Compliance Program is the establishment of a culture that promotes prevention, detection, and resolution of instances of conduct that does not conform to federal and state laws and regulations, requirements of federal, state, and private payer health care programs, ethical business practices, and SVMC policies and procedures. To promote this culture, SVMC maintains mechanisms to encourage reporting of suspected violations, perceived misconduct, as well as compliance-related concerns SVMC adheres to a strict non-retaliation policy to protect employees and others who report compliance-related concerns in good faith.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

1. SVMC employees, contingent work force, medical staff and agents have an affirmative duty and responsibility to report in good faith perceived misconduct, suspected violations of laws, regulations, policies and procedures, and the SVMC Code of Conduct.

2. SVMC employees, contingent work force, medical staff and agents may choose the communication channel he/she deems appropriate to ask a compliance question or submit a report. Reporting mechanisms include:

    a. Department leadership,
    b. Senior leadership,
    c. Human Resources,
    d. Compliance Hotline (559)791-4777 or ext. 4777,
    e. Electronic Compliance issue report form link – Compliance intranet page,
    f. Compliance Officer Inbox email
    g. Compliance/Privacy Officer (CPO) at (559)791-3838 or ext. 3838,
    h. Compliance/Privacy Analyst at (559)791-3917 or ext. 3917 or
    i. Locked Compliance drop box. Locations:
        i. Mailroom
        ii. By the time clock outside of the 1st floor EVS office
        iii. By the time clock on the 1st floor of the Medical Office Building.

3. An "open-door policy" will be maintained at all levels of SVMC leadership to encourage individuals to report problems and concerns.

4. All compliance-related issues will be reported to the CPO when received by sources other than direct reporting mechanisms to the CPO.

5. The CPO may redirect noncompliance-related issues to the appropriate department or individual for resolution.

6. To the extent practicable or allowed by law, the CPO will, when requested, maintain the confidentiality or anonymity of an employee reporting compliance-related concerns. See the Compliance Hotline policy regarding anonymous reporting.

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

8. Failure to report suspected violations in accordance with this Compliance Issue Reporting policy is, in itself, a violation of the Compliance Program that will subject an employee failing to make such a report to discipline, in accordance with the Progressive Discipline policy.

PROCEDURES THAT APPLY TO ALL EMPLOYEES:

1. Knowledge of misconduct, including suspected, actual or potential violations of laws, regulations, policies, procedures, or SVMC's Code of Conduct must be immediately reported via a reporting mechanism referenced in section 2 above.

2. Knowledge of a violation or potential violation of this policy must be reported via a reporting mechanism directly to the CPO

3. An employee with a concern or problem that has not been resolved to the employee's satisfaction, or with a special circumstance, should be promptly reported via a reporting mechanism directly to the CPO.

PROCEDURES THAT APPLY TO ALL LEADERSHIP:

1. Compliance is everyone's responsibility. All levels of leadership will take appropriate measures to support the Compliance Program and this policy to encourage employee reporting. At a minimum, the following actions will be taken and become an ongoing aspect of the leadership process:

    a. Promoting a culture of compliance within departments by providing on-going education and support to staff regarding the reporting mechanisms and processes discussed within this policy;

    b. Forwarding all compliance-related concerns and reports of suspected violations to the CPO for review and further Compliance investigation and follow-up when deemed necessary by the CPO.

REFERENCES:

- U.S. Department of Health and Human Services, Office of Inspector General, General Compliance Program Guidance 2023.

CROSS REFERENCES:

- Compliance Program/Plan
- Compliance Hotline
- Non-Retaliation - Compliance Issue Reporting

SUBJECT: **COMPLIANCE QUARTERLY REPORT**	SECTION:

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

PURPOSE:

To ensure a consistent reporting process to maintain the integrity of the SVMC Compliance Program, the Compliance/Privacy Officer (CPO) will establish a compliance quarterly reporting system to submit information pertinent to the Compliance Program to the Chief Executive Officer (CEO) and/or the Sierra View Medical Center (SVMC) Board of Directors.

POLICY:

The CPO will submit a Quarterly Report of compliance activities, which provides relevant compliance-related information to the CEO.

The CEO and/or the CPO will inform the Board of Directors regarding any substantial matter related to the implementation and monitoring of the SVMC Compliance Program.

DEFINITIONS:

"Substantial matter" includes, but is not limited to, any matter in which SVMC is the subject of existing litigation, or which significantly exposes SVMC to potential litigation. Litigation includes any adjudicatory proceeding before a court, administrative body exercising its adjudicatory authority, hearing officer, or arbitrator.

AFFECTED AREAS/PERSONNEL: *COMPLIANCE/PRIVACY OFFICER, CEO, BOARD OF DIRECTORS*

PROCEDURE:

1. The Quarterly Report submitted by the CPO to the CEO consists of information relevant to the implementation and monitoring of the SVMC Compliance Program, and should be sent each quarter to the CEO. The report may include, but not be limited to, information regarding compliance-related training, the development of compliance-related policies and procedures, a summary of compliance-related issues, including employee hotline calls and auditing and monitoring activities, and ongoing Program goals.

2. The CPO and/or the CEO will provide reports directly to the Board of Directors regarding any substantial compliance-related matters of which the CPO and/or the CEO are aware.

REFERENCES:

- Office of Inspector General, General Compliance Program Guidance, November 2023, pg. 44

CROSS REFERENCES:

SUBJECT: **COMPLIANCE QUARTERLY REPORT**	SECTION: **Page 2 of 2**

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

- Compliance Program/Plan
- Compliance Officer

SUBJECT:	SECTION:
SIMULATION LAB PROGRAM	*[Enter manual section here]*
	Page 1 of 9

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

PURPOSE:

To enhance, collaborate and support the growth and development of students and health care professionals in evidence-based practice, competency and scholarship by providing both a caring and an accommodating learning environment.

Sierra View Medical Center (SVMC) goal is to become a premier center of simulation-based education and best practice for health care professionals and students. These values are achieved and demonstrated by respect, compassion, collaboration, integrity and accountability.

DEFINITIONS:

Simulation in healthcare education has seen significant growth over the last few years. It is an educational activity designed to replicate clinical scenarios and situations. This process is implemented using simulation aides, tools and equipment. Research has shown that simulation is a useful teaching method for clinical skill competency assessment. In addition, simulation has the ability to enhance active student learning and to move nurse educators beyond their traditional roles. Simulation can facilitate staff in becoming more active participants in their own learning. It also provides the means to connect theory and concepts with the clinical practice milieu.

A. **Simulator**- a device (ex: manikin) used with specific conditions and situations that a designed to replicate real life patient events.

   1. Low fidelity- Often static. Used for basic skills and novice staff. Ex: Rubber IV arm

   2. Medium fidelity-Produce heart sounds, rhythms, pulses. Ex: Zoll© One Step See thru CPR pads and defibrillator with manikin.

   3. High fidelity- Manikin can breathe, blink, sweat, pupils change and talk.

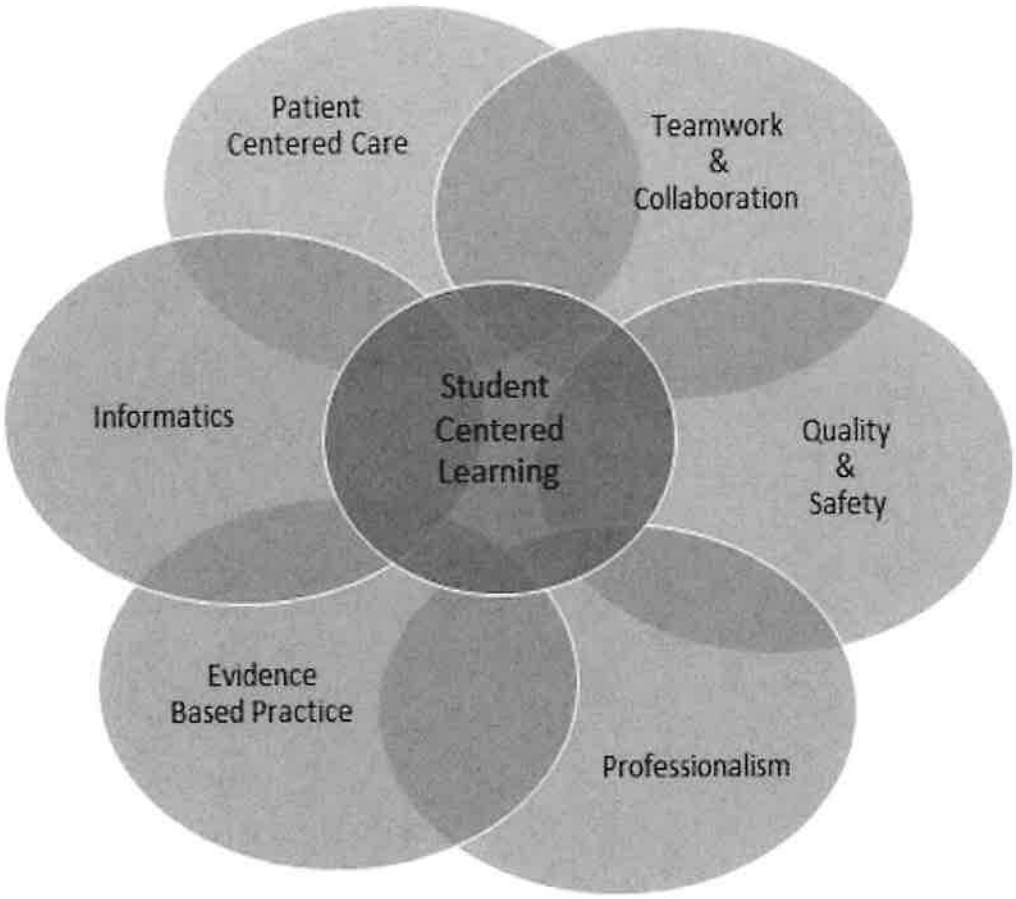
B. **Scenario**- an outline or projected sequence of events that are realistically recreated by the operator to simulate an actual patient.

C. **Debriefing**- a process to initiate discussion, learner centered, enhances critical thinking and encourages participants to analyze their performance and behaviors.

Evidence-based practice (EBP) debriefing types

Debriefing Nursing Simulations with QSEN Competencies using the G-A-S (Gather-Analyze-Summarize) Method for Healthcare Simulation

1. QSEN: Quality And Safety Education for Nurses



(https://www.healthysimulation.com/wp-content/uploads/formidable/10/Simulation-QSEN-Model-Nursing.png)

2. Debriefing using G-A-S (Gather-Analyze-Summarize) Method

A. The first phase is called **gather**. It encourages the team to recap the simulation event using a shared mental model.

Goal: listen to and understand how participants think and feel about SIM
Actions: Request narrative and clarifying or supplemental information
Questions: How do you feel? How do you think it went? Tell what happened?

B. The second phase is called **analyze.** It is based on learner centered reflection, analysis of actions and critical thinking.

Goal: provide performance feedback, facilitate reflection on actions and discover reasons for performance gaps
Actions: review record of events, report observations, question to assess thinking process, and stimulate reflection and redirection
Questions: "I noticed." "Tell me more about . . . "what were you thinking when. . . " I understand, however, tell me about . . . "

C. The third phase is called **summary**. This final phase encompasses the important learning objectives, reviews and assesses the learning of the participant.

Goal: facilitate the learner to review and identify what was learned in the lesson
Actions: identify positive outcomes, discuss behavioral changes and summarize
Questions: list 2 actions that were effective and positive, describe two areas of opportunities for improvement and how will you improve those areas in the future?

(Baily 2019)

ROLES AND RESPONSIBILITIES:

A. **SIMULATION member(s):**
- Actively participates
- Engaged in each learning activity
- Participates in SIM performance, skill and/or competency session(s)
- Adheres to all requirements in the Confidentiality Agreement
- Adheres to all the SIMULATION Lab "Rules"
- Actively participates and understands the importance of the debriefing process
- Takes care in the proper use and handling of all equipment and the SIM Lab room

B. **SIMULATION instructor(s):**
- Staff member in the Education department at SVMC
- Coordination, responsibility, implementation, scheduling and accountability for the Simulation Program at SVMC is done through the Education Department and Director of Education
- Prepared and timeliness of SIM session(s) is mandatory
- Facilitating the use, maintenance and care of the SIM Lab and equipment is the responsibility of each SIM instructor
- Actively participates
- Engaged in each learning activity
- Participates in SIM performance, skill and/or competency session(s)
- Adheres to all requirements in the Confidentiality Agreement
- Adheres to all the SIMULATION Lab "Rules"
- Actively participates and understands the importance of the debriefing process
- Takes care in the proper use and handling of all equipment and the SIM Lab room
- Participates in Education Department meetings and training activities related to Simulation Program at SVMC
- Communicates with SVMC VP / Chief Nurse Executive / GME DIO regarding the Simulation Program and/or education/training

C. **SIMULATION Program leadership:**
- General leadership and oversight of the Simulations Program at SVMC is under the direction of SVMC VP / Chief Nurse Executive / GME DIO in collaboration with the Director of Education

POLICY:
The Simulation Lab Program at SVMC is based upon the organizations mission, vision and values statement.

A. **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 continue to meet the health needs of the community

B. **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.

C. **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

SVMC mission, vision and values are in alignment with The Society for Simulation in Healthcare (SSIH) code of ethics. First published in December 2018 and titled ***Healthcare Simulationist Code of Ethics.*** The six core principles are: Integrity, transparency, mutual respect, professionalism accountability, and results oriented.

AFFECTED PERSONNEL/AREAS: *SIERRA VIEW MEDICAL CENTER STAFF MEMBERS AND AFFILIATED MEDICAL PROVIDERS*

PROCEDURE:

A Simulation session has been scheduled with the Education Department with at least 2 months advance notice.

A Simulation session is scheduled during normal posted SIM Lab hours.

A SVMC SIM Lab instructor must be present during every Simulation session.

A sign in sheet will be used for accurate record keeping. **If a participant is 10 minutes or more late to the sessions start time, the participant will need to reschedule the specific session.**

Agenda and objectives have been given to all participants in advance and/or prior to the session commencing.

Demonstration and/or use/location of the equipment/tools/assistive devices are reviewed prior to the session commencing.

A SVMC Simulation Lab Confidentiality Agreement has been reviewed, signed and/or is on record.

The SVMC posted SIMULATION LAB "RULES" have been reviewed by all the participants.

Any questions, issues and clarifications have been addressed in a timely manner.

Except for an emergency, participants must complete the entire session including the debriefing process to receive credit.

The Simulation Lab's Laerdal© SIM 3G Man and Noelle© are maintained and operated by trained SVMC Simulation instructors only or those persons who have been designated by the VP / Chief Nurse Executive / GME DIO and Director of Education.

EQUIPMENT:

- Laerdal© SIM 3G Man with 2 computers and accessories/attachments
- 1 Stryker© Gurney
- Noelle© Maternal Birthing Simulator with accessories/attachments
- 1 Stryker© OB Gurney
- ***SIM Lab storage Equipment List (located in SIM Lab Redwood room)***

REFERENCES:

- Al-Elq A. H. (2010). Simulation-based medical teaching and learning. *Journal of Family & Community Medicine*, *17*(1), 35–40. doi:10.4103/1319-1683.68787
- Baily, Kim MSN, PhD, RN, CNE. June 3rd, 2019. Gather-Analyze-Summarize: The Simple GAS Method for Healthcare Simulation Debriefing. Retrieved from http://www.healthsimulation.com/18874/gas-debriefing March 3rd, 2020
- Freytag J, Stroben F, Hautz WE, *et al*. (2017). Improving patient safety through better teamwork: how effective are different methods of simulation debriefing? Protocol for a pragmatic, prospective and randomized study. *BMJ* 7:e015977. doi: 10.1136/bmjopen-2017-015977
- Lippincott Nursing Education (2018). *The 411 on Debriefing in Clinical Simulation: How Nursing Simulation & Debriefing Create Better Nurses*, Wolters Kluwer
- McDougall, E.M. (2015). Simulation in education for health care professionals. *BCMJ,57,*(10),444-448
- Sierra View Medical Center (2020). Employee Intranet page: Mission, Vision and Values
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- https://vosaic.com/blog/guiding-principles-for-using-simulation-in-healthcare. Tom Hermanek III January 29th, 2019
- www.healthysimulation.com. Debriefing Nursing Simulations with QSEN Competencies Including Template. Retrieved December 23rd, 2019
- www.healthysimulation.com. DASH Debriefing Tools From Center for Medical Simulation. Retrieved December 23rd, 2019.

ATTACHMENTS:

SIERRA VIEW MEDICAL CENTER

SIMULATION LAB "RULES"

- Please be on time for any scheduled SIMULATION session
- SIM Instructor must be present to utilize the SIM Lab and ONLY during scheduled hours
- No food or liquids/ beverages are allowed in the SIM lab
- Cellphones and/or electronic mobile devices must be silenced during any training
- No video or audio recording by participants is allowed
- Simulation Confidentiality Agreement has been signed and is on record at SVMC
- Video/audio recordings is completed by SIM Instructor Only and used for debriefing and educational purposes only
- Using the SIMULATION Lab is a safe and confidential environment
- This is an important component of respectful, ethical and professional behavior
- Please be respectful and careful in the use of the equipment and adhere to proper team dynamics
- Breaks and/or meal times will be established before the session begins based on the agenda for the specific SIMULATION
- Use "inside voice" and be an active participant to maximize the learning experience

SIERRA VIEW MEDICAL CENTER

Simulation Lab Confidentiality Agreement

As an employee or contract provider and /or participant at Sierra View Medical Center, I will actively participate in simulations. I understand that the content of these simulations is to be kept confidential to maintain the integrity of the learning experience for myself and fellow participants. I also understand that in working and learning along-side my fellow colleagues, I will be observing their performance. It is unethical for me to share information in any format (verbal, written, electronic) regarding staff performance with persons outside the laboratory or classroom setting. Scenarios, case studies, debriefings, discussion and testing (if applicable) are included in the SIMULATION process.

I acknowledge that I fully understand any unauthorized release, inappropriate exchange, recording by any participant other than the designated Simulation Instructor(s) or mishandling of confidential information is prohibited. All HIPPA requirements will be adhered to throughout the SIMULATION process. I will practice professionally and ethically within the Simulation Lab Program Policy.

Name: _____ Date: _____

Department: _____

Simulation Instructor: _____

SUBJECT: **SOLICITATION AND DISTRIBUTION OF LITERATURE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To avoid disruption of healthcare operations or disturbance of patients and to maintain appropriate order and discipline.

DEFINITIONS:

"Working time" includes the working time of both the employee doing the soliciting or distributing and the employee to whom the soliciting or distributing is directed. "Working time" does not include authorized break periods or meal periods when the employee is not engaged in performing work tasks.

"Hospital" means Sierra View Medical Center (SVMC).

POLICY:

Any and all solicitations and or distributions of literature among Hospital Staff, patients, or the public at Sierra View Local Healthcare District property and facilities are subject to the following rules:

1. Solicitation or Distribution by Non-employees: Subject to Section 2, below, persons and organizations who are not employed by Hospital and persons employed by organizations that are not part of the Hospital may not solicit or distribute literature at any time, for any purpose. Notwithstanding this policy, organizations which do business with the Hospital or whose activities advance the mission of the Hospital or who engage in charitable activities consistent with the mission of the Hospital, may be granted permission to engage in solicitation or distribution, provided such permission is specifically granted in writing by the Chief Executive Officer or his/her designee. In addition, the Chief Executive Officer or her/his designee may annually grant written permission to a limited number of charitable organizations to solicit and distribute materials consistent with their charitable mission, provided such solicitation/distribution is consistent with, and occurs during the time period specified in, the written permission.

2. Access by Employee Organizations: Access to the premises of the Hospital and contacts with Hospital employees, by the representative of employee organizations that have not been recognized by the Hospital pursuant to the District's Resolution shall be governed by the provisions of the Meyer-Milias-Brown Act, Government Code Sections 3500 et seq., as interpreted by the Public Employment Relations Board and/or courts of competent jurisdiction.

   The Hospital will promulgate guidelines and a protocol which will set forth the specific parameters of its solicitation and distribution policy located in the Employer-Employee Relations Resolution.

3. Solicitation by Hospital Employees: Hospital employees may not solicit at any time, for any purpose, in immediate patient care areas, such as patients' rooms, operating rooms, and places where patients receive treatment, such as radiology and therapy areas, or in any other area that

would cause disruption of health care operations or disturbance of patients, such as corridors in patient treatment areas, and rooms used by patients, and rooms used by patients for consultations with physicians or other health care providers, or meetings with families or friends.

4. No Solicitations for Profit by Hospital Employees: Subject to this policy, solicitations or distributions in any way connected with the sale of any goods or services for profit are strictly prohibited at any time by or among Hospital staff, patients or visitors, or in any place where Hospital services are performed.

5. Distribution by Hospital Employees: Employees may not distribute literature during working time (see definition above),for any purpose. Employees may not distribute literature at any time for any purpose in Hospital working areas.

   Working areas are all areas on Sierra View Local Healthcare District property except cafeteria(s), employee lounges, Hospital lobbies, and Hospital parking areas.

6. Notice of Intent to Solicit or Distribute Literature: In order to ensure the maintenance of order and discipline in the workplace, the Hospital requires that prior to soliciting or distributing literature for any purpose, an employee who intends to engage in solicitation and or distribution of literature must identify himself or herself and must notify the Human Resources Department of his or her intent before engaging in such activity.

7. Posting on Hospital Bulletin Boards: The Hospital maintains bulletin boards located throughout its facilities for the purpose of communicating with its employees. Postings on these boards are limited to Hospital-related material including statutory and legal notices, safety and disciplinary rules, Hospital policies, memos of general interest related to Hospital, operating rules and procedures, and other Hospital items. All postings require the approval of the Human Resources Department. No postings will be permitted for other purposes.

AFFECTED PERSONNEL/AREAS: *ALL HOSPITAL EMPLOYEES*

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

The Annual meeting of the Board of Directors of Sierra View Local Health Care District was held **January 23, 2024 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 5:02 p.m.

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

Others Present: Bedolla, Art, MAKO, Blazar, Dan, Patient Experience Officer, Cabeje, Deniece, R.N., Canales, Tracy, VP of Human Resources, Dickson, Doug, Chief Financial Officer, Gomez, Cindy, Director of Compliance, Franer, Julie, Administrative Director of Revenue Cycle, Fee, Jeff, MAKO, Hefner, Donna, President/Chief Executive Officer, Hudson, Jeffery, VPPCS/CNO/DIO, Johns, Karen, Sierra View Foundation, Parsons, Malynda, Public Relations, Reed-Krase, Alex, Legal Counsel Sandhu, Harpreet, Chief of Staff, Stringham, Zaelin, Director of Food and Nutrition, Wallace, Marcella, Director of Communications, Watts, Whitney, Executive Assistant and Clerk to Board of Directors, Wheaton, Ron, VP Professional Services and Physician Recruitment, Wilbur, Gary, Admin Director of General Services

I. Approval of Agenda:

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Absent
PANDYA	Absent
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:03 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 – *deferred to February 2024*

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

D. 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

III. Open Session: Chairman REDDY adjourned Closed Session at 5:37 p.m., reconvening in Open Session at 5:38 p.m.

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

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Discussion Regarding Trade Secret and Strategic Planning

Information only; no action taken

D. Conference with Legal Counsel

Information only; no action taken.

IV. Public Comments

Art Bedolla and Jeff Fee, Representatives from Stryker attended the Board of Directors Meeting to introduce themselves and thank the Board for the opportunity to bring the Stryker Mako Robot to Sierra View Medical Center. There are currently 16 cases scheduled for February.

V. Consent Agenda

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Vice Chair LOMELI and seconded by Director KASHYAP to approve the December 19, 2023 Regular Board Meeting Minutes as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Absent
PANDYA	Absent
KASHYAP	Yes

VII. CEO Report

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

VIII. Business Items

A. Sierra View Foundation Check Presentation

Karen Johns, Sierra View Foundation chair presented the district with a check for $131,000 to go toward a new Cardio Echo machine and an automatic Impella Controller.

The goal of the Foundation for 2024 is to raise funds for the 4 new fetal monitors, new Stryker Surgery Light, and inpatient Dialysis Treatment Center.

The Annual Golf Tournament will be held on 4/26/2024 at Valley Oaks Golf Course.

Information only; no action taken.

B. December 2023 Financials

Doug Dickson, CFO presented the Financials for December 2023. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $12,859,155. Supplemental Funds were $1,873,890. Total Operating Expenses were $13,927,439. Loss from operations of $1,068,284.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA and carried to approve the December 2023 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Annual Appointments

1. Food and Dietetic Services Director

Doug Dickson, CFO presented credentials for Zaelin Stringham, Director of Food and Nutrition.

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Environmental Safety/Security Officer

Ron Wheaton, VP Professional Services and Physician Recruitment presented credentials for the Environmental Safety/Security Officer, Gary Wilbur.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ and carried to approve Gary

Wilbur as the Environmental Safety/Security Officer as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

3. Patient Safety Officer

Donna Hefner, President and CEO presented credentials for the Patient Safety Officer, Melissa Mitchell.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ and carried to approve Melissa Mitchell as the Patient Safety Officer as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

4. Infection Control Officer

Jeffery Hudson-Covolo presented credentials for Nancy Hurtado Ziola, Infection Control Officer.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ and carried to approve Gary Wilbur as the Environmental Safety/Security Officer as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

D. SVLHCD Board of Directors Annual Self Evaluation to comply with SVLHCD Bylaw 4.2

Return to Whitney Watts

Information only; no action taken.

E. Resolution 1.23.2024/01 Appointing Director Hans Kashyap to Treasure of the Board

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ and carried to approve Gary Wilbur as the Environmental Safety/Security Officer as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

XII. Announcements:

A. Regular Board of Directors Meeting – March 26, 2024 at 5:00 p.m.

The meeting was adjourned 6:40 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: ww

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FINANCIAL PACKAGE
January 2024

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
January 2024

Statistic	Jan-24 Actual	Jan-24 Budget	Jan-24 Over/ (Under)	Jan-24 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 23 YTD	Increase/ (Decrease) Jan-23	% Change
Utilization											
SNF Patient Days									892	(470)	-52.7%
Total	31	108	(77)	-71.3%	422	756	(334)	-44.2%	639	(217)	-34.0%
Medi-Cal	31	86	(55)	-64.1%	422	533	(111)	-20.8%			
Sub-Acute Patient Days									6,030	797	13.2%
Total	1,023	871	152	17.5%	6,827	6,097	730	12.0%	4,125	1,668	40.4%
Medi-Cal	899	560	339	60.6%	5,793	4,172	1,621	38.9%	-		
Acute Patient Days	1,675	1,848	(173)	-9.4%	11,720	12,938	(1,218)	-9.4%	12,887	(1,167)	-9.1%
Acute Discharges	416	480	(64)	-13.3%	3,005	3,360	(355)	-10.6%	3,309	(304)	-9.2%
Medicare	178	183	(5)	-2.7%	1,164	1,274	(110)	-8.7%	1,255	(91)	-7.3%
Medi-Cal	201	241	(40)	-16.8%	1,492	1,660	(168)	-10.1%	1,632	(140)	-8.6%
Contract	36	58	(22)	-37.5%	327	412	(85)	-20.7%	405	(78)	-19.3%
Other	1	3	(2)	-67%	22	17	5	26.8%	17	5	29.4%
Average Length of Stay	4.03	3.85	0.18	4.6%	3.90	3.85	0.05	1.3%	3.89	0.01	0.1%
Newborn Patient Days									1,267	(32)	-2.5%
Medi-Cal	157	172	(15)	-8.7%	1,235	1,194	41	3.5%	233	(38)	-16.3%
Other	20	33	(13)	-39.4%	195	241	(46)	-19.2%	1,500	(70)	-4.7%
Total	177	205	(28)	-13.7%	1,430	1,435	(5)	-0.3%			
Total Deliveries	96	116	(20)	-17.2%	719	812	(93)	-11.5%	834	(115)	-13.8%
Medi-Cal %	85.42%	82.81%	2.61%	3.1%	85.10%	82.81%	2.29%	2.8%	82.93%	2.17%	2.6%
Case Mix Index											
Medicare	1.7500	1.6395	0.1105	6.7%	1.6129	1.6395	(0.0266)	-1.6%	1.6481	(0.0352)	-2.1%
Medi-Cal	1.2190	1.1881	0.2573	21.7%	1.2002	1.1881	0.0121	1.0%	1.1710	0.0292	2.5%
Overall	1.4454	1.3732	(0.1542)	-11.2%	1.3702	1.3732	(0.0030)	-0.2%	1.3516	0.0186	1.4%
Ancillary Services											
Inpatient											
Surgery Minutes	7,352	9,041	(1,689)	-18.7%	57,980	63,287	(5,307)	-8.4%	63,587	(5,607)	-8.8%
Surgery Cases	86	104	(18)	-17.3%	656	728	(72)	-9.9%	764	(108)	-14.1%
Imaging Procedures	1,501	1,479	22	1.5%	9,818	10,355	(537)	-5.2%	10,679	(861)	-8.1%
Outpatient											
Surgery Minutes	8,180	12,448	(4,268)	-34.3%	80,949	87,136	(6,187)	-7.1%	83,417	(2,468)	-3.0%
Surgery Cases	189	190	(1)	-0.5%	1,393	1,330	63	4.7%	1,269	124	9.8%
Endoscopy Procedures	165	142	23	16.2%	1,290	994	296	29.8%	1,230	60	4.9%
Imaging Procedures	4,277	3,715	562	15.1%	27,338	26,006	1,332	5.1%	27,191	147	0.5%
MRI Procedures	318	295	23	7.8%	2,102	2,065	37	1.8%	2,062	40	1.9%
CT Procedures	1,197	1,178	19	1.6%	8,741	8,246	495	6.0%	8,249	492	6.0%
Ultrasound Procedures	1,271	1,102	169	15.3%	8,591	7,714	877	11.4%	6,889	1,702	24.7%
Lab Tests	33,333	33,247	86	0.3%	221,640	232,729	(11,089)	-4.8%	237,968	(16,328)	-6.9%
Dialysis	2	3	(1)	-33.3%	25	21	4	19.0%	15	10	66.7%

Sierra View Medical Center
Financial Statistics Summary Report
January 2024

Statistic	Jan-24 Actual	Jan-24 Budget	Jan-24 Over/ (Under)	Jan-24 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 23 YTD	Increase/ (Decrease) Jan-23	% Change
Cancer Treatment Center											
Chemo Treatments	1,813	1,713	100	5.8%	11,105	11,991	(886)	-7.4%	12,448	(1,343)	-10.8%
Radiation Treatments	2,187	1,653	534	32.3%	12,342	11,571	771	6.7%	11,126	1,216	10.9%
Cardiac Cath Lab											
Cath Lab IP Procedures	16	10	6	60.0%	87	70	17	24.3%	66	21	31.8%
Cath Lab OP Procedures	26	28	(2)	-7.1%	210	196	14	7.1%	205	5	2.4%
Total Cardiac Cath Lab	42	38	4	10.5%	297	266	31	11.7%	271	26	9.6%
Outpatient Visits											
Emergency	3,444	3,411	33	1.0%	24,329	23,877	452	1.9%	23,913	416	1.7%
Total Outpatient	14,087	12,811	1,276	10.0%	92,915	89,677	3,238	3.6%	90,575	2,340	2.6%
Staffing											
Paid FTE's	863.64	841.56	22.09	2.6%	854.06	841.56	12.50	1.5%	901.63	(47.57)	-5.3%
Productive FTE's	735.73	735.98	(0.24)	0.0%	732.83	735.98	(3.15)	-0.4%	766.78	(33.95)	-4.4%
Paid FTE's/AOB	5.16	5.06	0.10	2.0%	5.06	5.02	0.04	0.8%	5.33	(0.28)	-5.2%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,003	11,032	(28)	-0.3%	10,641	11,032	(391)	-3.5%	10,885	(244)	-2.2%
Cost/Adj.Patient Day	2,861	2,620	242	9.2%	2,660	2,631	29	1.1%	2,733	(73)	-2.7%
Revenue/Adj. Discharge	58,039	53,107	4,932	9.3%	53,886	53,108	778	1.5%	52,960	926	1.7%
Cost/Adj. Discharge	15,093	12,610	2,483	19.7%	13,471	12,666	805	6.4%	13,296	175	1.3%
Adj. Discharge	983	1,071	(88)	-8.2%	7,172	7,492	(320)	-4.3%	7,470	(298)	-4.0%
Net Op. Gain/(Loss) %	-5.91%	-2.13%	-3.79%	177.9%	-6.04%	-2.13%	-3.91%	183.8%	-15.39%	9.35%	-60.8%
Net Op. Gain/(Loss) $	(828,310)	(281,277)	(547,033)	194.5%	(5,500,600)	(2,498,824)	(3,001,776)	120.1%	(13,244,332)	7,743,732	-58.5%
Gross Days in Accts Rec.	96.89	88.87	8.02	9.0%	96.89	88.87	8.02	9.0%	85.85	11.04	12.9%
Net Days in Accts. Rec.	58.90	72.82	(13.92)	-19.1%	58.90	72.82	(13.92)	-19.1%	76.11	(17.21)	-22.6%

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

	JAN 2024	DEC 2023
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 10,156,560	$ 8,105,426
SHORT-TERM INVESTMENTS	1,444,154	13,006
ASSETS LIMITED AS TO USE	62,983	843,410
PATIENT ACCOUNTS RECEIVABLE	174,351,169	175,676,484
LESS UNCOLLECTIBLES	(25,632,761)	(27,357,523)
CONTRACTUAL ALLOWANCES	(124,191,740)	(123,562,713)
OTHER RECEIVABLES	21,753,258	22,479,022
INVENTORIES	4,082,113	3,951,126
PREPAID EXPENSES AND DEPOSITS	3,276,853	3,228,992
LEASE RECEIVABLE - CURRENT	299,577	299,577
TOTAL CURRENT ASSETS	65,602,167	63,676,806
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	33,427,501	32,841,073
LONG-TERM INVESTMENTS	129,363,914	131,487,441
PROPERTY, PLANT AND EQUIPMENT, NET	80,514,247	81,253,817
INTANGIBLE RIGHT OF USE ASSETS	483,179	495,137
SBITA RIGHT OF USE ASSETS	2,985,666	3,083,841
LEASE RECEIVABLE - LT	1,119,619	1,144,628
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,615,430	1,636,410
TOTAL ASSETS	$ 315,361,723	$ 315,869,153

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

	JAN 2024	DEC 2023
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 130,617	$ 783,700
CURRENT MATURITIES OF BONDS PAYABLE	4,055,000	4,055,000
CURRENT MATURITIES OF LONG TERM DEBT	1,201,171	1,201,171
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	3,477,591	4,301,484
ACCRUED PAYROLL AND RELATED COSTS	8,671,047	7,307,886
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,590,133	3,678,991
LEASE LIABILITY - CURRENT	133,974	133,974
SBITA LIABILITY - CURRENT	1,272,203	1,272,203
TOTAL CURRENT LIABILITIES	22,531,737	22,734,409
SELF-INSURANCE RESERVES	1,378,708	1,437,253
CAPITAL LEASE LIAB LT	1,358,501	1,441,949
BONDS PAYABLE, LESS CURR REQT	37,510,000	37,510,000
BOND PREMIUM LIABILITY - LT	2,994,911	3,053,481
LEASE LIABILITY - LT	367,135	378,324
SBITA LIABILITY - LT	1,912,097	2,011,059
OTHER NON CURRENT LIABILITIES	187,927	187,927
DEFERRED INFLOW - LEASES	1,355,450	1,381,751
TOTAL LIABILITIES	69,596,464	70,136,152
UNRESTRICTED FUND	245,134,891	245,134,891
PROFIT OR (LOSS)	630,368	598,110
TOTAL LIABILITIES AND FUND BALANCE	$ 315,361,723	$ 315,869,153

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

JAN 2024 ACTUAL	JAN 2024 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,381,378	5,730,675	349,297	(6)%	INPATIENT - NURSING	37,837,410	40,114,725	2,277,315	(6)%
18,762,891	19,760,695	997,804	(5)%	INPATIENT - ANCILLARY	124,319,234	138,326,843	14,007,610	(10)%
24,144,269	25,491,370	1,347,101	(5)%	TOTAL INPATIENT REVENUE	162,156,644	178,441,568	16,284,925	(9)%
32,905,905	31,371,732	(1,534,173)	5%	OUTPATIENT - ANCILLARY	224,319,615	219,448,956	(4,870,659)	2%
57,050,174	56,863,102	(187,072)	0%	TOTAL PATIENT REVENUE	386,476,259	397,890,524	11,414,265	(3)%
				DEDUCTIONS FROM REVENUE				
(19,775,089)	(17,105,659)	2,669,430	16%	MEDICARE	(124,392,489)	(119,739,613)	4,652,876	4%
(17,525,019)	(20,103,940)	(2,578,921)	(13)%	MEDI-CAL	(122,582,323)	(140,727,580)	(18,145,257)	(13)%
(5,926,211)	(6,634,411)	(708,200)	(11)%	OTHER/CHARITY	(47,464,843)	(46,440,877)	1,023,966	2%
3,071	(13,158)	(16,229)	(123)%	DISCOUNTS & ALLOWANCES	(75,175)	(92,106)	(16,932)	(18)%
(380,187)	(439,236)	(59,049)	(13)%	BAD DEBTS	(4,478,403)	(3,074,652)	1,403,751	46%
(43,603,435)	(44,296,404)	(692,969)	(2)%	TOTAL DEDUCTIONS	(298,993,233)	(310,074,828)	(11,081,595)	(4)%
13,446,739	12,566,698	(880,041)	7%	NET SERVICE REVENUE	87,483,025	87,815,696	332,671	0%
560,865	654,369	93,504	(14)%	OTHER OPERATING REVENUE	3,632,176	4,580,583	948,408	(21)%
14,007,604	13,221,067	(786,537)	6%	TOTAL OPERATING REVENUE	91,115,201	92,396,279	1,281,078	(1)%
				***** OPERATING EXPENSE *****				
5,888,845	5,311,345	577,500	11%	SALARIES	39,351,288	37,051,986	2,299,302	6%
1,293,759	567,717	726,042	128%	S&W PTO	5,016,676	3,957,852	1,058,824	27%
1,416,681	1,443,459	(26,778)	(2)%	EMPLOYEE BENEFITS	9,524,497	10,670,448	(1,145,951)	(11)%
1,593,256	1,406,070	187,186	13%	PROFESSIONAL FEES	9,412,345	9,781,602	(369,257)	(4)%
777,606	862,461	(84,856)	(10)%	PURCHASED SERVICES	6,012,535	5,961,370	51,165	1%
2,049,263	1,973,623	75,640	4%	SUPPLIES & EXPENSES	14,136,851	13,836,099	300,752	2%
229,548	258,777	(29,229)	(11)%	MAINTENANCE & REPAIRS	1,596,133	1,753,080	(156,947)	(9)%
204,269	263,897	(59,628)	(23)%	UTILITIES	1,811,789	1,847,279	(35,490)	(2)%
27,599	11,257	16,342	145%	RENT/LEASE	193,786	101,967	91,819	90%
122,026	118,267	3,759	3%	INSURANCE	877,124	827,869	49,255	6%
967,527	959,953	7,574	1%	DEPRECIATION/AMORTIZATION	6,802,663	6,852,563	(49,900)	(1)%
265,536	325,518	(59,983)	(18)%	OTHER EXPENSE	1,880,114	2,252,988	(372,874)	(17)%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
14,835,914	13,502,344	1,333,570	10%	TOTAL OPERATING EXPENSE	96,615,800	94,895,103	1,720,697	2%
(828,310)	(281,277)	547,033	195%	NET GAIN/(LOSS) FROM OPERATIONS	(5,500,599)	(2,498,824)	3,001,775	120%
116,558	116,558	0	0%	DISTRICT TAXES	815,906	815,906	0	0%
376,114	277,386	(98,728)	36%	INVESTMENTS INCOME	2,237,564	1,941,702	(295,862)	15%
58,630	43,282	(15,348)	36%	OTHER NON OPERATING INCOME	381,369	302,974	(78,395)	26%
(87,646)	(105,715)	(18,070)	(17)%	INTEREST EXPENSE	(634,291)	(659,293)	(25,002)	(4)%
(87,609)	(36,775)	50,834	138%	NON-OPERATING EXPENSE	(337,956)	(257,425)	80,531	31%
376,046	294,736	(81,310)	28%	TOTAL NON-OPERATING INCOME	2,462,592	2,143,864	(318,728)	15%
(452,263)	13,459	465,722	(3,460)%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	(3,038,008)	(354,960)	2,683,048	756%
484,522	0	(484,522)		NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	3,668,376	0	(3,668,376)	
32,258	13,459	(18,799)	140%	NET GAIN/(LOSS)	630,368	(354,960)	(985,328)	(278)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
01/31/24

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(828,310)	(5,500,599)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	967,527	6,802,663
Provision for bad debts	(1,724,762)	(2,109,041)
Change in assets and liabilities:		
Patient accounts receivable, net	1,954,340	3,570,106
Other receivables	725,764	(6,076,584)
Inventories	(130,987)	(64,154)
Prepaid expenses and deposits	(47,861)	(893,874)
Advance refunding of bonds payable, net	20,980	146,858
Accounts payable and accrued expenses	(823,893)	(2,293,338)
Deferred inflows - leases	(26,301)	(336,533)
Accrued payroll and related costs	1,363,161	1,314,086
Estimated third-party payor settlements	(88,858)	434,863
Self-insurance reserves	(58,545)	(287,248)
Total adjustments	2,130,565	207,804
Net cash provided by (used in) operating activities	1,302,255	(5,292,795)
Cash flows from noncapital financing activities:		
District tax revenues	116,558	815,906
Noncapital grants and contributions, net of other expenses	(42,064)	(66,990)
Net cash provided by (used in) noncapital financing activities	74,494	748,916
Cash flows from capital and related financing activities:		
Purchase of capital assets	(215,999)	(2,083,119)
Proceeds from lease receivable, net	25,009	330,960
Principal payments on debt borrowings	-	(3,880,000)
Interest payments	(786,215)	(1,673,212)
Net change in notes payable and lease liability	(95,424)	(664,673)
Net changes in assets limited as to use	193,999	1,454,842
Net cash provided by (used in) capital and related financing activities	(878,630)	(6,515,202)
Cash flows from investing activities:		
Net (purchase) or sale of investments	2,608,049	6,063,748
Investment income	376,114	2,237,564
Net cash provided by (used in) investing activities	2,984,163	8,301,312
Net increase (decrease) in cash and cash equivalents:	3,482,282	(2,757,769)
Cash and cash equivalents at beginning of month/year	8,118,432	14,358,483
Cash and cash equivalents at end of month	11,600,714	11,600,714

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
January 2024

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Feb-23	10,444,477	1,486,294	11,930,771
Mar-23	11,036,309	4,353,856	15,390,165
Apr-23	9,611,508	8,659,999	18,271,507
May-23	13,011,917	3,474,340	16,486,257
Jun-23	10,589,289	5,045,026	15,634,315
Jul-23	9,542,222	1,209,276	10,751,498
Aug-23	11,411,456	2,278,509	13,689,964
Sep-23	11,153,141	297,374	11,450,515
Oct-23	10,806,912	1,614,798	12,421,710
Nov-23	11,048,937	5,395,178	16,444,115
Dec-23	9,261,593	1,749,227	11,010,820
Jan-24	**12,040,509**	**3,417,973**	**15,458,481**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - Receipts for Café, rebates, refunds, and miscellaneous funding sources

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

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

January 2024 Summary of Other Activity:

2,148,975	OPPS Remedy for 340B Drugs
982,229	Property Taxes
286,769	Miscellaneous
3,417,973	01/24 Total Other Activity