SIERRA VIEW
MEDICAL CENTER

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

AGENDA
August 22, 2023

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

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

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b); Cal. Civ. Code § 3426.1(d): Discussion Regarding Trade Secrets (1 Item) Estimated Date of Disclosure – February 2030 (Time Limit – 20 minutes)

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b); Cal. Civ. Code § 3426.1(d): Discussion Regarding Trade Secrets Pertaining to Service (1 Item). Estimated Date of Disclosure – December 2024 (Time Limit – 20 minutes)

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning; Gov. Code Section 54956.9 (b)(3)(F): significant exposure to litigation; privileged communication (1 Item). Estimated Date of Disclosure – February 2026

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

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

B. Quality Review

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

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

C. Discussion Regarding Trade Secret
Recommended Action: Approve/Disapprove Report as Given

D. Discussion Regarding Trade Secret
Recommended Action: Approve/Disapprove Report as Given

E. Discussion Regarding Trade Secrets and Strategic Planning
Recommended Action: Information only; no action taken

F. Conference with Legal Counsel
Recommended Action: Information only; no action taken

VI. Public Comments

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

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

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

VIII. Approval of Minutes

A. **July 25, 2023 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove July 25, 2023 Minutes of the Regular Meeting of the Board of Directors

IX. CEO Report

X. Business Items

A. **July 2023 Financials**
Recommended Action: Approve/Disapprove Report as Given

B. **Investment Policy and Quarterly Investment Report Per Cal. Gov. Code § 53646**
Recommended Action: Approve/Disapprove Report as Given

XI. Announcements:

A. Regular Board of Directors Meeting – September 26, 2023 at 5:00 p.m.

XII. Adjournment

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
August 22, 2023

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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Senior Leadership Team	8/22/2023
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	8/22/2023

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
August 22, 2023
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	Action
Policies:		Approve ↓
1. Bariatric Bed Rental Procedure	1-2	
2. Dietary Accountability to Administration and Medical Staff	3-4	
3. Diet Manual & Therapeutic Diet Menus	5-6	
4. Earthquake Procedures	7-9	
5. Fire Safety Ansul System R102 Wet Chemical Fire	10	
6. Food Preparation	11-12	
7. Food Service Corrugated Cardboard Management	13-14	
8. Interim Life Safety Measures (ILSM) Fire Watch	15-16	
9. Meal Trays	17-19	
10. Medical Gas System PM	20	
11. Medical Records Security During Evacuation Procedures	21	
12. Nourishment Room Floor Stock	22-23	
13. Ownership of Medical Records	24	
14. Patient Food From Home Acute	25	
15. Performance Improvement Food and Nutrition	26	
16. Recording Hours Worked	27-29	
17. Value Analysis Committee	30-33	
18. Vacation/Holiday Leave	34-40	

SUBJECT: **BARIATRIC BED RENTAL PROCEDURE**	SECTION:

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

PURPOSE:

To streamline and formalize the bariatric bed rental process to assure the prompt and timely placement of patients into the appropriate bed upon their admittance to Sierra View Medical Center (SVMC). This assures that all key personnel in this chain are versed and can secure the proper accommodation.

Note: This same process is also used for regular bed rentals.

DEFINITIONS:

1. **Bariatric Bed**: Bed utilized for a patient in excess of 500 lbs.

2. **Hill-Rom**: Vendor used by the hospital for the rental of normal and specialty beds.

POLICY:

A. It is the policy of SVMC to follow the procedure *herein* when requesting a bariatric or rental bed for a patient.

AFFECTED PERSONNEL/AREAS: *ALL NURSING PERSONNEL REQUIRING BARIATRIC BEDS, FACILITIES, ENGINEERING, AND MATERIALS MANAGEMENT PURCHASING PERSONNEL*

EQUIPMENT:

- SVMC-owned bariatric bed
- Hill-Rom rental bed

PROCEDURE:

A. Upon notification to nursing staff that a bariatric bed is required for a patient, nursing staff will:

   1. Contact Engineering at extension 2236 to request a bariatric bed.

   2. Engineering will verify if the SVMC-owned bariatric bed is available. If the bed is not in the Engineering storage area, they will verify with the last department the bed was issued to and ascertain its availability.

      a. If Engineering verifies that the bed is available, they will deliver the bed to the designated department for patient use.

      b. If it is discovered that the bed is still in use, Engineering will tell the requestor that the bed is in use and to contact Hill-Rom for a rental.

B. The Rental Process

1. A designated staff member from the requesting floor will then contact Hill-Rom at (800) 638-2546 and request a bariatric bed

2. A purchase order number will be requested by Hill-Rom. During regular work hours, contact Materials Management Purchasing for purchase order number.

3. After hours, weekends and holidays, the nursing representative is not required at this time to contact Materials Management for a Purchase Order. The nursing representative will use the current date followed by a department descriptor. Here is an example:

   a. Telemetry Department, September 8th, 2023, should read as follows: 09082023TELE

4. The nursing staff representative should then request a confirmation number from the Hill-Rom representative. Please record this number with your recording of the Purchase Order created to turn in to Materials Management Purchasing Buyer/Manager at the conclusion of the rental.

C. Upon completion of use of the bariatric bed, it is the responsibility of the utilizing nursing department staff to:

1. Contact Engineering to remove the SVMC-owned bariatric bed – or –

2. Contact Hill-Rom to notify them

   a. The actual stop date of the rental bed use

   b. Send the completed purchasing requisition to Materials Management Purchasing Buyers or Manager, with:

      i. Patient Name

      ii. Department and Room Number

      iii. Start and Stop Dates

      iv. Confirmation Number

SUBJECT:	SECTION:
DIETARY ACCOUNTABILITY TO ADMINISTRATION AND MEDICAL STAFF	**Page 1 of 2**

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

PURPOSE:

This policy shall delineate responsibilities for Food & Nutrition Service (FNS) Department. The FNS Director and/or the Clinical Nutrition Manager (CNM) will supervise food service operations.

POLICY:

The FNS Director and CNM are responsible to the Sierra View Medical Center (SVMC) administration & medical staff to uphold the standards, where applicable, for all federal, state and local regulatory agencies.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, ADMINISTRATION, MEDICAL STAFF*

PROCEDURE:

1. Under the direction of the FNS Director, the CNM is responsible for:

   a. Planning, coordinating, and managing patient/resident nutritional care activities complying with federal, state and local regulatory standards established by SVMC, regulatory agencies, and the patient/resident/customer.

   b. The CNM will collaborate with the FNS Director in monitoring patient food service to ensure the provision of high quality, nutritious food prepared in accordance with diet modification(s).

   c. The CNM will attend meetings between the FNS Director and Administration and assigned meetings as required.

   d. The CNM will provide written reports as required by Administration.

   e. The CNM will participate on any committees as required by administration, medical staff and any federal, state or local regulatory agency.

   f. The CNM will provide food in the quantity and quality to meet the nutritional needs of the patient in accordance with the physician's diet order, and provide a comprehensive nutrition care program including food and nutrition therapy in a timely, effective and efficient manner. The nutrition care program is integrated with nursing and other appropriate disciplines, as needed.

2. In compliance with A-0620, §482.28, the FNS Director shall be a full-time employee who is granted the authority and delegated responsibility by SVMC's governing body and medical staff for the operation of the FNS department. The authority and delegated responsibility includes the daily management of food service, implementing training programs for FNS staff and assuring the established policies and procedures are maintained that address at least the following:

   a. Safety practices for food handling.

   b. Emergency food supplies.

   c. Orientation, work assignments, supervision of work, and personnel performance.

   d. Menu planning, purchasing of foods and supplies, and retention of essential records.

   e. Service Quality Assurance & Performance Improvement (QAPI) program

   f. Plan, prepare and manage the Department's budget.

REFERENCES:

- CMS Title 42, Conditions of participation: Food and dietetic services § 482.28 (Tag A-0621)

- The Joint Commission (2023). Hospital accreditation standards.
  - LD.04.01.05, EP 3
  - HR.01.01.01, EP 2

SUBJECT: **DIET MANUAL & THERAPEUTIC DIET MENUS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish a standard for therapeutic diets and non-therapeutic diets.

POLICY:

A current therapeutic diet manual is used for standardization of the diet orders, defining diets, and planning diets. The therapeutic diet manual must be approved by the dietitian and the medical staff. The publication or revision date of the approved therapeutic diet manual must not be more than five (5) years old. The therapeutic diet manual is available to all medical, nursing and food service personnel.

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

DEFINITIONS:

Therapeutic diets: A diet ordered as part of the patient's treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

PROCEDURE:

1. The Clinical Nutrition Manager (CNM) will review the therapeutic diet manual annually.

2. The therapeutic diet manual will be updated a minimum of every five (5) years.

3. The CNM, Pharmacy & Therapeutics Committee, Medical Executive Committee (MEC) and the CEO/Board of Directors will approve the manual.

4. A diet manual is available for viewing on Sierra View Medical Center (SVMC) Employee Portal under "Nutrition Links" Sierra View Clinical Diet Manual. The SVMC Interpretation of Diet Services will serve as a reference for medical and nursing personnel when ordering hospital-specific diets.

5. A hard copy of the therapeutic diet manual is kept in the Food & Nutrition Service diet office and in the dietitian office. This serves as a guide for food service staff for special diet food preparation.

6. The nutritional adequacy is based on weekly average of each nutrient. Menus are designed to meet nutritional requirements specified in accordance with the Dietary Reference Intake (DRI) from the Food and Nutrition Board, Institute of Medicine, and National Academies of Science's guidelines. Nutritional adequacy is referenced to a male of 51-70 years of age, unless otherwise specified.

7. Any modified diets not outlined in the diet manual will be transcribed by the dietitian(s), using reputable nutrition references.

8. Due to limitations within the nutrient database, not all micronutrient values are available. Every effort will be made for adequate provision of these micronutrients.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. PC.02.02.03, EP 22

- Centers for Medicare & Medicaid Services. Title 42 Regulations:
  - A-0629 §482.28(b) (1).
  - A-0631§482.28(b) (3).

SUBJECT:	SECTION:
EARTHQUAKE PROCEDURES	*Special Circumstances* **Page 1 of 3**

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

POLICY:

Safety of staff, patients and visitors depends on staff remaining calm and assisting in the protection of patients, the rapid search and rescue of injured, and assessment of the facility's ability to continue to render care and treatment safely.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS

PROCEDURE:

1. Everyone's safety depends on each employee remaining calm.

    a. Employees will not panic or run through or outside the building. The greatest point of danger is just outside doorways and close to outer walls because of falling debris.

    b. If an employee is in the building, they will remain where they are; If possible, they will take cover under a desk, table, or bench, or in doorways, hallways, or against inside walls. These areas are the most structurally sound during an earthquake.

    c. Visitors, patients, and other employees must be kept out of stairwells and elevators.

    d. If employees are outside, they will stay away from the building. They will stay clear of walls, utility poles, downed wires, trees, and windows.

    e. Patients and visitors will be reassured and assisted. DO NOT ABANDON YOUR PATIENTS.

2. Each area will evaluate its area and account for all persons. Institute search and rescue and emergency treatment procedures when the earthquake has stopped.

3. Engineering Department must immediately begin damage assessment survey to identify safety issues, identify the need to institute disruption of essential services mitigation procedures, and to determine the facility's ability to continue to function.

    a. Gas meters will be checked and shut down if necessary. Gas meters are protected by an earthquake valve that is automatically activated by seismic activity. If the valve fails to operate, and a shutdown is necessary, a manual shut down is located upstream of the meter. A large crescent wrench will be required to turn the valve. The valve must be turned one-quarter turn to shut off gas. Gas meters are located at one story boiler area, the East Side of the loading dock areas, the South Side of Human Resources building, and the East side of the Cancer Treatment Center.

    b. Liquid oxygen tank will be checked for damage. If necessary and only in case of an emergency, the tank may be shut down. The main shutoff valve is at the tank. Individual

service valves are located underneath the regulator manifold, south side of oxygen cage area. All other medical gases will be checked for damage. Clinical areas will be notified immediately of the need to shut down the oxygen and provide the clinical areas with a portable tank for oxygen needs in the event of a shut down.

c. Emergency generators will be checked for damage and functioning if power is out.

d. The boiler and main steam manifold will be checked for damage. Affected systems will be shut down as necessary. All boilers to all autoclaves in the facility will be checked.

e. Old basement will be checked for damage. Affected systems will be shut down as necessary.

f. Four-story building equipment room will be checked for damage. Affected systems will be shut down as necessary.

g. Elevators will be checked for damage and proper operation.

h. All buildings will be checked for structural damage.

4. Emergency Operations Plan will be activated and Command Center will be opened if it is apparent that essential services or structural damage has occurred.

5. The Incident Commander will coordinate decisions to evacuate or shut down services after receiving damage assessment information. See "Evacuation Procedure". The damaged, evacuated areas will be closed and cordoned off.

6. Steps will be taken to evaluate damage to medical equipment (monitors, lab, X-Ray, etc.). Action will be taken quickly to salvage as many essential supplies as possible.

7. Preparedness and Mitigation – Hospitals must be prepared to restore basic services to the community as quickly as possible following an earthquake. Several steps may be taken prior to an incident to better prepare.

a. Internal contents of supply shelves, essential medical equipment, filing cabinets, and office fixtures will be fastened, braced, anchored or otherwise secured.

b. Plans for procuring essential medical supplies will be in place.

c. Contingency plans will be in place for securing essential services (water, power, communications, etc.)

Incident Command Post will coordinate the assignment of teams to handle recovery functions – debris clearance, clean up, restocking, equipment inventory, etc.

8

REFERENCES:

- California Code of Regulations (2020). Title 22. §70741, 70743, 70745, 70746. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- The Joint Commission (2023). Hospital accreditation standards. EM.09.01.01 Joint Commission Resources. Oak Brook, IL.

SUBJECT:	SECTION:
FIRE SAFETY ANSUL SYSTEM R102 WET CHEMICAL FIRE	**Page 1 of 1**

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

PURPOSE:

To outline preventative maintenance schedules for the fire suppression system and cleaning schedules for the exhaust ducts system.

POLICY:

Inspection and servicing of the kitchen hood fire extinguishing system, Ansul R102 Wet Chemical Fire, will be conducted by qualified personnel semi-annually. The grease exhaust duct system will be cleaned and chemically treated to retard the accumulation of grease quarterly. The manual pull stations will be inspected monthly to ensure the ring and tiepins are properly secured.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, ENGINEERING*

PROCEDURE:

1. The Engineering Department will perform preventative maintenance and inspect all actuation components, including the remote manual pull stations and actuators, etc., for proper operation using the manufacturers listed procedures.

2. The Engineering Department will inspect fusible links and automatic sprinkler heads at least annually to assure proper operation of the system. In addition, they will visually inspect the control cylinders and pressure gauges to determine if cylinders have been activated and assure no falling weights may activate the tension cable.

3. A contracted company will clean hoods, grease removal devices, ducts, and other apparatus and coat them with an approved fire retardant material. At no time will flammable solvents be utilized for cleaning.

4. Food service employees will clean hoods and vents a minimum of weekly. At no time will flammable solvents be utilized for cleaning.

5. In the event of the Ansul system failure, manual fire extinguishers will be utilized.

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov.

- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **FOOD PREPARATION**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish safe principles for food preparation.

POLICY:

Employees will prepare food in a clean and safe manner to protect patients, residents, staff and visitors from food borne illness. Food shall be prepared by methods which conserve nutritive value, flavor and appearance. Food shall be served attractively at appropriate temperatures and in a form to meet individual needs.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. Foods must be defrosted from the freezer using proper thawing methods. Frozen foods will be thawed under refrigeration. When frozen food needs to be thawed expeditiously, food may be thawed in a clean sink under running potable water.

2. The use of latex gloves is prohibited in food facilities and retail food establishments. Food employees shall use non-latex utensils, including scoops, forks, tongs, paper wrappers, gloves, or other implements, to assemble ready-to-eat food or to place ready-to-eat food on tableware or in other containers.

3. Single-use gloves shall be used for only one task, such as working with ready-to-eat food or with raw food of animal origin, used for no other purpose, and shall be discarded when damaged or soiled, or when interruptions in the food handling occur. Employees will wash hands and change gloves after any source of possible contamination.

4. Foods will be cooked to minimum temperature or greater:

   - Poultry/Ground Poultry 165ºF
   - Casserole Dishes 165ºF
   - Ground Meat & Eggs 155ºF
   - Pork, Beef, Veal, Lamb 145ºF
   - Fish 145ºF
   - Vegetables & Grains 135 ºF

5. Foods which are prepared and not served on the day of preparation will be cooled from 140ºF - 70ºF within two (2) hours and from 70ºF - 41ºF within the next four (4) hours, with a total cooling time not to exceed 6 hours. Foods that have not cooled to these guidelines must be reheated to 165º and the cooling process repeated. If product does not meet the criteria on the second attempt, food must be discarded.

6. To cool food rapidly, leave all or partially uncovered during cooling period, separate food into smaller portions, place foods in shallow pans and place foods in refrigerator or use ice bath and stir frequently. Food may also be placed in the freezer for a short period of time.

7. Foods which are prepared and not served on the day of preparation are to be stored appropriately, covered, clearly identified and dated with the date of preparation. These foods will be used within 2 days.

8. All foods reheated will be heated to a minimum of 165ºF. Foods may only be reheated once.

9. All hot foods will be held at 140ºF or above. Cold foods will be held at 41ºF or below.

10. All eggs will be pasteurized.

REFERENCES:

- California Retail Food Code (Revised January 2022) California Department of Public Health
  - Article 1.113980: Protection from contamination
  - Article 2: Time and Temperature Relationships
  - Article 3.114024: Egg and milk products, pasteurized
- The Joint Commission (2023). Hospital accreditation standards. PC.02.02.03, EP 6
- GACH Title 22 Regulations: Article 3: §70273.(h)(k)

SUBJECT: **FOOD SERVICE CORRUGATED CARDBOARD MANAGEMENT**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose for this document is to define procedures for management, use and storage of corrugated cardboard boxes in the Food & Nutrition Service (FNS) department.

POLICY:

Food and supplies are purchased, received and stored in accordance to regulatory standards to maintain optimal nutritional composition and prevent all sources of contamination. FNS assures that all food and supplies are stored in accordance with the Food & Drug Administration (FDA) guidelines recommended for cardboard containers.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS, PATIENT CARE AREAS, PHYSICIANS, VOLUNTEERS*

PROCEDURE:

1. To retain information such as manufacturer's production data, expiration dates, ingredients and other vital information required for product recall, food and supplies are stored in the original cardboard packaging in compliance with the FDA 3-201.11; *21 Code of Federal Regulations (CFR) 101, 9 CFR 317*, unless original cardboard packaging is compromised.

2. Food & supply pallets are transferred directly from the delivery truck to the hall adjacent to the kitchen to be disassembled. Perishable items are delivered to appropriate areas within the kitchen. Shelf stable supplies are delivered to the storage room or staged in the hall adjacent to the kitchen area until time permits for appropriate storage. At no time are food and supplies left unattended on the external loading dock.

3. Products are rejected at delivery when packaging is compromised and easily assessed visually. All compromised cardboard packaging discovered subsequent to delivery exhibiting potential pest damage is removed immediately from the kitchen to eliminate potential pest propagation.

4. The storeroom is an integral part of the kitchen design and opens directly to the food preparation area. The storeroom is in close proximity to the delivery area. It has sufficient light and ventilation, and is of solid construction to discourage rodent and insect access. The storeroom is maintained at a comfortable temperature.

5. The storeroom floor, shelves and adjacent areas are cleaned and monitored daily. Sierra View Medical Center maintains a contracted pest control company. The pest control company monitors the kitchen areas monthly at a minimum and is available anytime for consultation.

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov.

- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance

- The Joint Commission (2023). Hospital accreditation standards. LD.04.01.01., IC.02.02.01 EP 4. Joint Commission Resources. Oak Brook, IL.

- Food and Drug Administration 2023. FDA Food Code Version 2017 https://www.fda.gov/food/fda-food-code/food-code-2022

- Code of Federal Regulation 1011. CFR 21 CFR 101. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?CFRPart=101.

SUBJECT:	SECTION:
INTERIM LIFE SAFETY MEASURES (ILSM) - FIRE WATCH	*Life Safety Management* **Page 1 of 2**

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

PURPOSE:

The purpose of conducting a fire watch is to supplement the existing fire detection and response systems, and to provide increased safety of patients, visitors and staff. The Fire Watch will identify and report hazard, for corrective action, and will document the findings and activities. All Fire Watch reports will be presented quarterly to the Safety Committee and to other appropriate governmental agencies on an as needed basis.

POLICY:

A Fire Watch is required when "hot work" is being conducted, such as cutting or welding, or when the fire or fire protection system, such as sprinklers, will be inoperative for any four hours or more in a 24 hour period. Engineers/Security Officers are mandated to conduct a Fire Watch tour on an hourly basis.

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

PROCEDURE:

1. A Fire Watch inspection tour is to be made hourly throughout the affected areas.

2. Engineers / Security Officers conducting the Fire Watch tour of the affected area will utilize the attached "Fire Watch Checklist" to identify potential hazards and problems.

3. Each item identified will be documented on the Fire Watch Checklist and the appropriate staff of the affected area and the Administrative Director of General Services or designee, will be informed of the items needing corrections.

4. The identified items are to be corrected immediately and dated when complete.

5. Open items will be reviewed by the Safety Officer or designee, to allow ongoing evaluation of the problems and documentation of the corrections completed.

6. Non-corrected items or items which are not corrected in a timely fashion will be brought to the attention of management of that specific area and the Safety Officer or designee.

Documentation:

- The status of the identified items in the Fire Watch Checklist to be corrected will be documented on the attached "Follow-Up to Identified Issues" form.

- The name of the contacted person or staff in the affected area during the "Follow-Up" will be documented on the inspection form.

- The Fire Watch Checklist and Follow-Up form will become part of the record of the project.
- All Fire Watch reports of activity or corrections made will be presented quarterly to the Safety Committee by the Safety Officer.
- The Fire Watch Checklist will be reviewed on an annual basis to assure that all appropriate elements are being met.

Training:

Engineers/Security Officers who conduct fire watches will be trained and the training will include:

- The purpose of the fire watch.
- The key elements on the fire watch checklist which are to be observed.
- The documentation process, including notifications of the appropriate staff in the affected areas and the Safety Officer.
- The areas and the specific elements to be included in the observations.
- Name of the individual responsible for the fire watch process, and who the appropriate person is to contact if there are questions or questionable items.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. LS.01.02.01 Joint Commission Resources. Oak Brook, IL.
- Fire Watch Checklist Form
- SVMC Hot Work Permit

SUBJECT: **MEAL TRAYS**	SECTION: **Page 1 of 3**

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

PURPOSE:

The purpose of this policy is to establish the processes by which meal trays are ordered, prepared and delivered.

POLICY:

Meal trays for patients are prepared and served in accordance with the physician diet order. A minimum of three (3) meals are served daily with no more than fourteen (14) hours between the dinner meal and the breakfast meal. Patient tray line begins at 0700, 1130 and 1700.

AFFECTED PERSONNEL/AREAS: *FOOD & NUTRITION SERVICE (FNS), NURSING, PATIENT CARE AREAS*

PROCEDURE:

1. All food is prepared in the kitchen and served in accordance with the patient's diet order as determined by the physician.

2. Trays are appropriately identified with the patient's name, room number and diet order. Assembled trays are checked by the diet aide for accuracy.

3. FNS personnel transport trays to the patient units in enclosed or covered food carts. On the occasion trays are transported in open carts, all food items not under a protective dome are covered with plastic wrap or other type of covering.

4. Utilizing two (2) patient identifiers, FNS personnel distribute, retrieve and record meal trays for the acute care patients. Skilled nursing staff distributes, retrieve and record meal trays for long term care residents.

5. Prior to being served to the patient/resident, nursing compares trays against the diet census sheet to assure patients are receiving the diet as ordered.

6. Isolation trays will be sent on re-usable dining wares unless otherwise specified by the physician order, nursing, or the FNS Director. Isolation trays will be delivered into, and retrieved from, the patient room by nursing staff, and will be cleaned by FNS using proper sanitation and disinfection procedures.

7. Patients placed on a "NPO" (nothing by mouth) tray hold will not receive a tray. The NPO order will be communicated through the electronic medical record system. A call will be placed to FNS for any NPO tray holds that occur within a half hour of meal periods.

8. Nursing will request a late tray for all patients admitted after the scheduled meal periods. A tray with hot food will be sent upon request when available. Hot food is available 0700-0930, 1130-

1400 and 1700-1900. Cold sandwiches are available from the kitchen between meal service and until 2000.

9. Nourishment rooms located on each unit have food available at all times for all patients.

10. Courtesy trays may be provided to breastfeeding mothers, one parent of a pediatric patient, caregivers of developmentally disabled patients and law enforcement officers assigned to guard a patient. Meals provided will be the same as the non-select regular diet for patients. The FNS director, nursing unit supervisor or dietitian will approve any exceptions.

11. Special lunch meals will be served on Thanksgiving Day and Christmas Day.

12. FNS personnel are responsible for recording meal intake. Nursing staff are responsible for recording meal intake if they remove the tray from the room. The percentage is determined according to the point system (information included in this policy).

PERCENTAGE MEAL/SNACK INTAKE - POINT SYSTEM

PERCENTAGE OF MEALS CONSUMED

Tray Items→		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
→	1	100	50	33	25	20	17	14	13	11	10	9
P	2	----	100	67	50	40	33	29	25	22	20	18
O	3	----	----	100	75	60	50	43	38	33	30	27
I	4	----	----	----	100	80	67	57	50	44	40	36
N	5	----	----	----	----	100	83	71	63	56	50	45
T	6	----	----	----	----	----	100	86	75	67	60	55
	7	----	----	----	----	----	----	100	88	78	70	64
T	8	----	----	----	----	----	----	----	100	89	80	73
O	9	----	----	----	----	----	----	----	----	100	90	82
T	10	----	----	----	----	----	----	----	----	----	100	91
A	11	----	----	----	----	----	----	----	----	----	----	100
L												

13. Points given for food/drink consumed (do not include coffee, tea, or water.):

a. Less than ¼ - no point is given.

b. ¼ to ½ - ½ point is given.

c. ¾ or more - 1 point is given.

14. Process:

a. Visually inspect the patient's tray and add up the total number of food items on the tray.

b. Add up the points for the food eaten using the above guidelines. Round up to the next whole number if ½ or higher.

c. Use the chart to determine the meal percentage.

d. Document the percentage in the electronic medical record (EMR).

Examples:

Mr. Doe has the following items on his dinner tray: Coffee, juice, roast beef, mashed potatoes; carrots, salad, roll, dessert

- *Total number of items to count for meal %: 7 (The coffee does not count.)*
- *He consumes: ½ coffee, ½ potatoes, ¼ of salad, all of the beef, juice, carrots, and roll.*
- *Total points = 5*
- *Meal % = 71%*

REFERENCES:

- California Code of Regulations (2023). Title 22. § 70273(a)
  Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). 482.28(b)(2). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2023). Hospital accreditation standards. PC.02.01.03. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **MEDICAL GAS SYSTEM PM**	SECTION: *Utility Management* **Page 1 of 1**

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

POLICY:

There is a scheduled maintenance system which is used to schedule, monitor and document the testing and maintenance of the medical gas system.

PROCEDURE:

- Normal and reserve supplies:
  - The Engineering Department personnel inspect the normal and reserve supplies of liquid oxygen each day. The levels are documented in the Engineering Department log. Tank readings are transmitted to the Medical Gas supplier and deliveries are set at a minimum of 26 "level of reserve."
  - The Engineering Department personnel inspect the normal and reserve supplies of nitrous oxide once each shift. The levels are documented in the Engineering Department log. Additional nitrous oxide is ordered when the primary supply is diminished and the secondary supply is activated. The engineer shuts off the valve on the empty tanks to prevent backflow.
  - A maintenance engineer assists with the delivery and transfer of oxygen. All invoices indicating volumes and purity delivered are kept on file in the Accounts Payable Department.
- Following periods of construction or evidence that the system has been breached, the medical gas system will be tested from the point of the breach to verify that the gases being delivered are pure. Documentation of such testing will be kept on file in the Engineering Department. When system is breached or during construction periods, the medical gas system will be tested from the point of breach for cross connections, contamination and pressure maintenance back to the nearest zone valve or in total for new installations.
- The medical gas delivery system will be inspected by the facilities contracted vendor, and repairs will be made as necessary, in accordance with the environmental maintenance procedures for nonflammable anesthetizing locations, special care areas, and general patient care areas. The inspecting engineer will also verify the zone and control valves to assure they are labeled appropriately. Automatic pressure switches, flexible connectors and outlets will be included in inspection.
- The low pressure alarm on the control panel will be tested for alarm at 26" main and 12" reserve. The engineer performing the test will document the testing.
- The entire medical gas system will be tested annually.

REFERENCES:

The Joint Commission (2023). Hospital accreditation standards. EC.02.05.09 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **MEDICAL RECORDS SECURITY DURING EVACUATION PROCEDURES**	SECTION: **Page 1 of 1**

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

PURPOSE:

To ensure the confidentiality and safety of the medical record during an evacuation.

POLICY:

Sierra View Medical Center (SVMC) shall safeguard the confidentiality and integrity of medical records at all times.

PROCEDURE:

1. In the event of an emergency or disaster requiring evacuation of hospital building(s), medical records shall be given to the appropriate, individual patient for protection and removal during the evacuation process.

2. Patients will be instructed as to the importance of protecting these records from loss, for privacy as well as continuity of care.

    a. If the patient is bedridden, his/her medical record shall be placed under the head of the bed for transport.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. IM.01.01.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **NOURISHMENT ROOM FLOOR STOCK**	SECTION:

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

PURPOSE:

To establish protocol for stocking patient nourishment rooms.

POLICY:

Adequate quantities of nourishments and condiments will be delivered to the patient nourishment rooms on the nursing units according to par levels developed for each area.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICES, ENVIRONMENTAL SERVICES, NURSING, PATIENT CARE AREAS*

PROCEDURE:

1. Food & Nutrition Service (FNS) will inventory and stock nourishment rooms daily.

2. The designated FNS employee(s) will deliver floor stock daily.

3. All items placed in the refrigerators will have an expiration date, be labeled, and appropriately sealed. The stock will be rotated to ensure FIFO (first in first out).

4. All items found to be outdated will be discarded. Any items found to be open or not clearly labeled and dated will be discarded.

5. All employee items will be stored in an area other than the patient nourishment rooms. All employee items found in patient nourishment rooms will be discarded immediately. FNS employees will not be responsible for discarding employee items found in the patient nourishment room.

6. Patient nourishments will be stored and maintained under sanitary conditions.

7. FNS employees will be responsible for cleaning the inside of refrigerators and inside of floor stock drawers daily.

8. Environmental Services will be responsible for cleaning the general area of the nourishment rooms. The outside of the refrigerator, counters, floors, ice machine, and microwave will be cleaned daily.

9. Opened items, e.g. cans, milk cartons are NOT to be placed in the refrigerator. All partially used items will be discarded immediately.

10. Any person who spills food is responsible for cleaning it up.

11. All food items will be handled under sanitary conditions and using clean hands.

12. All items intended for a specific patient stored in the nourishment room areas will be identified with patient's name, room number, and will be properly covered, labeled, and dated. No items that have been in a patient room may enter the patient nourishment areas. No partially consumed items may be stored in patient nourishment areas.

13. Perishable items shall not be left on the counters.

14. Nutritional supplements will be routinely checked by nursing and FNS employees for expired dates. Expired items will be discarded.

15. FNS employees are responsible for monitoring the temperature of refrigerators in the patient nourishment rooms, maintaining a thermometer, and storing the recorded data.

16. At no time will medications, lab specimens or items other than patient designated food items be stored in patient nourishment areas.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. PC.02.02.03 EP 11

SUBJECT: **OWNERSHIP OF MEDICAL RECORDS**	SECTION:

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

POLICY:

The medical record is the property of Sierra View Medical Center (SVMC) and is maintained for the benefit of the patient, the medical staff and the hospital. SVMC is responsible for safeguarding both the record and its informational content against loss, defacement, tampering and from the use by unauthorized individuals.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL PERSONNEL*

CHANGE OF OWNERSHIP:

1. In the event that the ownership of the hospital changes, both the previous licensee and the new licensee will provide the Department of Health, prior to change of ownership, written documentation that:

    a. The new licensee will have custody of the patients' records upon transfer of the hospital and that the records are available to both new and former licensee and other authorized persons.

    b. Arrangements have been made for the safekeeping of patients' records, as required, and that the records are available to both the new and former licensees and other authorized persons.

CESSATION OF OPERATION:

- In the event that the hospital ceases operation, arrangement will be made for safe preservation of patients' records.
- The Department of Health shall be notified within 48 hours of cessation and arrangements will be made for the safe preservation of the medical records.

REFERENCE:

- Cal. Code Regs. Tit. 22, § 70751 - Medical Record Availability

SUBJECT: **PATIENT FOOD FROM HOME - ACUTE**	SECTION: **Page 1 of 1**

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

PURPOSE:

Sierra View Medical Center (SVMC) may permit family members to bring food to patients. This policy defines the procedure for patient food brought from home.

POLICY:

Food that may be brought into the hospital for patients will be for that specified meal. All leftover food will be disposed or removed from the hospital. Patient food will not be stored in the nourishment rooms.

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

PROCEDURE:

1. Visitors are not permitted to bring food to the hospital for patients on a mechanically altered diet unless approved by their physician, dietitian, nurse or speech therapist.

2. Visitors may bring food for patients that are on a regular textured diet (not a pureed, ground, chopped or thickened liquid diet).

3. The physician, dietitian, nurse, or social service may recommend the need for food from home.

4. Food brought into the hospital for patients will be for one meal at a time. All leftover food will be disposed or removed from the hospital. Patient food will not be stored in the nourishment rooms.

REFERENCES:

- The Joint Commission. (2023). Hospital Accreditation Standards. PC.02.02.03

SUBJECT: **PERFORMANCE IMPROVEMENT - FOOD AND NUTRITION**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish protocol for measurable performance improvement.

POLICY:

The Food and Nutrition Service (FNS) Department demonstrates a consistent endeavor to deliver clinical care and food service that is optimal with available resources and consistent with achievable goals. In order to reach optimal service, the FNS department participates in the hospital performance improvement program. The program is designed to enhance clinical care and food service through the ongoing objective assessment of important aspects of FNS and the correction for improvement of the identified problems.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. The FNS Director and Clinical Nutrition Manager (CNM) are responsible for quality assurance /performance improvement (QAPI).

2. The FNS Director and/or CNM will identify QAPI opportunities, determine desired results, and develop measurable goals for resolution.

3. The collected data results will be presented to the Performance Improvement/Patient Safety Committee at least annually.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards.
  - PI.01.01.01
  - PI.02.01.01, EP 2
  - LD.03.07.01, EP 2

SUBJECT: **RECORDING HOURS WORKED**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide standard guidelines for the accurate documentation of all hours worked by employees in order to ensure full compliance with Wage and Hour Guidelines as well as other relevant state and federal statutes.

POLICY:

Exempt Employees:

Employees who work in a position designated as exempt under the Fair Labor Standards Act (FLSA) are exempt from overtime payments under federal law. To qualify as an exempt employee, he/she must be paid on a salary basis and must qualify for exempt status under applicable federal and state law. Should the exempt employee work on a holiday, all hours worked must be approved by their Vice-President. Please refer to HR Policies: Exempt Employee Compensation, Holiday Pay and Vacation/Holiday. Their individual schedules may vary based on the needs of the department, but all full-time exempt employees are expected to work a minimum of forty hours per week. The hospital will follow the provisions of the Federal Fair Labor Standards Act (FLSA) and applicable California wage statutes to establish a "salaried" exempt status for Executive, Professional, or Administrative employees who are classified as exempt from the overtime provisions. For pay practices for exempt employees who work extra shifts, refer to HR Policy: Exempt Staff Working Extra Shifts.

Non-Exempt Employees:

Federal Wage and Hour laws require that non-exempt employees be paid for every hour they are "suffered or permitted" to work. Time sheets are considered to be legal documentation and, as such, must accurately reflect all hours worked and all non-productive hours (Education, Orientation, In-service, etc.) utilized by each employee. Non-exempt employees will be expected to accurately record all hours worked utilizing the timekeeping system. For purposes of overtime computation, hours worked will include actual hours worked and other approved hours.

All productive hours worked or non-productive hours utilized by employees to complete their daily time commitments will be accurately recorded and approved on a daily basis.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

CLOCKING IN AND OUT

1. Employees have the option of using the computer or time clock to clock in/out.

2. Employees will be considered tardy if they clock-in eight (8) or more minutes after their scheduled shift start time.

Failure to follow this procedure or instructions/counseling will result in disciplinary action.

EMPLOYEE REVIEW OF TIME RECORDS

1. Employees are responsible for the accuracy of their timecards. Responsibilities include using time clocks and computers to accurately record hours worked, pay code hours such as Vacation/Holiday, late or missed meal and rest breaks, and any hours transferred to other departments and/or secondary job codes. Employees are required to review and attest to the accuracy of all hours and totals as presented on their time cards on a daily basis.

2. Any earning adjustments received by Payroll after the close of the prior pay period due to error by employees will be corrected in the next pay period. Any discrepancies with time sheets must be directed to the employee's immediate supervisor for correction.

3. Any earning adjustments received by Payroll after the close of the prior pay period due to error by department leadership or the District will be processed as soon as practical.

LEADERSHIP REVIEW OF TIME RECORDS

The Director or Manager will review and approve time cards each week, certifying that the hours were properly recorded, are accurate and that each employee is entitled to compensation accordingly. As part of the time card review, leaders are responsible for ensuring their staff are getting all meal and rest breaks by reviewing the attestation completed by the employee indicating they had a late or missed meal or rest period. If the attestation by the employee results in a meal/rest penalty, leaders will need to discuss this with their staff members and submit a Payroll Earnings Adjustment Request form as necessary.

It is the responsibility of the Director or Manager to review and approve the previous pay period time cards by 10:00 a.m. on payroll Mondays. Failure to ensure accurate documentation of hours worked and/or edits could result in disciplinary action.

FALSIFICATION OF RECORDS PROHIBITED

Employees approving inaccurate data about their hours on their time cards will be grounds for immediate disciplinary action, up to and including termination.

Clocking in for another employee's time is prohibited and will be grounds for immediate disciplinary action, up to and including termination.

HOURS WORKED

A paid ten(10) minute rest period is provided for every 4 hours of work. For additional detail, please refer to HR Policy: Meal and Break Periods.

PRE OR POST-SHIFT ACTIVITIES

Any activity that non-exempt employees are required to perform before they can begin

their jobs or before they can leave the premises must, by law, be considered time worked. Such activities may include, but are not limited to:

- Changing clothes (when such changes must be made on premises);
- Setting up a work station;
- Mandatory showers or scrub-downs; and cleanup activities.

VOLUNTEERED TIME – (Non-exempt)

Non-exempt employees are prohibited from volunteering to work before or after scheduled shifts performing substantially the same type of duties for which they would normally be compensated.

DIRECTOR RESPONSIBILITY FOR ADMINISTRATION OF SALARY POLICIES

Managers and Directors may not unilaterally create, promise or implement agreements with employees involving wages, premiums, or recording of time, or otherwise modify or exceed the hospital's wage and salary policies. Wage practices and benefits defined by exempt or non-exempt status will not be altered.

REFERENCES:

- Fair Labor Standards Act
- California Labor Code and Industrial Welfare Commission

CROSS REFERENCES:

- OVERTIME
- HOLIDAY PAY
- EXEMPT STAFF WORKING EXTRA SHIFTS
- MEAL AND BREAK PERIODS
- EXEMPT EMPLOYEE COMPENSATION

SUBJECT: VALUE ANALYSIS COMMITTEE	SECTION: Page 1 of 4

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

PURPOSE:

The Value Analysis Committee (VAC) is a multidisciplinary committee, charged with improving patient care and controlling product costs, with an emphasis on the purchase and utilization of cost-effective, high quality products through an approved process of determining clinical efficacy, product evaluation, and financial impact to Sierra View Medical Center (SVMC). This committee should also bring to the forefront programs that enhance the existing products and equipment in the current supply formulary.

POLICY:

It shall be the policy of Sierra View Medical Center (SVMC) that a Value Analysis Committee (VAC) will be structured in a framework that results in the development of an effective medical supply formulary.

AFFECTED PERSONNEL/AREAS: *ALL SVMC DEPARTMENTS, EMPLOYEES, AGENTS AND PHYSICIANS*

DUTIES AND RESPONSIBILITIES:

A. Evaluation and approval of existing/requested products and equipment

B. Evaluation and approval of new/improved technologies:

1. To be knowledgeable of new and improved technologies/products and sources.
2. To evaluate the voluminous and continuous flow of new and improved technologies/products.
3. To keep SVMC Senior Leadership Team and Department Leadership informed of changes in equipment and products.

C. Product Standardization:

1. Promote intra-departmental knowledge and understanding with regard to product standardization
2. To reduce the expense of utilizing, educating and training personnel to many and varied products, techniques, etc., through product standardization
3. To promote cross-departmental collaboration in understanding and solving mutual issues in regards to product standardization and equipment
4. To control the quantity of inventory kept by various departments by reducing the variety and amount of products

D. Monitor progress

E. Communicate all findings/request approvals and/or prepare reports to appropriate SVMC Leadership

MEETINGS:

A. The Value Analysis Committee will be comprised of the following individuals: Director of Materials Management, Supply Chain Systems Analyst, Vice President of Patient Care Services/Chief Nurse Executive, Manager of Pharmacy, Director of Surgical Services, Director of Acute Care and Nursing Excellence, Director of Maternal and Child Health Services, Senior Cost Accountant, Manager of Infection Control, Director of Compliance, Admin Director of Imaging & PT, Radiology, Manager of Emergency Services, Manager of Respiratory Care, Wound Care Specialist, Vice President of Quality/Regulatory Affairs, Hospital Administration, Chief Financial Officer, Vice President of Professional Services/Physician Recruitment and other individuals on an *ad hoc* basis.

B. A quorum shall be present to transact business. A quorum is defined as a simple majority (one more than half the members as the Committee is presently structured).

C. Meeting will generally be scheduled for one hour, unless a change in duration is approved by committee members prior to the meeting.

1. Ad hoc meetings or members can be instituted by committee approval as needed

D. Meetings will have a formal agenda published one (1) week in advance of the meeting

E. Committee members are required to attend seventy percent (70%) of the meetings. In their absence, a designee needs to attend who is a decision maker for voting purposes.

MATERIALS MANAGEMENT'S ROLE:

A. The Director of Materials Management will act as the Chairperson for the VAC.

B. Materials Management staff will:

1. Create VAC Agenda
2. Facilitate the meeting
3. Compose meeting minutes
4. Issue and receive the Physician Preference Item and New Product or Equipment Form
5. Assemble meeting packets
6. Act as the repository of all VAC activities

PROCEDURE:

A. **Items submitted for Review by Value Analysis Committee (VAC)**

1. Physician preference items and new product requests ("PPI/NPE's") are defined as medical products, technologies, supplies, and instruments that are needed specifically for medical procedures performed by physicians and staff. PPI/NPE's need to be requested

and approved by the VAC as defined in this document prior to use within the organization.

B. **PPI and New Product or Equipment Form**

1. All PPI and new product requests must be submitted to the Director of Materials Management or the Supply Chain Manager via a completed PPI and New Product or Equipment form (PPI/NPE). PPI/NPE forms should be submitted at least two weeks prior to the VAC meeting. The PPI/NPE form will be completed as follows:

   a. Requester information, answers to questions

   b. Manufacturer information, usage information, product rationale, product compatibility/trials and pilots/approvals

   c. An approval from the department director. Submit all documents to the Director of Materials Management and/or Supply Chain Manager

   d. Prices from Materials Management

   e. Cost Analysis from Financial Planning

      i. Calculate the PPI/NPE's cost/reimbursement
      ii. Identify positive or negative impact to contribution margin.

C. **PPI/NPE Used in Tandem with New Capital Equipment**

1. If the PPI/NPE is Capital Equipment, the PPI/NPE is required to be submitted to the department Vice President for capital approval.

D. **Urgent/Emergency PPI/NPE Requests**

1. The need to purchase urgent/emergency PPI/NPE should not occur. It is expected that all PPI/NPE's are requested with sufficient lead time through the process described herein.

   a. If an urgent/emergency request is necessary, a PPI/NPE form will be completed and routed to the Director of Materials Management. The product and/or equipment will be vetted to assure all departments and personnel affected by said product or equipment have been notified and have input on item. An in-service should be supplied by vendor for all affected staff.

E. **Costs and Timeline to Trial New Requests**

1. PPI/NPE trials/pilots are to be conducted at the expense of the manufacturer or supplier, whenever possible. If there is a cost for the PPI/NPE trial/pilot, the evaluation must be coordinated, approved and funded by the requesting department.

2. If multiple physicians need to participate in the trial/pilot, Materials Management will work with affected department to ensure appropriate participation.

3. The VAC's final decision to add the PPI to the supply formulary will follow the completion of the trial/pilot period.

F. **Presentations and Responses**

1. Unless other arrangements have been made in advance, presenters of PPI/NPE's will be given 10 minutes with a 5 minutes answer period to present to the VAC. The presentation will be prepared by the requester in advance and e-mailed to the Director of Materials Management if it requires to be shown via PowerPoint. All presenters will be asked to leave the room to allow the VAC to engage in a closed session discussion and to vote.

2. The presentation will be followed by questions from VAC members. Questions to anticipate include efforts to standardize PPI/NPE, and whether or not other departments are impacted by the introduction of new PPI/NPE.

G. **Denied PPI/NPE's and Rebuttals**

1. If a proposed PPI/NPE is denied by the VAC, the presenter can present a rebuttal at the next scheduled VAC meeting.

H. **Approved PPI/NPE's**

1. If approved, Materials Management will begin to add the item(s) and start the purchasing process and stocking of appropriate items. A timeline of when the product will be expected and be available for use will be included in the approval memo. Any product education will be required to be completed before the product is available for use. If this is a change in products currently being used, the new timeline will include the estimated time to use up the current product before the new product will arrive.

I. **Vendor Notice**

1. Vendors have been advised to comply with the VAC procedure, and not to fill an order without a valid Purchase Order issued by Materials Management.

CROSS REFERENCE:

- Vendor Management Policy

PURPOSE:

To define/delineate the accrual, management, and utilization of Vacation/Holiday Leave at Sierra View Medical Center (SVMC).

POLICY:

The use of Vacation/Holiday Leave shall be at the request of the employee and the discretion of the department director acting within established policies and procedures. Vacation/Holiday leave accruals are combined and may be requested for the following reasons:

- Vacation
- Holiday
- Emergency
- Personal Business

Vacation/Holiday Leave can also be used for an employee's illness when the employee's Sick Leave accruals have been exhausted and upon approval of the department director, or his/her designee.

AFFECTED AREAS/PERSONNEL: *ALL ELIGIBLE EMPLOYEES GME RESIDENTS, REFER TO YOUR SPECIFIC GME RESIDENCY POLICY*

PROCEDURE:

ACCRUAL RATES

	Length of Current Full Time Employment	**Accrual Per Hour***	**Total # of Weeks**
~~New A Hire~~	0 – 5 years hired prior to 9/1/2023	0.10783 per hour	5.0
	0 – 5 years~~3 months~~ hired on or after ~~red as of~~ 9/1/2023 ~~(Accrued but not accessible during 90 day introductory period)~~	0.08445~~10783~~ per hour	5~~4~~.0
~~A.~~	~~3+ months – 5 years~~	~~0.10783 per hour~~	~~5.0~~
~~B.~~	5+ years – 10 years	0.13210 per hour	6.0
C.	10 +	0.15762 per hour	7.0

Transfers: Employees who change status to full time on or after 9/1/2023 will receive the lesser accrual amount.

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Employees may accrue Vacation/Holiday hours on the following hours up to 80 hours per pay period.

*Hours worked include: Regular hours, Overtime hours, Call Back hours, Education hours, Orientation hours, Make Up Day Regular hours, In-service hours, Jury Duty hours, Witness Duty hours, Bereavement hours, Vacation/Holiday Leave utilized when asked to flex off, and hours missed when asked to flex off where Vacation/Holiday Leave is not utilized.

Maximum Accruals:

The maximum Vacation/Holiday Leave employees are permitted to accrue is equal 1.5 times the annual accrual. Maximum accruals of Vacation/Holiday Leave are based on length of service (refer to accrual chart). Once the maximum accrual is reached, Vacation/Holiday Leave ceases to accumulate until the employee utilizes Vacation/Holiday Leave and their accrual amount falls below the maximum allowable.

0 – 5 years prior to 9/1/2023	
0~~+ month~~ – 5 years as of 9/1/2023	~~300~~ 300 hours 240 hours
5+ years – 10 years	360 hours
10 + years	420 hours

NOTE: Vacation/Holiday Leave payments are based on the employee's current actual base rate of pay at the time Vacation/Holiday Leave is taken.

New Employee Accrual (Exempt and Non-exempt Full-time employees):

Vacation/Holiday Leave during the ninety-day (90) introductory period is accrued at a rate prescribed by the incumbent's position. However, newly hired employees may not utilize any Vacation/Holiday Leave the first ninety (90) days of employment. The 91st day of employment, Vacation/Holiday Leave accrued becomes accessible, and with each successive payday subsequent accruals are credited to the employee's account. Accruals and adjustments to accruals will appear on paycheck stubs the first pay period following the initial ninety (90) days of employment.

HOLIDAYS (Coordination of **Vacation/Holiday Leave**)

1. Employees scheduled to work on a recognized calendar holiday shall receive actual base rate of pay, applicable overtime, holiday differential if on one of the eight ~~three~~ premium-paid holidays, and other appropriate differentials. Employees scheduled off due to a holiday must elect one of two choices:

   a. Employees who have completed their initial ninety (90) day introductory period must elect Vacation/Holiday Leave be paid for the holiday. Employees who have not yet completed their initial (90) day introductory period will not be paid on the holiday.

--OR--

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b. Employees who do not intend to utilize Vacation/Holiday Leave for a holiday may work on the holiday if pre-approved by their Department Director.

2. Employees scheduled to be on call during the Holiday must use their Vacation/Holiday Leave to complete their scheduled hours. If an employee is called in to work while on call, the employee may count their called back hours in conjunction with their Vacation/Holiday Leave hours to complete their scheduled hours. Example: Employee is regularly scheduled to work 8 hour shifts, employee is on call during the Holiday and gets called in to work for 2 hours, the employee may use 6 hours of Vacation/Holiday Leave to complete the 8 hour shift.

3. Exempt employees who are within the first ninety (90) days of employment must report to work on the holiday unless otherwise approved by their Department Director. For additional details, please see policy, Holiday Pay.

EXEMPT EMPLOYEES

1. When an exempt employee has exhausted all accrued Vacation/Holiday Leave, or is within his/her ninety (90) day introductory period (when Vacation/Holiday Leave is accrued but is not available for use), a deduction in pay will be made for absences of one or more full days due to personal reasons, sickness or disability. For greater detail, please refer to the policy, Exempt Compensation.

NON-EXEMPT EMPLOYEES REQUESTING Vacation/Holiday Leave

1. To request Vacation/Holiday Leave, employees must submit a written request to their Department Director. If approved, the Vacation/Holiday Leave hours must be recorded by the employee on their Kronos time sheet during the week the Vacation/Holiday Leave is utilized unless it is already entered into the Kronos schedule. Vacation/Holiday Leave not recorded and approved accurately by the employee on their Kronos time sheet will be paid on the next scheduled paycheck. Vacation/Holiday Leave is to be requested in one hour increments. Each 24-hour day stands alone for the purpose of computing Vacation/Holiday Leave.

2. Employees may utilize regular Vacation/Holiday Leave for requested time off even if it results in being paid more than the employees' full-time scheduled hours. If the employee chooses to use Vacation/Holiday Leave, it must be recorded in the pay period it occurs.

   - Example: Employee normally works Monday through Friday and takes a vacation day during the week and is requested to work 8 hours on Saturday. If employee chooses, he/she will be paid 40 hours of regular time and 8 hours of Vacation/Holiday Leave

   - Example: Employee normally works Tuesday, Wednesday, and Friday and takes a vacation day for Friday and is requested to work 12 hours on Saturday. If employee chooses, he/she will be paid 36 hours of regular time and 12 hours of Vacation/Holiday Leave.

3. Regular Vacation/Holiday Leave must be utilized by full-time employees to complete their normal full-time hours in the event they request to take any time off unless the time is for a

protected leave of absence and they are collecting either Disability or Paid Family Leave. (Please see LEAVES OF ABSENCE below.)

4. Vacation/Holiday Leave Flex, paid or unpaid, may be requested by full-time employees to complete their normal full-time hours only in the event they have been called off or sent home by their Director due to any reason other than disciplinary issues.

5. When an employee is unable to provide advance notice, every effort will be made to accommodate the request. The Hospital reserves the right to approve, disapprove, or reschedule Vacation/Holiday leave at any time based on operational needs.

EMPLOYMENT STATUS CHANGES

1. **Full-time to Part-time employment** - Accrual of Vacation/Holiday Leave will cease with the effective date of the status change and will be paid out with receipt of the following pay check.

2. **Part-time Status to Full-time employment** - Accrual of Vacation/Holiday Leave will begin with the effective date of the status change. Employee with unbroken continuous part-time service (i.e. FT-PT-FT) will accrue Vacation/Holiday Leave at previous full-time accrual. If service is broken, the employee is treated as a new employee for accrual purposes.

3. **Full-time to Per-diem Status employment** - Accrual of Vacation/Holiday Leave will cease with the effective date of the status change and be paid out with receipt of the following paycheck. When returning to Full-time employment, the previous status is treated as a break-in service and Vacation/Holiday Leave accrual begins at the starting rate.

4. **Per-diem Status to Full-time employment** – Accrual of Vacation/Holiday Leave will begin with the effective date of the status change. Previous per-diem employment is not credited for Vacation/Holiday Leave accrual purposes.
    - New full time employees may not utilize any Vacation/Holiday hours the first ninety days (90) of Full Time status. On the 91st day of Full Time status, Vacation/Holiday hours accrued becomes accessible.

RESUMPTION OF BENEFIT ELIGIBILITY

Employees resuming their Vacation/Holiday Leave status after a separation of employment with an accompanying new service date will be treated as a new employee (i.e., the employee will accrue Vacation/Holiday Leave but will be unable to use any earned Vacation/Holiday Leave for the initial ninety (90) days of employment and the accrual rate will be based on that of a new hire.).

TERMINATION OF EMPLOYMENT

Payment of accrued Vacation/Holiday Leave will occur for employees terminating their employment status through retirement and/or voluntary/involuntary separation of employment. Payment of accrued Vacation/Holiday Leave will be made to any employee who is terminated within the first (90) days of employment even though she or he is unable to utilize accrued Vacation/Holiday Leave during that time.

Accrual of Vacation/Holiday Leave will cease with the effective date of the status change and be paid with receipt of the final paycheck. Payments are based on the employee's current actual base hourly pay rate at the time of the termination, and will be treated as supplemental wages.

PROMOTIONS

Management positions begin with a Vacation/Holiday Leave accrual rate of 0.13210 per hour. The effective date is either the date of hire into a management position or the promotion date. If years of service are greater than five (5) years, the rate will be adjusted to 0.15762 per hour.

LEAVES OF ABSENCE

1. **Workers' Compensation**

   Accrual of Vacation/Holiday Leave ceases upon the last date worked. Employees may elect to supplement either their workers' compensation benefits or contributions toward dependent health care premiums and elected benefits through the use of Vacation/Holiday Leave.

2. **FMLA/CFRA Leaves of Absences**

   Accrual of Vacation/Holiday Leave will cease with the last date worked. Since employees are expected to return from a leave status, Vacation/Holiday Leave will not be cashed out. The use of Vacation/Holiday Leave is required for exempt and non-exempt employees who are on a Family Medical Leave Act (FMLA) and/or California Family Rights Act (CFRA) leave of absence unless they are receiving either disability payments, (i.e. state disability, insurance, workers' compensation) or Paid Family Leave (PFL) payments while on FMLA/CFRA leave. If the employee is receiving disability or PFL payments, the employee may elect to supplement his/her disability or PFL benefit payments with Vacation/Holiday Leave.

   The use of Vacation/Holiday Leave is also required for exempt and non-exempt employees when on an intermittent FMLA/CFRA leave of absence, unless disability or PFL payments are being received.

3. **Pregnancy Disability Leaves of Absence**

   Accrual of Vacation/Holiday Leave will cease with the last day worked. Vacation/Holiday Leave will not be cashed out when an employee commences a leave of absence due to pregnancy. Exempt and non-exempt employees have the option of utilizing Vacation/Holiday Leave while out on a PDL leave to the extent that the employee's Sick Leave accruals have been exhausted. If available Vacation/Holiday Leave is not requested, such pregnancy leave will be unpaid.

4. **Medical Leaves of Absence**

   Accrual of Vacation/Holiday Leave will cease with the last date worked. Vacation/Holiday Leave will not be cashed out when an employee commences a medical leave of absence. The use of Vacation/Holiday Leave is required for exempt and non-exempt employees unless they are receiving disability payments, (i.e. state disability, insurance, workers' compensation) while on Medical

Leaves of Absence. If the employee is receiving disability payments, the employee may elect to integrate his/her disability payments with Vacation/Holiday Leave.

5. **Personal Leaves of Absence**

Accrual of Vacation/Holiday Leave will cease with the last date worked. Since employees are expected to return from a leave status, Vacation/Holiday Leave will not be cashed out when the employee commences a personal leave of absence. Exempt and non-exempt employees are required to exhaust all accrued Vacation/Holiday Leave while on a Personal Leave of Absence (PLOA) before going on an unpaid PLOA.

6. **Military Leaves of Absence**

Accrual of Vacation/Holiday Leave ceases with the last date worked to the extent permitted by law. Vacation/Holiday Leave will not be cashed out when an employee commences a military leave of absence. Non-exempt employees may elect to integrate payments received from the government with the use of Vacation/Holiday Leave. Exempt employees will be paid for temporary military leaves of absence; however, fees received by the employee will be applied to offset the pay otherwise due to the employee for the week. Please refer to the hospital's Exempt Compensation Policy.

7. **Jury Duty/Bereavement**

Time off for jury duty or bereavement will not be deducted from Vacation/Holiday Leave during the first five (5) days for jury duty or the first (3) days for bereavement (for full-time employees only). Vacation/Holiday Leave may be used by non-exempt employees when the need for time off for either event surpasses the authorized days paid by SVMC. Exempt employees' pay will not be deducted for absences for jury duty unless no work is performed during the workweek. However, an exempt employee may utilize Vacation/Holiday Leave for jury duty, witness leave and/or bereavement if he or she wishes to avoid a deduction in pay for weeks where no work is performed Please refer to the hospital policies on jury duty/witness leave and bereavement.

Coordination with SDI Benefits

Vacation/Holiday Leave hours may be designated by the employee to integrate SDI benefits up to the maximum of the employee's normal scheduled hours and actual base rate of pay.

VACATION/HOLIDAY LEAVE PAY OUT ELECTION

Employees may elect the option of receiving their actual base hourly rate for a maximum of forty (40) hours. The employee's election request must be received during the last pay period of December for receipt with the last paycheck in March of the following year. Employees must maintain a base of eighty (80) hours following withdrawal.

EMPLOYEE HARDSHIP WITHDRAWALS

Employees experiencing an unforeseeable emergency may access their Vacation/Holiday Leave account prior to their eligible Vacation/Holiday Leave pay out election. An unforeseeable emergency is defined by law as a severe financial hardship resulting from an illness or accident of the employee, the employee's spouse or the employee's dependent as defined by IRS regulations, loss of property due to casualty other than a natural disaster, imminent foreclosure or eviction from the employee's primary residence, medical expenses, including non-refundable deductibles, as well as for the cost of prescription drug medication, and funeral expenses of a spouse or a dependent as defined by IRS regulations.

The withdrawal of Vacation/Holiday Leave due to an unforeseeable emergency replaces the employee's December election, as only one withdrawal is permitted annually. The request cannot exceed an amount reasonably necessary to satisfy the emergency need, which may include amounts necessary to pay any fFederal, state, local or foreign income taxes or penalties reasonably anticipated to result from the ~~pay-out~~payout. Hours will be reimbursed at the employee's actual base hourly rate of pay. Employees must maintain a base of eighty (80) hours following withdrawal.

CROSS REFERENCES:

- HOLIDAY PAY
- LEAVE OF ABSENCE – FMLA/CFRA
- LEAVE OF ABSENCE – PERSONAL
- LEAVE OF ABSENCE – MILITARY
- JURY DUTY & WITNESS DUTY
- BEREAVEMENT LEAVE
- SICK LEAVE
- ATTENDANCE AND PUNCTUALITY

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MEDICAL EXECUTIVE COMMITTEE	08/02/2023
BOARD OF DIRECTORS APPROVAL	
	08/22/2023
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
August 22, 2023 BOARD APPROVAL

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

	Pages	Action
I. Policies:		**APPROVE**
• Amnisure Rupture of Fetal Membranes (ROM) Test	1-11	↓
• Change of Physician	12	
• Criteria for Collection of Stool for Ova and Parasites #1020	13-14	
• Provision of Anesthesia Services	15-23	
• Radiation Protection and Safety	24-25	
• Traffic Patterns in the OR	26-28	

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW MEDICAL CENTER
Medical Executive Committee
August 2, 2023

CONSENT AGENDA

TOPIC	ACTION	PAGES
I. Policies:	APPROVE ↓	
• Amnisure Rupture of Fetal Membranes (ROM) Test		1- 11
• Change of Physician		12
• Criteria for Collection of Stool for Ova and Parasites #1020		13-14
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SUBJECT: **AMNISURE RUPTURE OF FETAL MEMBRANES (ROM) TEST**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 11**

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

PURPOSE:

To establish the procedure for the use of the AmniSure ROM test.

POLICY:

Laboratory and Maternal Child Health (MCH) staff will follow the appropriate procedure for the AmniSure ROM test.

AFFECTED AREAS/PERSONNEL: *ALL LABORATORY AND MCH STAFF*

PROCEDURE:

1. **Principle:**

The AmniSure ROM test is a rapid, non-instrumented, qualitative test for the detection of amniotic fluid in vaginal discharge of pregnant patients who report signs, symptoms or complaints suggestive of rupture of membranes. Rupture of membranes (pPROM) prior to 37 weeks' gestation complicates up to 12% of all pregnancies.[1] It uses the principle of immunochromatography to detect human PAMG-1 (placental α-1 microglobulin) protein present in amniotic fluid of pregnant women. Placental Microglobulin was selected as a marker of fetal membrane rupture due to its unique characteristics, i.e. its high level in the amniotic fluid, low level in blood, and extremely low background level in cervico-vaginal discharge when the fetal membranes are intact.

The test does not require a speculum exam. A sample of amniotic fluid (taken by vaginal swab) is placed into a vial with solvent. The solvent extracts the sample from the swab for one minute, after which the swab is disposed. The AmniSure test strip, a lateral flow device, is then placed into the vial. The solvent containing the PAMG-1 flows from the pad region of the strip to the Test Region. If PAMG-1 is present in the patient sample it will bind with antibodies in the test region producing a second line. The test result is indicated visually and can be read immediately or within 10 minutes. One line (Control) indicates no membranes are ruptured. Two lines indicate there is a rupture.

This method is classified by the Clinical Laboratory Improvement Amendments of 1988 (CLIA'88) as a "moderately complex" test procedure (per FDA update 7/19/04). FDA cleared the use of this test by Nurses and Midwives, as well as physicians. This test is used for definitive purposes.

2. **Responsible Persons:**

Only authorized operators may perform AmniSure testing. Authorized operators are those individuals who have attended a training session and successfully demonstrated the skills required for testing.

3. Hazards:

a. Kit contents are for *in vitro* diagnostic use.

b. Do not use kit contents after the expiration date printed on the outside of the kit.

c. Do not use test strips if bent or damaged.

d. Use appropriate precautions in the collection, handling, storage and disposal of the patient samples and used kit contents. Discard used materials in proper biohazard container.

e. The test strip should remain sealed in foil pouch until just prior to use (must use within 6 hours).

f. Proper testing protocol must be followed to obtain accurate results.

4. Specimen Requirements:

a. Patient Preparation:

If the patient gives a history of possible ruptured membranes and the nurse does not see visible amniotic fluid, yet suspects that the membranes have ruptured, an AmniSure test can be performed. Prepare patient for vaginal exam.

b. Type:

- Collect sample of vaginal discharge using sterile vaginal swab provided in kit.
- Remove swab from packaging using care not to touch anything prior to insertion into vagina.
- Collect sample from surface of vagina, holding swab in the middle of the stick while patient is lying flat on back.
- Carefully insert the polyester tip of the swab into the vagina until fingers contact the skin no more than 2-3 inches (5-7 cm) deep.
- Withdraw the swab after 1 minute.
- Rinse swab after collection in solvent vial for 1 minute, and dispose of as indicated in test procedure.

- Test the patient sample as soon as possible after collection~~., preferably within 4 hours.~~

- If patient sample is not tested within 4 hours and sample storage is necessary, tightly close the sample vial and place in refrigerator for no more than 6 hours.

5. Materials:

a. AmniSure ROM Kit in foil pouch with desiccant (FMRT-1-25 for 25 test kit; FMRT-1-10 for 10 test kit)

b. Sterile polyester swab (supplied in kit)

c. Plastic vial with solvent (supplied in kit; contains 0.9% sodium chloride, 0.01% triton x 100, 0.01 NaN3)

d. Timer and Sample Rack

e. Storage Requirements:

- Store kits in dry location at room temperature 4-24 °C (40-75°F)

- Kits may be used until printed expiration date.

- Once AmniSure Test Strip is removed from foil pouch, it must be used **within 6 hours.**

6. Quality Control:

a. Internal Controls

- Each AmniSure test strip has built in reagent and procedural controls with an internal quality control line to ensure that adequate sample volume was present and adequate capillary migration of the sample has occurred.

- Patient tests where the internal quality control line is not visible must not be interpreted as the AmniSure test strip may be defective or the sample volume may be inadequate. Testing must be repeated with a new AmniSure test strip.

- External Quality Control fluids containing PAMG-1 and not containing PAMG1 are tested on each new lot number and shipment of AmniSure test strips to ensure accurate test strip performance.

- The appearance of one or two lines in the test area verifies the integrity of the test procedure. The appearance of the control line assures that adequate sample volume

was present and that adequate capillary migration (lateral flow) of the sample has occurred.

- It also verifies proper assembly of the test strip by manufacturer.

b. External Controls

- Prior to patient testing, external positive and negative controls must be run with random kits selected from each new shipment of AmniSure ROM kits to verify performance (i.e. validation or acceptability testing).
- External controls will also be run whenever there is suspicion that product performance is compromised or whenever kits have not been stored according to its labeling instructions.
- The External Controls will be provided by Point of Care Testing, SVMC Lab.

c. Quality Control Procedure

- External Positive Control: Protein positive control (available from the manufacturer).
- External Negative Control: AmniSure Solvent solution.
- After reconstituting positive protein control with the provided AmniSure Solvent solution, the obtained solution can be stored under refrigeration at 4-8°C for up to 24 hours. It is preferred, however, to run the QC procedure immediately after preparing a sample of positive protein control.

d. External Positive Control – Procedure:

- Take the vial containing 10 ng of freeze-dried Human PAMG-1 protein and add the provided 1 ml of AmniSure Solvent Solution. Mix solution well to ensure full reconsitution (e.g. vortex or shake vigorously).
- This solution from step #1 may be aliquoted out into 5 separate vials (similar to the original vial), each containing 0.2 ml of the solution. This optional method allows 5 positive controls to be run from 1 vial of PAMG-1 protein.
- Use the solution from step #1 for positive quality control of the AmniSure® ROM Test by following the two steps below:
  - Dip the white end of the test strip into the vial with solvent **for exactly 10 minutes**.
  - Remove the test strip after exactly 10 minutes. Read results by placing

the test strip on a clean, dry, flat surface. Do not interpret results **after 15 minutes have passed** since dipping test strip into vial.

e. Negative External Control - Procedure:

- Using AmniSure Solvent for the external negative control, follow steps 6.1.2 to 6.1.3 of the above procedure. Document external QC on QC log.

To interpret the AmniSure quality control results follow the chart below		
If the negative control (saline) is…	**Then…**	**And then…**
Negative	Quality control has passed	Proceed to positive control interpretation
Positive or invalid	Quality control has not passed	Repeat procedure NOTE: Do not release strips to nursing for patient testing
If the positive control (PAMG-1 protein) is…	**Then…**	**And then…**
Positive	Quality control has passed	Quality control has passed AmniSure test kits can be released to the nursing floors for patient testing
Negative or invalid	Quality control has not passed	Repeat procedure NOTE: Do not release test strips to nursing for patient testing
NOTE: Both levels of positive and negative controls need to pass for each new lot number or new shipment of test strips for the performance of the test strips to be acceptable. If the test strips do not pass quality control with an acceptable performance, sequester the kits and contact the manufacturer.		

Results reporting	**1.**	Locate the AmniSure Test kit Quality Control Log sheet
	2.	Fill out the positive and negative control results and the lot number of test strips

f. Expected Results:

- 1 Line Present (Control) in Test Area: Negative for Ruptured Membranes
- 2 Lines Present (Control and Patient) in Test Area: Positive for Ruptured Membranes
- 0 Lines Present in Test Area: Invalid Test

7. **Procedure – Patient Testing (Refer to Section 3.0 – Specimen Requirements)**

a. Open the AmniSure test kit and remove the contents

b. Shake the solvent vial to make sure that all of the liquid in the vial settles to the bottom

c. Open the solvent vial and place it in a vertical position

d. Insert the sterile polyester swab from the AmniSure test kit into the vagina for 2-3 inches.

e. Withdraw the swab after one minute has elapsed

f. Place the polyester swab into the vial

g. Rise the swab by rotating for one minute

h. Remove and dispose of the swab after one minute

i. Tear open the foil pouch at the test notches and remove the AmniSure test strip.

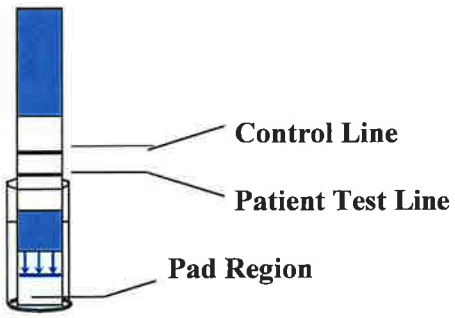
j. Dip the white end of the test strip (marked with arrows) into the solvent

k. Allow strip to remain in vial for 10 minutes, unless 2 lines are clearly visible.

NOTE: Strong leakage of amniotic fluid will make results visible within minutes, while a small leak may take up to 10 minutes.

l. Read the results by placing the strip on a clean, dry flat surface.

m. Do not read or interpret results after 15 minutes have passed since placing test strip into vial.



Results interpretation	**If the result area on the test stick has…**	**Then the test result is…**	**And then…**
	One line	Negative	The amniotic membranes have not ruptured
	Two lines	Positive	The amniotic membranes have ruptured

	No lines	Invalid	The test is invalid and must be repeated with a new swab, test vial and stick.
	Chart the results.		

8. Procedure Notes:

a. Properly identify the patient and solvent vial used in testing.

b. Test strip must remain sealed in foil pouch until just prior to use. Once open, the test strip must be used within 6 hours.

c. When there is a **significant presence of blood** on the swab, the test can malfunction and is not recommended. In cases of only trace amounts of blood on the swab, the test still functions properly.

d. Do not interpret results after 15 minutes have passed since placing test strip into vial.

e. Positive test results from a strong leakage of amniotic fluid may be visible right away.

f. A very small leak of amniotic fluid may take the full 10 minutes to become positive and a negative result must not be interpreted until the full 10 minutes have elapsed.

g. False negative results may occur when the sample is taken more than 12 hours after the fetal membrane rupture has occurred.

h. The AmniSure test should not be performed within 6 hours after the removal of any disinfectant solutions or medicines from the vagina

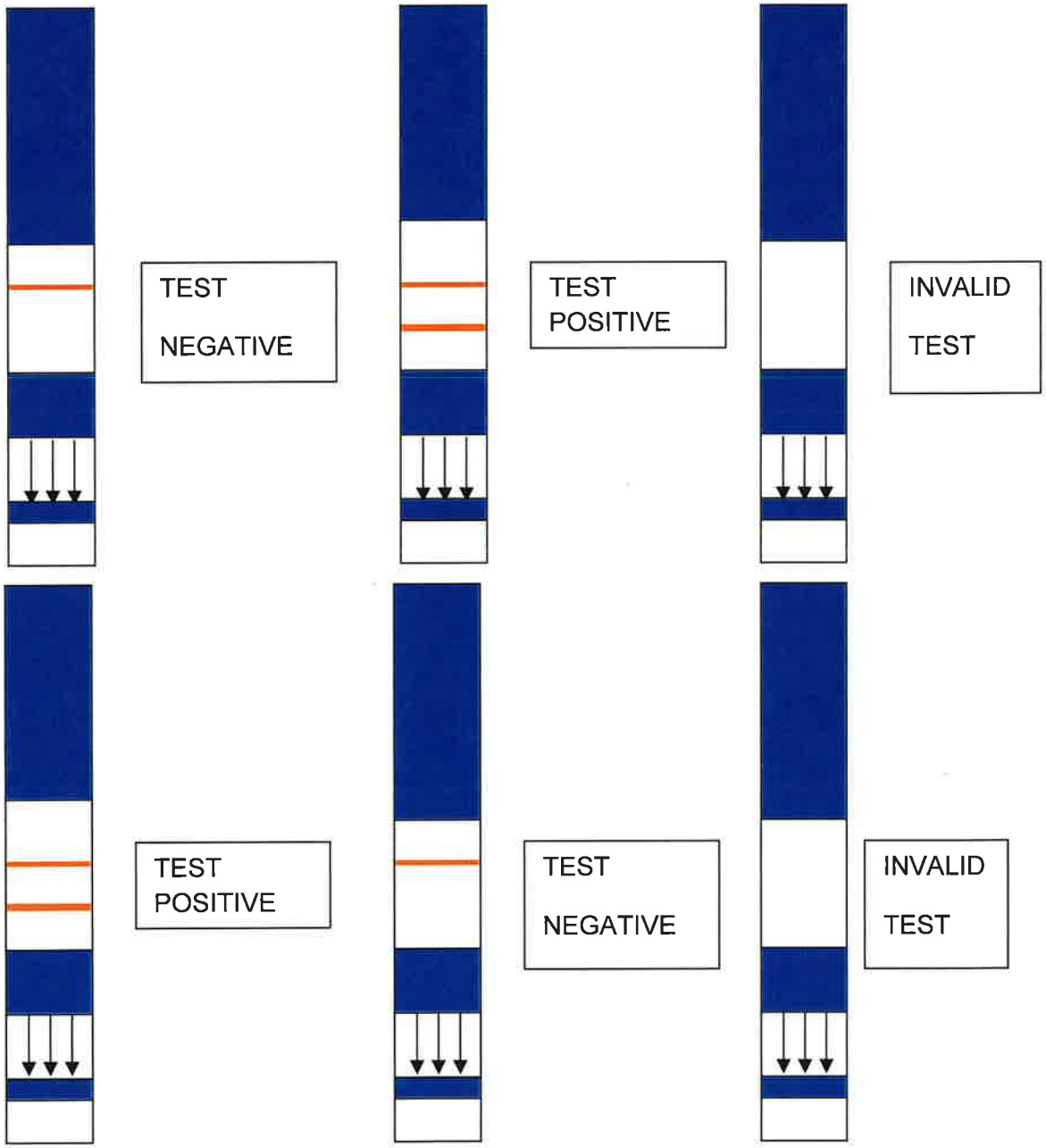
i. If AmniSure is performed as a lab test, L&D will collect the sample and send it to the lab that will run the test and record/interpret the results. In such a scenario, follow the following procedure:

- After step #5 of the procedure (i.e. after "Remove and dispose of the swab" step), place the cap on the vial.
- Complete the collection worksheet and bring~~send~~ the sample vial and paperwork ~~via the pneumatic tube system~~directly to the Laboratory ~~as soon as possible~~within 30 minutes of collection. Sample collection time must be recorded on the collection sheet and attested to by a CLS in the laboratory. ~~The sample must be tested within 30 minutes of collection, if specimen is stored at room temperature.~~
- If absolutely necessary, the sample may be held in the refrigerator (+4°C) by the lab for up to six (6) hours.

9. Reporting Results:

There are 3 possible result interpretations:

Only Control Line Present in Test Area:	**Control Line and Test Line Present in Test Area:**	**Control Line Not Present in Test Area: TEST**
INVALID, NO MEMBRANE RUPTURE	**THERE IS A RUPTURE**	**repeat specimen collection and testing**



- The darkness of the lines may vary.
- The test is valid even if the lines are faint or uneven.
- Do not try to interpret the test result based on the darkness of the line.

10. Reporting Format:

a. Document the internal control QC for one patient each day of patient testing.

b. All AmniSure patient results must be documented on the patient chart and must be accompanied by the internal QC, date and time of testing and operator's initials.

11. Expected Values and Clinical Significance:

Leakage of amniotic fluid is indicative of the fetal membrane rupture in all women. Studies of placental a-1-microglobulin protein (PAMG-1) have established it as a marker of amniotic fluid. Concentration of PAMG-1 in cervical and vaginal discharge of pregnant women without complications in pregnancy was measured and is ranged from 0.05 to 0.22ng/ml. When vaginitis or non-significant admixture of blood is present, the background level of PAMG-1 can reach the maximum level of 3ng/ml. PAMG-1 concentrations in the amniotic fluid fall into the 2,000-25,000 ng/ml range. Clinically significant leakage of amniotic fluid increases PAMG-1 concentration in cervico-vaginal discharge by a factor of thousands. The sensitivity threshold of the AmniSure Test is set by a factor of 20 above the background level of PAMG-1 (AmniSure detects ~5 ng/ml of PAMG-1).

12. Procedural Limitations

a. AmniSure test kit is for the in vitro detection of human amniotic fluid PAMG-1 protein in vaginal secretion of pregnant women. The test should be used to evaluate patients with clinical signs/symptoms suggestive of fetal membranes rupture.

b. Until the diagnosis of membrane rupture is excluded, avoid digital cervical examination to prevent infection and shorten the latency period.

c. Exclusion criteria include active vaginal bleeding from any source and placenta previa.

d. Interrupted leakage with minimal residual fluid can lead to false negative result.

e. Operators must follow all directions carefully to get an accurate reading of the results.

f. Each test is a single use disposable unit and cannot be reused.

g. The results obtained are qualitative and no quantitative interpretation should be made based on the results.

h. When there is a significant presence of blood on the swab, the test can malfunction and is not recommended. In cases of only trace amounts of blood on the swab, the test still functions properly.

i. In very rare cases when a sample is taken 12 hours or later after a rupture, a false negative result may occur due to the obstruction of fetus or resealing of the amniotic sac.

j. AmniSure should not be used earlier than 6 hours after the removal of any disinfectant solutions or medicines from the vagina.

k. Test performance in patients without signs or symptoms of ROM is unknown.

l. Results should always be used in conjunction with other clinical information.

m. Placenta previa and performing digital exams prior to sample collection can lead to inaccurate test results.

n. Women may labor spontaneously despite a negative test result.

13. Interfering Substances

a. Vaginal infections or urine do not interfere with the results of the AmniSure test.

b. The performance of AmniSure has not been established in the presence of the following contaminants: meconium, anti-fungal creams or suppositories, K-Y Jelly, Baby Powder (Starch and Talc), Replens, and Baby Oil.

c. Studies have shown that there is no interference of sperm factor in results.

d. The performance of the Amnisure ROM test has not been established in the presence of meconium in the amniotic fluid.

REFERENCES:

- [1] Excerpt from "Technical Innovations in Clinical Obstetrics," Joong Shin Park and Errol Norwitz.
- Contemporary OB/GYN, September 15, 2005, Vol. 50.
- Cousins LM et al. (2005). "AmniSure Placental Alpha Microglobulin-1 Rapid Immunoassay versus Standard Diagnostic Methods for Detection of Rupture of Membranes", American Journal of Perinatology, Volume 22.
- AmniSure ROM test package insert (04/01/2019).

SUBJECT: **CHANGE OF PHYSICIAN**	SECTION: **Page 1 of 1**

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

PURPOSE:

To define the process to be followed in assisting the patient to change physicians.

POLICY:

Sierra View Medical Center supports the patient's or the designated decision-makers right to participate in making decisions about their healthcare to include which physician they want to handle their care. While hospital staff may not be directly involved with the decision as to which physician the care is to be transferred to, staff may offer guidance as listed below.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS*

PROCEDURE

1. Once the patient or their designated decision-maker makes the decision to change physicians, they can do so by the following:

    a. The patient / designated decision-maker must make their selection of a new physician either from a list of physicians, or one of their choosing;

    b. They must first approach the new physician to determine whether he/she will take over their care. If agreed upon, then the patient / designated decision-maker must speak with the current physician letting him/her know of their wishes to change physicians and who has agreed to take over the case.

2. The current physician must sign off the case in the medical record noting which physician he/she is turning the case over to, and the accepting physician then takes over the care.

3. Once the transition is complete, nursing will notify the Admissions office of the change so that the information in the computer and in the medical record can remain current.

4. Hospital personnel must remain neutral and may not suggest nor promote one physician over another.

REFERENCE

- The Joint Commission (2023). Oakbrook Terrace, IL. Rights and Responsibilities of the Patient chapter.

SUBJECT: **CRITERIA FOR COLLECTION OF STOOL FOR OVA AND PARASITES #1020**	SECTION: **Page 1 of 2**

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

PRINCIPLE:

One of the most important steps in the diagnosis of intestinal parasites is the proper collection of specimens. Improperly collected specimens can result in inaccurate results.

SPECIMEN CONTAINER:

Total-Fix transport system

AFFECTED AREAS/PERSONNEL: *NURSING, LABORATORY STAFF*

PROCEDURE:

- Collect all fecal specimens prior to the administration of antibiotics or antidiarrheal agents. Avoid the use of mineral oil, bismuth, and barium prior to fecal collection, since all of these substances may interfere with the detection or classification of intestinal parasites.
- A bedpan is an ideal initial collection container provided it has been thoroughly cleaned and the patient is cautioned against contaminating the specimen with urine. A clean, wide mouthed container or a plastic bag or plastic wrap placed over the toilet seat is also acceptable.
- An appropriate (i.e. bloody, slimy, watery) area of stool should be selected and sampled with the collection spoon provided in the cap of the transport container. Add sufficient specimen to bring the liquid level up to the "Add Specimen to this Line" mark. This will result in approximately 5 ml of sample. Repeat for the other transport container.
- Agitate each specimen with the spoon along the sides of the vial, tighten the cap and shake firmly to insure that the specimen is adequately mixed. The specimen should appear homogenous.
- Label each specimen, return the containers to the ziplock bag and transport specimens to the laboratory.

PROCEDURE NOTES:

- To ensure the recovery of parasitic organisms that are passed intermittently and in fluctuating numbers, the examination of a minimum of three specimens collected over a 7- to 10-day period is recommended. Infections with Entamoeba histolytica/E. dispar or Giardia lamblia may require the examination of up to six specimens before the organism is detected.
- Stools from inpatients who have been in the hospital for >3 days are of limited value. Patients may become symptomatic with diarrhea after they have been inpatients for a few days; however symptoms are usually attributed not to parasitic infections but generally to other causes.

CRITERIA FOR SPECIMEN REJECTION:

When a specimen is rejected for any of the reasons listed below, the nursing unit will be notified by phone, giving the reason for the rejection and a new specimen will be requested.

- Specimen received in improper transport container, or appears to be dry on the surface or edges. Protozoan trophozoites will not survive if the stool specimen begins to dry out.
- Specimen contaminated with urine or water from the toilet.
- Specimens contaminated with the materials listed in the table below.

Materials and/or Drugs Used	Required Interval After Use
Iron Bismuth (in some ulcer medications) Oil (castor or mineral) Particulate substances (Metamucil or others)	One Week
Barium Gallbladder dye Antibiotics Iodine preparations Antiamebic drugs Antimalarial drugs (certain)	Three Weeks

REFERENCE:

- Patricia M. Tille, PhD, MLS(ASCP), AHI(AMT), FACSc, (2022), Bailey and Scott's Diagnostic Microbiology, C.V. Mosby Co., St. Louis, Missouri, 15th edition.
- Isenberg, Henry D., Clinical Microbiology Procedures Handbook, American Society for Microbiology, 1994
- Murray, Patrick R., Manual of Clinical Microbiology, American Society for Microbiology, 1995
- Medical Chemical Corporation, Total-Fix package insert, Rev. 05/15

SUBJECT: **PROVISION OF ANESTHESIA SERVICES**	SECTION: **Page 1 of 9**

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

PURPOSE:

To establish a consistent standard of care for patients receiving anesthesia services.

POLICY:

1. This is an organization-wide policy. As referenced herein, portions or all of this policy shall apply to all areas involved in the provision of anesthesia services throughout the hospital.

2. Anesthesia services throughout the organization shall be organized into one anesthesia service, under the direction of a qualified doctor of medicine (MD) or doctor of osteopathy (DO). The medical staff shall establish criteria for the qualifications for the director of anesthesia services in accordance with State laws and acceptable standards of practice. The director of anesthesia services is responsible for:

   a. Planning, directing, and supervising all activities of the service

   b. Establishing staffing schedules for the anesthesia department

   c. Evaluating the quality and appropriateness of the anesthesia patient care

4. The anesthesia service is responsible for developing policies and procedures governing the provision of all categories of anesthesia services.

DEFINITIONS:

Anesthesia Services: Includes both anesthesia and analgesia, provided along a continuum, ranging from the application of local anesthetics for minor procedures to general anesthesia for patients who require loss of consciousness, as well as control of vital body functions in order to tolerate invasive operative procedures. This continuum also includes minimal sedation, moderate sedation/analgesia (conscious or procedural sedation), monitored anesthesia care (MAC), and regional anesthesia.

General Anesthesia: A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory support is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Regional Anesthesia: The delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves, including epidurals and spinals and other central neuraxial nerve blocks, is used when loss of consciousness is not desired but sufficient analgesia and loss of voluntary and involuntary movement is required.

* **Exception**: The administration of medication via an epidural or spinal route for the purpose of

analgesia during labor and delivery, is not considered anesthesia. However, if the obstetrician or other qualified physician attending to the patient determines that an operative delivery (i.e., C-section) of the infant is necessary, it is likely that the subsequent administration of medication is for anesthesia, as defined above, and is therefore considered regional anesthesia.

Monitored Anesthesia Care (MAC): Anesthesia care that includes the monitoring of the patient by an individual credentialed to administer monitored anesthesia care. Indications for MAC depend on the nature of the procedure, the patient's clinical condition, and/or the potential need to convert to a general or regional anesthetic. Deep sedation/analgesia is included in MAC.

Deep Sedation/Analgesia: A drug-induced depression of consciousness, during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilator function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

Moderate Sedation/Analgesia: ("Conscious Sedation") A drug-induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Minimal Sedation: A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected.

Topical or Local Anesthesia: Administration of a drug that produces only a localized response with no systemic effect.

Analgesia: Involves the use of a medication to provide relief of pain through the blocking of pain receptors in the peripheral and/or central nervous system. The patient does not lose consciousness, but does not perceive pain to the extent that may otherwise prevail.

AFFECTED AREAS/ PERSONNEL: *MEDICAL STAFF, SURGICAL SERVICES STAFF, MATERNAL CHILD HEALTH STAFF, CARDIAC SERVICES*

PROCEDURE:

ANESTHESIA EQUIPMENT AND SAFETY PRACTICES

Proper patient care requires inspection of anesthesia equipment by the anesthesia provider prior to administration of every anesthetic.

- The oxygen analyzer will be calibrated at the beginning of the day.

- The carbon dioxide (CO_2) absorber is to be checked and replaced as needed.
- Confirm that the suction apparatus is functioning before the start of each case.
- Pin indexing system needs to be verified prior to changing oxygen and nitrous oxide cylinders.
- Verification of scavenging system should be completed.
- Check vaporizer container for anesthesia gases prior to start of each case.
- Anesthesia machine must be inspected and tested by the anesthesia provider. If any leak or other defect is observed, the equipment must not be used until the defect is corrected.
- Anesthesia equipment shall be properly monitored, inspected, tested and maintained by the hospital biomed service.
- Only equipment approved by the biomed service will be utilized.
- Only non-flammable anesthesia agents will be utilized.

INFECTION CONTROL PRACTICES

The administration of anesthesia and use of anesthesia equipment poses a potential vector in the transmission of microorganisms to patients. Each anesthesia provider is responsible for observing the surgical services dress code policy and hospital wide infection control policies.

- Hand washing with soap should be performed whenever there is visible contamination with blood or body fluids. Alcohol-based hand scrubs are recommended when there is no visible contamination.
- Standard precautions will be observed with gloves being worn for all contact with body fluids and secretions.
- All single use items such as suction catheters, breathing circuits, bags, airways, and forceps will be discarded after each use.
- All equipment that will enter or contact any normally sterile area should be sterile at the time of use, and aseptic techniques will be employed to maintain sterility.
- Prevention of medication contamination will include strict preparation and administration of medication. All single-use vials and ampoules are single-patient, single-dose, opened at the time of use and appropriately discarded. Medications from a syringe are not administered to multiple patients, even if the needle or syringe is changed.

- Multi-dose vials should be dated and signed when first entered, and be discarded following hospital policy expiration guidelines. Multi-dose vials should be discarded if the sterility is questionable.

PROVISION OF GENERAL ANESTHESIA, REGIONAL ANESTHESIA, MAC, & DEEP SEDATION

The policy requirements of this section apply to the provision of general, regional, and monitored anesthesia (MAC), and deep sedation (hereinafter known collectively in this section as "anesthesia").

1. Individuals Permitted to Administer Anesthesia
   Only those individuals privileged by the medical staff shall be permitted to administer anesthesia. These individuals include:

   a. A qualified anesthesiologist

   b. A doctor of medicine or osteopathy (other than an anesthesiologist)

   c. A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law

   d. A certified registered nurse anesthetist (CRNA)

2. Anesthesia Planning

   There shall be sufficient personnel and resources to safely provide anesthesia services. At a minimum, this shall include:

   a. Individuals administering anesthesia shall be qualified and have credentials to manage and rescue patients at whatever level anesthesia is achieved, either intentionally or unintentionally.

   b. In addition to the individual performing the procedure, a sufficient number of qualified personnel shall be present to evaluate the patient, to provide the sedation anesthesia, to help with the procedure, and to monitor and recover the patient.

   c. There shall be equipment available to monitor the patient's physiological status.

   d. There shall be equipment available to administer intravenous fluids and medications, and blood and blood components.

   e. There shall be resuscitation equipment available.

   f. There shall be cardiac and respiratory emergency support through Code Blue and Rapid Response Teams.

3. Pre-Anesthesia Evaluation

The pre-anesthesia evaluation may only be performed by an individual permitted to administer anesthesia as noted in this section of the policy.

A pre-anesthesia evaluation must be performed and documented within 48 hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. The delivery of the first dose of medication(s) for the purpose of inducing anesthesia, as defined above, marks the need of the 48 hour timeframe.

At a minimum, the pre-anesthesia evaluation of the patient should include:

a. Review of the medical history, including anesthesia, drug and allergy history

b. Interview, if possible, given the patient's condition, and examination of the patient

c. Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk – see Addendum A); Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access)

d. Additional pre-anesthesia data or information, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation)

e. Development of the plan for the patient's anesthesia care including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia

4. Consent for Anesthesia

The individual administering anesthesia is responsible for ensuring that the patient has received the information necessary for an informed consent to occur.

5. Reassessment Immediately Prior to Administration of Anesthesia

Patients shall be reassessed immediately prior to the administration of anesthesia to ensure they are ready for induction. This reassessment shall be performed by individuals permitted to administer anesthesia as noted in this section of the policy. At a minimum, the reassessment shall consist of documenting the patient's vital signs (blood pressure, pulse, and respiration) prior to anesthesia administration, or a

summary statement or note entered into the medical record that the reassessment was performed.

6. Plan for Anesthesia

There shall be a documented plan for anesthesia entered into the patient's medical record prior to the administration of anesthesia. The plan for anesthesia shall be done by an individual permitted to administer anesthesia as noted in this section of the policy. If the individual privileged to administer anesthesia is not a licensed independent practitioner (LIP), then an LIP must concur with the plan for anesthesia.

7. Monitoring of Patients During Anesthesia (Intraoperative Anesthesia Record)

Patients shall be appropriately monitored during the administration of anesthesia. Monitoring shall be documented on an intra-operative/intra-procedure anesthesia record. This documentation shall address at a minimum:

a. Name and hospital identification number of the patient

b. Name(s) of practitioner who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner

c. Name, dosage, route and time of administration of drugs and anesthesia agents

d. Techniques(s) used and patient position(s), including the insertion/use of any intravascular or airway devices; Names and amounts of IV fluids, including blood or blood products if applicable

e. Time-based documentation of vital signs, as well as oxygenation and ventilation parameters

f. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment

8. Post-Anesthesia Monitoring & Care

Patients shall be appropriately monitored and cared for during the post-anesthesia recovery period. At a minimum, this shall include:

a. A Post-Anesthesia Care Unit (PACU) or an area which provides equivalent post-anesthesia care (for example, an Intensive Care Unit) shall be available to receive patients after anesthesia care. All patients who receive anesthesia care shall be admitted to the

PACU or its equivalent except by specific order of the anesthesiologist responsible for the patient's care.

b. The medical aspects of care in the PACU (or equivalent area) shall be governed by policies and procedures which have been reviewed and approved by the Department of Anesthesiology.

c. Patients shall be transported to the PACU accompanied by a member of the anesthesia care team who is knowledgeable about the patient's condition. The patient shall be continuously evaluated and treated during transport with monitoring and support appropriate to the patient's condition.

d. Upon arrival in the PACU, the patient shall be re-evaluated and a verbal report provided to the responsible PACU nurse by the member of the anesthesia care team that accompanied the patient.

e. The member of the anesthesia care team shall remain in the PACU until the PACU nurse accepts responsibility for the nursing care of the patient.

f. The patient shall be observed and monitored by methods appropriate to the patient's medical condition. Particular attention should be given to monitoring oxygenation, ventilation, circulation, level of consciousness and temperature. During recovery, a quantitative method of assessing oxygenation, such as pulse oximetry, should be employed in the initial phase of recovery. This is not intended for application during the recovery of the obstetrical patient on whom regional anesthesia was used for labor and vaginal delivery.

g. An accurate documented report of the PACU period shall be maintained. Use of an appropriate PACU scoring system is encouraged for each patient on admission, at appropriate intervals prior to discharge, and at the time of discharge.

h. The patient's physiological status, mental status, and pain level at a frequency and intensity consistent with the potential effect of the operative or other high risk procedure or anesthesia administered shall be monitored.

i. A qualified licensed independent practitioner discharges the patient from the recovery area or from the hospital. In the absence of a qualified licensed independent practitioner, patients may be discharged according to approved criteria.

j. Patients who have received anesthesia as outpatients are discharged in the company of an individual who accepts responsibility for the patient.

9. Post-Anesthesia Evaluation

A post-anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. The calculation of the 48-hour timeframe begins at the point the patient is moved into the designated recovery area. The evaluation must be completed and documented by any practitioner who is qualified to administer anesthesia as noted in this section of the policy.

The evaluation may not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation, (e.g., answer questions appropriately, perform simple tasks, etc.). The evaluation can occur in the PACU/ICU or other designated recovery location. For outpatients, the post-anesthesia evaluation must be completed prior to the patient's discharge.

The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:

a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation

b. Cardiovascular function, including pulse rate and blood pressure

c. Mental status

d. Temperature

e. Pain

f. Nausea and vomiting

g. Post-operative hydration

* Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

For those patients who are unable to participate in the post-anesthesia evaluation (e.g., post-operative sedation, mechanical ventilation, etc.), a post anesthesia evaluation should be completed and documented within 48 hours, with notation that the patient was unable to participate. The documentation should include the reason for the patient's inability to participate as well as the expectation for recovery time if applicable.

REFERENCE:

- The Joint Commission ~~(2019).~~ Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- The Joint Commission ~~(2019).~~ (2023) Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- American Society of Anesthesiologists (n.d.) Retrieved from https://www.asahq.org/.

- Department of Health and Human Services. (2011). CMS Manual System. 482.52 Condition of Participation: Anesthesia Services. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R74SOMA.pdf.

SUBJECT: **RADIATION PROTECTION AND SAFETY**	SECTION: **Cath Lab** **Page 1 of 2**

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

PURPOSE:

To establish guidelines to keep exposure at a minimum and protection against radiation hazards for both staff and patients.

POLICY:

1. All personnel are required to wear an exposure monitor (dosimeter)
2. A record on exposure amounts will be kept in the Imaging Department.
3. Cath Lab doors will be closed during fluoroscopy and cine procedures.
4. All personnel required to be present in the room during the procedure will wear lead aprons.
5. Personnel not directly involved in the procedure will remain outside the room during exposure.
6. Shielding evaluation will be made of the structures to comply with state and federal regulations.
7. Evaluation records will be kept on file in the Cardiac Cath Lab.
8. Any malfunction of equipment will be immediately reported to the Cath Lab Director.
9. Operators will know the location of all emergency off and on switches.
10. All staff will have taken the Radiation Safety Module in E-Learning
11. All X-ray equipment will be maintained and preventative maintenance will be done per manufacturer's guidelines.
12. Fluoroscopy checks will be done and recorded on a weekly basis.

AFFECTED PERSONNEL/AREAS: *ALL CATH LAB STAFF*

EQUIPMENT:

- Lead Apron
- Thyroid Collar
- Protective Glasses
- Film Badge
- Other Protective Shields

PROCEDURE:

1. Film badges will be issued to each individual who enters the Cardiac Cath Lab that is likely to receive, in any calendar quarter, a dose exceeding 300 millirems to the whole body, or 5 rems to the hands and forearms, or feet and ankles, or 2 rems to the skin of the whole body.

2. All Cardiac Cath Lab personnel and physicians must wear their film badge at all times when they are in the department.

3. Film badges, when not in use, must be placed on the racks provided in the break room. They should not be left on the lead aprons, and should not be taken outside the facility.

4. Under no circumstance shall an employee or physician be permitted to use a film badge other than their own.

5. The X-ray unit in Cath Lab will be turned on at the beginning of each day and left on throughout the day to allow for adequate operation.

6. All Cath Lab staff will use caution in the fluoroscopy rooms between procedures and while prepping patients to ensure no exposure to radiation by accidentally stepping on the fluoroscopy pedal.

7. The designated staff will verify fluoroscopy time automatically documented for each case.

8. Each Cath Lab staff member must assume responsibility for adequately protecting themselves and others in the procedure room with lead aprons and protective accessories during procedures and must follow As Low As Reasonably Achievable (ALARA).

9. A designated Imaging Services Employee will be responsible for the distribution of the film badges, the procedures governing their use, and the maintenance of permanent radiation records on each individual.

10. Reports will be provided to any individual of their radiation exposure data at their request and in writing.

11. Quarterly film badge reports will be posted in the Imaging Department break room.

REFERENCES:

- California Department of Public Health (2020). Radiologic Health Branch. Retrieved from https://www.cdph.ca.gov/Programs/CEH/DRSEM/pages/rhb.aspx.

- California Health and Safety Code: Sections 114960 and 106965 (Radiation Control Law). Added by Stats. 1995, Ch. 415, Sec. 6. Effective January 1, 1996.

SUBJECT: **TRAFFIC PATTERNS IN THE OR**	SECTION: **Page 1 of 3**

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

PURPOSE:

To identify appropriate traffic patterns into and out of the surgical area.

POLICY:

All persons entering the surgical area will follow the established traffic patterns as defined for the designated areas: Signs will provide a visual cue that alerts persons to the restrictions required for entry into each area. Doors provide a physical barrier to assist in maintaining control of the HVAC.

Unrestricted: Area accessible from the exterior of the building, other unrestricted areas, or semi-restricted areas and do not require the wearing of surgical attire (ie. Wearing of street clothes is permitted) Street clothes are permitted in outside hallways, locker room, pathology, X-ray room, and entrance areas (delineated by red lines on the floor). The central station in the Operating Room (OR) and Post-Anesthesia Care Unit (PACU) is the control point established to monitor the entrance of patients, personnel, and materials. Communication with the entire health care facility, not excluding outside medical offices, occurs at the central station.

Semi-Restricted: Area accessible from unrestricted, other semi-restricted, or restricted areas; require the wearing of surgical attire[47]; have floors with no seams or sealed seams and a cove base; have walls with no seams or sealed seams; and have ceilings that are either monolithic or are drop-in ceiling tiles.

Scrub Clothes (hospital-laundered attire, shoe covers, and hats) are required in this are with the exception of the Post-Anesthesia Care Unit-second floor.a. This zone includes most peripheral support area of the operating rooms, including storage areas for clean supplies and corridors to restricted areas. Food and drinks are not permitted. Hats and shoe covers are optional in the PACU.

Restricted: Area accessible only from a semi-restricted area; require the wearing of surgical attire[47] and masks in the presence of open sterile supplies[2]; have floors with no seams or sealed seams and a cove base; have walls that are smooth with no seams or sealed seams; and have ceilings that are monolithic or are drop-in gasketed ceiling tiles.

Masks must be worn in addition to appropriate scrub attire. This zone includes the operating room suites when surgeries are in progress and the clean core. Food and drinks are not permitted.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR)-MATERNAL CHILD HEALTH OPERATING ROOM (MCH OR), PACU, FLEXCARE, CATH LAB, INTERVENTIONAL RADIOLOGY, ASDE/ALL EMPLOYEES, VISITORS/MEDICAL STAFF*

SUBJECT: **TRAFFIC PATTERNS IN THE OR**	SECTION: **Page 2 of 3**

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

PROCEDURE:

1. Access to the semi-restricted and restricted zones is through the locker areas where scrub attire is donned. The exception to this is the short-term use of disposable coveralls by other hospital personnel or visitors. (Coveralls are available at the entrances.)

2. Doors to operating rooms are to remain closed except when personnel are entering or exiting. Movement of personnel in and out of operating rooms is kept to a minimum while surgery is in progress.

3. Life-threatening patient emergencies or fire safety hazards may necessitate modification in traffic control practices during the emergency only.

4. Movement of patients to and from the surgical suite will be along the most direct route that prevents cross contamination and shields patients from potentially upsetting sights and sounds.

5. The patient is transported to the surgical suite by bed, stretcher, wheelchair or ambulation. The conveyance is cleaned by damp dusting with the hospital approved cleaning agent after each patient use and then clean linens are applied.

6. During transport from the Operating Room to the Post Anesthesia Care Unit the patient is carefully monitored by the RN and anesthesia provider who are thoroughly familiar with the patient and his/her anesthetic course.

7. Traffic patterns for clean and sterile supplies and equipment will be separated from patterns of soiled equipment and waste by space.

8. Clean and sterile supplies are delivered to the unrestricted area of the suite where external packing containers are removed before storage. The integrity of sterile packaging is protected at all times.

9. Sterile supplies processed in Central Processing (CP) are sent up by the "clean" dumbwaiter to the clean core. The flow of supplies is from the clean core, through the operating room, to the peripheral core, to the clean-up room, to the "dirty" dumbwaiter. CP has appropriate collection areas for trash and linen.

10. If instruments and/or other supplies are partially or totally reprocessed within the clean-up room, the traffic pattern is from this decontamination area to Central Processing to sterile storage. Work areas for each task are clearly identified to eliminate crossover or mixing of soiled and clean supplies.

11. Sterile supplies are stored on separate shelves from clean, nonsterile supplies to prevent inadvertent use of nonsterile items. Storage conditions should minimize dust, moisture, and insect contamination. Sterile items are physically separated from soiled waste materials at all times.

12. Supplies are organized so that stock allotment of an item is kept in one location to facilitate retrieval and inventory control.

13. The storage of supplies in the operating suites is kept to a minimum, especially items that are used in several rooms at one time. These items are stored in a central area as close to the point of use as possible to facilitate retrieval and aid in maintaining traffic patterns.

14. Equipment from outside the surgical suite (X-ray machines, gas cylinders, new equipment) are damp dusted with appropriate agent in the unrestricted or semi-restricted area prior to being brought into the Operating Room.

15. Description of traffic patterns and their interpretation are included in the orientation of all personnel working within the surgical suite and on-going education is provided.

16. The Surgical Services Clinical Managers and ~~OR~~ Charge RNs are responsible for assisting in the enforcement of standards for traffic patterns.

REFERENCE:

- AORN Standards & Recommended Practices (Nov 2018). Retrieved from https://aornguidelines.org/guidelines/content?sectionid=173721980&view=book#173721980.

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

The regular meeting of the Board of Directors of Sierra View Local Health Care District was held **July 25, 2023 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 5:06 p.m.

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

Others Present: Blazar, Dan, Patient Experience Officer, Canales, Tracy, VP of Human Resources, Dickson, Doug, Chief Financial Officer, Espinoza, Alexis, Porterville Recorder, Hefner, Donna, President/Chief Executive Officer, Mandujano-Roberts, Silvia, Manager of Care Integration for Social Services and Case Management, Mitchell, Melissa, VP Quality and Regulatory Affairs, Pryor-DeShazo, Kimberley, Director of Marketing, Reed-Krase, Alex, Legal Counsel, Sandhu, Harpreet, Chief of Staff, Wallace, Marcella, Director of Communications, Watts, Whitney, Executive Assistant and Clerk to Board of Directors, Wheaton, Ron, VP Professional Services and Physician Recruitment

I. Approval of Agenda:

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:04 p.m. to discuss the following items:

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update

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

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

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

III. Open Session: Chairman REDDY adjourned Closed Session at 5:38 p.m., reconvening in Open Session at 5:39 p.m.

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

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Abstain
KASHYAP	Yes

2. Quality Division Report

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Conference with Legal Counsel

Information only; no action taken

G. Discussion Regarding Trade Secret

Information only; no action taken.

IV. Public Comments

None.

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). It was moved by Director MARTINEZ, 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 Director MARTINEZ and seconded by Director KASHYAP to approve the June 27, 2023 Regular Board Meeting Minutes as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Abstain
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VII. CEO Report

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

In the District:

- Sierra View Medical Center is proud to be nationally recognized by the American Heart Association and American Stroke Association for our commitment to high-quality stroke care.

- Fitch Ratings affirms Sierra View Local Healthcare District 'A' rating!

- An SVMC Nurse Residency Program submission was published in the Summer 2023 Vizient National Newsletter. The article showcases the collaboration between our Vizient Nurse Residents and our GME Internal Medicine Residents on an EBP project called Stethoscope Hygiene. Congratulations for all the teamwork and a special thanks to our very own Christine A. Williams MSN, RN, CCRN, PHN, Nurse Residency Coordinator and Clinical Educator, for submitting this inspirational piece!

- Join the Sierra View Foundation on October 14th, 2023 to Rock N Roll for a Cause! Enjoy a night of great company and fun entertainment as Run for Cover shows us what it means to Rock N Roll for a good cause!

- Join the Porterville Breakfast Rotary Club's 20th Annual Cancer Run/Walk at Granite Hills High School on September 9, 2023.

VIII. Business Items

A. June 2023 Financials

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

Total Operating Revenue was $15,249,976. Supplemental Funds were $4,503,129. Total Operating Expenses were $15,665,432. Loss from operations of $415,456.

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

IX. Closed Session: Board adjourned Open Session at 6:04 p.m. and went into Closed Session at 6:05 p.m. to discuss the following items:

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

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

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

X. Open Session: Board adjourned Closed Session at 7:42 p.m. and went into Open Session at 7:42 p.m. to discuss the following items:

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

E. Discussion Regarding Trade Secret. Information only; no action taken.

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

XII. Announcements:

A. Regular Board of Directors Meeting – August 22, 2023 at 5:00 p.m.

The meeting was adjourned 7:43 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: ww