SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
465 West Putnam Avenue, Porterville, CA – Board Room
585 N. Belmont Street, Porterville - CA

AGENDA
May 24, 2022

OPEN SESSION (4:30 PM – 4:35 PM)

The Board of Directors will call the meeting to order at 4:30 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 4:35 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:00 P.M. or via Zoom: https://svmc.zoom.us/j/85249774335

Call to Order/Roll Call

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. **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 then that item may be removed from the Consent Agenda and moved to the Business Agenda for separate action by the Board. Items on the Consent Agenda are posted on the Hospital Website at least 72 hours prior to each meeting and can be viewed by the public at https://www.sierra-view.com/about-us/board-of-directors/board-of-directors-meetings/. A hard copy is also available for review at the Hospital Administrative Office at 465 W. Putnam Ave., Porterville, CA 93257.

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
May 24, 2022

III. Approval of Minutes

A. April 26, 2022 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove April 26, 2022 Minutes of the Regular Meeting of the Board of Directors

B. May 12, 2022 Minutes of the Special Meeting of the Board of Directors
Recommended Action: Approve/Disapprove May 12, 2022 Minutes of the Special Meeting of the Board of Directors

IV. Adjourn Open Session and go into Closed Session

CLOSED SESSION

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

V. Closed Session Business

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

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

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

2. Quality Division Update –Quality Report

3. Patient Safety Report – Quarter 3 Report

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – December 2022

Bindusagar Reddy, MD Zone 1 | Gaurang Pandya, MD Zone 2 | Ashok Behl, MD Zone 3 | Liberty Lomeli, PA-C Zone 4 | Kent Sorrells, PhD Zone 5

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 54956.9, Exposure to Litigation to subdivision (d)(2): Conference with Legal Counsel. BETA Claim No. 22-000785 (Time Limit – 10 minutes)

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 (1Item)

G. Pursuant to Gov. Code Section 54957(b): Discussion Pertaining to Personnel: Public Employee Performance Evaluation (Time Limit – 30 minutes)

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.

VI. Adjourn Closed Session and go into Open Session

OPEN SESSION

VII. 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: Vote to Approve/Disapprove

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

Bindusagar Reddy, MD Zone 1 | Gaurang Pandya, MD Zone 2 | Ashok Behl, MD Zone 3 | Liberty Lomeli, PA-C Zone 4 | Kent Sorrells, PhD Zone 5

3. Patient Safety Quarter 3 Report
   Recommended Action: Approve/Disapprove

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

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

E. Conference with Legal Counsel regarding BETA Claim No. 22-000785
Recommended Action: Approve/Reject

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

G. Discussion Pertaining to Personnel: Public Employee Performance Evaluation
Recommended Action: Approve/Disapprove

VIII. Public Comments

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

IX. Hospital CEO Report

X. Business Action Items

A. **Patient Experience Report**
Recommended Action: Approve/Disapprove

B. **April 2022 Financials**
Recommended Action: Approve/Disapprove

Bindusagar Reddy, MD Zone 1 | Gaurang Pandya, MD Zone 2 | Ashok Behl, MD Zone 3 | Liberty Lomeli, PA-C Zone 4 | Kent Sorrells, PhD Zone 5

C. **SVLHCD Fiscal Year 2023 Investment Policy**
Recommended Action: Approve/Disapprove

D. **Café Price Increase**
Recommended Action: Approve/Disapprove

E. **Final Map Scenario D**
Recommended Action: Information only; no action taken

F. **Medical Staff Bylaws**
Recommended Action: Approve/Disapprove

XI. Announcements:

A. Regular Board of Directors Meeting – June 28, 2022 at 4:30pm

XII. Adjournment

SPECIAL NOTICE

Pursuant to Executive Order N-25-20 signed by Governor Newsom on March 12, 2020, and in an effort to protect public health and slow the rate of transmission of COVID-19, Sierra View Local Health Care District is allowing for electronic public participation at Regular Board Meetings. Public comments may be submitted to wwatts@sierra-view.com and will be read aloud during Public Comments as applicable, for Board consideration. Members of the public are encouraged to submit comments prior to 4:00 p.m. the day of the meeting to participate in said meeting.

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 Fuentes, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, between 8:00 a.m. – 5:00 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

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

Bindusagar Reddy, MD Zone 1 | Gaurang Pandya, MD Zone 2 | Ashok Behl, MD Zone 3 | Liberty Lomeli, PA-C Zone 4 | Kent Sorrells, PhD Zone 5

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Senior Leadership Team	5/24/2022
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	5/24/2022 Date

SIERRA VIEW MEDICAL CENTER-
CONSENT AGENDA
May 24, 2022
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	**Action**
Policies:		Approve ↓
1. Care Level Classifications	1-2	
2. Cash Control and Check Requests	3	
3. Unannounced Regulatory Surveys	4-7	
Forms:		
1. 0244815 Good Faith Estimate Form	8	

SUBJECT: **CARE LEVEL CLASSIFICATIONS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To clarify the classification of level charges for Sierra View Medical Center.

POLICY:

All charges will correlate with the required Hospital Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) coding methods. The care, assessment, observation, treatment, evaluation, monitoring activities, and management services by levels will be delineated for the purpose of generating a charge for services. This standard is set to also reflect the CPT and HCPCS for reporting medical services and procedures performed.

AFFECTED PERSONNEL/AREAS: *EMERGENCY DEPARTMENT, CANCER TREATMENT CENTER, ALL CLINICS, AND NURSING*

PROCEDURE:

Charges will be generated according to the following guidelines:

- For Emergency Department charges there is no distinction made between new and established patients.
- For Cancer Center and Clinic charges, a distinction is made between new and established patients. A patient will be identified as new if they have not had an encounter in any department of the healthcare system within the past three years.

The physician's Professional Fee is generated separately by the physician following their established guidelines.

LEVELS:

The level charges for the Emergency Department are determined by clinical interventions and signs and symptoms. Please refer to the Care Level Classifications – Emergency Department Policy for the specific guidelines.

For all other Clinics and the Cancer Treatment Center, the level charges are determined by the clinical acuity of the patient encounter based on point tabulations.

REFERENCES:

- American Medical Association (2022). CPT Professional Edition. Chicago, IL: American Medical Association.

- American Medical Association (2022). HCPCS 2022 Level II Professional Edition. Chicago, IL: American Medical Association.
- American Medical Association (2022). Retrieved from https://www.ama-assn.org/.

CROSS REFERENCE:

- Academic Health Clinic Level of Care/Point Tabulation Sheet (Public\Financial Planning\Care Levels)
- Care Level Classifications – Emergency Department Policy
- CTC Evaluation and Management Charge Sheets (Public\Financial Planning\Care Levels)
- Healogics Clinic Level of Care/Point Tabulation Sheet (Public\Financial Planning\Care Levels)
- Rural Health Clinic Level of Care/Point Tabulation Sheet (Public\Financial Planning\Care Levels)
- Surgery Clinic Level of Care/Point Tabulation Sheet (Public\Financial Planning\Care Levels)
- Urology Clinic Level of Care/Point Tabulation Sheet (Public\Financial Planning\Care Levels)

SUBJECT: **CASH CONTROL AND CHECK REQUESTS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To outline general responsibilities for the handling of cash and to define when and how a check request is to be used.

POLICY:

1. Cashiers will not disburse cash requests for any amount. Instead, a Check Payment Request Form must be electronically submitted to Accounts Payable for processing.

    a. Check requests shall only be utilized as an exception to standard purchasing procedures.

    b. The Chief Executive Officer (CEO), acting in conjunction with the Chief Financial Officer (CFO), is responsible for oversight and management of all Sierra View Medical Center funds.

2. Non-purchase order transactions (any transaction that is handled without the use of a Purchase Order) shall use the Check Payment Request Form to generate payment. Non-purchase order transactions are for the following:

    a. Fees, subscriptions, membership dues, or expenses when no invoice is available.

    b. Purchased services and non-tangible items when no invoice is available.

3. All information on the Check Payment Request Form must be filled out completely with supporting documents attached and must be signed by the Department Head or Manager.

4. Accounts Payable will not process a check request which does not have an appropriate authorized signature.

5. The party initiating the check request cannot also be the authorizing approval signature. Two parties must sign the request; the requestor and the approver.

6. Check requests that exceed $5,000 also require administrative approval and must be signed by the appropriate Vice-President, CFO, or CEO.

7. Completed forms must be received electronically by General Accounting no later than 12:00 pm on the Thursday preceding each check run date (Thursday of each non-payroll week) in order to be processed in the regularly scheduled check run on the following Monday.

AFFECTED PERSONNEL/AREAS: *ALL PERSONNEL*

SUBJECT: **UNANNOUNCED REGULATORY SURVEYS**	SECTION: *Leadership (LD)* **Page 1 of 4**

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

PURPOSE:

- To define the steps to be taken when unannounced regulatory surveys occur.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to remain in regulatory compliance at all times. Unannounced surveys can affect schedules and organizational operations if not planned. The purpose of this policy is to define the organization's orderly and professional response to an unannounced regulatory survey.

AFFECTED AREAS/PERSONNEL: *ALL*

PROCEDURE:

STAGE I – NOTIFICATION

1. The **Survey Coordinator** (VP of Quality and Regulatory Affairs), or designee, will check the **Joint Commission** website daily for important communications. Regulatory surveys occur every three years and can occur any time after the 18-month mid-point Periodic Performance Review (PPR) is submitted. Beginning in the 18-month window, the website will be checked daily by 0730 for official notification that a survey team has been deployed to SVMC and is due any time that day. The **Survey Coordinator, or designee,** will activate the notification of key Administrative and Leadership personnel.

2. In the event a survey team arrives on the premise prior to normal business hours and before official credentials can be verified from the Joint Commission website, the Nursing House Supervisor will have Security escort the Survey Team to the Board Room and activate the following call schedule:

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3. Each of the above will be responsible for activating a call schedule of identified members of the Leadership Team and Elected Medical Staff Leaders responsible for identified survey activities.

STAGE II – SURVEY DOCUMENT GATHERING

1. The **Accreditation and Regulatory Coordinator** will be responsible for maintaining a complete set of up to date documents that could be requested by surveyors at the time of an unannounced survey. These manuals can be retrieved by any person designated to have access to the office. These documents are to be kept in physical copy (in binder) as well as in electronic thumb drive for ease of use by surveyors.

   These manuals are as follows (for CMS/CDPH/and TJC surveys):

   a. Licensure and Certifications

      - A copy of all hospital current licensure and certifications
      - Program flexes
      - Documents specified on the "survey entrance list of documents" provided by each specific regulatory/accreditation entity

   b. Bylaws

      - Board of Directors
      - Medical Staff

   c. Organization Structure

      - Organizational Chart
      - Medical Staff Chain of Command and Committee Structure

   d. Organizational Hard Copy of Policy and Procedures as requested or listed on the survey entrance lists

   e. Organizational Performance Improvement

      - Current Dashboards

- Current External Reports
- Most recent Patient Satisfaction Report
- Completed FMEAs

f. Current Census and Surgery Schedule as of 1630 the previous day

These manuals will be labeled and placed in a position that anyone designated can remove these manuals and proceed to the designated survey command center room while other data is gathered. These manuals will provide the survey team with enough **information** to begin planning the survey schedule. The following documents will be brought to the Board Room by the appropriate Director upon arrival:

Upon completion of their initial data review, the Survey Team will meet with the VP of Quality and Regulatory Affairs, or designee, and members of Senior Management and provide the organization with the planned survey schedule.

STAGE III – THE SURVEY

1. Upon receipt of the Survey Team's proposed schedule, the proposed survey schedule will be emailed to all Directors and Managers by the Administrative Assistant while the surveyors are escorted to their first survey location by designated escorts and scribes.

2. Dietary/Catering will be contacted and meals requested as appropriate by the Accreditation and Regulatory Coordinator

3. An overhead announcement will be delivered to hospital operator and shall be as follows for TJC surveys:

   "***Sierra View Medical Center is proud to welcome the Joint Commission on Healthcare Accreditation and the California Department of Health Services to our facility*** for our ***triennial inspection. Please welcome them as you see them in your areas."***

   This announcement will serve to alert hospital personnel throughout the facility that surveyors are present.

4. The designated escorts and scribe team will continue to coordinate schedules and escorts throughout the facility over the length of the survey and inform the survey Command Center of planned survey activity, findings, and requested documentation by the surveyors.

5. Directors and Managers will be expected to adjust their schedules over the survey period to be present from 0700 to 1630 to ensure the orderly operation of their departments and assistance to their staff during periods when surveyors may be present.

STAGE IV – THE EXIT CONFERENCE

The Survey Team will meet with members of Senior Management, Board of Directors, Medical Staff Leadership, Directors, and Managers, as designated, to discuss the outcome of the survey. Upon official receipt of survey findings, the Leadership Team will meet to discuss:

- Immediate Impact on Organization
- Press Releases
- Corrective Action Planning as needed

STAGE V – ONGOING SURVEY PREPAREDNESS

A summary of the issues identified will be completed by the VP of Quality and Regulatory Affairs during the unannounced survey, for discussion and implementation into ongoing preparedness for future unannounced survey activity.

SIERRA VIEW MEDICAL CENTER **GOOD FAITH ESTIMATE**

Date of Good Faith Estimate: _____

Patient Information

Patient First Name: _____ Middle Name: _____ Last Name: _____

Patient Date of Birth: _____

Patient Medical Record Number: _____ Account Number: _____

Patient Mailing Address, Phone Number, and Email Address

Street Address or P.O. Box: _____

City, State, and Zip Code: _____

Phone #: _____

Email Address: _____

Patient Contact Preference: (check one) ☐ by mail ☐ by email ☐ by phone

Provider/Facility Info: SVMC NPI: 1639143381 Tax ID: 94-1397461

Provider/Facility Contact: Financial Counselors Monday - Friday 8:00am - 4:30pm

PHONE: (559) 788-6143 or (559) 788-6002 FAX: (559) 791-3808

FINANCIALCOUNSELING@SIERRA-VIEW.COM

Patient Diagnosis

Primary Service or Item Requested/Scheduled: _____

Patient Primary Diagnosis: _____

Patient Secondary Diagnosis: _____

If scheduled, list the date(s) the service will be provided: _____

☐ Check this box if the service or item is not yet scheduled:

Summary of Expected Charges:

Procedure Code(s):	Charges
CPT	
CPT	
CPT	
CPT	
CPT	

Insurance details

Service Type:		Estimated Total Cost:	
Co-Pay Amount for Service:		Total Contracted Discount:	
Deductible Amount:		Total Allowed Charges:	
Coinsurance:		Estimated Patient Liability:	
Out Of Pocket Max:			

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

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MEDICAL EXECUTIVE COMMITTEE	05/04/2022
BOARD OF DIRECTORS APPROVAL	
	05/24/2022
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
May 24, 2022 BOARD APPROVAL

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

	Pages	Action
I. Policies:		**APPROVE**
• Annual Infection Prevention Plan	1-28	↓
• Discharge Planning and Reporting Requirements for Patients with Suspected or Confirmed TB	29-30	
• Disinfectants: Their Selection and Use	31-32	
• Environmental Facility Cleanliness	33-34	
• Floating Guidelines	35-37	
• Forensic/Developmentally Disabled Patients in Surgery	38-39	
• Hyperbaric Chamber Operator Qualifications	40-42	
• Latex Sensitivity	43-46	
• Measurement of Dialystate Conductivity and PH	47-50	
• Measurement of Recirculation in the Vascular Access	51-52	
• Patient Assessment and Reassessment – Acute Renal Services	53-55	
• Power Failure – Acute Renal Services	56-57	
• Pre-Anesthesia Assessment Guidelines	58	
• Provision of Anesthesia Services Organization and Direction	59-61	
• Recirculation of Blood in Extracorporeal Circuit – Acute Renal Service	62-63	
• Scope of Service – Renal Services	64	
• Surgical Privileges/Appropriate Assistants to the Surgeon	65-73	
• Unannounced Regulatory Surveys	74-77	
II. Healogics Clinical Policies and Procedures - 2022	78-81	

SUBJECT:	SECTION:
ANNUAL INFECTION PREVENTION PLAN	***Surveillance, Prevention, Control of Infection (IC)***
	Page 1 of 28

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

PURPOSE:

Through epidemiological principles, methods, and by ensuring appropriate standards and measures set to maintain awareness and working knowledge of guidelines and recommendations that are published by regulatory and accrediting agencies (e.g., the Joint Commission, Centers for Medicare & Medicaid Services (CMS), professional allied health services, and professional organizations (e.g., APIC, SHEA, SGNA, AORN), that provide current and evidence-based infection control services, the Infection Prevention Manager, under the guidance of the Pharmacy, Therapeutics and Infection Prevention Committee (P&T/IPC) and Chairperson, will develop and conduct infection surveillance, prevention and control to promote optimal health of patients, personnel and the community surrounding Sierra View Medical Center (SVMC). The goal is to establish a comprehensive Infection Prevention (IP) and Control Program to ensure that SVMC has a functioning, coordinated process in place to reduce the risks of endemic and epidemic healthcare-associated infections (HAIs) in patients, personnel, volunteers, licensed independent practitioners (LIPs), and the community. The Infection Prevention and Control Program will incorporate the following in a continuing series:

- Surveillance, prevention and control of infections throughout the organization, in both inpatient and outpatient areas (IC.02.01.01).
- Screening and surveillance of diseases with pandemic potential (e.g., Ebola, Zika, SARS-CoV-2)
- Develop alternative techniques to address the real and potential exposures (IC.01.04.01)
- Select and implement the best interventions to minimize adverse processes/outcomes (IC.01.04.01)
- Evaluate and monitor the results and revise techniques as needed (IC.03.01.01)

DEFINITIONS:

1. National Healthcare Safety Network (NHSN): A national database of healthcare-associated infections under the Division of Healthcare Quality Promotion (DHQP) that is sponsored by the Centers for Disease Control and Prevention (CDC). Transitioned in 2005 from National Nosocomial Infection Surveillance System, these databases are developed by the CDC utilizing uniform definitions and surveillance methods to collect, report, and analyze HAI data.

OVERVIEW:

Infection Prevention and Control at SVMC is an important consideration in every decision and plan. Infection Prevention is an integral responsibility of all personnel. A successful program requires cooperation between all departments. Hospital administration has responsibility to oversee and provide resources for the Infection Prevention Program and to ensure that all hospital personnel including medical staff, volunteers, students and contract personnel, etc. are made aware of their responsibilities related to Infection Prevention.

All personnel, in partnership with medical staff, are responsible for safety and health of all patients, residents, visitors, and hospital staff while at the facility. The responsibility may be met by working together continuously to promote safe infection prevention practices, observing all rules, regulations and procedural

guidelines, and continually striving to improve the quality of patient care. For those reasons, SVMC has established an Infection Prevention Program that requires the participation, support and cooperation of all personnel. (IC.02.01.01)

Each department, in partnership with medical staff, will be responsible and held accountable for its role in SVMC's Infection Prevention Program. Each department will be responsible for reporting any IP concerns to the Manager of Infection Prevention. Each department will be responsible for full and timely cooperation with the Pharmacy & Therapeutics/Infection Prevention and Control Committee (P&T/IPC).

Specific assignments will be made to committees, departments, and individual personnel. When assigned, completion of these assignments in a timely and thorough manner is expected.

To coordinate infection prevention and control activities, infection prevention management functions are delegated to the Infection Prevention Manager and P&T/IPC, to investigate and follow-up on clinical issues.

Scope of Service includes: All departments within the acute care facility and the following outpatient areas: the Distinct Part Skilled Nursing Facility (DP/SNF), Cancer Treatment Center (CTC), Medical Office Building (MOB), Ambulatory Surgery Department (ASD), Wound Care Center, the Urology Center, Outpatient Physical Therapy Center, Urgent Care, Sierra View Community Health Center-Terra Bella, ~~and~~ Cardiac Catheterization Laboratory and Surgery Clinic.

Hospital personnel and medical staff are hereby directed to assist the President and Board of Directors wherever possible in the implementation of an effective hospital Infection Prevention Program.

POLICY:

1. IP Policy Foundations

   a. Infection Prevention and Control policies are based on recognized guidelines, applicable laws and regulations, and address measures to prevent the transmission of infections among patients, employees, medical staff, volunteers, visitors, and the general public. Policies have been developed that define surveillance, prevention and control measures in all patient care, support and service areas, and identify methods effective in reducing the risk of transmission of microorganisms, while increasing patient safety.

   b. Policies are reviewed and revised by Infection Prevention and contributing departments at least every three years and as needed. New policies and those policies with major revisions are approved by the P&T/IPC. Hospital-wide policies include those that are general and are followed throughout the hospital, and are located on the SVMC intranet in the Policy Library. Department-specific policies may include policies for tasks or IP measures unique to that particular area. Many of the IP approved practices are integrated into department policies that are kept by the Director/Manager of the department, and Infection Prevention is consulted for input and revisions.

2. Oversight of the Infection Prevention and Control Program (IC.01.01.01)

a. Qualified individuals implement the infection prevention program. A full-time Infection Prevention Manager, an Infection Prevention Registered Nurse, Infection Prevention Analyst, and the P&T/IPC oversee the Infection Prevention program. The Infection Prevention Manager reports to the Vice President of Quality & Regulatory Affairs.

b. Employee Health, the Education Department and Infection Prevention collaborate to develop policies and provide education to staff. Policies and educational offerings are created jointly with the goal to reduce infections.

c. The P&T/IPC assists with development and approves all Infection Prevention activities and the surveillance program. This approval process considers the following elements:

i. Criteria used for defining a hospital acquired infection (HAI) and for differentiating them from community-acquired infections. The National Healthcare Safety Network (NHSN) definitions for HAI are utilized.

ii. Rationale for selecting a specific approach or combination of approaches, and the time frame for using that approach or combination. Targeted surveillance for NHSN and SVMC–specific indicators are used, as described below:

a) Patient population to be studied

b) Data collection methods employed

c) Quality control procedures for ensuring accuracy and completeness of case findings

d) Assignment or responsibility for data evaluation and follow-up

e) Method for reporting and follow-up

f) Reporting of infections to public health as required

g) Documentation of infections of epidemiological significance among healthcare personnel

3. Risk Assessment (Appendix A) (IC.01.03.01)

a. At least once a year, P&T/IPC completes a risk assessment, evaluates, revises as necessary, and approves the type and scope of surveillance activities by reviewing the following items:

i. Data trend analysis generated by surveillance activities during the past year

ii. Effectiveness of prevention and control intervention strategies in reducing the HAI risk

iii. Services instituted, procedures performed, priorities of significant community and world health, and problems identified during the past year

4. Resources for Infection Prevention and Control Program (IC.01.02.01)

a. SVMC provides resources for the program through Meditech computer services, laboratory services, equipment, supplies and personnel.

5. Healthcare-Associated Infection Surveillance Overview

a. The SVMC Infection Prevention Program is responsible for monitoring HAIs. Since July 2008, the SVMC Infection Prevention Program has been an active participant in the CDC NHSN program using NHSN infection indicators, definitions, and methodologies for data collection and analysis. Data is entered into the Infection Prevention Database regularly and electronically transmitted into an Infection Prevention Database maintained by NHSN.

b. Since 2003, a targeted surveillance program for an HAI has been utilized at SVMC. With targeted surveillance, infection prevention outcome objectives are determined, priorities are established, and resources are allocated to the major types of infections and the patient populations at highest risk of acquiring an HAI. Numerators and denominators are clearly established with the focus on procedures that have preventable risk factors that may contribute to the development of an HAI.

c. In addition to the infection types specified in the targeted surveillance plan, non-targeted infections, single occurrences, and/or outbreaks of an HAI related to any unusual or virulent pathogenic organism are evaluated. The Infection Prevention Manager, Vice President of Patient Care Services, and P&T/IPC determine interventions.

6. Definitions for Healthcare-Associated Infections (HAI)

a. Determination of an HAI depends on evaluation of clinical, laboratory and other diagnostic information gathered on the patient. Consistency in determining HAIs within the healthcare setting is necessary to compare infection rates from one evaluation period to the next. When comparing hospital infection rates to a national infection rate, consistent determination of HAIs from all participating hospitals is essential.

b. The CDC is the recognized authority for HAI surveillance in the United States. Definitions published by the CDC and NHSN system are the standard for use in hospitals. Updated definitions from NHSN are utilized as provided. A hard copy of these definitions is located in the NHSN binder in the Infection Prevention office. There is also access to NHSN electronically.

7. Priorities for Healthcare-Associated Infection (HAI) Surveillance

   a. Surgical Site Infections (SSIs) (National Patient Safety Goal.07.05.01): Prevention of surgical site infections is a high priority. CDC (2021) estimates that surgical site infections are associated with nearly 1 million additional inpatient days annually and an estimated annual cost of $3.3 billion. Methods to reduce surgical site infections are well documented in medical literature by medical associations/organizations (e.g., AORN, APIC, ASA). SSIs are monitored, reported, and analyzed on an ongoing basis.

   b. Ventilator Associated Pneumonia (VAP): Prevention of VAP in the Intensive Care Unit (ICU) is a high priority because of high mortality rates, expense associated with prolonged ICU stays, and many preventable factors contributing to these infections. At SVMC, VAP in ICU is monitored on an ongoing basis. All VAPs will be monitored and reported.

   c. Central Venous Catheter-Associated Blood Stream Infections (CLABBSI) (NPSG.07.04.01): Nationally, bloodstream infections associated with central venous catheters are often preventable and have a high mortality rate. It is a high priority to reduce risk factors leading to these infections. Patients in the ICU who develop a BSI are 2-3 times more likely to die and stay in the hospital an average number of 24 days (John Hopkins Medicine, 2013). Estimates of added costs attributed to Central Line Associated Blood Stream Infections (CLABSI) $40,034,450 annually (LaTasha R. Pwell RN, 2018). At SVMC,- CLABSI are monitored house-wide and reported on an ongoing basis to P&T/& IPC and to the involved clinical units.

   d. Catheter-Associated Urinary Tract Infections (CAUTI): Urinary tract infections associated with indwelling urinary catheters have relatively small morbidity and financial consequences. UTIs account for more than 9.5% of infections reported by acute care hospitals. It has been estimated that each year, more than 13,000 deaths are associated with UTIs. At SVMC, house-wide monitoring for CAUTIs in all units will be continued and reported.

8. Surveillance Documentation of All Infections

   a. Infection Prevention has created databases for documenting targeted and non-targeted HAIs as a method to track and trend occurrences. The surveillance fulfills internal requirements for SVMC, California Department of Public Health Services (CDPH), and the Joint Commission (TJC) standard of IP that asks for review as a sentinel event of any HAI that causes death.

   b. Excel spreadsheets have been created and contain information about the infection surveillance of many types of infections and may be used to guide the response to any outbreak of HAI.

   c. Surveillance includes, but is not limited to, surgical procedures, obstetric procedures, and catheterization procedures, as well as antibiotic resistant bacteria.

9. Infection Control Reports

a. The SVMC infection prevention process is designed to lower risks and decrease rates or numerical trends of epidemiologically significant infections. Infection prevention reports are presented in a manner that facilitates this process. Infection rates are established using recognized statistical methodology. Histograms and process control charts are utilized when feasible to enhance the identification of infection trends and variations.

b. Results of infection surveillance are reported regularly by Infection Prevention to P&T/IPC and documented in the meeting minutes. Minutes are forwarded to the Chief Executive Officer, Vice President of Patient Care Services, Vice President of Quality & Regulatory Affairs, and to the medical staff through various committees. A report of HAI rates is provided regularly by Infection Prevention to the Performance Improvement/Patient Safety (PIPS) Committee, various nursing departments, individual medical staff members, nursing staff, and anyone who may benefit from and provide prevention measures toward decreasing infections. Additional reporting of infection rates, when benchmark rates are exceeded, is managed by Infection Prevention utilizing a team approach of performance improvement processes. If infections require immediate intervention strategies, a Statement of Authority allows Infection Prevention to go forth with prevention plans and actions without taking the issues before the P&T/IPC.

10. Surveillance Strategies

a. NHSN Indicators: Since July 2008, SVMC has participated in the NHSN system. Infection Prevention collects data using the definitions, methodology and computer software developed by the CDC. The data are used internally to determine HAI rates, and are also sent on a regular basis to the CDC for inclusion in the national database.

b. Surgical Site Surveillance Component:

i. All patients who undergo operative procedures are monitored for surgical site infections.

ii. For each patient having surgical procedures, information is collected about the patient's underlying condition. This information includes:

a) American Society of Anesthesiology (ASA) score rated by assessing variables of age, sex, duration of operation, method of approach

b) Surgical Wound class

c) Whether the operation was performed as an emergency or as a result of trauma

d) If multiple procedures were performed through the same incision

c. Surgical Surveillance:

i. Objectives:

a) Identify HAI trends above NHSN benchmark rates

b) Evaluate procedures, policies, and practices, looking for preventable risk factors when infection trends are identified

c) Reduce infection by reducing risk factors

ii. Methodology:

a) Infection Prevention collects data on an ongoing basis

b) Numerator: Number of patients developing surgical site infection following surgery

c) Denominator: Total number of patients undergoing surgery

d) Stratification of patients by risk factors as recommended by NHSN (utilizing intrinsic patient risk as evidenced by ASA score, wound class, and duration of surgery).

iii. Data Sources:

a) Daily surgery schedule

b) Monthly report of all procedures

c) Daily admission report from the computer data systems

d) Concurrent and/or retrospective chart review by Infection Prevention if there is an occurrence of infection

e) Communication from the surgical nursing staff

f) Post discharge communication is quarterly during the year, from surgeons to Infection Prevention via "follow-up letter"

iv. Defining Indicators for Infections:

a) Infections occurring following surgery at SVMC

b) NHSN definition for surgical site infection

v. Follow-up:

a) Reports are provided quarterly to P&T/IPC, participating surgeons, and other committees with a vested interest in these rates

b) When SVMC rates exceed NHSN rates, Infection Prevention makes a determination as to significance

c) Information is shared with Surgical Services and the Performance Improvement/Patient Safety (PIPS) Committee

d) If the infection rate is significant, an evaluation of relevant procedures, policies and practices is undertaken by Surgical Services and Infection Prevention.

e) A report is presented by Infection Prevention to P&T/IPC describing the result of the evaluation

f) If preventable risk factors are identified, an action plan outlining ways to reduce risk is included in this report

d. Ventilator Associated Pneumonia (VAP)

i. Objectives:

a) Compare with the NHSN VAP infection rate

b) Identify trends above the NHSN benchmark rate and established SVMC rate

c) Evaluate procedures, policies and practices, looking for preventable risk factors when infection trends are identified

d) Maintain "0" rate of VAP

e) Reduce infections by reducing risk factors

ii. Methodology:

a) Infection Prevention collects data on an ongoing basis

b) Reports are provided quarterly to P&T/IPC and appropriate Directors and Clinical Managers

c) Numerator: Number of patients who develop pneumonia following placement on a ventilator

d) Denominator: Number of ventilator days

iii. Data Sources:

a) Monthly number of ventilator days

b) Daily sputum gram stain and culture and sensitivity (C&S) reports from Microbiology

c) Daily admission report from computer data system

d) Communication from staff to Infection Prevention

e) Communication from physicians to Infection Prevention

f) Concurrent and/or retrospective chart review

iv. Defining Indicators for Infections:

a) Patient developing pneumonia following placement on ventilator

b) NHSN definitions for pneumonia

v. Follow-up

a) Reports are presented quarterly to the P&T/IPC, Clinical Director and Manager for presentation to appropriate staff

b) When SVMC rates exceed NHSN or SVMC benchmark rates, a determination is made by Infection Prevention as to significance

c) If it is determined that the pneumonia rate is significant, evaluation of relevant procedures, policies and practices is undertaken by P&T/IPC

d) A report is presented by Infection Prevention to the P&T/IPC describing the result of the evaluation.

e) If preventable, risk factors are identified and an action plan outlining ways to reduce risks is developed, with a schedule for implementation.

e. Central Line Associated Blood Stream Infections (CLABSI) (NPSG.07.04.01)

i. Objectives:

a) Identify CLABSI rates above NHSN and SVMC benchmark rates

b) Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified

c) Reduce infections by reducing risk factors

ii. Methodology:

a) Infection Prevention collects data on an ongoing basis.

b) Reports are provided quarterly to the P&T/IPC and Clinical Directors and Managers.

c) Numerator: Number of episodes of CLABSI infections

d) Denominator: Number of CVC days

iii. Data Sources:

a) Monthly report of number of CVC days

b) Daily microbiology reports of blood, site, gram stain and C&S

c) Concurrent and/or retrospective chart review of patients with CVCs

iv. Defining Indicators for Infection:

a) Patient with CVC

b) NHSN definitions for BSI

v. Follow-up:

a) Reports are presented quarterly to the P&T/ IPC and other groups as needed.

b) When the SVMC rate exceeds NHSN or SVMC benchmark rates, a determination is made by Infection Prevention as to significance.

c) If it is determined that the infection rate is significant, evaluation of relevant procedures, policies and practices is undertaken by IP and critical care, looking for preventable risk factors.

d) If preventable risk factors are identified, an action plan outlining ways to reduce risks, with a schedule for implementation, is included in this report.

f. Catheter-Associated Urinary Tract Infections (CAUTI):

i. Objectives:

a) Benchmark with established SVMC rate and NHSN rate

b) Identify CAUTI rates above NHSN and SVMC benchmark rates

c) Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified

d) Reduce infections by reducing risk factors

ii. Methodology:

a) Infection Prevention collects data on an ongoing basis

b) Reports are provided quarterly to the P&T/IPC, Infection Prevention and clinical directors and managers

c) Numerator: Number of episodes of CAUTI in patients

d) Denominator: Number of urinary catheter days in patients.

iii. Data Sources:

a) Daily catheter report generated electronically

b) Daily microbiology reports of urine analysis, urine gram stain and C&S

c) Daily admission reports from the computer data system

d) Communication from nursing staff to Infection Prevention

e) Concurrent and/or retrospective chart review of patients with indwelling urinary catheters

iv. Defining indicators for infection:

a) Patients with indwelling urinary catheter

b) NHSN definitions for CAUTI

v. Follow-up:

a) Reports are presented quarterly to the P&T/IPC and nursing units

b) When the SVMC rate exceeds NHSN or SVMC benchmark rates, a determination is made by Infection Prevention as to significance.

c) If it is determined that the infection rate is significant, an evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors.

d) A report is presented by infection prevention to the P&T/IPC, describing the result of the evaluation.

ii. If preventable risk factors are identified, an action plan outlining ways to reduce risks, with a schedule for implementation, is developed.

11. Additional Surveillance Strategies/Other Indicators – in addition to the NHSN indicators, infection surveillance is performed for the following types of infections:

a. Housewide Bloodstream Infections (BSI):

i. Objectives:

a) Identify BSI rates above SVMC benchmark rates

b) Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified

c) Reduce infections by reducing risk factors

ii. Methodology:

a) Infection Prevention collects data on an ongoing basis

b) Reports are provided quarterly to the P&T/IPC and nursing units

c) Numerator: Number of bloodstream infections in SVMC patients

d) Denominator: Number of patient days

iii. Data Sources:

a) Quarterly report of the number of bloodstream infection days from the Infection Prevention Department, Radiology, and quarterly report of the number of admissions from the hospital data system

b) Daily microbiology reports of blood cultures

c) Daily admission reports from the computer data system

d) Communication from nursing staff to Infection Prevention

e) Concurrent and/or retrospective chart review of patients with bloodstream infections

iv. Defining Indicators for Infection:

a) Bloodstream infections will meet the NHSN definition for bloodstream infection

v. Follow-up:

a) Reports are presented quarterly to the P&T/IPC and nursing units. When the rate exceeds SVMC benchmark rates, a determination is made by Infection Prevention as to significance

b) If Infection Prevention determines that the rate is significant, this information is shared with the P&T/IPC

c) An evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors. The Infection Prevention Department reviews identified infections and assists in investigation.

d) A report is presented by Infection Prevention describing the result of the evaluation

e) If preventable risk factors are identified, an action plan outlining ways to reduce risks is developed, with a schedule for implementation

b. MRSA, VRE and *C. difficile* colonization and infections: (NPSG.07.03.01)

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i. Objectives:

a) Identify HAI rates above SVMC benchmark rates

b) Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified

c) Reduce infections by reducing risk factors

ii. Methodology:

a) Data is collected on a daily basis

b) Reports are provided quarterly to the P&T/IPC, nursing units, and other committees as necessary

c) Numerator: Number of episodes of HAI

d) Denominator: Number of patient days

iii. Follow-up:

a) Reports are presented quarterly to the P&T/IPC and nursing units. When the rate exceeds SVMC benchmark rates, a determination is made by Infection Prevention as to significance.

b) If Infection Prevention determines that the rate is significant, this information is shared with the P&T/IPC.

c) An evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors. The Infection Prevention Department reviews identified infections and assists in investigation.

d) A report is presented by Infection Prevention describing the result of the evaluation.

e) If preventable risk factors are identified, an action plan outlining ways to reduce risks is developed, with a schedule for implementation.

12. Requirements for Surveillance of All Infections:

All patients admitted with an infection, and those acquiring an HAI, will be reviewed by Infection Prevention on a regular basis in order to determine baseline infection rates and identify any outbreaks in the community and the hospital. Patient infections will be categorized by type of infection utilizing ICD-10 codes and provided to infection prevention. The purpose is to reduce all HAIs and develop an action plan if there is a significant increase in infections.

13. Precautions: (IC.02.01.01 EP 2 & EP 3)

Transmission-based precautions to protect against exposure to a suspected or identified pathogen are utilized. Based on the transmission of a specific pathogen, precautions are selected. Contact, droplet, airborne or a combination is used, depending on the pathogen. Standard precautions are always used

with all patients. Personal Protective Equipment (PPE) is used specific to the precaution to reduce the risk of infection.

14. Hand Hygiene Compliance: (NPSG.07.01.01)

Infection Prevention monitors compliance with hand hygiene by unannounced direct observation. At least monthly, one or more patient care departments is chosen. Infection Prevention makes observation for opportunities to wash hands with soap and water and/or use the alcohol hand rub. Everyone within the department is observed, including visitors. In addition, each patient care department is assigned 30 observations per month (for non-clinical areas) via "secret shoppers" to be reported to Infection Prevention on a monthly basis. The opportunity is the denominator, the opportunity taken is the numerator, and a percentage rate is assigned. Rates of compliance are established, documented results shared and recommendations for improvement given. Observations are reported to various committees, directors, managers, physicians, and healthcare personnel.

15. Additional Reports to the Pharmacy and Therapeutics/Infection Control Committee

Infection Prevention and Employee Health are responsible for many other activities to prevent and control infection transmission in the hospital and outpatient areas.

a. Influenza Vaccinations: The hospital provides an influenza vaccination to all staff and all licensed independent practitioners. (IC.02.04.01).

i. Education is provided to all staff and licensed independent practitioners about influenza, the vaccine, non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.

ii. Annually, vaccine is provided through Employee Health Services (EHS) during business hours and after hours. For after hours, vaccine is given at Employee Health Services on designated weekends. On designated days, EHS opens earlier to accommodate night shift staff.

iii. In the 2020-2021 influenza season, 95% of all staff received the influenza vaccination. 100% either received the vaccine or signed a letter of declination. Declination letters listed a variety of reasons for declining. 44% percent of the Medical staff either received the vaccine or declined.

iv. The goal for 2020-2021 influenza season is to increase the influenza vaccine rate to 100%. Improvements will be made through the use of education, the requirement that unvaccinated staff wear masks while working, and by making vaccine available frequently by taking the vaccine to the staff as well as continuing the present vaccine program.

v. The goal for the next four years is to increase and maintain vaccine rate at 100% of staff and licensed independent practitioners by working with Employee Health, Infection Prevention and Human Resources.

b. Employee Health Reports: Report employee compliance to vaccines annually. A report is provided on a weekly basis to all departments listing compliance of employees' receipt of seasonal influenza vaccinations or declination of vaccination.

c. Sharps Injuries: A report is provided by Employee Health about the number of needle sticks and safety needle devices available, and provides information about review and trials of prospective safety devices. Employee Health provides the report quarterly.

d. Reportable Infections Reports: Infection Prevention is the liaison between the hospital and local, metropolitan and state public health departments for issues related to infectious diseases. Infection Prevention provides information to the appropriate health department for each reportable infectious disease report that is processed by the hospital laboratory. A summary of all infections reported to public health agencies by Infection Prevention is provided quarterly to the P&T/IP Committee.

e. Sterilizer Monitoring Reports: A sterilizer monitor report for all steam, ETO, Sterrad and Steris sterilizers used in the hospital is provided quarterly by Surgery and Central Processing.

f. Microbiology Reports: A report from Microbiology about antibiotic resistant organisms and other relevant topics as determined by the P&T/IP Committee and the microbiology lab is provided quarterly.

g. Pharmacy Reports: A report from the Pharmacy providing information about antimicrobial usage and other relevant topics as determined by the Infection Control Committee and the pharmacy is provided quarterly.

h. Dialysis Water Report: A report from Facilities Management about sterility monitoring of dialysis water is provided quarterly.

i. Ventilation Reports: A report from Facilities Management about ventilation in negative-pressure isolation areas and surgery operating rooms is provided at least annually.

16. Additional Infection Prevention Activities

Infection Prevention has a responsibility for many other activities to prevent and control infection transmission in the hospital and outpatient areas:

a. Healthcare Personnel and Public Education: Government regulations, bioterrorism, and unusual microorganisms such as H1N1 influenza, Ebola, Coronavirus (SARS-CoV-2), Yellow Fever, West Nile Virus, and Zika Virus have greatly increased the need for education and training. Infection Prevention will continue to update and present information as necessary to

keep healthcare personnel, volunteers, and the public informed. Annual requirements for healthcare personnel education is maintained in Human Resources.

b. Role as Liaison with Public Health Departments: Infection Prevention is responsible for notifying state, county and local Public Health departments when reportable disease is identified for all inpatients and outpatients of SVMC. In addition, IP will assist with concurrent and retrospective chart review as necessary for the health departments in gathering epidemiological information.

c. Input on Purchases: Infection Prevention is consulted regarding the purchase of equipment and medical supplies used for patient care, procedures, sterilization, disinfection and decontamination, and regarding any major change in cleaning products and techniques.

d. Resource and Trouble-Shooting: Infection Prevention has responsibility to respond to questions and concerns about infections, hospital practices, isolation requirements, and incidents of exposure to blood and other potentially infectious body fluids, and other topics as requested. In addition, Infection Prevention assists with Employee Health needs when Employee Health is unavailable.

e. Continuing Education and Professional Networking: In order for the Infection Prevention Manager and Infection Prevention Registered Nurse to remain knowledgeable regarding IC issues, and to keep abreast of current information and resources, ongoing formal and informal education is necessary. Participation in the Association of Professionals in Infection Control and Epidemiology (APIC) on the local and national levels, as well as attending educational programs, is an important part of this process.

f. Construction: Infection Prevention has the responsibility to be involved in all hospital renovations and construction. Infection Prevention collaborates with engineering, facilities management, and the Safety Director to ensure a safe environment for patients, personnel, volunteers, and visitors during construction and renovation projects. Before any construction or renovation begins, an infection risk assessment of the project is completed. Based on the assessment, an Infection Control Construction Permit is developed and posted. Monitoring continues on a regular basis during renovations and construction in order to prevent transmission of an infectious disease.

g. Environmental Cleanliness: Working with environmental services, clinical departments, and hospital leadership, the IP Clinical Workgroup was established to better serve the hospital and to meet CMS standards. The IP Clinical Workgroup has many other responsibilities as well, such as determining needed competencies by staff in infection prevention. Education and training will be an integral part of the EVS new hire process and as needed.

17. Unscheduled Reports

a. Focused Studies: Focused studies and identification of infection prevention measures occurs from data generated from targeted hospital surveillance, government regulations, and the

recommendations of recognized experts in Infection Prevention such as APIC and the CDC. Focused studies include retrospective and concurrent chart reviews, literature reviews and surveys of clinical procedures and observations of clinical practices. Infection prevention measures include employee education, revision of policies and procedures when indicated, evaluation and modification of hospital equipment, disinfectants and work practices. Ongoing evaluation and monitoring of infection rates is required to access effectiveness of infection prevention measures.

18. Risk Assessment and Prioritization of Goals: (IC.01.03.01) Appendix A

The P&T/IPC, in collaboration with hospital leaders, identifies risks for transmitting and acquiring infections based on the following as discussed below. The Infection Prevention staff in conjunction with the P&T/ IPC will develop a risk assessment at least annually or whenever significant changes occur in the factors noted below using information from all applicable committees and individuals as appropriate. Consideration will be given for those issues that are high risk, high volume, and problem prone, new techniques related to emerging or reemerging trends and other issues as identified. The Infection Prevention Staff, in collaboration with appropriate staff from other units, will develop action plans to address these issues. (See Appendix A for the risk assessment and the current prioritization list). The factors addressed in the risk assessment include at a minimum:

a. Geographic Location and Community Environment

Sierra View Medical Center is located in an agricultural community with high rates of farm workers, migrant and foreign workers. In addition, during drought years, construction sites are potential sources of Coccidioidomycosis in the San Joaquin Valley where SVMC is located. Although Coccidioidomycosis is not infectious from person to person, serious infections may result and patients must be monitored and the disease reported. Additionally, SVMC is geographically located near the Porterville Development Center (PDC), serving a large number of developmentally disabled clients on site and in group homes in the area.

b. Characteristics of the Population Served

SVMC serves a diverse population, with Latinos being the majority, and who have a high incidence of diabetes, hypertension and vascular disease. SVMC also serves a large number of developmentally disabled individuals, as a result of its location.

c. Results of Analysis of Sierra View Medical Center's Infection Prevention, and Control Data

The surveillance results from surgical procedures, device related infections, communicable disease exposure events and environmental incidents are reviewed for variances.

d. Care, Treatment and Services Provided

The organization's plan notes the services that are provided. The high volume and/or high-risk services are assessed for surveillance and adaptable measures that can be followed.

e. Employee Health

SVMC provides a safe working environment for employees through the coordination of infection Prevention and Employee Health to identify potentially infectious conditions that may pose a risk for patients and staff.

f. Emergency Preparedness

The organization works continuously to be ready for an internal or external emergency, including, but not limited to, a short or long term influx of infectious patients.

Goal # 1: Limiting unprotected exposure to pathogens throughout the hospital (**NSPG.07.01.01, IC.02.01.01**)

Risk Priority	Infection Prevention Goal	Measurable Objective	Strategies	Evaluation	Responsibility
Hand hygiene compliance	Improve hand hygiene compliance	Achieve 90% hand hygiene compliance through 2021. Achieve 90% of proper technique for hand hygiene	Education, Monitor compliance, and provide feedback to staff and committees, PI teams. Visual reminders (signs, posters) and written materials, for staff, visitors, patients and licensed independent practitioners (LIPS).	Monitoring hand hygiene of staff and LIPs. Monitor quantity of hand sanitizer utilized. Report to Infection Prevention Committee and to directors of units. Report to hospital physician leadership.	Directors of all units, Managers, Infection Prevention, Staff, Medical Staff

Goal #2 Implement evidence-based practices to prevent HAI due to multidrug resistant organisms (MDROs) in the hospital (**NPSG.07.03.01, IC.02.01.01**)

Risk Priority	Infection Prevention Goal	Measurable Objective	Strategies	Evaluation	Responsibility
HAI multidrug resistant organisms	Implement evidence-based practices to reduce MDROs	Reduce incidence of HAI MDROs below 1% through 2021.	Identify appropriate patients on admit, and/or transfer by using Nasal Smear. Education of staff, LIPs, patients, and families as appropriate. Hand hygiene Standard precautions and as needed, contact precautions. Cleaning and disinfecting patient care equipment and patient's environment. Posters, signs, and pamphlets utilized	Report and document education of staff, LIPs, and patient education plans. Hand hygiene will be monitored and reported. Precautions monitored and reported to directors and P&T/IPC.	Infection Prevention, Directors, Managers, Staff, Medical Staff Services Director.

Goal # 3 Minimizing the risk of transmitting infections associated with the use of procedures, medical equipment and devices. (**IC 02.02.01, NPSG 07.04.01, NPSG.07.05.01**)

Risk Priority	Infection Prevention Goal	Measurable Objective	Strategies	Evaluation	Responsibility
Catheter-related BSI	Reduce Central Line BSI in patients	Reduce incidence of CLABSI below 1% through December 31, 2021.	Feedback of surveillance data to staff, LIPs Report rates to Infection Prevention Committee quarterly. Report to hospital physician leadership quarterly. Education of patients, staff, and LIPs. Initiate evidence-based practice catheter checklist for central line insertion throughout hospital. Provide supplies/products that facilitate adherence to recommendations	Monitor changes in incidence rates of infections. Monitor Checklist adherence. Report rates to IP Committee, hospital and physician leadership quarterly. Conduct annual risk assessments for compliance with evidence-based practices hospital wide. 100% rate as goal.	Infection Prevention, Medical Staff, Central Line Insertion staff.
Catheter - associated Urinary Tract Infection	Reduce catheter-associated urinary tract infections in patients	Maintain catheter-associated urinary tract infections below 0.5% by 12/31/2021.	Surveillance of catheters, education of staff to decrease catheter usage. Encourage removal of catheters.	Monitor incidence of catheter use and monitor infections. Report to Pharmacy and Infection Prevention, clinical units.	Clinical units, physicians, infection prevention.
Ventilator	Maintain	Maintain VAP	Surveillance by	Monitor	Respiratory

Associated Pneumonia	VAP at 0%	at 0%.	respiratory therapists (RT), nursing staff and IP. Continue to utilize the VAP "bundle"	infections in Ventilated patients.	Therapists, Clinical staff, and IP.
Surgical Site Infections	Reduce Surgical Site Infections.	Maintain incidence of SSI below 1% through December 31, 2021.	Educate staff and LIPs involved in surgical procedures: upon hire, annually, and whenever involvement in surgical procedures is added to individual's job responsibilities. Educate patients and/or families undergoing a surgical procedure about infection prevention.	Monitor education sign in sheets. Nursing care plans reviewed for patient education.	Surgical Staff, Infection Prevention, Surgical Nursing Department, Nursing Staff, Performance Improvement

Goal # 4 Limiting unprotected exposure to pathogens throughout the hospital (**IC.01.06.01**)

Risk Priority	Infection Prevention Goal	Measurable Objective	Strategies	Evaluation	Responsibility
Preparation of influx of infectious patients (Surge Capacity)	Prepare for the response to an influx or risk of influx of infectious patients	Meet equal to or greater than 90% of Hospital Emergency Incident Command System Plan requirements as related to infectious patients	Maintain Infection Prevention representation on Emergency Preparedness team. Provide expert Infection Prevention input on infection prevention issues during emergencies.	Perform observations during drills. Report compliance to Hospital Emergency Incident Command System to Safety Committee, hospital leadership, and	Infection Prevention, Safety Officer, Security officers, Disaster team, Clinical leaders, Others as appropriate.

			Continue participation in surveillance with local health department. Maintain and/or revise policies or procedures for influx of patients, outbreaks, emerging infections, and bioterrorism. Utilize resources of the County Health Department, State Department, and the Public Health System.	Infection Prevention Committee	

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APPENDIX A

Annual Infection Control Risk Assessment 2021

	Probability of Occurrence				Potential Severity/Risk Level of Failure				Potential Change or Delay in Care, Treatment, Services				Preparedness			Risk Level
	High	Med	Low	None	Life Threatening	Permanent Harm	Temp Harm	None	High	Med	Low	None	Poor	Fair	Good	
Score	3	2	1	0	3	2	1	0	3	2	1	0	3	2	1	
GEOGRAPHY AND COMMUNITY																
Increasing Population with TB		2				2			3						1	8
POTENTIAL INFECTION																
Surgical Site Infection		2			3					2				2		9
Vent Associated Pneumonia			1		3				3					2		9
Central Line Related Blood Stream Infection (CLABSI)		2			3					2					1	8
C. Diff		2				2				2					1	7
Catheter-associated urinary tract infections (CAUTI)			1			2				2					1	6
MRSA (hospital Acquired			1			2				2					1	6
VRE (hospital Acquired)			1			2				2					1	6
EXPOSURE RELATED																
Influenza (seasonal)	3					2				2					1	8
Emergency Mgmt.		2				2				2					1	7

	Probability of Occurrence				**Potential Severity/Risk Level of Failure**				**Potential Change or Delay in Care, Treatment, Services**				**Preparedness**			**Risk Level**
	High	Med	Low	None	Life Threatening	Permanent Harm	Temp Harm	None	High	Med	Low	None	Poor	Fair	Good	
Score	3	2	1	0	3	2	1	0	3	2	1	0	3	2	1	
Procedure-Influx of Infectious Patients																
Infectious Disease Outbreak		2				2				2				2		8
EBOLA			1		3				3				3			10
COVID-19 Outbreak	3				3				3					2		11
COMMUNICATION																
Lack of notification of presence of HAI (Internal Transfer)			1				1			2					1	5
Lack of notification of employee with illness/disease			1				1				1				1	4
PEOPLE																
Poor Hand Hygiene Compliance	3					2				2				2		9
Sharps Injury (HCW)		2				2					1			2		7
Poor TB Screening (Hospital)			1			2					1				1	5
Poor TB Screening (LIP)		2				2				2				2		8
Inappropriate use of Isolation		2				2				2					1	7
Ineffective Screening of Employees/Contract/Agency Staff, LIPs, Volunteers,			1				1				1				1	4

	Probability of Occurrence				Potential Severity/Risk Level of Failure				Potential Change or Delay in Care, Treatment, Services				Preparedness			Risk Level
	High	Med	Low	None	Life Threatening	Permanent Harm	Temp Harm	None	High	Med	Low	None	Poor	Fair	Good	
Score	3	2	1	0	3	2	1	0	3	2	1	0	3	2	1	
and Students.																
Ineffective Fit Testing (Hospital)			1			2					1				1	5
ENVIRONMENT																
Inappropriate handling of biohazard waste		2			3					2				2		9
Ineffective preconstruction IC Planning (Meeting & risk assessment)			1				1				1				1	4
Ineffective notification for applicable utilities issues/ shutdown (HVAC, etc.)			1				1			2					1	5
Major Biohazard spill			1			2				2					1	6
Failure Air Exchange & Pressure Monitoring Issue (isolation room, OR, other)			1			2				2					1	6
SUPPLIES/EQUIPMENT																
Improper storage or disposal of supplies			1			2				2					1	6
Improper cleaning/disinfection of environment		2				2				2					1	7
Ineffective reprocessing of devices		2			3				3					2		10
Improper Sterilization (including positive		2			3				3						1	9

	Probability of Occurrence				Potential Severity/Risk Level of Failure				Potential Change or Delay in Care, Treatment, Services				Preparedness			Risk Level
	High	Med	Low	None	Life Threatening	Permanent Harm	Temp Harm	None	High	Med	Low	None	Poor	Fair	Good	
Score	3	2	1	0	3	2	1	0	3	2	1	0	3	2	1	
biologicals) of supplies/ equipment																

SUBJECT: **DISCHARGE PLANNING AND REPORTING REQUIREMENTS FOR PATIENTS WITH SUSPECTED OR CONFIRMED TB**	SECTION: **Page 1 of 2**

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

PURPOSE:

To ensure that reporting requirements for patients with suspected or confirmed tuberculosis (TB) are met.

To ensure that between diagnoses and discharge, there is communication between Sierra View Medical Center (SVMC) and Tulare County Public Health Department, and that written approval is sought from the Public Health Department one (1) working day prior to discharge. This is required by law.

POLICY:

SVMC shall comply with all regulatory requirements for reporting and discharging of TB or suspect TB patients.

AFFECTED AREAS/PERSONNEL:

NURSING STAFF, UTILIZATION REVIEW/DISCHARGE PLANNING, INFECTION PREVENTION, LABORATORY, MEDICAL STAFF

PROCEDURE:

1. Immediately report all suspected or confirmed TB cases to the Infection Prevention Department or designee.

2. The Infection Prevention Manager or designee will submit Tuberculosis Suspect Case Report (see TB Suspect Case Report_- Tulare County Department of Health Services) within 24 hours after a patient has been diagnosed with suspected or confirmed TB.

    a. A suspected case of tuberculosis can be defined as any person who, based on clinical or epidemiological evidence, has a reasonable likelihood of having tuberculosis, whether started on anti-tubercular therapy or not.

    b. Examples of suspected cases include:

        - Any person with clinical or laboratory evidence consistent with active TB, even if the diagnostic evaluation is incomplete or culture results are pending.
        - Any person who has been started on anti-tuberculosis therapy for suspicion of active TB.
        - Any person with findings consistent with active TB, unless other clinical evidence makes a diagnosis of TB unlikely.

3. The Infection Prevention Manager or designee, in consultation with the Discharge Planner, will communicate with the Tulare County Public Health Department about possible discharge plans.

   a. One (1) working day prior to discharge or transfer, a written discharge plan (see Tuberculosis Discharge Planning Summary- Tulare County Department of Health Services) will be submitted to the Health Officer or his/her designee.
   By phone: Monday through Friday (559) 685-5730 -By Fax: (559) 687-6938

      - The patient may not be discharged, transferred, or released without the approval of the Tulare County Public Health Officers in the following situations:

         - Discharge or release from SVMC
         - Transfer to another health care facility unless the transfer is to an acute care hospital when there is an immediate need for a higher level of care.
         - Transfer to a local detention facility.

REFERENCES:

- Communicable Disease and Other Required Reporting (n.d.). Retrieved on ~~January 16~~February 21, 2022, ~~2019, from https://tchhsa.org/eng/index.cfm/public-health/communicable-disease-and-other-required-reporting/~~ https://tchhsa.org/eng/public-health/communicable-disease-and-other-required-reporting/

CROSS REFERENCE:

- Communicable Disease Reporting Policy & Procedure

SUBJECT:	SECTION:
DISINFECTANTS: THEIR SELECTION AND USE	***Surveillance, Prevention, Control of Infection (IC)***

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

PURPOSE:

To establish infection control standards for selection, review and approval of changes to established Food and Drug Administration (FDA) approved cleaning products.

POLICY:

Products selected and used at Sierra View Medical Center (SVMC) for cleaning and disinfecting will be FDA-approved products. These products will be reviewed and approved by the Pharmacy and Therapeutics/Infection Prevention Council annually, but no less than every two years.

AFFECTED PERSONNEL/AREAS: *ALL AREAS*

PROCEDURE:

To make the right selection of a product:

A. Study the manufacturer's recommendations carefully, particularly the restrictions.

B. Consult with the microbiologist for assistance in interpreting company claims and laboratory studies.

C. Be sure which products can be used in specific areas and on particular types of equipment.

D. Be sure that personnel will have the necessary personal protective equipment (PPE), such as gloves, and can be properly instructed in the use of the product.

E. Purchase products in sizes appropriate for storage, usage and economy.

The three main categories of disinfectants are: phenolics, quaternary ammonium compounds and iodine solution. Each is generally used for certain purposes only.

A. Phenolic

These are the strongest disinfectants and are used on surfaces that do not have direct contact with patients. Germicidal effectiveness of the phenolic solutions depends on the strength and combination of ingredients in a particular product.

Generally, a phenolic detergent with a phenol coefficient of at least 6 will be effective in destroying or inactivating harmful organisms.

B. Quaternary Ammonium Compounds

These are most commonly used in the food service area because they destroy or inhibit the organisms most commonly found in these areas. They are less caustic than the phenolics and do not have the pungent odors of the phenolics.

C. Iodine Solutions

These have come into wide usage in recent years and are most often recommended for equipment that comes in direct contact with the patient. It is not recommended for cleaning heavily soiled surfaces since its detergent actions are not as effective as that of the phenolics and ammoniums.

NOTE: Hospitals must attempt to keep down the number of different products stocked for disinfection uses. Thus, proper selection is extremely important. The products chosen should be effective for the job to be done, and personnel should be fully instructed in proper usage. New products should be given a ***controlled trial period.***

Future research should examine new emerging strategies, such as, but not limited to, peracetic acid, and hydrogen peroxide wipes as cleaning strategies, and adenosine triphosphate and ultraviolet light technologies as monitoring strategies.

REFERENCES:

- ~~Association for Professionals in Infection Control and Epidemiology – Agency Healthcare Research and Quality (AHRQ) (2015). Environmental Cleaning for the Prevention of Healthcare-Associated Infections (HAI). Retrieved from https://effectivehealthcare.ahrq.gov/topics/healthcare-infections/technical-brief/~~ Leas BF, Sullivan N, Han JH, Pegues DA, Kaczmarek JL, Umscheid CA. Environmental Cleaning for the Prevention of Healthcare-Associated Infections. Technical Brief No. 22 (Prepared by the ECRI Institute – Penn Medicine Evidence-based Practice Center under Contract No. 290-2012-00011-I.) AHRQ Publication No. 15-EHC020-EF. Rockville, MD: Agency for Healthcare Research and Quality; August 2015. https://www.ncbi.nlm.nih.gov/books/NBK311016/

- The Joint Commission (retrieved February 21, 2022). Infection Prevention and Control - Disinfection and Sterilization. Retrieved on February 21, 2022 from https://www.jointcommission.org/resources/patient-safety-topics/infection-prevention-and-control/disinfection-and-sterilization/

- ~~The Joint Commission (2017). Infection Prevention and HAI External Resources-Disinfection and Sterilization. Retrieved on October 4, 2017 from https://www.jointcommission.org/topics/hai_portal_external_resources_disinfection_sterilization.aspx.~~

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SUBJECT: **ENVIRONMENTAL FACILITY CLEANLINESS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish infection control guidelines for environmental cleanliness throughout the facility.

POLICY:

1. Identify equipment and surfaces requiring scheduled cleaning.
2. Assign responsibilities.
3. Define acceptable cleaning materials and frequency.
4. Clarify processes related to repair and inspection of instruments.

AFFECTED AREAS/PERSONNEL: *ENIVRONMENTAL SERVICES STAFF, NURSING, VOLUNTEERS, ALL PATIENT CARE STAFF, PHARMACY, SURGICAL SERVICES, MATERIALS MANAGEMENT, DIETARY STAFF, RESPIRATORY STAFF, AND SURGERY CLINIC.*

PROCEDURE:

1. General Guidelines: Separate clean items from soiled items at all times and ensure a process for cleaning and disinfection of all equipment/supplies that are used in patient care.
2. Separation of Clean and Soiled Supplies and Equipment:
   a. Clean supplies shall not be stored near soiled supplies. Cross contamination can occur.
      - Use separate drawers, cabinets, or areas for clean and soiled supplies and equipment in patient rooms.
      - Keep drawers and cabinets closed.
      - Once removed, clean supplies and linens shall not be returned to a clean area, drawer, or cabinet.
   b. Clean Utility Room
      - Only clean supplies and equipment shall be kept in the clean utility room.
      - Unused supplies removed from an equipment cart shall not be returned. Any supplies taken into a patient or treatment room are considered "contaminated" and are not to be shared with another patient.
      - No supplies are to be stored under any sink.

c. Soiled Utility Room

- No clean supplies or equipment shall be kept in the soiled utility room.
- Equipment removed from patient rooms shall be cleaned by a designated person with a hospital-approved disinfectant solution accessed through the environmental services department. Equipment shall be taken to the soiled utility room if it needs to be processed by Central Processing.

3. For Cleaning of Specific Equipment/Areas Refer to: High Touch Surfaces spreadsheet master list.xls located in the Public drive.

REFERENCES:

- California Code of Regulations, Title 22, Social Security. Section 70015, 70025, 70739, 70827APIC
- Association of Professionals in Infection Control (APIC), (2014). Environmental Cleaning for the Prevention of Healthcare-Associated Infections (HAI). Retrieved on April 23, 2019 from https://effectivehealthcare.ahrq.gov/topics/healthcare-infections/research-protocol

CROSS REFERENCE:

- Refer to "High Touch Surfaces" spreadsheet master list located in the Public Drive.

SUBJECT: **FLOATING GUIDELINES**	SECTION: ***Management of Human Resources (HR)*** **Page 1 of 3**

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

PURPOSE:

To define the guidelines to be utilized when establishing the staffing and skill for RN requirements the next shift prior to that shift beginning.

POLICY:

- The House Supervisor or Staffing Coordinator at Sierra View Medical Center (SVMC) will utilize the Floating Guidelines when establishing the staffing assignments prior to the beginning of each shift.
- Anyone floating to the Emergency Department must be able to document in the Emergency Documentation Module (EDM) unless they are specifically assigned to care for admitted patients only.
- All nursing staff who float must have completed an orientation to that unit and be competent in their job specific Core Competencies. *Nurses can be floated to lend helping hands; they will not be given a patient assignment but can be delegated tasks that they have competency in (such as starting an IV).*

AFFECTED PERSONNEL/AREAS: *ALL NURSING PERSONNEL (WITH THE EXCEPTION OF DIALYSIS, UROLOGY CLINIC, SURGERY CLINIC, WOUND HEALING DEPARTMENT, CTC & RADIOLOGY)*

PROCEDURE:

1. Generally, the float assignment will be determined according to the Float Log in each unit keeping in mind the premises of "Novice to Expert" (Benner) principles.
2. Once floated to a specific unit, the skills needed and the familiarity with the assigned unit will determine the placement of the assigned patients to the nurse floating.
3. ICU, ED, Telemetry and MCH RNs will only be required to handle a care assignment, with the exception of the Skilled Nursing Unit (DP/SNF). Exceptions will be considered based on the individual's past experience and familiarity with the unit.
4. Utilization of Float Pool (FP) Staff:
    a. These staff can only float to the units to which they have been oriented. (See updated Staffing Grid in House Supervisor's binder.)
    b. New FP Staff, once oriented to a specific unit, should be assigned to lesser acuity patients if at all possible. More experienced FP staff may be assigned higher acuity patients based on their ability.

5. Determination for float assignments will take place prior to the start of the shift. It will be the responsibility of the designated leadership on the shift to determine which individual will be floated, taking into consideration the staff member's skills and basic nursing competencies, as well as overall patient safety. It is recommended that those floating to a unit will be assigned lower acuity patients than the regular staff of the receiving unit.

6. It is the responsibility of the "float" employee:

   a. To arrive at the assigned designated unit within ten (10) minutes of being assigned.

   b. To document their name, date and float assignment in their departmental float log.

7. It is the responsibility of the sending leadership to communicate with the receiving unit leadership circumstances that may delay the "float" staff member from arriving within the designated time frame.

8. When the 8 week schedule is posted, all staff with SCHEDULED extra shifts shall take their turn with floating assignments.

   a. Travelers on long-term contracts will be added to the Float Log Book and take their turn in rotation with hospital staff, providing they have agreed to do so by their contract.

   b. Those Travelers that have by contract stated that they prefer not to float, will be asked if they would be willing to be in-serviced to another unit for one 12-hour shift. If they agree and the in-service has been conducted, they will be added to the unit's float log and take their turn in rotation with hospital staff.

9. Staff called in as "last-minute add-ons" to complete a specific unit's staffing for the shift, will NOT be considered for floating purposes if the unit's census should drop.

10. ***No staff member will be considered exempt from floating.*** Float assignments shall be divided equally between all staff members. Everyone will be expected to take their turn in rotation including per diem, casual per diem Staff will not be allowed to select where or if to float when called in.

11. When floating, every effort will be made to ensure that:

    a. No float personnel will be assigned to more than two (2) areas within the 12-hour shift.

    b. The same nurse will not be floated two (2) or more days in a row (unless they agree).

    c. The staff member who is considered "in-servicing" will not be considered to float to another department.

d. The Preceptor who has an assigned staff member for "in-service" may be considered to float, ***only*** when there are no other personnel available. If floated, the Preceptee will follow their Preceptor.

12. New graduate RNs (Nurse Residents) will not be eligible to float for 12 months after their hire to the hospital.

13. The designated Charge Nurse for the shift will not float.

14. Whenever possible, before placing a scheduled employee On-Call or sending a scheduled employee home, or when staff is available, the employee may be scheduled for cross-training/in-servicing to another unit. An in-service should be considered when a given employee has not floated to an area for greater than 60 days, e.g. ED. The receiving unit will handle the in-service of the person floating to their unit.

15. No scheduled employee is to be "sent home" by the primary unit. This decision shall rest with the House Supervisor or Staffing Coordinator based on Hospital need.

16. The Charge Nurse (CN) is to familiarize the "float" nurse with the unit layout, unit routine, and arrange for report either from the off-going staff member or by the Charge Nurse.

17. When staff have been floated from one department to another, the "floating department" will have first right of recall to get their staff member back if the need should arise. After hours, weekends and holidays, it will be the responsibility of the House Supervisor to verify the primary unit's need for the return of the floated employee.

18. Once it is noted that an employee has been floated to their department, the receiving department will work on a contingency plan for coverage should the staff member be returned to their primary department. In any event, the floated employee will be stationary for a minimum of 4 hours before being returned to their primary unit unless other arrangements have been made.

REFERENCES:

- Accreditation Resource Services. (March 2020). Plan for nursing services 2394. Retrieved from https://www.cihq-ars.org/resources.asp#sort reviewed on 11/24/2020.

SUBJECT: **FORENSIC / DEVELOPMENTALLY DISABLED PATIENTS IN SURGERY**	SECTION:

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

PURPOSE:

To establish guidelines for developmentally disabled/forensic clients who come to Sierra View Medical Center for a surgical/invasive procedure accompanied by a care provider or law enforcement officer.

POLICY:

1. All developmentally disabled clients who are unable to cooperate, who are combative, or self-abusive will be brought into the surgical/procedure room accompanied by their care provider.

2. All forensic clients who have been brought to the facility with a law enforcement officer will be accompanied into the surgical/procedure room by the law enforcement officer.

3. When a forensic client is brought to the hospital for surgical/invasive procedures it is the responsibility of the nursing staff to notify the Hospital's Security Department. (Reference, Patients under Legal/Correctional Restriction Policy)

AFFECTED AREAS/PERSONNEL:

MAIN OR-ASD-PACU-FLEX-CARE/ENDOSCOPY SUITE/RADIOLOGY/CATH LAB

PROCEDURE:

1. Care providers/law enforcement officers will be expected to follow established standards within the department of patient privacy, dress code, traffic patterns, and aseptic technique.

2. Any official accompanying a patient for a surgical procedure will be dressed in the white cover suit, hat and shoe covers.

3. Conversation in the operating room suite will be limited to business and will be conducted in a quiet tone of voice.

4. When the care provider accompanies the patient into the surgical/procedure room, he/she will remain with the patient as long as needed, or in the case of surgery until the patient is anesthetized. He/she will then wait in the waiting room until called by the PACU nurse to come to be with the patient.

5. When the law enforcement officer accompanies the patient into the surgical/procedure room, he/she will remain until the patient has been anesthetized and will then wait outside the room until the procedure is finish and return to the operating room to be in attendance during emergence from anesthesia. He/she will remain until the patient is transported to the PACU.

6. The law enforcement officer will remain with the patient in the PACU and until discharge.

CROSS REFERENCE:

- SVMC Patients Under Legal/Correctional Restriction Policy
- SVMC Attire in the Operating Room

SUBJECT: **Chamber Operator Qualifications**	SECTION: ***Patient Care Services*** **Page 1 of 3**

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

PURPOSE:

To outline the initial Chamber Operator or Emergency Chamber Operator qualifications, to provide a list of the frequency of competency completions, and to outline the criteria for persons qualified to sign Chamber Operator or Emergency Chamber Operator competencies.

DEFINITIONS:

1. Chamber Operator (CO) – A healthcare professional who has been educated in hyperbarics and has completed Healogics initial or subsequent annual chamber operator competencies.

2. Emergency Chamber Operator (ECO) – A healthcare professional who has been educated in hyperbarics and has completed Healogics initial or subsequent annual ECO competencies. An ECO is only able to remove a patient from a chamber. An ECO is not to be used for monitoring of patients or conducting HBO treatments.

POLICY:

Hyperbaric chambers may only be operated by Chamber Operators or Emergency Chamber Operators.

AFFECTED PERSONNEL/AREAS: *WOUND HEALING DEPARTMENT, HYPERBARIC CHAMBER OPERATOR, EMERGENCY HYPERBARIC CHAMBER OPERATOR*

EQUIPMENT: *N/A*

PROCEDURE:

A. QUALIFICATIONS

1. A CO or ECO must be a healthcare professional who is actively certified or licensed in one of the following vocations to meet the minimum education and experience requirements:

• Physician (MD, DO, NPP)	• Physical Therapist
• RN, LPN, or LVN	• CHRN- Certified Hyperbaric Registered Nurse
• Respiratory Therapist	• CHWS- Certified Hyperbaric Wound Specialist
• EMT or Paramedic	• Life Support Technician
• Military Corpsman	• Certified Nursing Assistant (CNA)
• CHS- Certified Hyperbaric Specialist	• Certified/Registered Medical Assistant (CMA)
• CHT- Certified Hyperbaric Technologist	

1.1 Exception to the above is an individual who has successfully completed U.S. Department of Defense (DOD) hyperbaric training.

2. A CO or ECO must complete a 40-hour in-person or web-based Introductory Hyperbaric Training Course as approved by either the American College of Hyperbaric Medicine, U.S. Department of Defense, Undersea and Hyperbaric Medical Society or the National Board of Diving and Hyperbaric Medical Technology.

2.1. Exceptions to this requirement are those individuals who are already a CHT, CHRN, CHWS or CHS
2.1.1. Active certification will be verified by the Program Director or designee through the applicable certifying body's website.

3. A CO or ECO must successfully complete the Healogics Hyperbaric Competency Assessments (See Competency Content and Frequency section below).

B. COMPETENCY CONTENT AND FREQUENCY:

1. Initially: Chamber Operators must complete:

Initial Hyperbaric Chamber Skills Checklist prior to independently operating

2. Annually: Chamber Operators must complete:

2.1 Annual Competency - Chamber Operator
2.2 A minimum of 1 Daily Start-Up, 1 Daily Shutdown and 1 Weekly Check per quarter; as documented on the Chamber Operator Competency Log.
2.3 A minimum of 3 HBO treatments per quarter is required to maintain competence; as documented on the Chamber Operator Competency Log.

(HBO treatment is defined as delivery of one day's treatment to a single patient, not a complete course of treatments.)

3. Initially: Emergency Chamber Operators must complete:

3.1. Initial Emergency Chamber Operator Skills Checklist prior to independently operating

4. Annually: Emergency Chamber Operators must complete:

4.1. Annual Competency - Emergency Chamber Operator
4.2. A minimum of 3 depressurizations per quarter; as documented on the Chamber Operator Competency Log.

C. COMPETENCY REVIEWERS

The following are qualified to review and validate competencies for Chamber Operators and Emergency Chamber Operators:

1.1. Vice President of Hyperbaric Services for Healogics, Inc. ("HI");
1.2. Regional Director of Safety (RDS) for HI;
1.3. Clinical Vice President of Operations (HI);

1.4. Clinical Director of Operations (HI);
1.5. A Competent Operator that has been approved (via email) by one of the staff listed above

REFERENCES:

Whelan, H. T., & Kindwall, E. P. (Eds.). (2017). Hyperbaric medicine practice (4th Ed.) (Chapter 6). North Palm Beach, FL: Best Publishing Company.

Garrett, D. & Guilliam, A. (Eds) (2021). UHMS Guidelines for Hyperbaric Facility Operations. (3rd Ed.) North Palm Beach, FL: Best Publishing Company.

O'Neill, O. (Eds) (2018). UHMS Clinical Hyperbaric Facility Accreditation Manual (4th Ed.). North Palm Beach, FL: Best Publishing Company

Credentialing Committee of UHMS (rev. 2018) UHMS Guidelines for Credentialing, Privileging and Supervision of Hyperbaric Oxygen Therapy in the U.S.A Retrieved on 02/09/22 https://www.uhms.org/images/Position-Statements/UHMS_Cred_and_Priv_Guide_Jan_31_2018.pdf

SUBJECT: **LATEX SENSITIVITY**	SECTION: **Page 1 of 4**

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

PURPOSE:

To identify specific guidelines for safe nursing care of latex sensitive patients in the surgical services setting.

POLICY:

- The perioperative nurse will identify the patient's allergies through the preoperative history and patient interview.
- Safe nursing care of the latex-sensitive patient in the perioperative setting will be to minimize the risk of an allergic/anaphylactic reaction.
- All perioperative personnel will adhere to the specific guidelines for latex sensitivity when caring for these patients.
- The perioperative nurse will ensure that latex-sensitive patients will not come into contact with products made of latex.

AFFECTED AREAS/ PERSONNEL: *SIERRA VIEW MEDICAL CENTER PERSONNEL, CONTRACT EMPLOYEES AND PHYSICIANS*

GENERAL CONSIDERATIONS:

1. Latex exposure can cause a local allergic reaction. Symptoms of a local reaction might be itching, redness or urticaria. A local reaction may be a sign of increased risk for an intraoperative systemic reaction.

2. Latex exposure may cause a systemic anaphylactic reaction. A systemic reaction might manifest as difficulty in breathing, anxiety, palpitations, chest tightness and pain, hypotension, facial and peripheral edema and shock. Even a trivial exposure may result in a cardiorespiratory arrest.

3. Patients at high risk for latex sensitivity include:

    a. Patients with neural tube defects (i.e., myelomeningocele or spina bifida);

    b. Patient with chronic bladder catheterizations;

    c. Patients with occupational exposure (i.e., workers in the latex industry and healthcare worker);

    d. Patients that have had multiple operations;

e. Patients with a history of atopy and multiple allergies;
f. Those patients with a history of an allergic reaction after touching balloons, rubber medical devices;

g. Patients with a history of asthma, hay fever, allergy to bananas, avocados, pears or chestnuts;

h. Thus patients that have experienced an anaphylactic reaction during surgery, urinary catheterization, rectal or vaginal examination and/or bladder stimulation.

PROCEDURE:

1. The perioperative RN will identify and confirm the patient's allergies through the preoperative history and the pre-procedural interview or by the pre-op phone interview. When the latex allergy is identified the following units will be notified:

   a. Flex Care

   b. PACU

   c. OR

   Allergies will be documented in the electronic chart and place on the ~~in the ORM~~ schedule.

2. The words "Latex Allergy" will be posted on the OR board and all doors to the OR suite.

3. Non-latex products will be substituted for those products containing latex. All latex products will be removed from the operating room.

4. A list of the most commonly used latex products and their substitutes will be available to those providing care in the perioperative setting.

5. Communication between the OR team, surgeons, and anesthesia will occur.

6. PACU will be notified of the allergy status prior to transfer

7. Anesthesia is responsible for:

   a. Replacing all anesthesia supplies containing latex with non-latex supplies.

   b. Collaborating with Pharmacy for appropriate drugs use in the case.

   c. Having emergency drugs for contracting anaphylactic reaction.

REFERENCES:

- Association of Perioperative Registered Nurses ~~(January 2019)~~ (March 2022). AORN Guideline for a Safe Environment of Care, ~~Part 1. DOI:10.6015/psrp.15.01.239. Retrieved from https://www.aorn.org/guidelines/guideline-implementation-topics/patient-and-worker-safety/environment-of-care-part-i.~~ https://aornguidelines.org/guidelines/content?sectionid=17372064S&view=book#200100619
- Centers for Disease Control and Prevention ~~(April 2018)~~ (June 2014). ~~Guideline for prevention of surgical site infection. *Infection Control and Hospital Epidemiology*, 20(4):247-278.~~ Latex Allergy Prevention Guide. https://www.cdc.gov/niosh/docs/98-113/default.html

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LATEX	NON-LATEX ALTERNATIVE
Gloves:	**Gloves:**
Triflex Protexis Gloves in Prep Tray	Protexis PI Biogel Neoderm Gammex Protexis Neoprene Unsterile Exam Gloves
Catheters:	**Catheters:**
Red Rubber Catheters Foley Catheter Kits Malecot Feeding Tubes (some have latex)	Feeding Tubes (some latex free) Bard Hemovac Drain Bard Silicone Granade Reservoir Bard Round and Flat Silicone Drain Cystoscopy Tubing Bard Silicone Foley Catheter Bladder Irrigation Leg Urine Drainage Bag Bard Infection Control Urinary Drainage Bag
Drapes:	**Drapes:**

	Sterile Drapes Ioban Drapes Extremity Sheet Split Sheet U-Drape Laparoscopy Sheet Pediatric Laparotomy Drape II Laparotomy Pack I & II Laparotomy Drape Laparoscopic Abdominal Drape
Dressing and Tapes: Elastikon	**Dressing and Tapes:**
Coban Band-Aids (Some latex)	Medipore H Tegaderm Steri Strips Microfoam Tape Transpore Tape Band-Aids (Some latex free) Paper Tape Cloth Tape
Miscellaneous: Disposable syringes with rubber stoppers Pediatric Circuits	**Miscellaneous:** Gel Pads Disposable Adult and Pediatric BP Cuff 3M Ranger Irrigation Fluid Warmer Disposable Adult and Pediatric Oxygen Mask Adult Cushion Nasal Cannula Salem Sump Dual Chamber Stomach Tube Tri-Flo Suction Catheter Adult and Pediatric SpO2 Sensor Adult Circuits Adult and Pediatric LMA's Adult and Pediatric Resuscitation Ambu Bag Tourniquet

SUBJECT: **MEASUREMENT OF BICARB AND DIALYSATE CONDUCTIVITY AND PH**	SECTION: 06-05 *Renal Services* **Page 1 of 4**

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

PURPOSE:

To monitor ~~bicarbonate and~~ dialysate conductivity and potential hydrogen (pH).

POLICY:

In order to ensure patient safety:

- ~~The dialysis unit must test for conductivity and pH on every batch of bicarbonate.~~
- ~~T~~The dialysis unit must test for conductivity and pH of dialysate before each patient treatment.
- ~~If the conductivity or pH levels are not within the normal acceptable ranges, the batch shall be discarded and a new batch made until acceptable levels have been attained.~~

AFFECTED AREAS/ PERSONNEL: *DIALYSIS PERSONNEL*

EQUIPMENT:

- pHoenix Meter
- 14.0 mS Conductivity Calibrator Solution (used for verification of calibration of meter when used to check conductivity of ~~bicarbonate concentrate and~~ dialysate)
- 7.00 pH Calibrator Solution (used for verification of calibration of meter when used to check pH of ~~bicarbonate concentrate and~~ dialysate)
- Tri•Station (used to rinse, disinfect and check the calibration of meter)

PROCEDURE:

~~Establishing Conductivity Range of Bicarbonate Concentrate~~

~~It will be necessary to establish the conductivity and pH of the total volume of the bicarbonate solution prior to the initial use of the pHoenix meter to verify that the bicarbonate concentrate solution has been prepared in accordance with the manufacturers' specifications. The conductivity and pH of the concentrate solution will be established as follows:~~

~~1. Carefully prepare a batch of bicarbonate concentrate following the manufacturer's directions. Make certain that the quantity of powder and total volume used is correct and accurate.~~

~~2. After all bicarbonate powder is dissolved, draw a sample of the bicarbonate~~

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~~solution using the pHoenix meter and record the readings from the meter.~~

~~3. Verify the calibration of the pHoenix meter using the 14 mS Conductivity Calibrator Solution.~~

~~4. Verify the calibration of the pHoenix meter using the 7.0 pH Calibrator Solution.~~

~~5. Press and release the [MODE] switch to turn the meter on.~~

~~6. Fill the sample collection cup approximately ¾ full with test solution.~~

~~7. Draw liquid through the cell. Liquid should be flowing while measurement is taken. When no air bubbles are present and the readings stabilize, press and release the [MODE] switch to hold the readings on the display. A "HOLD" symbol will appear on the display. Press [MODE] again to deactivate the hold feature.~~

~~8. Discard the used solution in the appropriate disposal or waste container. The instrument will turn off automatically, three minutes after final use.~~

~~9. Thoroughly rinse the cell, syringe interior, and sampling cup/tube with reverse osmosis (RO) water after use.~~

Establishing Conductivity Range of Dialysate

1. Verify the calibration of the pHoenix meter using the 14 mS Conductivity Calibrator Solution.

2. Verify the calibration of the pHoenix meter using the 7.0 pH Calibrator Solution.

3. Press and release the [MODE] switch to turn the meter on.

4. Fill the sample collection cup approximately ¾ full with test solution from the distal port.

5. Draw liquid through the cell. Liquid should be flowing while measurement is taken. When no air bubbles are present and the readings stabilize, press and release the [MODE] switch to hold the readings on the display. A "HOLD" symbol will appear on the display. Press [MODE] again to deactivate the hold feature.

6. Discard the used solution in the appropriate disposal or waste container. The instrument will turn off automatically, three minutes after final use.

7. Thoroughly rinse the cell, syringe interior, and sampling cup/tube with RO water after

use.

Disinfection Requirements

Frequency and Disinfectant:

1. The meter will be disinfected just prior to the first use on each day that it is used with a 1% bleach solution (one part bleach to 99 parts RO water), followed by a thorough rinsing with RO water.

2. Rinse 2-3 times with RO water to ensure that all residual disinfectant solution has been removed.

Calibration and Use of Meter after Disinfection

Each meter is to be checked for proper calibration prior to each day's use using 14 mS Conductivity standard solution and 7.0 pH standard solution.

1. Connect the cell to the 14 mS Conductivity standard solution bottle.

2. Hold the syringe with the plunger end elevated to eliminate any remaining air bubbles in the syringe.

3. Slowly draw solution through the cell. Observe the reading on the display while the solution is flowing. If the display reads the value of the conductivity standard solution being measured, calibration is not needed.

4. Rinse again with RO water before use or storage.

5. If calibration is needed, refer to the appropriate instrument calibration guide (02-04-01A).

6. Repeat steps 2- 5 with 7.0 pH buffer solution.

Overnight Cleaning and Storage Requirements

Frequency, Cleaning and Storage:

1. The meter will be rinsed with NEO-CARE Solution at the end of each day. To clean, rinse the meter thoroughly by filling the syringe and expelling NEO-CARE slowly, three times. After the third time, expel the NEO-CARE from the meter, draw the syringe back halfway, and cap the sample port to prevent the residual NEO-CARE in the cell and syringe from drying out.

2. Never Store the meter with dialysate, bleach or RO water in the cell.

3. The facility will maintain a record of the date and time that the meter was disinfected, tested, calibrated and cleaned. If more than one meter is used by the facility, a separate record will be maintained for each meter. Each meter will be marked with a unique code to distinguish one meter from the other.

REQUIRED OBSERVATIONS and DOCUMENTATION

1. Confirm pH and conductivity are within normal ranges before putting the system in service for treatments.

2. Document levels of pH and conductivity. Findings should be documented on the following weekly log:

   a. Weekly Conductivity and pH Monitor Sheet for ~~Bicarbonate Mix System and~~ Total Chlorines & Testing.

REFERENCE:

- ~~Counts, C. (2015). Core Curriculum for Nephrology Nursing, 6th edition. Pitman, New Jersey. American Nephrology Nurses Association.~~

- Mesa Labs (n.d.) Test Instrument User's Guide for the NEO-STAT+ Meter, phoenix Meter and HYDRA Water Quality Instrument. Retrieved on 3/1/2022 from https://dialyguard.mesalabs.com/wp-content/uploads/sites/8/2014/01/Neo-Stat+Calibration-Guide.930004.RevD_.pdf

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SUBJECT: **MEASUREMENT OF RECIRCULATION IN THE VASCULAR ACCESS**	SECTION: **Page 1 of 2**

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

PURPOSE:

Recirculation occurs when there is an obstruction or partial obstruction in the vascular access. The amount of recirculation during dialysis should be 10% or less.

POLICY:

- This procedure will be used when recirculation is suspected within a vein graft.
- The accuracy of this procedure is questionable when used on an AV fistula because of collateral circulation.

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

KEY POINTS:

1. Recirculation is an admix of arterial and venous blood during dialysis.
2. Signs of recirculation may include: saline returning through the arterial needle, increased venous resistance or blood becoming progressively darker as the dialysis proceeds.
3. The % of recirculation (R) is calculated as follows:

$$R = 100 \quad \frac{(Cs - Ca)}{Cs - Cv} \quad x\ 100$$

   a. Where Cs is the BUN in the systemic blood sample,

   b. Ca is the BUN in the arterial blood sample, and

   c. Cv is the BUN in the venous blood sample.

EQUIPMENT:

- Non-sterile gloves
- Gown, Goggles and Mask
- Three (3) Lab Tubes
- Four (4) 10 ml Syringes
- Three (3) 22 Gauge Needles
- Alcohol Wipes

SUBJECT: **MEASUREMENT OF RECIRCULATION IN THE VASCULAR ACCESS**	SECTION: **Page 2 of 2**

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

PROCEDURE:

- Put on gloves, gown, goggles and mask.
- Turn ultrafiltration pressure to zero (0) or as close as possible to minimize BUN clearance due to convective forces.
- Record the blood flow rate.
- Simultaneously draw blood samples from the arterial and venous sample ports.
- Turn the blood pump OFF. After clamping the arterial blood line and the arterial needle tubing, separate the line from the needle tubing.
- To clear the tubing, draw a 10 ml blood sample from the arterial needle tubing and discard.
- Draw a blood sample from the arterial needle tubing or dialysis catheter for the systemic blood sample.
- Fill three separate lab tubes with the blood samples. Label each tube with the appropriate sample site - venous, arterial or systemic.
- Send the samples to the lab for BUN.
- Use the formula to calculate the results.
- Document the procedure and results in patient EMR.

REFERENCE:

- Kallenback, J. (2016). Review of hemodialysis for nurses and dialysis personnel: Ninth ed. p. 153. St. Louis, Missouri: Elsevier.
- BerkoBen,M. and Blankestijn,P. (Feb 2022). Arteriovenous fistula recirculation in hemodialysis. Retrieved on 3/22/22 from https://www.uptodate.com/contents/arteriovenous-fistula-recirculation-in-hemodialysis

SUBJECT: **PATIENT ASSESSMENT AND REASSESSMENT- ACUTE RENAL SERVICES**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 3**

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

PURPOSE:

To provide safe and effective dialysis by assessing the patient and monitoring equipment.

POLICY:

- Patient assessment and reassessment is a series of repeated or continuous observations of the patient's appearance and physiologic state before, during and after the dialysis procedure. These observations are recorded and made part of the patient's record. The objective is to provide a comfortable and safe procedure for the patient and to identify and respond to any complication that may result from the patient's disorder or from some untoward event as a part of the procedure.

- Patients will be assessed PRE and POST treatment.
  -PRE treatment assessment will be completed prior to treatment initiation.
  -POST treatment assessment will be completed after safe blood return and disconnect from dialysis access.
  -All data must be documented.

- The patient's general condition, changes and responses to treatment will be assessed and monitored while on dialysis on a continual basis with vital signs and machine parameters being monitored and documented at least every thirty (30) minutes if stable, and every fifteen (15) minutes if unstable (BP drop > 20 mm Hg from previous reading).

AFFECTED AREAS/ PERSONNEL: *DIALYSIS PERSONNEL*

PROCEDURE:

1. Patient:

   a. Observe patient for changes in sensorium and unusual physical responses. Patient may not verbalize or be aware of signs representing complications.

      - Hemodynamic Complications
      - Hypotension
      - Angina
      - Arrhythmias
      - Congestive Failure
      - Pulmonary Complications

- Hypoxia
- Shortness of Breath
- Muscle Cramping
- Generalized Weakness/Lethargy
- Hypoglycemia/Hyperglycemia
- Headache
- Nausea/Vomiting
- Dialysis Disequilibrium

b. Evaluate patient complaints and refer to primary nurse or physician if necessary. Patient may need medication, specific treatment or reassurance.

c. Check temperature, pulse, blood pressure and respirations every thirty (30) minutes or more often as needed. Changes in vital signs can occur rapidly and can indicate possible complications.

d. Observe lines every thirty (30) minutes to verify that they are well secured. Safety devices should be used during treatment to prevent line disconnection. Tape may become loose during treatment.

EQUIPMENT:

- Monitor lines and chambers for leaks and/or air to prevent blood loss and air-foam emboli.
- Monitor dialysate temperature and conductivity to prevent hemolysis and to maintain dialysate prescribed by physician.
- Monitor blood flow rate to provide an effective hemodialysis.
- Monitor arterial pressure and venous resistance pressure to prevent air from entering system. Prevent pressure build up in system.
- Monitor Transmembrane Pressure (TMP) to provide appropriate fluid loss.
- Monitor dialysate flow to provide an effective hemodialysis.

- Monitor heparin infusion to maintain correct anticoagulation, if used.
- Monitor air-foam detector to prevent air-foam emboli.

REFERENCES:

- Counts, C. (2020~~0415~~). Core Curriculum for Nephrology Nursing, 7~~6~~th edition. Pitman, New Jersey. American Nephrology Nurses Association.

SUBJECT: **POWER FAILURE - ACUTE RENAL SERVICES**	SECTION:

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

PURPOSE:

To give direction to staff who are on duty when there is a power failure.

POLICY:

- If there is a power failure, the hospital emergency generator will take over.
- In the event of a power failure, all machine plugs will be moved to the emergency (red) outlets.
- The emergency generator will power auxiliary lighting. Always have a flash light available.
- In the event that power is not restored, the blood pump will be hand cranked by the renal services staff.
- If after fifteen (15) minutes the power is not restored, dialysis will be terminated.

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

PROCEDURE:

- Power OFF the machine by pushing POWER ON/OFF panel switch. NOTE: This will silence on-going "Loss of Power Alarm."
- If power
  - Is restored with generators, restart machines by pushing POWER ON/OFF panel switch and continue dialysis.
  - Is not restored after 5 minutes, continue with the procedure.
- Clamp and disconnect the patient's access and ARTERIAL Blood Line
  - CATHETER-Clamp catheter clamp and blood line clamp. Obtain a 10 ml NS syringe. Disconnect clamped blood line from catheter. Irrigate catheter using NS Syringe and re-clamp art line securely. Place blood line into designated rinse port on blood line.
  - NEEDLES- Clamp needle clamp and blood line clamp. Obtain 10 ml NS syringe. Disconnect clamped blood line from catheter. Irrigate catheter using NS Syringe and re-clamp art line securely. Place blood line into designated rinse port on blood line.
- Obtain EMERGENCY BLOOD PUMP HAND CRANK from the rear of the dialysis machine and place appropriately into the blood pump to prepare for Emergency Power Failure Blood return.
- Open appropriate clamps to return blood.
  - Upper Saline Line Clamp

- Arterial Blood Line Clamp

- Open the Venous Air Trap door so that the venous chamber can be observed while returning the patients' blood. Do not remove chamber.
- Remove the Venous Blood Line from the Line Clamp.
- Inspect Venous Blood Line to assure NO AIR IS PRESENT. IF AT ANY TIME AIR IS NOTED IN VENOUS BLOOD LINE, DISCONTINUE BLOOD RETURN AND IMMEDIATE CLAMP VENOUS BLOOD LINE AND VENOUS ACCESS LINE PER NEXT STEP
- Using the Emergency Hand Crank, slowly return the patients' blood, always noting for air in Venous Chamber or Blood Line. Return blood as under normal conditions.
- Clamp and disconnect the patient's access and VENOUS Blood Line.
  - CATHETER-Clamp catheter clamp and Blood line Clamp. Obtain a 10 ml NS Syringe. Disconnect clamped blood line from catheter. Irrigate catheter using NS Syringe and re-clamp Art Line securely. Place blood line into appropriate site where leakage will not occur and line will later be discarded.
  - NEEDLES- Clamp needle clamp and blood line clamp. Obtain 10 ml NS Syringe. Disconnect clamped blood line from catheter. Irrigate catheter using NS Syringe and re-clamp art Line securely. Place blood line into appropriate site where leakage will not occur and line will later be discarded.
- Once blood is returned, use appropriate normal policies and procedures to end dialysis.
- Document data and any abnormalities encountered during the Emergency Return Procedure. Notify the patient's nephrologist of the situation and obtain new orders if applicable. Shut the machine off to stop the "Loss of Power Alarm" from buzzing.

The machine should always be plugged into a source that will ensure automatic transfer to emergency power if necessary.

REFERENCES:

- FRESENIUS Medical care. (n.d.~~2017~~). Preventative maintenance procedures retrieved on February 7, 2022 from https://www.manualslib.com/manual/439583/Fresenius-Medical-Care-2008k.html?page=104.
- ~~https://fmcna.com/wp-content/uploads/2017/10/508033_Rev_.pdf~~

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SUBJECT: **PRE-ANESTHESIA ASSESSMENT GUIDELINES**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish the guidelines for a pre-anesthesia assessment and a pre-induction assessment accomplished by the anesthesia provider.

POLICY:

1. Any patient scheduled to receive anesthesia will receive a pre-anesthesia assessment to determine if patient is appropriate for treatment.

2. The anesthesia provider will perform an anesthesia assessment before the patient is ~~being~~ transferred to the operating room.

3. The patient will be re-evaluated immediately before the induction or regional anesthesia is given.

PROCEDURE:

1. An evaluation will include a review of the patient's chart and an interview with the patient for pertinent information relative to the anticipated procedure and type of anesthesia to be used.

2. The patient's previous and present drug history, other anesthesia experiences, any pertinent medical or family history will be obtained and documented.

3. ASA classification will be obtained and documented. Discussion with the patient and family, if applicable, regarding the anesthesia options and risks will also be documented on the pre-anesthesia evaluation.

4. An informed consent, given by the anesthesia provider, will be obtained from the patient and the type of anesthesia that is anticipated will be documented on the pre-anesthesia record.

REFERENCES:

- American Society of Anesthesiologists (December 2020). ~~Association of Perioperative Registered Nurses (January 2019).~~ *Basic Standards for Preanesthesia Care. Retrieved from https://www.asahq.org/standards-and-guidelines/basic-standards-for-preanesthesia-care* ~~*AORN Guideline for a Safe Environment of Care, Part 1.* DOI:10.6015/psrp.15.01.239. Retrieved from https://www.aorn.org/guidelines/guideline-implementation-topics/patient-and-worker-safety/environment-of-care-part-i.~~

SUBJECT: **PROVISION OF ANESTHESIA SERVICES ORGANIZATION AND DIRECTION**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define the oversight of Anesthesia Services by the Medical Director or Department Chair of Anesthesiology.

POLICY:

All anesthesia services shall be under the direction of the Medical Director of Anesthesiology or Department Chair of Anesthesiology.

The Director/Department Chair must meet the following minimum qualifications:

- Be a licensed physician (MD or DO) on active staff
- Graduation from a medical school accredited by the Liaison Committee on Medical Education (LCME), from an osteopathic medical school or program accredited by the American Osteopathic Association (AOA), or from a foreign medical school that provides medical training acceptable to and verified by the Educational Commission on Foreign Medical Graduates (ECFMG)
- Completion of an anesthesiology residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or by the AOA
- Board certification in a specialty recognized by the American Board of Medical Specialties (ABMS) or demonstration of equivalent education, training, and experience

Responsibility for directing anesthesia services, includes, but is not limited to the following:

- Developing policies and procedures governing the provision of all categories of anesthesia services
- Specifying the minimum qualifications for each category of practitioner who is permitted to provide anesthesia services that are not subject to the anesthesia administration requirement of 42 CFR 482.52(a)
- Planning, directing, and supervising all activities of the service
- Establishing staffing schedules for the department
- Evaluating the quality and appropriateness of the anesthesia patient care as part of the hospital's Quality Assurance/Performance Improvement (QAPI) program

DEFINITIONS:

Anesthesia services involve the administration of general, regional, monitored anesthesia, or deep or moderate sedation.

AFFECTED AREAS/ PERSONNEL: *MEDICAL STAFF, SURGICAL SERVICES STAFF*

PROCEDURE:

CRITERIA FOR GRANTING CLINICAL PRIVILEGES

The Medical Director of Anesthesia or Department Chair of Anesthesia shall have authority to determine the criteria for granting anesthesia privileges and will forward candidates to the Credentials Committee for recommendation to the Medical Executive Committee. Medical Executive Committee recommendation will be forwarded to the Governing Board for final approval.

A. Criteria for Granting Privileges for General, Regional, or Monitored Anesthesia

Physicians (MD or DO) wishing to administer general, regional, or monitored anesthesia care must meet the following minimum criteria:

1. Graduation from a medical school accredited by the LCME, from an osteopathic medical school or program accredited by the AOA, or from a foreign medical school that provides medical training acceptable to and verified by the ECFMG

2. Completion of an anesthesiology residency training program approved by the ACGME or by the AOA

3. Board certified or board eligible in anesthesiology recognized by the ABMS or demonstrates comparable education, training, and experience

Certified Registered Nurse Anesthetists (CRNA) wishing to administer general, regional, or monitored anesthesia care must meet the following minimum criteria:

1. Current active licensure to practice professional nursing or advanced practice nursing in the nurse anesthetist category by the California State Board of Medical Examiners or the state board of nursing

2. Meets any licensure requirements that the State imposes with respect to non-physician anesthetists

3. Graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs

4. Passed a certification examination of the Council on Certification of Nurse Anesthetists (CCNA), or the Council on Recertification of Nurse Anesthetists

B. Criteria for Granting Privileges to Administer Deep Sedation

MD, DO, Dentist, Oral Surgeon, Podiatrist or CRNA wishing to administer deep sedation must meet the following minimum criteria:

1. Graduation from a medical school accredited by the LCME, from an osteopathic medical school or program accredited by the AOA, or from a foreign medical school that provides medical training acceptable to and verified by the ECFMG

2. Completion of an emergency medicine residency training program approved by the ACGME or by the AOA

3. Board certified or board eligible in emergency medicine recognized by the ABMS or demonstrates comparable education, training, and experience

4. CRNA: Successful completion of a nurse anesthesia educational program accredited by the American Association of Nurse Anesthetists (AANA) and certification by the CCNA or recertification by the Council on Recertification. Current active licensure to practice professional nursing or advanced practice nursing in the nurse anesthetist category by the state board of medical examiners or the state board of nursing

REFERENCES:

- American Society of Anesthesiology: Guidelines of Delineation of Clinical privileges in Anesthesiology, October 1722, 20181.
- ~~American Society of Anesthesiology: Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, Anesthesiology 2011, 2019, 96: 1004-17.~~
- American Society of Anesthesiology: Statement on Granting Privileges for Deep Sedation to non-anesthesiologist, October 2017~~0~~.
- Centers for Medicare and Medicaid Services (2019). CMS - §482.52, Conditions of Participation: Anesthesia Services. Retrieved from https://www.govinfo.gov/content/pkg/CFR-2002-title42-vol3/xml/CFR-2002-title42-vol3-sec482-52.xml.

SUBJECT: **RECIRCULATION OF BLOOD IN EXTRACORPOREAL CIRCUIT- ACUTE RENAL SERVICES**	SECTION: 04-04 *3022 Renal Services* **Page 1 of 2**

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

PURPOSE:

To recirculate through the dialyzer, for no more than 30 minutes with a Blood Flow Rate of 100 ml/minute, the blood in the extracorporeal circuit without damage or contamination. This procedure is used when a fistula/access must be replaced or modified as a result of infiltration, clotting, inadequate blood flow, increased resistance to flow, a dislodged needle or to remove air/foam from blood lines or dialyzer.

POLICY:

Recirculation of blood in Extracorporeal Circuit

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

EQUIPMENT:

- Recirculation Tube
- Tubing with Clamps
- Two (2) 10 ml Syringes with Saline Solution
- Gloves

PROCEDURE:

1. Pause the treatment.
2. Turn off the blood pump.
3. Clamp both the arterial and venous blood lines and both the needle tubing/catheter lines.
4. Disconnect the blood lines from the access and ensure that all ends are sterile. Attach both blood lines together via the recirculation tube. Decrease the negative pressure to -20 mm/Hg. Set the blood pump on 100 ml/minute.
5. Remove the clamps. Start the blood pump at 100 ml/minute. Open the saline line as needed to replace fluid lost due to minimal ultrafiltration. Push heparin, as needed, to prevent clotting.
6. Flush the access that is functioning properly with saline to prevent clotting.
7. Attempt to reposition the malfunctioning needle. If this is not successful, leave this needle in place, if possible, until treatment is finished.

8. Insert a new needle/de-clot cannula.

   Note: Never recirculate more than 30 minutes.

9. To restart dialysis:

   a. Check the entire circuit for air.

   b. Turn off the blood pump.

   c. Clamp the arterial and venous blood lines.

   d. Reconnect the arterial blood line to arterial access.

   e. Reconnect the venous blood line to venous access.

   f. Remove the clamps.

   g. Turn the blood pump on and gradually increase the blood flow rate. Clamp the saline line.

   h. Reset negative pressure, monitors and limits. Check the remaining heparin (may be insufficient amount to finish treatment).

   i. Perform all routine monitoring checks

REFERENCE:

- Beroben, M. and Blankentijin, M. (2018). "*Arterivenous fistula recirculation in hemodialysis*". Up to Date, Inc. retrieved on 12/11/18 from https://www.uptodate.com/contents/arteriovenous-fistula-recirculation-in-hemodialysis

SUBJECT: **SCOPE OF SERVICE- RENAL SERVICES**	SECTION: **Page 1 of 1**

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 guidelines for the scope of renal services.

POLICY:

Renal Services is an acute service that provides dialysis and hemoperfusion treatment on an "as needed" basis to acute areas. All equipment, disposable supplies, staff and services are provided for the following conditions:

- Acute renal failure
- Exogenous intoxication
- End-stage renal failure patient requiring hospitalization
- Other conditions deemed eligible by the nephrologist
- All patients 18 years and older regardless of ability to pay.

This service will be ordered by an attending nephrologist. A physician orders and consent for hemodialysis must be on the chart prior to treatment. The nephrologist is responsible for all hemodialysis treatments performed at Sierra-View Medical Center. . If multiple patients need dialysis, they will be prioritized by the Nephrologist.

Dialysis is performed by and is the responsibility of the Dialysis Services nurse. Primary patient care is the responsibility of the hospital nursing staff. A Dialysis Flowsheet will be maintained by the dialysis nurse for the patient medical record.

After hours there is only one (1) nurse on-call and patients will be dialyzed on a first call basis. In the event that there is more than one emergent need the on-call nurse will make every effort to recruit another qualified nurse.

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

REFERENCES:

- Centers for Medicare and Medicaid Services. (Jan. 2022). Dialysis. retrieved on 2/3/22 from. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Dialysis

SUBJECT: **SURGICAL PRIVILEGES/APPROPRIATE ASSISTANTS TO THE SURGEON**	SECTION: **Page 1 of 9**

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

PURPOSE:

To provide guidelines to ensure appropriately credentialed physicians are providing surgical/invasive procedures within the Surgical Services Department, and to identify which surgical/invasive procedures need what level of assistant, Registered Nurse First Assist (RNFA), Physician Assistant (PA) or Operating Room Technician (ORT).

The intent of the Surgical Services General Requirements of Title 22 is accomplished by having the appropriate Medical Staff Department Committee approve the assistance level for the case types specific to that Department. (*See Addendum*) Specific privileges are approved by OB/GYN and the Surgery Committee.

POLICY:

A committee of the medical staff shall be assigned responsibility for:

1. Recommending to the governing body the delineation of surgical privileges for individual staff members of the medical staff. A current list of such privileges shall be kept with this policy.

2. Determining which operative procedures require an assistant surgeon or assistants to the surgeon.

AFFECTED PERSONNEL/AREAS: *MAIN OPERATING ROOM (OR)& MATERNAL CHILD HEALTH (MCH) OR / REGISTERED NURSE (RN)/REGISTERED NURSE FIRST ASSIST (RNFA); OR TECHNICIAN; PHYSICIAN ASSISTANTS (PA)*

PROCEDURE:

Surgical Privileges

1. Physician privileges for all credentialed surgeons can be found on the computerized program, E>Priv, which is available for all surgical staff.

2. Refer to the Medical Staff Bylaws for credentialing procedures. Medical staff office personnel update the privileges as needed.

3. Surgeries are scheduled only for those physicians having privileges for the specific procedure. Emergency, life and death situations, with no qualified provider available, preclude physician privileges being enforced.

4. Special privileges are granted on a case-by-case basis for visiting surgeons. Application is made through the Medical Staff Office.

Surgical Assistants

1. Physicians are preferred assistants for all surgical cases. However, non-physician providers are available to assist with surgery per physician request.

2. An addendum is provided with this document regarding the necessity of an assistant as well as the acceptable level of assistant needed for specific surgeries. (See Addendum.)

3. Information regarding non-physician assistants can be found in the Standardized Nursing Procedure for Registered Nurse First Assistants (RNFA). Registered Nurse First Assistant may perform the following activities under the direction of the primary surgeon:

    a. Provide retraction, hemostasis and knot tying.

    b. Handle and sever tissue.

    c. Drilling, reaming, sawing, screwing and utilizing orthopedic hardware/equipment.

    d. Provide wound closure and assist the surgeon with completing the case.

4. Operating Room Technicians will only perform procedures within their scope of practice. The law in the State of California has been interpreted to indicate that it is illegal to delegate certain medical practices to unlicensed personnel. This includes severing or cauterizing tissue or suturing.

5. In an event a RNFA is not available, with the surgeon's approval, two surgical technicians may be used in the operating room. All surgical technicians will work within their scope of practice.

REFERENCE:

- The Joint Commission. (2017). Comprehensive Accreditation Manual. (MS.06.01.11). Oakbrook Terrace, IL.
- American College of Surgeons. 2017

CROSS REFERENCES:

- Sierra View Medical Center Medical Staff Bylaws
- Physicians Privileges Manuals

ADDENDUM

General Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Abscess, Incision and Drainage			X
Appendectomy		X	
Biopsies:			
a. Breast	X		X
b. Liver (open would require RNFA assist)		X	X
c. Lymph Node	X	X	
** d. Muscle		X	
e. Scalene Node		X	
Bowel Resection		X	
Breast Augmentation, Bilateral		X	
Cholecystectomy; Operative Cholangiogram		X	
** Lap. Cholecystectomy; with or without CBDE	X	X	
** Lap. Cholecystectomy w/Operative Cholangiogram	X	X	
Colostomy		X	
Drainage of Subdiaphragmatic Abscess			X
Enterotomy with Exploration		X	
Empyema drainage; Closed and Open			X
Face Lift		X	
Finger or Toe Nails, Removal of			X
Fistulectomy			X
Foreign Body, Removal		X	X
Gastric Resection		X	
a. Gastrectomy, Total		X	
b. Hemigastrectomy, Subtotal or		X	
c. Vagotomy and Pyloroplasty		X	
Gastrostomy with Exploration		X	
** Gynecomastia, Exicision of	X	X	X
Hematoma, Evaculation of		X	X
Hemorrhoidectomy			X
** Herniorrhaphy, Laparoscopic	X	X	
Hernia Repair:			
a. Diaphragmatic		X	
b. Epigastric		X	
** c. Femoral	X	X	
d. Inguinal	X	X	
** e. Incisional	X	X	
** f. Umbilical	X	X	
** g. Ventral	X	X	

SUBJECT: **SURGICAL PRIVILEGES/APPROPRIATE ASSISTANTS TO THE SURGEON**	SECTION: **Page 4 of 9**

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

General Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
~~Hydrocelectomy~~		~~X~~	~~X~~
Intestinal Plication complete Noble type procedure		X	
Intra-abdominal Cysts or Tumors, Excision of		X	
Laparotomy		X	
** Lesion Removal with Skin Graft	X	X	X
Leukoplaka, Excision of Mouth		X	X
** Lymph Node Resection	X	X	
** Meckels Lesion, Excision of	X	X	
Mediastinal Surgery:			
a. Biopsies of Mediastinal Structures	X		X
b. Drainage of Mediastinal Abscesses			X
** c. Removal of Tumors and cysts	X	X	
d. Thymectomy		X	
Mesentary Lesion, Excision of		X	
~~Orchiectomy~~		~~X~~	~~X~~
Paracentesis with/without Medication instillation			X
Parathyroidectomy		X	
Parathyroidectomy with Mediastinal Exploration		X	
Parotidectomy		X	
Pilonidal Cystectomy			X
Plantar Wart, Excision of			X
Preauricular Cyst, Excision of			X
Pulmonary Resections:			
a. Biopsy Procedures		X	
b. Enucleations		X	X
c. Lobectomy		X	
d. Pneumonectomy		X	
e. Segmental Resections		X	
f. Wedge Resections		X	
Radical Resections:			
a. Axillary		X	
b. Cervical		X	
c. Inguinal		X	
d. Retroperitoneal		X	
e. supra-hyoid		X	
Rectal Polypectomy			X
Retroperitoneal Tumors and Cysts, Excision of		X	
Scar Revision			X
Subeceous Cyst, Extension of			X
Splenectomy		X	

SUBJECT: **SURGICAL PRIVILEGES/APPROPRIATE ASSISTANTS TO THE SURGEON**	SECTION: **Page 5 of 9**

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

General Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Submucous Resection			X
Thyroidectomy		X	
** Tacheostomy		X	
Trachestomy Wound, Surgical Closure of			X
** Tumor, Excision of Soft Tissue	X		X
** Vein Ligation and Stripping	X	X	

OB/GYN Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Anterior and Posterior Repair	X	X	
Abdominal Hysterectomy		X	
Bartholin Cystectomy			X
Bartholin Cyst -- Marsupialization			X
Cervical Cerclage			X
Cesarean Section		X	
Cervical Conization			X
Dilation and Curettage			X
Exp. Laparatomy; Ectopic or Ovarian Cyst		X	
Exam under Anesthesia			X
Fulgeration Vaginal, Perianal or Cervical Lesions			X
Hymenotomy			X
Hysteroscopy			X
Laparoscopy – Diagnostic (Sterilization)		X	X
Laser Ablation of Vaginal/Perineal/Cervical Lesions			X
Perinorrhaphy			X
Removal I.U.D.			X
Suction Curettage			X
Tubal Ligation		X	X
** Vaginal Hysterctomy	X	X	
** Vaginal Vulvar Lesions, Excision of	X		X

Urological Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Bladder Biopsy with Fulgeration			X
Circumcision			X
Cystogram – Retrograde Pyelogram			X
Cystoscopy			X
Cystoscopy with resection and/or fulgeration of small urethral or bladder tumors			X
Dorsal Slit			X
Fulgeartion Bladder Neck			X

SUBJECT: **SURGICAL PRIVILEGES/APPROPRIATE ASSISTANTS TO THE SURGEON**	SECTION: **Page 6 of 9**

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

Urological Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Hydrocelectomy		X	X
Lithotripsy			X
Meatotomy			X
Nephrectomy		X	
Open Prostatectomy		X	
Orchiectomy		X	X
Orchiopexy		X	X
Penile Implant			X
Prostrate Needle Biopsy			X
Retrograde Pyelogram			X
Scrotal Exploration		X	X
Transurethral Resection Bladder Neck			X
Transurethral Resection Bladder Tumors			X
Transurethral Resection Prostate			X
Ureteral Stone Manipulation			X
Ureterolithotomy			X
Urethral Dilation			X
Urethropexy			X
Urethoscopy			X
Varicocelectomy			X
Vasectomy			X
** Vasovasotomy			X

Orthopedic Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Amputation	X	X	
Arthroscopy	X		X
** Arthrotomy	X	X	
Bunionectomy			X
** Bone Graft	X	X	X
Carpal Tunnel Release			X
Cast Application			X
Closed Reduction of Fractures or Dislocations			X
Debridement, Irrigation, Closure Small Wound			X
Exostosis, Excision of (Toe, Finger)			X
Foreign Body, Removal of			X
Fusion of Joints		X	X
Ganglion, Excision of			X
Hammertoe Correction			X
Hand Surgery			X
** Hardware Removal	X	X	X

SUBJECT: **SURGICAL PRIVILEGES/APPROPRIATE ASSISTANTS TO THE SURGEON**	SECTION: **Page 7 of 9**

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

Orthopedic Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Hemiarthroplasty		X	
** Irrigation and Debridements	X	X	X
Ligament Reconstruction of Ankle/Knee Shoulder		X	
Manipulation of Joints			X
Neuroma, Excision of (Pheripheral)			X
** Open Reduction Internal Fixation of Fractures	X	X	
Osteotomy		X	X
Repair Nerves and Tendons		X	
** Rotator Cuff Repair	X	X	
Tendon Sheath, Release			X
Tenotomy (Hand or Foot)			X
Total Joints	X	X	
Trigger Finger Release			X

ENT Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Adenoidectomy			X
Antral Puncture			X
Arch Bars, Removal or Application of			X
Branchial Cleft Cyst, Excision of			X
Caldwell Luc			X
Closed Reduction (Nose or Zygoma)			X
Closed Reduction Fractured Maxilla or Mandible			X
** Facial Fractures	X	X	
Fracture Inferior Turbinates			X
Frenulectomy			X
Functional Sinus Endoscopy			X
Laryngoscopy – Panendoscopy			X
Ligation of Internal Maxillary Anterior Ethmoid Arteries			X
Lymphadenectomy			
a. Excision of Node		X	
b. Radical Resection		X	
Myringotomy			X
Nasal Polypectomy			X
Parotid of Submaxillary Stones, Excision			X
Reduction of Jaw Fracture			X
Radical Neck		X	
Rhinoplasty			X
Septal Reconstruction			X
Septoplasty			X
Stapedectomy			X

SUBJECT: **SURGICAL PRIVILEGES/APPROPRIATE ASSISTANTS TO THE SURGEON**	SECTION: **Page 8 of 9**

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

ENT Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Thyroglossal Duct Cyst or Sinus, Excision			X
Tonsillectomy and Adenoidectomy			X
Tracheotomy			X
Turbinectomy			X
Tympanoplasty and Mastiodectomy			X

Opthalmic Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Blepharoplasty			X
Cataract Extraction			X
Corneal Transplant			
Entropian Repair			X
Intropin Repair			X
Lacrimal Duct Probe			X
Ptergium Excision			X

Vascular Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Abdominal Aortic Aneurysm	X	X	
Angiograms			X
Aortic or Pulmonary Anastamosis		X	
Arterial Anastamosis			
a. Abdominal		X	
b. Grafts		X	
c. Peripheral		X	
d. Resections		X	
e. Thoracic		X	
Arterial Embolectomy		X	
Arterial Puncture or Cannulization			X
Axillo—Femoral Bypass Graft		X	
Carotid Endarterectomy		X	
Chest Tube Insertion			X
Embolectomy		X	
Femoral-Popliteal Bypass Graft		X	
Pacemaker Insertion			X
Pericardiectomy			X
Port-a-Cath Insertion			X
Rib Resection		X	
** Saphenous Vein, Ligation & Division of	X	X	
Thoracotomy		X	
Vena Cava, Plication or clipping of			X
Venous Anastamosis		X	

Vascular Surgical Procedures	EX. TECH	RNFA/PA	NO ASSIST
Venous Thrombectomy		X	

Endoscopic Procedures	EX. TECH	RNFA/PA	NO ASSIST
Bronchoscopy			X
Colonoscopy			X
Endoscopic Biopsies			X
Endoscopic Retrograde Cholangio-pancreatography			X
Esophageal Dilation			X
Esophago-gastroduodenoscopy			X
Gastrostomy Tube Insertion			X
Liver Biopsy			X
Polypectomy			X
Sclerotherapy			X
Sigmiodoscopy			X
Sphincterotomy			X
Upper G.I. Endoscopy			X

Dental/Oral Procedures	EX. TECH	RNFA/PA	NO ASSIST
Impacted Teeth, Removal of			X
Periodontal Procedures			X
Teeth Extractions			X

SUBJECT: **UNANNOUNCED REGULATORY SURVEYS**	SECTION: *Leadership (LD)* **Page 1 of 4**

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

PURPOSE:

- To define the steps to be taken when unannounced regulatory surveys occur.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to remain in regulatory compliance at all times. Unannounced surveys can affect schedules and organizational operations if not planned. The purpose of this policy is to define the organization's orderly and professional response to an unannounced regulatory survey.

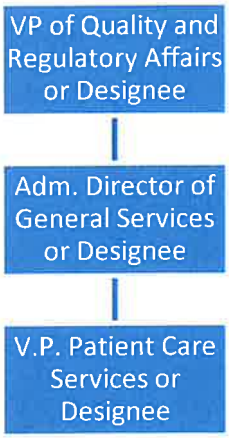
AFFECTED AREAS/PERSONNEL: *ALL*

PROCEDURE:

STAGE I – NOTIFICATION

1. The **Survey Coordinator** (VP of Quality and Regulatory Affairs), or designee, will check the **Joint Commission** website daily for important communications. Regulatory surveys occur every three years and can occur any time after the 18-month mid-point Periodic Performance Review (PPR) is submitted. Beginning in the 18-month window, the website will be checked daily by 0730 for official notification that a survey team has been deployed to SVMC and is due any time that day. The **Survey Coordinator, or designee,** will activate the notification of key Administrative and Leadership personnel.

2. In the event a survey team arrives on the premise prior to normal business hours and before official credentials can be verified from the Joint Commission website, the Nursing House Supervisor will have Security escort the Survey Team to the Board Room and activate the following call schedule:



3. Each of the above will be responsible for activating a call schedule of identified members of the Leadership Team and Elected Medical Staff Leaders responsible for identified survey activities.

STAGE II – SURVEY DOCUMENT GATHERING

1. The **Accreditation and Regulatory Coordinator** will be responsible for maintaining a complete set of up to date documents that could be requested by surveyors at the time of an unannounced survey. These manuals can be retrieved by any person designated to have access to the office. These documents are to be kept in physical copy (in binder) as well as in electronic thumb drive for ease of use by surveyors.

   These manuals are as follows (for CMS/CDPH/and TJC surveys):

   a. Licensure and Certifications

      - A copy of all hospital current licensure and certifications
      - Program flexes
      - Documents specified on the "survey entrance list of documents" provided by each specific regulatory/accreditation entity

   b. Bylaws

      - Board of Directors
      - Medical Staff

   c. Organization Structure

      - Organizational Chart
      - Medical Staff Chain of Command and Committee Structure

   d. Organizational Hard Copy of Policy and Procedures as requested or listed on the survey entrance lists

   e. Organizational Performance Improvement

      - Current Dashboards

- Current External Reports
- Most recent Patient Satisfaction Report
- Completed FMEAs

f. Current Census and Surgery Schedule as of 1630 the previous day

These manuals will be labeled and placed in a position that anyone designated can remove these manuals and proceed to the designated survey command center room while other data is gathered. These manuals will provide the survey team with enough **information** to begin planning the survey schedule. The following documents will be brought to the Board Room by the appropriate Director upon arrival:

Upon completion of their initial data review, the Survey Team will meet with the VP of Quality and Regulatory Affairs, or designee, and members of Senior Management and provide the organization with the planned survey schedule.

STAGE III – THE SURVEY

1. Upon receipt of the Survey Team's proposed schedule, the proposed survey schedule will be emailed to all Directors and Managers by the Administrative Assistant while the surveyors are escorted to their first survey location by designated escorts and scribes.

2. Dietary/Catering will be contacted and meals requested as appropriate by the Accreditation and Regulatory Coordinator

3. An overhead announcement will be delivered to hospital operator and shall be as follows for TJC surveys:

   "***Sierra View Medical Center is proud to welcome the Joint Commission on Healthcare Accreditation and the California Department of Health Services to our facility*** for our ***triennial inspection. Please welcome them as you see them in your areas."***

   This announcement will serve to alert hospital personnel throughout the facility that surveyors are present.

4. The designated escorts and scribe team will continue to coordinate schedules and escorts throughout the facility over the length of the survey and inform the survey Command Center of planned survey activity, findings, and requested documentation by the surveyors.

5. Directors and Managers will be expected to adjust their schedules over the survey period to be present from 0700 to 1630 to ensure the orderly operation of their departments and assistance to their staff during periods when surveyors may be present.

STAGE IV – THE EXIT CONFERENCE

The Survey Team will meet with members of Senior Management, Board of Directors, Medical Staff Leadership, Directors, and Managers, as designated, to discuss the outcome of the survey. Upon official receipt of survey findings, the Leadership Team will meet to discuss:

- Immediate Impact on Organization
- Press Releases
- Corrective Action Planning as needed

STAGE V – ONGOING SURVEY PREPAREDNESS

A summary of the issues identified will be completed by the VP of Quality and Regulatory Affairs during the unannounced survey, for discussion and implementation into ongoing preparedness for future unannounced survey activity.

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Last review date: **1/29/2022**

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Policy Name	Policy #	Last Revision	NOTES
Fee Handling and Collection	A157	Jan 2019	
History and Physical	A158	Jan 2022	
Program Support by Healogics' Home Office	A159	Jan 2022	
Training Support by Healogics	A160	Jan 2022	
Free Foot Screenings	A161	Jan 2012	
Consult Only Patients	A162	Jan 2021	
Clinical Policies and Procedures	A163	Jan 2022	
EHR Documentation Guidance	A164	Jan 2022	
Patient Progress Letter Delivery	A165	Jan 2021	
Wound Center Staff Functioning as Documentation Assistants	A166	Jan 2022	
Medical Transportation	A167	Jan 2022	
Temporary Clinic Closure or Relocation	A169	Jan 2020	
Telehealth Encounters	A170	Jan 2022	
Public Health Emergencies	A171	Jan 2020	
HCT/P and Medical Devices	B204	Jan 2021	
Discharge Process	B213	Jan 2022	
Referrals for Outside Services	B214	Jan 2022	
Prohibited Abbreviations	B215	Jan 2021	
Interpretative Services	B225	Jan 2021	
Medication Management	B227	Jan 2022	
New Patients	B230	Jan 2022	
Nurse Only Visits	B232	Jan 2021	
Pain Management	B234	Jan 2021	
Tests and Results	B256	Jan 2021	
Nursing Plan of Care	B257	Jan 2021	
Nursing Assessments/Reassessments	B262	Jan 2021	
Philosophy of Nursing	B263	Jan 2021	
Nursing Standards of Patient Care, Treatment and Services	B264	Jan 2021	
Medication List	B272	Jan 2022	
Patient Care Process	B275	Jan 2021	
Suicide Risk Assessment	B276	Jan 2022	
Accepted Indications for HBO Treatments	D401	Jan 2022	
Air Breaks	D402	Jan 2021	
Assessment and Treatment of HBO Patients	D403	Jan 2022	
Patient Education Prior to HBO	D404	Jan 2021	
Chamber Cleaning and Disinfecting	D405	Jan 2021	
Cylinder Safety, Storage and Procurement	D408	Jan 2022	
Daily, Weekly and Semi-Annual Chamber Checks	D409	Jan 2021	
Approved and Prohibited Materials/Devices	D415	Jan 2022	

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Policy Name	Policy #	Last Revi	NOTES
Materials Analysis	D416	Jan 2022	
Gastric Tube Management	D417	Jan 2021	
Non-Adherent HBO Patient	D418	Jan 2021	
Transcutaneous Oxygen ($PtcO_2$) Testing	D419	Jan 2022	
Transcutaneous Oxygen ($PtcO_2$) Testing in the HBO Chamber	D420	Jan 2021	
Pediatric and Adolescent Patients in HBO	D423	Jan 2021	
Staffing Guidelines for HBO Chambers	D424	Jan 2021	
Chamber Cleaning Solutions and Reagents	D426	Jan 2021	
Chamber Maintenance	D427	Jan 2021	
Glycemia Interventions Protocol	D428	Jan 2021	
Chamber Operator Qualifications	D429	Jan 2022	
Professional Supervision of Hyperbaric Therapy	D430	Jan 2022	
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Emergency Breathing Device	D432	Jan 2021	
Emergency Procedure Reference (Monoplace)	D433	Jan 2021	
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Weather Emergencies	E508	Jan 2021	
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Standard Precautions	**J011**	Jan 2022	
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FINANCIAL PACKAGE
April 2022

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
April 2022

Statistic	Apr-22 Actual	Apr-22 Budget	Apr-22 Over/ (Under)	Apr-22 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 21 YTD	Increase/ (Decrease) 04/2021	% Change
Utilization											
SNF Patient Days											
Total	81	61	20	32.8%	763	593	170	28.7%	906	(143)	-15.8%
Medi-Cal	81	61	20	32.8%	690	563	127	22.5%	863	(173)	-20.0%
Sub-Acute Patient Days											
Total	869	893	(24)	-2.7%	9,039	9,613	(574)	-6.0%	9,008	31	0.3%
Medi-Cal	614	705	(91)	-12.9%	5,986	7,609	(1,623)	-21.3%	7,321	(1,335)	-18.2%
Acute Patient Days	1,737	1,863	(126)	-6.8%	22,048	18,890	3,158	16.7%	18,400	3,648	19.8%
Acute Discharges	440	472	(32)	-6.8%	4,749	4,816	(67)	-1.4%	4,403	346	7.9%
Medicare	175	186	(11)	-6.2%	1,809	1,764	45	2.5%	1,607	202	12.6%
Medi-Cal	211	234	(23)	-9.9%	2,288	2,335	(47)	-2.0%	2,137	151	7.1%
Contract	51	45	6	12.2%	621	673	(52)	-7.8%	622	(1)	-0.2%
Other	3	6	(3)	-48.5%	31	44	(13)	-28.8%	37	(6)	-16.2%
Average Length of Stay	3.95	3.95	0.00	0.0%	4.64	3.92	0.72	18.4%	4.18	0.46	11.1%
Newborn Patient Days											
Medi-Cal	151	205	(54)	-26.4%	1,693	2,050	(357)	-17.4%	1,794	(101)	-5.6%
Other	45	40	5	13.5%	408	399	9	2.3%	444	(36)	-8.1%
Total	196	245	(49)	-19.9%	2,101	2,449	(348)	-14.2%	2,238	(137)	-6.1%
Total Deliveries	101	127	(26)	-20.5%	1,100	1,270	(170)	-13.4%	1,220	(120)	-9.8%
Medi-Cal %	82.83%	82.98%	-0.15%	-0.2%	81.69%	82.98%	-1.08%	-1.3%	80.02%	1.87%	2.3%
Case Mix Index											
Medicare	1.5075	1.6699	(0.1624)	-9.7%	1.6924	1.6699	0.0225	1.3%	1.7041	(0.0117)	-0.7%
Medi-Cal	1.0687	1.2297	(0.1610)	-13.1%	1.2447	1.2297	0.0150	1.2%	1.2616	(0.0169)	-1.3%
Overall	1.2454	1.4118	(0.1664)	-11.8%	1.4541	1.4118	0.0423	3.0%	1.4407	0.0134	0.9%
Ancillary Services											
Inpatient											
Surgery Minutes	9,376	9,172	204	2.2%	87,378	93,829	(6,451)	-6.9%	87,630	(252)	-0.3%
Surgery Cases	100	114	(14)	-12.3%	994	1,157	(163)	-14.1%	999	(5)	-0.5%
Imaging Procedures	1,321	1,260	61	4.8%	15,250	12,768	2,482	19.4%	11,890	3,360	28.3%
Outpatient											
Surgery Minutes	10,109	13,027	(2,918)	-22.4%	107,044	130,270	(23,226)	-17.8%	127,553	(20,509)	-16.1%
Surgery Cases	151	249	(98)	-39.4%	1,619	2,440	(821)	-33.6%	1,851	(232)	-12.5%
Endoscopy Procedures	212	222	(10)	-4.5%	1,687	2,220	(533)	-24.0%	1,146	541	47.2%
Imaging Procedures	4,145	3,147	998	31.7%	36,765	31,470	5,295	16.8%	31,691	5,074	16.0%
MRI Procedures	284	293	(9)	-3.1%	2,853	2,940	(87)	-3.0%	2,673	180	6.7%
CT Procedures	1,199	812	387	47.7%	10,263	8,126	2,137	26.3%	8,533	1,730	20.3%
Ultrasound Procedures	1,053	954	99	10.4%	9,377	9,090	287	3.2%	7,144	2,233	31.3%
Lab Tests	31,939	36,517	(4,578)	-12.5%	380,097	365,170	14,927	4.1%	362,902	17,195	4.7%
Dialysis	1	10	(9)	-90.0%	46	100	(54)	-54.0%	72	(26)	-36.1%

Sierra View Medical Center
Financial Statistics Summary Report
April 2022

	Apr-22				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 21 YTD	(Decrease) 04/2021	% Change
Cancer Treatment Center											
Chemo Treatments	1,585	1,685	(100)	-5.9%	17,931	16,848	1,084	6.4%	15,666	2,265	14.5%
Radiation Treatments	1,970	1,958	12	0.6%	16,237	19,583	(3,346)	-17.1%	16,753	(516)	-3.1%
Cardiac Cath Lab											
Cath Lab IP Procedures	12	6	6	100.0%	97	66	31	47.0%	83	14	16.9%
Cath Lab OP Procedures	29	35	(6)	-17.1%	242	350	(108)	-30.9%	326	(84)	-25.8%
Total Cardiac Cath Lab	41	41	-	0.0%	339	416	(77)	-18.5%	409	(70)	-17.1%
Outpatient Visits											
Emergency	3,233	2,885	348	12.1%	30,385	28,904	1,481	5.1%	24,567	5,818	23.7%
Total Outpatient	12,647	12,264	383	3.1%	123,533	122,996	537	0.4%	115,554	7,979	6.9%
Staffing											
Paid FTE's	894.60	918.19	(23.59)	-2.6%	912.83	918.19	(5.36)	-0.6%	880.68	32.15	3.7%
Productive FTE's	772.17	790.79	(18.62)	-2.4%	773.79	790.79	(17.00)	-2.1%	755.42	18.37	2.4%
Paid FTE's/AOB	5.28	5.49	(0.21)	-3.8%	5.16	5.44	(0.28)	-5.2%	5.43	(0.27)	-5.0%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	10,532	10,858	(326)	-3.0%	10,250	10,625	(375)	-3.5%	10,495	(244)	-2.3%
Cost/Adj.Patient Day	2,715	2,495	220	8.8%	2,599	2,443	156	6.4%	2,527	72	2.9%
Revenue/Adj. Discharge	52,196	53,490	(1,294)	-2.4%	59,365	52,606	6,759	12.8%	54,936	4,429	8.1%
Cost/Adj. Discharge	13,455	12,292	1,163	9.5%	15,052	12,096	2,956	24.4%	13,226	1,826	13.8%
Adj. Discharge	1,026	1,019	7	0.7%	9,293	10,364	(1,071)	-10.3%	9,423	(129)	-1.4%
Net Op. Gain/(Loss) %	-6.69%	-4.41%	-2.28%	51.8%	-7.20%	-4.41%	-2.79%	63.4%	-8.36%	1.17%	-13.9%
Net Op. Gain/(Loss) $	(865,404)	(528,558)	(336,846)	63.7%	(9,393,263)	(5,206,771)	(4,186,492)	80.4%	(9,619,732)	226,469	-2.4%
Gross Days in Accts Rec.	88.96	87.97	0.99	1.1%	88.96	87.97	0.99	1.1%	90.99	(2.03)	-2.2%
Net Days in Accts. Rec.	68.23	59.02	9.21	15.6%	68.23	59.02	9.21	15.6%	69.83	(1.60)	-2.3%

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

	APR 2022	MAR 2022
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 21,814,623	$ 22,666,118
SHORT-TERM INVESTMENTS	9,937,909	11,537,910
ASSETS LIMITED AS TO USE	1,809,638	1,806,079
PATIENT ACCOUNTS RECEIVABLE	159,446,941	156,460,214
LESS UNCOLLECTIBLES	(21,709,030)	(21,737,354)
CONTRACTUAL ALLOWANCES	(109,641,653)	(107,022,319)
OTHER RECEIVABLES	5,920,054	6,249,372
INVENTORIES	3,902,850	4,019,005
PREPAID EXPENSES AND DEPOSITS	2,354,184	2,608,977
TOTAL CURRENT ASSETS	73,835,516	76,588,002
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	33,046,991	32,577,387
LONG-TERM INVESTMENTS	135,784,635	135,645,506
PROPERTY, PLANT AND EQUIPMENT, NET	91,622,448	92,217,125
INTANGIBLE RIGHT OF USE ASSETS	529,394	441,028
OTHER ASSETS:		
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	2,056,002	2,076,982
TOTAL ASSETS	$ 337,124,986	$ 339,796,030

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

	APR 2022	MAR 2022
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 634,983	$ 476,238
CURRENT MATURITIES OF BONDS PAYABLE	3,715,000	3,715,000
CURRENT MATURITIES OF LONG TERM DEBT	1,164,509	1,164,509
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	6,334,938	6,270,861
ACCRUED PAYROLL AND RELATED COSTS	8,340,988	9,537,458
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,853,074	3,853,074
LEASE LIABILITY - CURRENT	262,276	249,021
TOTAL CURRENT LIABILITIES	24,305,768	25,266,159
SELF-INSURANCE RESERVES	1,048,759	1,086,381
CAPITAL LEASE LIAB LT	3,129,592	3,211,266
BONDS PAYABLE, LESS CURR REQT	45,445,000	45,445,000
BOND PREMIUM LIABILITY - LT	4,325,729	4,396,707
LEASE LIABILITY - LT	267,118	192,007
OTHER NON CURRENT LIABILITIES	563,781	563,781
TOTAL LIABILITIES	79,085,745	80,161,300
UNRESTRICTED FUND	263,162,280	263,162,280
PROFIT OR (LOSS)	(5,123,040)	(3,527,550)
TOTAL LIABILITIES AND FUND BALANCE	$ 337,124,986	$ 339,796,030

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

APR 2022 ACTUAL	APR 2022 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
4,791,130	5,203,429	412,299	(8)%	INPATIENT - NURSING	57,213,250	51,506,082	(5,707,168)	11%
18,292,376	20,043,857	1,751,481	(9)%	INPATIENT - ANCILLARY	217,066,907	201,842,966	(15,223,941)	8%
23,083,506	25,247,286	2,163,780	(9)%	TOTAL INPATIENT REVENUE	274,280,157	253,349,048	(20,931,109)	8%
30,467,578	29,253,961	(1,213,617)	4%	OUTPATIENT - ANCILLARY	277,413,195	291,873,316	14,460,121	(5)%
53,551,084	54,501,247	950,163	(2)%	TOTAL PATIENT REVENUE	551,693,353	545,222,364	(6,470,989)	1%
				DEDUCTIONS FROM REVENUE				
(16,947,487)	(19,133,224)	(2,185,737)	(11)%	MEDICARE	(179,378,232)	(191,332,240)	(11,954,008)	(6)%
(17,624,163)	(14,943,830)	2,680,333	18%	MEDI-CAL	(173,006,492)	(149,438,300)	23,568,192	16%
(6,840,473)	(8,318,072)	(1,477,599)	(18)%	OTHER/CHARITY	(69,142,791)	(83,180,720)	(14,037,929)	(17)%
17,233	(26,506)	(43,739)	(165)%	DISCOUNTS & ALLOWANCES	(86,145)	(265,060)	(178,915)	(68)%
(95,395)	(592,179)	(496,784)	(84)%	BAD DEBTS	(4,148,145)	(5,921,790)	(1,773,645)	(30)%
(41,490,286)	(43,013,811)	(1,523,525)	(4)%	TOTAL DEDUCTIONS	(425,761,805)	(430,138,110)	(4,376,305)	(1)%
12,060,798	11,487,436	(573,362)	5%	NET SERVICE REVENUE	125,931,548	115,084,254	(10,847,294)	9%
877,782	507,894	(369,888)	73%	OTHER OPERATING REVENUE	4,560,137	5,078,938	518,801	(10)%
12,938,580	11,995,330	(943,250)	8%	TOTAL OPERATING REVENUE	130,491,685	120,163,192	(10,328,493)	9%
				***** OPERATING EXPENSE *****				
4,935,336	5,014,192	(78,857)	(2)%	SALARIES	47,250,869	49,834,806	(2,583,937)	(5)%
920,773	606,162	314,611	52%	S&W PTO	6,536,702	6,033,452	503,250	8%
1,507,371	1,347,947	159,424	12%	EMPLOYEE BENEFITS	12,986,649	13,372,410	(385,761)	(3)%
2,127,880	1,226,507	901,373	74%	PROFESSIONAL FEES	27,016,905	12,268,322	14,748,583	120%
762,661	698,732	63,929	9%	PURCHASED SERVICES	7,555,616	7,043,202	512,414	7%
1,961,892	1,948,068	13,824	1%	SUPPLIES & EXPENSES	20,316,865	19,549,540	767,325	4%
164,503	194,276	(29,774)	(15)%	MAINTENANCE & REPAIRS	2,145,914	1,995,679	150,235	8%
186,155	163,719	22,436	14%	UTILITIES	2,070,358	1,637,190	433,168	27%
53,646	62,769	(9,123)	(15)%	RENT/LEASE	808,414	627,702	180,712	29%
20,060	97,200	(77,140)	(79)%	INSURANCE	936,272	972,000	(35,729)	(4)%
843,212	855,396	(12,184)	(1)%	DEPRECIATION/AMORTIZATION	8,594,860	8,895,637	(300,777)	(3)%
320,496	308,920	11,576	4%	OTHER EXPENSE	3,665,525	3,140,023	525,502	17%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
13,803,984	12,523,888	1,280,096	10%	TOTAL OPERATING EXPENSE	139,884,949	125,369,963	14,514,986	12%
(865,404)	(528,558)	336,846	64%	NET GAIN/(LOSS) FROM OPERATIONS	(9,393,263)	(5,206,771)	4,186,492	80%
110,972	110,973	1	0%	DISTRICT TAXES	1,109,720	1,109,723	3	0%
165,911	137,499	(28,412)	21%	INVESTMENTS INCOME	1,571,317	1,375,001	(196,316)	14%
722,969	171,269	(551,700)	322%	OTHER NON OPERATING INCOME	12,348,000	1,712,689	(10,635,311)	621%
(92,073)	(92,348)	(275)	0%	INTEREST EXPENSE	(924,914)	(923,488)	1,426	0%
(92,998)	(56,870)	36,128	64%	NON-OPERATING EXPENSE	(569,527)	(568,686)	841	0%
814,780	270,523	(544,257)	201%	TOTAL NON-OPERATING INCOME	13,534,596	2,705,239	(10,829,357)	400%
(50,624)	(258,035)	(207,411)	(80)%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	4,141,332	(2,501,532)	(6,642,864)	(266)%
(1,544,866)	0	1,544,866		NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	(9,264,372)	0	9,264,372	
(1,595,490)	(258,035)	1,337,455	518%	NET GAIN/(LOSS)	(5,123,040)	(2,501,532)	2,621,508	105%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
04/30/22

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(865,404)	(9,393,263)
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation and amortization	843,212	8,594,860
Provision for bad debts	(28,324)	(5,379,509)
Changes in assets and liabilities:		
Patient accounts receivable	(367,393)	1,854,803
Other receivables	329,318	797,541
Inventories	116,155	(203,079)
Prepaid expenses and deposits	254,793	(678,332)
Advance refunding of bonds payable	20,980	209,796
Accounts payable and accrued expenses	64,079	(1,792,121)
Accrued payroll and related liabilities	(1,196,470)	1,007,487
Estimated third-party payor settlements	-	(1,016,749)
Self-insured program reserves	(37,622)	(434,094)
Total adjustments	(1,272)	2,960,603
Net cash provided by (used in) operating activities	(866,676)	(6,432,660)
Cash flows from noncapital financing activities:		
District tax revenues	110,972	1,109,720
Noncapital grants and contributions, net of other expenses	629,954	11,777,879
Net cash provided by (used in) noncapital financing activities	740,926	12,887,599
Cash flows from capital and related financing activities:		
Purchase of capital assets, net of disposals	(248,535)	(4,488,816)
Intangible right of use assets	(88,366)	(529,394)
Principal payments on debt borrowings	-	(3,770,000)
Interest payments	(4,290)	(2,035,518)
Net change in notes payable and lease liability	6,692	(283,590)
Net changes in assets limited as to use	(473,163)	5,867,011
Net cash provided by (used in) capital and related financing activities	(807,662)	(5,240,307)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(1,683,995)	3,308,454
Interest and dividends received from investments	165,911	1,571,317
Net cash provided by (used in) investing activities	(1,518,084)	4,879,771
Net increase (decrease) in cash and cash equivalents:	(2,451,496)	6,094,403
Cash and cash equivalents at beginning of month/year	34,204,028	25,658,129
Cash and cash equivalents at end of month	31,752,532	31,752,532

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
April 2022

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
May-21	9,135,876	4,460,223	13,596,099
Jun-21	11,341,330	6,918,000	18,259,330
Jul-21	8,753,563	5,989,305	14,742,868
Aug-21	11,472,363	601,204	12,073,567
Sep-21	12,759,611	1,650,547	14,410,158
Oct-21	10,376,691	1,244,630	11,621,321
Nov-21	10,974,393	1,575,199	12,549,592
Dec-21	13,662,211	6,342,016	20,004,227
Jan-22	9,101,598	3,002,395	12,103,993
Feb-22	9,223,160	1,873,199	11,096,359
Mar-22	11,160,102	6,179,876	17,339,978
Apr-22	**10,302,842**	**5,121,377**	**15,424,219**

NOTE:

Cash receipts in "Other Activity" include the following:

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

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

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

April 2022 Summary of Other Activity:

1,410,113	Anthem BC IGT QIP 07/20 - 12/20
1,463,963	Health Net IGT QIP 07/20 - 12/20
100,538	Beta Healthcare Group Dividend 2nd Installment
43,643	Tulare County First 5 2nd Qtr 10/21 - 12/21
575,636	M-Cal IP DSH FY22 02/22 - 03/22
802,493	M-Cal OP DSH AB915 FY21
267,200	GME-Direct Medical Education 07/21 - 03/22
213,000	GME-OPPS (Part B) 07/21 - 03/22
244,791	Miscellaneous
5,121,377	04/22 Total Other Activity

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1. POLICY STATEMENT

Sierra View Local Health Care District ("District") is a California Health Care District formed by resolution of the Tulare County Board of Supervisors. The District was created pursuant to the California Health and Safety Code §32000 to address health care needs in the southeast portion of Tulare County. It is governed by an elected five-member board of directors.
All funds of the District shall be invested in accordance with principles of sound treasury management and in accordance with the provisions of the California Government Code §53600 et seq., (the Municipal Code), which sets forth the investment parameters for local agencies (including districts) in California, and guidelines established by the California Municipal Treasurer's Association, and this Investment Policy ("Policy").

2. INVESTMENT POLICY OBJECTIVES

A. Overall Risk Profile

The objectives of the District's Investment Program are, in order of priority:

1. Safety of principal of invested funds;
2. Maintenance of Sufficient Liquidity to Meet Cash Flow Needs; and
3. Attainment of the Maximum Yield Possible Consistent With the First Two Objectives.

To achieve these objectives, The District shall consider the following when making an investment:

1. Safety of Principal of Invested Funds

The District shall mitigate the risk to the principal of invested funds by limiting credit and interest rate risks. Credit Risk is the risk of loss due to the failure of a security's issuer or backer. Interest Rate Risk is the risk that the market value of the District's portfolio will fall due to an increase in general interest rates.

a) Credit risk will be mitigated by:

(i) Limiting investments to only the most creditworthy types of securities defined as "investment grade" by a Nationally Recognized Statistical Rating Organization (NRSRO) including (a). Standard and Poor's Rating Service, (b). Moody's Investors Service and (c). Fitch Ratings.

(ii) By pre-qualifying the financial institutions with which it will do business; and

(iii) By diversifying the investment portfolio so that the potential failure of any one issue or issuer will not place an undue financial burden on the District.

b) Interest rate risk will be mitigated by:

(i) Structuring the District's portfolio so that securities mature to meet the District's cash requirements for ongoing obligations, thereby avoiding the possible need to sell securities on the open market at a loss prior to their maturity to meet those requirements; and

(ii) Investing primarily in shorter term securities.

2. Liquidity

The District's investment portfolio shall be structured in a manner which emphasizes that securities mature at the same time the cash is needed to meet anticipated demands (Static Liquidity). Additionally, since all possible cash demands cannot be anticipated, the portfolio should consist of securities with active secondary markets (Dynamic Liquidity). The maximum percentage of different investment instruments and maturities is described in Appendix A of this Policy.

3. Yield

Yield on the District's investment portfolio is of secondary importance compared to the safety and liquidity objectives described above. Investments are limited to relatively low risk securities in anticipation of earning a fair return relative to the risk being assumed. While it may occasionally be necessary or strategically prudent for the District to sell a security prior to maturity to either meet unanticipated cash needs or to restructure the portfolio, this policy specifically prohibits trading securities for the sole purpose of speculating on the future direction of interest rates.

B. Basic Investment Strategy

The District shall pursue a "passive" strategy of investment under which investments shall be of "laddered" maturities, facilitating a "buy and hold" process where financial instruments are held until maturity rather than actively bought and sold at various times. An "active" strategy of market timing, sector rotation, indexing to a benchmark and similar strategies are considered inappropriate for the size of the District's portfolio. It is understood that it may be appropriate to sell a particular security prior to maturity to meet unanticipated cash needs. Any such transaction will be reported to the Board of Directors at its next regularly scheduled meeting.

The District's investment portfolio shall be structured to provide that sufficient funds from investments are available each month to meet the District's anticipated cash needs. Subject to the objectives stated above, the choice in investment instruments and maturities shall be based upon an

analysis of future anticipated cash needs, existing and anticipated revenues, interest rate trends and specific market opportunities. No investment may have a maturity of more than five (5) years from its date of purchase without receiving prior Board of Directors approval. After approval by the Board, reserve funds associated with bond issues may have a maturity of more than five (5) years, up to the earliest date the bonds may be redeemed or mature.

3. INVESTMENTS

This section of the Investment Policy identifies the types of investments in which the District will invest its idle or surplus funds.

A. Standard of Prudence

The District operates its investment portfolio under the Prudent Investor Standard (California Government Code §53600.3) which states, in essence, that "when investing, reinvesting, purchasing, acquiring, exchanging, selling or managing public funds, a trustee shall act with care, skill, prudence and diligence under the circumstances then prevailing, including, but not limited to, the general economic conditions and the anticipated needs of the District, that a prudent person in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the District".

This standard shall be applied in the context of managing the overall portfolio. Investment officers, acting in accordance with written procedures and this investment policy and exercising the above standard of diligence shall be relieved of personal responsibility for an individual security's credit risk or market price changes, provided deviations from expectations are reported in a timely fashion and appropriate action is taken to control adverse developments.

B. Allowable Investments

Investment of District funds is governed by California Government Code §53600 et seq. See Appendix A for a listing of Allowable Investments.

The District may choose to restrict its permitted investments to a smaller list of securities that more closely fits the District's cash flow needs and requirements for liquidity. If a type of investment is added to California Government Code §53600, it will not be added to the District's listing of Allowable Investments until this policy is amended and approved by the Board of Directors. If a type of investment permitted by the District should be removed from California Government Code §53600, it will be deemed concurrently removed from the District's listing of Allowable Investments, but existing holdings may be held until they mature.

A thorough investigation of any pool or fund is required prior to investing and on a continual basis. The investigation will, at a minimum, obtain the following information:

- A description of eligible investment securities, and a written statement of investment policies and objectives.
- A description of interest calculations and how it is distributed, and how gains and losses are distributed.
- A description of how securities are safeguarded (including the settlement process) and how often the securities are marked to market and how often an audit is conducted.
- A description of who may invest in the program, how often, what size deposits and withdrawals are permitted.
- A schedule for receiving statements and portfolio listings.
- Does the pool/fund maintain a reserve or retain earnings or is all income after expenses distributed to participants?
- A fee schedule which also discloses when and how fees are assessed.
- Is the pool or fund eligible for bond proceeds and/or will it accept such proceeds?

The purpose of this investigation is to determine the suitability of a pool or fund and evaluate the risk of placing funds with that pool or fund.

The District will generally avoid "Brokered CD's" pools in which brokers arrange for deposits (usually $250,000 each to obtain federal deposit insurance). Such brokered CD's are frequently issued by failing or marginal institutions whose safety is derived almost exclusively by the existence of federal insurance rather than by the strength of the issuing institution.

One of the purposes of this Investment Policy is to define what investments are permitted. If a type of security is not specifically authorized by this policy, it is not a permitted investment.

C. Qualification of Brokers, Dealers and Financial Institutions

The District's Chief Financial Officer (CFO) or designee will (1) establish and maintain a list of the financial institutions and broker/dealers authorized to provide investment and depository services to the District, (2) perform an annual review of the financial condition and registrations of the qualified bidders, and (3) require annual audited financial statements to be on file for each approved company. The District shall annually send a copy of its current Investment Policy to all financial institutions and broker/dealers approved to do business with the District. Receipt of the Policy and Enabling Resolution, including confirmation that it has been received and reviewed by the person(s) handling the District's account, shall be acknowledged in writing within thirty (30) days.

All broker-dealers and financial institutions that desire to become qualified bidders for investment transactions must submit a "Broker-Dealer Application" and related documents relative to eligibility. This includes a current audited financial statement, proof of state registration, proof of NASD registration and a certification they have received and reviewed the District's Investment Policy and agree to comply with the provisions outlined in the Investment Policy. The District's CFO or designee may establish any additional criteria deemed appropriate to evaluate and approve any financial services provider. The selection process for broker- dealers shall be open to both "primary dealers" and "secondary/regional dealers" that qualify under Securities and Exchange Commission Rule 15c3-1 (Uniform Net Capital Rule). The provider must have an office in California and the provider's representative must be experienced in institutional trading practices and familiar with the California Government Code as it relates to investments by a Special District. The current form of the Broker Dealer Questionnaire appears as Appendix B of this policy.

D. Collateralization Requirements

Uninsured Time Deposits with banks and savings and loans shall be collateralized in the manner prescribed by state law for depositories accepting municipal investment funds.

E. Diversification

The District will diversify its investments by security type and investment. The District's CFO or designee will adopt a strategy that combines current market conditions with the District's cash needs to maintain the maximum degree of safety of principal and liquidity throughout market and budgetary cycles. This strategy will include diversification by investment type and maturity allocations and will be included in the regular quarterly reports to the Board. This strategy will be reviewed quarterly and can be changed accordingly.

F. Confirmations

Receipts for confirmation of purchases or sales of authorized securities shall include at a minimum the following information: trade date, settlement date, description of the security, par value, interest rate, price, yield to maturity, District's name, net amount due and third party custodial information.

4. SAFEKEEPING OF SECURITIES

The District shall contract with a bank or banks for the safekeeping of securities that are owned by the District as a part of its investment portfolio.

All securities owned by the District shall be held in safekeeping by a third party bank trust department acting as agent for the District under the terms of a custody agreement executed by the

bank and the District. All securities will be received and delivered using standard delivery versus payment (DVP) procedures. The third party bank trustee agreement must comply with Section 53608, which states, in essence, the legislative body of a local agency may deposit its securities for safekeeping with a bank, of the California Government Code. No outside broker/dealer or advisor may have access to District funds, accounts or investments and any transfer of funds must be approved by the District's Chief Executive Officer or Chief Financial Officer.

The District's current custodian for General Fund investments is Fidelity Investments.

Certificates of Deposit purchased directly from local financial institutions may be maintained by the District in a safe deposit box at a local financial institution.

5. STRUCTURE AND RESPONSIBILITIES

This section of the policy defines the overall structure and areas of responsibility within the investment management program.

A. Responsibilities of the District's CFO

The District's CFO is charged with responsibility for maintaining custody of all public funds and securities belonging to or under the control of the District, and for the deposit and investment of those funds in accordance with principles of sound treasury management, applicable laws, ordinances and this Investment Policy. This includes establishing written procedures for the operation of the investment program consistent with this policy. The procedures should include reference to safekeeping, master repurchase agreements, wire transfer agreements, banking services contracts and depository agreements. Such procedures shall also include explicit delegation of authority to persons responsible for investment transactions. No person may engage in an investment transaction except as provided under the terms of this policy and the procedures established by the Board of Directors.

The Board has made a delegation of authority to the Chief Executive Officer and Chief Financial Officer, as set forth in Appendix D.

The current delegation of authority will be provided to all approved financial institutions. They will be notified of any changes to this delegation in a timely fashion and acknowledge receipt.

B. Responsibilities of the Chief Executive Officer and Chief Financial Officer

The Chief Executive Officer and Chief Financial Officer are responsible for keeping the Board of Directors fully advised as to the financial condition of the District.

C. Responsibilities of the Board of Directors

The Board shall consider and adopt a written Investment Policy. As provided in that policy, the Board shall receive, review and accept quarterly investment reports.

D. Ethics and Conflicts of Interest

All District officers and employees involved in the investment process shall refrain from personal business activity that could conflict with the proper execution of the investment program, or that could impair their ability to make impartial investment decisions. Those employees and investment officials shall disclose in their Annual Statement of Economic Interests (Form 700) any material financial interests in financial institutions that conduct business within the District, and they shall further disclose any large personal financial/investment positions that could be related to the performance of the District's investments.

The District has adopted a Conflict of Interest Code applicable to all elected officials and designated positions as set forth in the District's Conflict of Interest Code (Compliance With The Political Reform Act of 1974) policy.

6. REPORTING

The District's CFO shall prepare a quarterly investment report, including a succinct management summary that provides a clear picture of the status of the current investment portfolio and transactions made. This management summary shall be prepared in a manner that will allow the Chief Executive Officer and the Board to ascertain whether investment activities during the reporting period have complied with the District's Investment Policy.

The quarterly report shall include the following:

- A list of individual securities held at the end of the reporting period.
- Unrealized gains or losses resulting from amortization or accretion of principal versus market value changes by listing the cost and market value of securities owned by the District.
- Expected yield for the next 12 month period
- Maturity schedule by type, of each of the District's investments.
- Statement of compliance of the District's Investment Policy with California Government Code §536000 et seq.
- Statement as to ability to meet all scheduled expenditure requirements for the next six months.
- Market value, book value, par value and cost basis of all investments.

7. PERFORMANCE STANDARDS

The investment portfolio will be managed in accordance with the standards established within this Investment Policy and should obtain a market rate of return throughout budgetary and economic cycles. The Finance Committee will establish and periodically review the District's portfolio benchmarks and performance. A benchmark will be selected that compares with the portfolio composition, structure and investment strategy at that time.

8. REVIEW OF INVESTMENT POLICY

A. Policy Review

This Investment Policy shall be reviewed annually by the Board in accordance with State law to ensure its consistency with respect to the overall objectives of safety, liquidity and yield. Proposed amendments to the policy shall be prepared by the Chief Financial Officer and forwarded to the Board for its consideration and adoption in a public meeting.

B. Internal Control and Review

The external auditors shall annually review the investments and general activities associated with the investment program to ensure compliance with this Investment Policy. This review will provide internal control by assuring compliance with policies and procedures established by this Investment Policy.

9. DEFINITIONS

The District has adopted its definitions of terms as published by the California Debt and Investment Advisory Commission in its updated *Local Agency Investment Guidelines.* Definitions are included as Appendix E of this policy.

10. ADOPTION OF POLICY

This Policy was duly adopted by the Board of Directors of the Sierra View Local Health Care District on the 24th day of May, 2022

APPENDIX A ALLOWABLE INVESTMENTS

ALLOWABLE INVESTMENT INSTRUMENTS PER STATE GOVERNMENT CODE (AS OF JANUARY 1, 2021) A APPLICABLE TO ALL LOCAL AGENCIES

***Local Agency Investment Guidelines*, Update for 2021, by California Debt and Investment Advisory Commission. Reflects state law changes effective as of January 1, 2021.**

Figure 1

INVESTMENT TYPE	MAXIMUM MATURITY[C]	MAXIMUM SPECIFIED % OF PORTFOLIO[D]	MINIMUM QUALITY REQUIREMENTS	GOV'T CODE SECTIONS
Local Agency Bonds	5 years	None	None	53601(a)
U.S. Treasury Obligations	5 years	None	None	53601(b)
State Obligations—CA And Others	5 years	None	None	53601(c) 53601(d)
CA Local Agency Obligations	5 years	None	None	53601(e)
U.S Agency Obligations	5 years	None	None	53601(f)
Bankers' Acceptances	180 days	40% [E]	None	53601(g)
Commercial Paper—Non-Pooled Funds[F] (under $100,000,000 of investments)	270 days or less	25% of the agency's money[G]	Highest letter and number rating by an NRSRO[H]	53601(h)(2)(c)
Commercial Paper—Non-	270 days or less	40% of the agency's	Highest letter and	53601(h)(2)(c)

Pooled Funds (min. $100,000,000 of investments)		**money[G]**	**number rating by an NRSRO[H]**	
Commercial Paper— Pooled Funds[I]	**270 days or less**	**40% of the agency's money[G]**	**Highest letter and number rating by an NRSRO[H]**	**53635(a)(1)**
Negotiable Certificates of Deposit	**5 years**	**30%[J]**	**None**	**53601(i)**
Non-negotiable Certificates of Deposit	**5 years**	**None**	**None**	**53630 et seq.**
Placement Service Deposits	**5 years**	**50%[K]**	**None**	**53601.8 and 53635.8**
Placement Service Certificates of Deposit	**5 years**	**50%K**	**None**	**53601.8 and 53635.8**
Repurchase Agreements	**1 year**	**None**	**None**	**53601(j)**
Reverse Repurchase Agreements and Securities Lending Agreements	**92 days[L]**	**20% of the base value of the portfolio**	**None[M]**	**53601(j)**
Medium-Term Notes[N] *	**5 years or less**	**30%[G]**	**"A" rating category or its equivalent or better**	**53601(k)**
Mutual Funds And Money Market Mutual	**N/A**	**20%[O]**	**Multiple[P,Q]**	**53601(l) and 53601.6(b)**

Funds**				
Collateralized Bank Deposits[R]	**5 years**	**None**	**None**	**53630 et seq. and 53601(n)**
Mortgage Pass–Through and Asset–Backed Securities	**5 years or less**	**20%**	**"AA" rating category or its equivalent or better**	**53601(o)**
County Pooled Investment Funds	**N/A**	**None**	**None**	**27133**
Joint Powers Authority Pool	**N/A**	**None**	**Multiple[S]**	**53601(p)**
Local Agency Investment Fund (LAIF)	**N/A**	**None**	**None**	**16429.1**
Voluntary Investment Program Fund[T]	**N/A**	**None**	**None**	**16340**
Supranational Obligations[U]	**5 years or less**	**30%**	**"AA" rating category or its equivalent or better**	**53601(q)**
Public Bank Obligations	**5 years**	**None**	**None**	**53601(r), 53635(c) and 57603**

Table of Notes for Figure 1

A *Sources: Sections 16340, 16429.1, 27133, 53601, 53601.6, 53601.8, 53630 et seq., 53635, 53635.8, and 57603.*

B *Municipal Utilities Districts have the authority under the Public Utilities Code Section 12871 to invest in certain securities not addressed here.*

C *Section 53601 provides that the maximum term of any investment authorized under this section, unless otherwise stated, is five years. However, the legislative body may grant express authority to make investments either specifically or as a part of an investment program approved by the legislative body that exceeds this five year remaining maturity limit. Such approval must be issued no less than three months prior to the purchase of any security exceeding the five-year maturity limit.*

D *Percentages apply to all portfolio investments regardless of source of funds. For instance, cash from a reverse repurchase agreement would be subject to the restrictions.*

E *No more than 30 percent of the agency's money may be in bankers' acceptances of any one commercial bank.*

F *Includes agencies defined as a city, a district, or other local agency that do not pool money in deposits or investment with other local agencies, other than local agencies that have the same governing body.*

G *Local agencies, other than counties or a city and county, may purchase no more than 10 percent of the outstanding commercial paper and medium-term notes of any single issuer.*

H *Issuing corporation must be organized and operating within the U.S., have assets in excess of $500 million, and debt other than commercial paper must be in a rating category of "A" or its equivalent or higher by a nationally recognized statistical rating organization, or the issuing corporation must be organized within the U.S. as a special purpose corporation, trust, or LLC, have program wide credit enhancements, and have commercial paper that is rated "A-1" or higher, or the equivalent, by a nationally recognized statistical rating agency.*

I *Includes agencies defined as a county, a city and county, or other local agency that pools money in deposits or investments with other local agencies, including local agencies that have the same governing body. Local agencies that pool exclusively with other local agencies that have the same governing body must adhere to the limits set forth in Section 53601(h)(2)(C).*

J *No more than 30 percent of the agency's money may be in negotiable certificates of deposit that are authorized under Section 53601(i).*

K *Effective January 1, 2020, no more than 50 percent of the agency's money may be invested in deposits, including certificates of deposit, through a placement service as authorized under 53601.8 (excludes negotiable certificates of deposit authorized under Section 53601(i)). On January 1, 2026, the maximum percentage of the portfolio reverts back to 30 percent. Investments made pursuant to 53635.8 remain subject to a maximum of 30 percent of the portfolio.*

L *Reverse repurchase agreements or securities lending agreements may exceed the 92-day term*

if the agreement includes a written codicil guaranteeing a minimum earning or spread for the entire period between the sale of a security using a reverse repurchase agreement or securities lending agreement and the final maturity dates of the same security.

M ***Reverse repurchase agreements must be made with primary dealers of the Federal Reserve Bank of New York or with a nationally or state chartered bank that has a significant relationship with the local agency. The local agency must have held the securities used for the agreements for at least 30 days.***

N ***"Medium-term notes" are defined in Section 53601 as "all corporate and depository institution debt securities with a maximum remaining maturity of five years or less, issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States."***

O ***No more than 10 percent invested in any one mutual fund. This limitation does not apply to money market mutual funds.***

P ***A mutual fund must receive the highest ranking by not less than two nationally recognized rating agencies or the fund must retain an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of $500 million, and has at least five years' experience investing in instruments authorized by Sections 53601 and 53635.***

Q ***A money market mutual fund must receive the highest ranking by not less than two nationally recognized statistical rating organizations or retain an investment advisor registered with the SEC or exempt from registration and who has not less than five years' experience investing in money market instruments with assets under management in excess of $500 million.***

R ***Investments in notes, bonds, or other obligations under Section 53601(n) require that collateral be placed into the custody of a trust company or the trust department of a bank that is not affiliated with the issuer of the secured obligation, among other specific collateral requirements.***

S ***A joint powers authority pool must retain an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of $500 million, and has at least five years' experience investing in instruments authorized by Section 53601, subdivisions (a) to (o).***

T ***Local entities can deposit between $200 million and $10 billion into the Voluntary Investment Program Fund, upon approval by their governing bodies. Deposits in the fund will be invested in the Pooled Money Investment Account.***

U ***Only those obligations issued or unconditionally guaranteed by the International Bank for Reconstruction and Development (IBRD), International Finance Corporation (IFC), and Inter-American Development Bank (IADB), with a maximum remaining maturity of five years or less.***

**** Limit of 10% of total investment assets in the medium-term notes of any single issuer.***

***** Maximum 10% in any single fund.***

APPENDIX B
SIERRA VIEW LOCAL HEALTH CARE DISTRICT BROKER/DEALER QUESTIONNAIRE

1. **Name of Firm:** ___
2. **Address:** _____
3. **Telephone:** _____
4. **Principal(s)/Manager(s)/Partner(s):**

   Name:____ **Title:** _

   Name:____ **Title:** _

5. **Is your firm:**

   Broker? Yes □ No □ (a firm that does not own the securities being offered) Dealer? Yes □ No □ (a firm that owns a position in the securities being offered)

6. **Year founded:** ___
7. **Firm's total volume of U.S. government securities traded in most recent fiscal year:**

   $ _____

8. **Financial instruments most regularly offered:** _____

   _____

   _____

9. **References: (Public sector clients in the local geographical area are preferred):**

   Name:_____

   Title:_____ Telephone:_____

   Address:_____

   Name:_____

   Title:_____ Telephone:_____

   Address:_____

   Name:_____

   Title:_____ Telephone: _____

Address: _____

10. **Local office and representative assigned to the Sierra View Local Health Care District account**: Address: _____
Name:_____Title: _____

11. **Has any client sustained a loss on a securities transaction arising from a misunderstanding or misrepresentation of the risk characteristic of the financial instrument?**

Yes □ No □

If yes, please explain: _____

_____

12. **Has your firm, its employees, or local office been the subject of a state or federal investigation for alleged unfair, illegal, or fraudulent activities?**

Yes □ No □

If yes, please explain: _____

_____

13. **Please explain your usual custody or delivery process. Who audits these fiduciary systems?**

_____

_____

_____

14. **Describe the capital line and trading limits imposed on the office that would service the account and conduct business with the Sierra View Local Health Care District.**

_____

_____

15. **Please enclose recent financial statements and/or other indications of your firm's capitalization.**

16. **Please describe the limits of insurance (Securities Investor Protection Corporation, excess SIPC, etc.) available:**

_____

_____

_____

17. **Please provide proof of National Association of Securities Dealers (NASD) certification.**

18. **Please provide proof of registration with the State of California.**

19. **Please provide proof that your firm is qualified under SEC Rule 15c3-1 (Uniform Net Capital Rule).**

20. **What information do you require of the Sierra View Local Health Care District?**

_____

_____

21. **What transaction documents can the Sierra View Local Health Care District expect to receive from you?**

_____

_____

22. **Please confirm that your representatives have read and understand the Sierra View Local Health Care District Investment Policy and that they are familiar with Government Code §53600 et seq.**

Attach resumes of all persons receiving a copy of our investment policy:

Name:_____ **Title:** _____

Name:_____ **Title:** _____

Name:_____ **Title:** _____

APPENDIX C

Annual Broker Certification for (year) _____

I hereby certify that the preceding is true and correct to the best of my knowledge and that I am authorized to execute this request for information on behalf of the broker/dealer Firm. I further agree to notify the Sierra View Local Health Care District (the District) immediately in the event of a material adverse change in the Firm's financial condition.

The Firm has in place reasonable procedures and a system of controls designed to preclude imprudent investment activities arising out of transactions conducted between the Firm and the District.

All individuals assigned to the District's account have read the District's Investment Policy for the current fiscal year, understand the objectives and constraints set forth by the Policy, agree to disclose potential conflicts or risks to public funds that might arise out of business transactions between the Firm and the District, and will incorporate due diligence in conforming to the provisions of the Policy as well as all applicable state and federal regulations as they apply to the investment activities of California special districts.

The Firm shall be provided annually the District's Investment Policy and shall be informed of any changes to the policy. The undersigned certify that no securities will be sold to the District which are in violation of State Code or the District's Investment Policy; however, the District shall be responsible for ensuring compliance with percentage limits established by State Code and the District's Investment Policy.

The Firm and the broker are in receipt of the District's Investment Policy for (Year)_____.

Firm Name:_____ Signature: _____

Broker assigned to City:_____ Date: _____

Name of Principal:_____ Manager Title: _____

Signature:_____ Date: _____

APPENDIX D
DELEGATION OF AUTHORITY

The following named individuals are hereby designated authority to act as authorized agents of the Sierra View Local Health Care District including the purchase and sale of public funds and securities:

Donna J. Hefner, President/Chief Executive Officer
Douglas S. Dickson, Chief Financial Officer/Treasurer

This designation shall remain valid until May 31, 2023 or until rescinded or superseded.

Executed this 24th day of May, 2022

_____

Kent Sorrells

Secretary, Sierra View Local Health Care District Board of Directors

APPENDIX E
GLOSSARY

A

ACCRUED INTEREST

Coupon interest accumulated on a bond or note since the last interest payment or, for a new issue, from the dated date to the date of delivery.

ASSET ALLOCATION

The division of an investment portfolio among different asset categories, such as stocks, bonds, and cash.

ASSET-BACKED SECURITIES

Securities that are supported by pools of assets, such as installment loans or leases, or by pools of revolving lines of credits. Asset-backed securities are structured as trusts in order to perfect a security interest in the underlying assets.

B

BANK DEPOSITS

Deposits in banks or other depository institutions that may be in the form of demand accounts (checking) or investments in accounts that have a fixed term and negotiated rate of interest.

BANKERS' ACCEPTANCE

A draft or bill or exchange accepted by a bank or trust company. The accepting institution, as well as the issuer, guarantees payment of the bill.

BASIS POINTS

Refers to the yield on bonds. Each percentage point of yield in bonds equals 100 basis points (1/100% or 0.01%). If a bond yield changes from 7.25% to 7.39% that is a rate of 14 basis points.

BENCHMARK

A passive index used to compare the performance, relative to risk and return, of an investor's portfolio.

BONDS

A debt obligation of a firm or public entity. A bond represents the agreement to repay the debt in principal and, typically, interest on the principal.

BOOK VALUE

The value at which an asset is carried on a balance sheet.

BROKER

A person or firm that acts as an intermediary by purchasing and selling securities for others rather than for its own account.

BUY AND HOLD STRATEGY

A strategy based on holding all securities until maturity, regardless of fluctuations in the market.

C

CALL OPTION

The terms of the bond contract giving the issuer the right to redeem or call an outstanding issue of bonds prior to its stated date of maturity.

CALL RISK

The risk to a bondholder that the bond issuer will exercise a callable bond feature and redeem the issue prior to maturity.

CALLABLE SECURITIES

An investment security that contains an option allowing the issuer to retire the security prior to its final maturity date.

CASH FLOW

A comparison of cash receipts (revenues) to required payments (debt service, operating expenses, etc.).

CERTIFICATE OF DEPOSIT

A short-term, secured deposit in a financial institution that usually returns principal and interest to the lender at the end of the loan period. Certificates of Deposit (CDs) differ in terms of collateralization and marketability. Those appropriate to public agency investing include:

Negotiable Certificates of Deposit

Generally, short-term debt instrument that usually pays interest and is issued by a bank, savings or federal association, state or federal credit union, or state-licensed branch of a foreign bank. The majority of negotiable CDs mature within six months while the average maturity is two weeks. Negotiable CDs are traded in a secondary market and are payable upon order to the bearer or initial

depositor (investor). Negotiable CDs are insured by FDIC up to $250,000, but they are not collateralized beyond that amount.

Non-Negotiable Certificates of Deposit

CDs that carry a penalty if redeemed prior to maturity. A secondary market does exist for non-negotiable CDs, but redemption includes a transaction cost that reduces returns to the investor. Non-negotiable CDs issued by banks and savings and loans are insured by the Federal Deposit Insurance Corporation up to the amount of $250,000, including principal and interest. Amounts deposited above this amount may be secured with other forms of collateral through an agreement between the investor and the issuer. Collateral may include other securities including Treasuries or agency securities such as those issued by the Federal National Mortgage Association.

COLLATERALIZATION OF DEPOSITS

Process by which a bank or financial institution pledges securities, or other deposits for the purpose of securing the repayment of deposited funds.

COMMERCIAL PAPER

An unsecured short-term promissory note issued by corporations or municipalities, with maturities ranging from 2 to 270 days.

COUNTY POOLED INVESTMENT FUNDS

The aggregate of all funds from public agencies placed in the custody of the county treasurer or chief finance officer for investment and reinvestment.

COUPON

The annual rate of interest that a bond's issuer promises to pay the bondholder on the bond's face value; a certificate attached to a bond evidencing interest due on a payment date.

CREDIT RATING

The three most commonly used nationally recognized statistical rating organizations (NRSROs) are Standard & Poor's, Fitch Ratings, and Moody's.

Moody's		S&P		Fitch		Rating description	
Long-term	Short-term	Long-term	Short-term	Long-term	Short-term		
Aaa	P-1	AAA	A-1+	AAA	F1+	Prime	Investment-grade
Aa1		AA+		AA+		High grade	
Aa2		AA		AA			
Aa3		AA–		AA–			
A1		A+	A-1	A+	F1	Upper medium grade	
A2		A		A			
A3	P-2	A–	A-2	A–	F2		
Baa1		BBB+		BBB+		Lower medium grade	
Baa2	P-3	BBB	A-3	BBB	F3		
Baa3		BBB–		BBB–			
Ba1	Not prime	BB+	B	BB+	B	Non-investment grade speculative	Non-investment grade aka high-yield bonds aka junk bonds
Ba2		BB		BB			
Ba3		BB–		BB–			
B1		B+		B+		Highly speculative	
B2		B		B			
B3		B–		B–			
Caa1		CCC+	C	CCC	C	Substantial risks	
Caa2		CCC				Extremely speculative	
Caa3		CCC–				Default imminent with little prospect for recovery	
Ca		CC					
		C					
C		D	/	DDD	/	In default	
/				DD			
				D			

Source: benzinga.com

CREDIT RISK

The chance that an issuer will be unable to make scheduled payments of interest and principal on an outstanding obligation. Another concern for investors is that the market's perception of an issuer/borrower's credit will cause the market value of a security to fall, even if default is not expected.

CUSIP NUMBER

The Committee on Uniform Security Information Procedures (CUSIP) Number refers to a security's identification number assigned to each publicly traded security by the CUSIP Service Bureau operated

by Standard & Poor's for the American Bankers Association. The CUSIP Number is a nine-character identifier unique to the issuer, the specific issue and the maturity, if applicable (the first six characters identifying the issuer, the next two identifying the security and the last digit providing a check digit to validate the accuracy of the preceding CUSIP number).

CUSTODIAN

A bank or other financial institution that keeps custody of stock certificates and other assets.

D

DEALER

Someone who acts as a principal in all transactions, including underwriting, buying, and selling securities, including from his/her own account.

DEFAULT RISK

The risk that issuers/borrowers will be unable to make the required payments on their debt obligations.

DELIVERY VS. PAYMENT (DVP)

The payment of cash for securities as they are delivered and accepted for settlement.

DERIVATIVE

Securities that are based on, or derived from, some underlying asset, reference date, or index.

DISCOUNT

Discount means the difference between the par value of a security and the cost of the security, when the cost is below par. Investors purchase securities at a discount when return to the investor (yield) is higher than the stated coupon (interest rate) on the investment.

DIVERSIFICATION

The allocation of different types of assets in a portfolio to mitigate risks and improve overall portfolio performance.

F

FIDUCIARY

An individual who holds something in trust for another and bears liability for its safekeeping.

FLOATING RATE SECURITY

A security that has a variable or "floating" interest rate.

G

GOVERNMENT ACCOUNTING STANDARDS BOARD (GASB)

A standard-setting body, associated with the Financial Accounting Foundation, which prescribes standard accounting practices for governmental units.

GUARANTEED INVESTMENT CONTRACT (GIC)

An agreement acknowledging receipt of funds for deposit, specifying terms for withdrawal, and guaranteeing a rate of interest to be paid.

I

INTEREST RATE RISK

Interest rate risk is the risk that an investment's value will change due to a change in the absolute level of interest rates, spread between two rates, shape of the yield curve, or any other interest rate relationship.

INSTITUTIONAL ACCOUNT

As defined by the Financial Industry Regulatory Authority (FINRA), an institutional account includes one of the following: (1) a bank, savings and loan association, insurance company or registered investment company; (2) an investment adviser registered either with the SEC under Section 203 of the Investment Advisers Act or with a state securities commission (or any agency or office performing like functions); or (3) any other person (whether a natural person, corporation, partnership, trust or otherwise) with total assets of at least $50 million.

L

LIQUIDITY

The measure of the ability to convert an instrument to cash on a given date at full face or par value.

LIQUIDITY RISK

The risk that a security, sold prior to maturity, will be sold at a loss of value. For a local agency, the liquidity risk of an individual investment may not be as critical as how the overall liquidity of the portfolio allows the agency to meet its cash needs.

LOCAL AGENCY INVESTMENT FUND (LAIF)

A voluntary investment fund open to government entities and certain non-profit organizations in California that is managed by the State Treasurer's Office.

M

MARKET RISK

The chance that the value of a security will decline as interest rates rise. In general, as interest rates fall, prices of fixed income securities rise. Similarly, as interest rates rise, prices fall. Market risk also is referred to as systematic risk or risk that affects all securities within an asset class similarly.

MARKET VALUE

The price at which a security is trading and presumably could be purchased or sold at a particular point in time.

MATURITY

The date on which the principal or stated value of an investment becomes due and payable.

MEDIUM-TERM NOTE

Corporate or depository institution debt securities meeting certain minimum quality standards (as specified in the California Government Code) with a remaining maturity of five years or less.

MONEY MARKET MUTUAL FUNDS

MMF's are mutual funds that invest exclusively in short-term money market instruments. MMF's seek the preservation of capital as a primary goal while maintaining a high degree of liquidity and providing income representative of the market for short-term investments.

MORTGAGE BACKED SECURITIES

Mortgage-backed securities (MBS) are created when a mortgagee or a purchaser of residential real estate mortgages creates a pool of mortgages and markets undivided interests or participations in the pool. MBS owners receive a prorata share of the interest and principal cash flows (net of fees) that are "passed through" from the pool of mortgages. MBS are complex securities whose cash flow is determined by the characteristics of the mortgages that are pooled together. Investors in MBS face prepayment risk associated with the option of the underlying mortgagors to pre-pay or payoff their mortgage. Most MBS are issued and/or guaranteed by federal agencies and instrumentalities (e.g., Government National Mortgage Association (GNMA), Federal National Mortgage Association (FNMA), and Federal Home Loan Mortgage Corporation (FHLMC)).

MORTGAGE PASS-THROUGH OBLIGATIONS

Securities that are created when residential mortgages (or other mortgages) are pooled together and undivided interests or participations in the stream of revenues associated with the mortgages are sold.

MUNICIPAL NOTES, BONDS, AND OTHER OBLIGATIONS

Obligations issued by state and local governments to finance capital and operating expenses.

N

NET ASSET VALUE

Net asset value (NAV) is a term used in the mutual fund industry to determine the average price per share of a pool or mutual fund. How this measure varies over time provides information on whether the pool is stable or variable. NAV is the market value of all securities in a mutual fund, less the value of the fund's liabilities, divided by the number of shares in the fund outstanding. Shares of mutual funds are purchased at the fund's offered NAV.

NEW ISSUE

Securities sold during the initial distribution of an issue in a primary offering by the underwriter or underwriting syndicate.

NOTE

A written promise to pay a specified amount to a certain entity on demand or on a specified date. Usually bearing a short-term maturity of a year or less (though longer maturities are issued— see "Medium-Term Note").

P

PAR AMOUNT OR PAR VALUE

The principal amount of a note or bond which must be paid at maturity. Par, also referred to as the "face amount" of a security, is the principal value stated on the face of the security. A par bond is one sold at a price of 100 percent of its principal amount.

PORTFOLIO

Combined holding of more than one stock, bond, commodity, real estate investment, cash equivalent, or other asset. The purpose of a portfolio is to reduce risk by diversification.

PREMIUM

Premium means the difference between the par value of a security and the cost of the security, when the cost is above par. Investors pay a premium to purchase a security when the return to the investor (yield) is lower than the stated coupon (interest rate) on the investment.

PRINCIPAL

The face value or par value of a debt instrument, or the amount of capital invested in a given security.

PRUDENT INVESTOR STANDARD

A standard of conduct where a person acts with care, skill, prudence, and diligence when investing, re-investing, purchasing, acquiring, exchanging, selling, and managing funds. The test of whether the standard is being met is if a prudent person acting in such a situation would engage in similar conduct to ensure that investments safeguard principal and maintain liquidity.

R

REINVESTMENT RISK

The risk that interest rates may be lower than the yield on a fixed income security when the investor seeks to reinvest interest income or repaid principal from the security.

REPURCHASE AGREEMENTS

An agreement of one party (for example, a financial institution) to sell securities to a second party (such as a local agency) and simultaneous agreement by the first party to repurchase the securities at a specified price from the second party on demand or at a specified date.

REVERSE REPURCHASE AGREEMENTS

An agreement of one party (for example, a financial institution) to purchase securities at a specified price from a second party (such as a public agency) and a simultaneous agreement by the first party to resell the securities at a specified price to the second party on demand or at a specified date.

RISK

The uncertainty of maintaining the principal or interest associated with an investment due to a variety of factors.

S

SAFEKEEPING SERVICE

Offers storage and protection of assets provided by an institution serving as an agent.

SAFETY In the context of investing public funds, safety relates to preserving the principal of an investment in an investment portfolio; local agencies address the concerns of safety by controlling exposure to risks.

SECURITIES AND EXCHANGE COMMISSION (SEC)

The federal agency responsible for supervising and regulating the securities industry.

SUPRANATIONAL INSTITUTIONS

International institutions formed by two or more governments that transcend boundaries to pursue mutually beneficial economic or social goals. There are three supranational institutions that issue obligations that are eligible investments for California local agencies: the International Bank for Reconstruction and Development (IBRD), International Finance Corporation (IFC), and Inter-American Development Bank (IADB).

T

TRUSTEE, TRUST COMPANY OR TRUST DEPARTMENT OF A BANK

A financial institution with powers to act in a fiduciary capacity for the benefit of the bondholders in enforcing the terms of the bond contract.

U

U.S. TREASURY OBLIGATIONS

Debt obligations of the U.S. Government sold by the Treasury Department in the forms of bills, notes, and bonds. Bills are short-term obligations that mature in one year or less and are sold at a discount. Notes are obligations that mature between one year and ten years. Bonds are long-term obligations that generally mature in ten years or more.

Y

YIELD

The current rate of return on an investment security generally expressed as a percentage of the securities current price.

YIELD CURVE

A graphic representation that shows the relationship at a given point in time between yields and maturity for bonds that are identical in every way except maturity.

YIELD-TO-CALL

The rate of return to the investor earned from payments of principal and interest, with interest compounded semi-annually at the stated yield when the security is redeemed on a specified call date. In addition, if the security is redeemed at a premium call price, the amount of the premium is also reflected in the yield.

YIELD-TO-MATURITY

The rate of return to the investor earned from payments of principal and interest, with interest compounded semi-annually at the stated yield as long as the security remains outstanding until the maturity date.

YIELD-TO-WORST

For a given dollar price on a municipal security, the lowest of the yield calculated to the pricing call, par option or maturity.

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SIERRA VIEW MEDICAL CENTER – MEDICAL STAFF
PROPOSED REVISIONS TO THE MEDICAL STAFF BYLAWS
MAY 24, 2022

The below four (4) revisions to the Medical Staff Bylaws were recommended by the Bylaws Committee and approved by the Medical Executive Committee on April 6, 2022. Notification was made to the voting members of the Medical Staff on April 7, 2022. The final ballots were received on May 9, 2022. Ballots returned included the required 75% quorum of voting members with 100% of those ballots approving all four (4) revisions.

1. **ARTICLE II MEMBERSHIP, SECTION 2.2-2 BASIC QUALIFICATIONS a) 1)**
(Lines underscored are additions)
After January 1, 2014, an initial applicant for physician membership on the Medical Staff, except for retired or Honorary Staff, must hold an MD or DO degree and must have completed a residency training program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association and hold a valid and unsuspended license to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners. The completion of a residency training program is waived for Emergency Medicine Residents working in the Emergency Room. The Medical Executive Committee may make an exception for completion of an accredited residency training program for current medical school faculty that are trained outside the United States with completion of a one-year US accredited fellowship in their specialty of practice.

2. **ARTICLE II MEMBERSHIP, SECTION 2.4 NONDISCRIMINATION**
(Lines underscored are additions and line through are deletions)
No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, ~~creed~~, color, religion, ancestry, national origin, disability, ~~or~~ physical or mental impairment, marital status, sexual orientation, or registered domestic partner status, if after reasonable accommodation, the applicant complies with the medical staff bylaws, rules and regulations, and policies and procedures and other policies and procedures jointly adopted by the medical staff and board of directors, e.g., to ensure orderly hospital operations.

3. **ARTICLE IX CLINICAL DEPARTMENTS AND DIVISIONS, SECTION 9.6-2 SELECTION** (Lines underscored are additions)
Department chairs and vice-chairs shall be elected every two (2) years by those members of the department who are eligible to vote for general officers of the medical staff. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt. If there is a vacancy for the chairman and the unexpired term is less than one year, the vice chairman shall assume the chairman role, without need for a special election. Department Chairperson shall not concurrently serve as officer of the medical staff.

SIERRA VIEW MEDICAL CENTER – MEDICAL STAFF
PROPOSED REVISIONS TO THE MEDICAL STAFF BYLAWS
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4. **ARTICLE X COMMITTEES, SECTION 10.5-3 JOINT CONFERENCE COMMITTEE MEETINGS** (Lines underscored are additions and line through are deletions)

The Joint Conference Committee ~~shall~~ may meet, ~~at least quarterly~~ annually or as needed, and shall transmit written reports of its activities to the Medical Executive Committee and to the Board of Directors.