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

AGENDA
November 25, 2025

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

1. **General Update;**
2. **Report on Peer Review/Credentials**

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

1. **Quality Division Report**
2. **Compliance Report for Quarter 1**

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): **Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning**. Estimated date of disclosure December 1, 2026.

D. Pursuant To Gov. Code Section 54956.9(D)(2), **Conference With Legal Counsel** About Recent Work Product (B)(1) And (B)(3)(F): Significant Exposure To Litigation; Privileged Communication (1 Items).

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

A. Chief of Staff Report:

1. **General Report**
   Recommended Action: Information only; no action taken

2. **Report on Peer Review/Credentials**
   Recommended Action: Approve/Disapprove Report on Peer Review and Credentials as Given

B. Quality Division Update

Recommended Action: Approve/Disapprove Report as Given

1. **Quality Division Report**
   Recommended Action: Approve/Disapprove Quality Division Report as Given

2. Compliance Quarter 1 Report
Recommended Action: Approve/Disapprove Report as Given

C. Discussion Regarding Trade Secrets Pertaining to Services and General Strategic Planning
Recommended Action: Information Only; No Action Taken

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

II. Public Comments

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

III. Consent Agenda

Recommended Action: Approve/Disapprove Consent Agenda as presented

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

IV. Approval of Minutes

A. October 28, 2025, Minutes of the Regular Meeting of the Board of Directors

Recommended Action: Approve/Disapprove October 28, 2025, Minutes of the Regular Meeting of the Board of Directors

V. Business Items

A. October 2025 Financials
Recommended Action: Approve/Disapprove October Financial Report as Presented

B. Annual Nursing Report
Recommended Action: Approve/Disapprove Annual Nursing Report

VI. SVLHCD Board Chair Report

VII. SVMC CEO Report

VIII. Announcements:

Regular Board of Directors Meeting – December 16, 2025, at 5:00 p.m.

IX. Adjournment

PUBLIC NOTICE

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

PUBLIC NOTICE ABOUT COPIES

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

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

HOSPITAL POLICIES AND REPORTS FOR REVIEW
APPROVED BY SENIOR LEADERSHIP TEAM

SUBJECT:	SECTION:
CODE ORANGE - INTERNAL HAZARDOUS MATERIALS SPILL	***Hazardous Materials & Waste Mgt*** **Page 1 of 3**

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

PURPOSE:

To ensure that departmental personnel are prepared to properly respond to hazardous materials (HAZMAT) incidents in a safe manner that occurs within the buildings or on the grounds of District properties.

POLICY:

In all HAZMAT situations, the primary responsibility of all personnel is to keep themselves, patients, and visitors safe from further exposure/contamination.

A list of all hazardous materials will be available through the Safety Data Sheet (SDS) Online data base. It is the responsibility of the Director of Environmental Services to update and maintain the SDS data base which is available online in the hospital intranet.

Department personnel will receive initial and annual orientation regarding the use of the SDS data base, evacuation procedures and alerting the identified Emergency Response Personnel.

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

EQUIPMENT:

“Spill Kit Cart" containing the following items will be readily available in Engineering Department:

- Absorbents
- Nitrile Gloves
- Plastic Bags and Containers
- Surgical Masks
- Impervious Shoe Covers
- Isolation Gowns
- Wet-Vac
- Goggles
- Head Covers

Note: The “Spill Kit Cart” will be checked every 6 months by the Engineering Department to ensure that all required materials are present and in usable condition.

In the care of a spill, the SDS for that item will be quickly obtained by personnel from the affected department and/or Engineering.

Point of use spill kits have been placed throughout the facility in identified locations to perform minor HAZMAT spill containment and clean up. Extreme caution should be used in all HAZMAT spills to protect all persons from hazardous material exposure.

PROCEDURE:

MAJOR SPILL – HANDLING OF

A major spill is defined when any of the following conditions are present:

- The condition ***required the immediate evacuation*** of all personnel from the affected area or building;
- The spill involves quantities ***greater than 2.0 liters of material;***
- The contents of the spilled material is ***unknown;***
- The spilled material is ***highly toxic, bio-hazardous, radioactive or flammable.***

When a major hazardous material spill occurs, the following "**Code Orange**" process must be followed:

1. Immediately evacuate all individuals from the affected area and close all doors.

2. Contact the Hospital Operator by dialing "55" and make notification of the "Code Orange" and the specific location of the spill (e.g. "Code Orange to the Lab").

3. The operator will announce the "Code Orange" by overhead page and via two-way radio.

4. Security, EVS and Engineering will respond to the location of the spill to evaluate the extent of the spill and to attempt to identify the material.

5. Personnel initiating the "Code Orange" shall stand by the area of the spill at a safe distance to direct the Responders to the affected area. Advise Responders of the quantity and any special hazards, e.g. flammability, corrosiveness or toxic fumes, including the type of material, if known.

6. Upon initial evaluation of the spill, a determination will be made if emergency services (local Fire Department) response will be necessary to assist with the spill containment and cleanup. The House Supervisor, Administrator on Call or the Safety Officer will have the authority to make the "911" notification and inform emergency services of the HAZMAT incident. For significant releases or threatened releases of hazardous materials, the following notifications must also be made. **The County of Tulare Department of Health and Human Services Environmental Health & Safety at 1-559-733-6441 and the Governor's Office of Emergency Services at 1-800-852-7550**.

7. The responders and/or Emergency Services will attempt to identify the material if not known and proceed to contain and clean up the hazardous material by use of SDS and/or manufacturer's recommendations only after it is determined safe to do so. All hazardous material shall be placed in a safe, sealed container for proper disposal. Do not use respiratory protective equipment unless you are trained in its safe use.

8. The affected area may be re-entered by department staff only after the spill has been eliminated and the "All-Clear" has been announced by overhead page from the House Supervisor, Administrator on Call, Safety Officer or Emergency Responders.

MINOR SPILLS – HANDLING OF

A minor spill involves hazardous materials that do not meet the criteria listed under Major Spill shown above. A minor spill can be easily cleaned up by department personnel without the assistance of

HAZMAT responders by use of a point of use spill kit. A relatively small area is involved, thereby only a relatively small number of personnel may need to evacuate the area until the spill is cleaned up.

1. Obtain point of use Spill Kit and don PPE provided in the spill kit. Put absorbent from the Spill Kit on the material if the material spilled is in liquid form (and if this can be safely accomplished). Place the absorbed material and all exposed tools including used PPE in the spill kit container and seal with the lid provided.

2. Call the Engineering Department for needed assistance and to remove the absorbed material for safe storage and proper disposal.

3. Environmental Services staff will be contacted to perform additional cleanup to the area if needed.

4. Additional information or assistance on *minor spill cleanup* may be obtained from the Safety Officer or the Director of Environmental Services.

5. After all clean up and removal of hazardous materials has been accomplished, the area may return to normal operations.

REFERENCES:

- Safety Data Sheet (SDS) – SDS Online
- The Joint Commission (2025). Hospital accreditation standards. EC.02.02.01 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **DEMOTION OF POSITION TO NEW POSITION**	SECTION: ***Human Resources*** **Page 1 of 1**

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

POLICY:

Sierra View Medical Center (SVMC) may at times need to reassign an employee to a position with lesser responsibilities, authority and overall impact on the organization as measured by their performance or business needs of the hospital. The employee's compensation will be adjusted to reflect work being performed if demoted to another position.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

Demotion means the reassignment of an employee from their current position to a new position with lesser duties, responsibilities, and authority. The employee will then move to a position with a lower pay grade assignment whether the personnel action is for performance or non-performance reasons related to the business needs of the hospital.

Compensation will be reduced by the amount necessary to maintain the same relationship to the minimum of the new salary range.

If the employee returns to his or her previous job assignment, the salary should not be reduced to an amount lower than the employee's original salary in that job.

The annual review date changes upon demotion. The new review date will be the effective date of the demotion. The employee's performance in the new position will be reviewed at ninety (90) days and then again at his or her next new annual review date.

Downgrade means the assignment of an employee to a lower pay grade based on reduced responsibilities or the restructuring of job duties in lieu of a new position.

The employee's salary shall be reviewed with the Human Resources department to set the appropriate salary in the new pay range.

REFERENCES:

- Equal Employment Opportunity Commission. Usa.gov (n.d.). Retrieved from https://www.usa.gov/federalagencies/equal-employment.

- DFEH | Department of Fair Employment & Housing (n.d.). Retrieved from https://www.dfeh.ca.gov.

CROSS REFERENCES:

- SALARY GRADES AND RANGES
- PERFORMANCE ACCOUNTABILITY AND COMMITMENT

SUBJECT: **JOB POSTING**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide a consistent and equal employment opportunities ~~-~~process for employees applying for advancement and career opportunities within Sierra View Medical Center (SVMC).

POLICY:

SVMC supports the retention strategy of growing employees and allowing them to gain career growth opportunities while being employed. The job posting system provides employees with a process to apply for advancement and career opportunities which also supports the practice of promotions from within and ensures employees of equal opportunity practices.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

Current qualified employees will be considered for posted positions before external candidates are actively recruited.

Department ~~Directors~~ Leadership are responsible for assessing staffing levels following each vacancy and determining if the job description should be modified based on business and departmental needs. If the position should be posted, a ~~-~~request for a job posting is initiated with an approved electronic Position Control Request.

Generally, all job openings are posted internally except where departmental staffing realignment and consolidation may otherwise intervene.

Job postings can be viewed online at ~~jobs.sierra-view.com.~~ https://www.sierra-view.com/careers/

Open positions are posted for a minimum of five days. Current employees should apply for posted positions using their UKG portal by clicking "My Company" and the selecting "View Opportunities" ~~on-line using the "Current Employees" link found on SVMC's website.~~ Employees on a Leave of Absence and unable to apply with their UKG employee portal must apply using the external website and need to notify the HR Recruiter of their external application.

To be eligible to transfer:

a. The employee should have been employed in his or her position for at least 6 months.

b. Employees who have been issued corrective actions at the documented written warning level within six months of the date of an interview are required to share the content and expectations with the hiring manager prior to receiving a job offer. This information may be a deciding factor in the hiring decision. Failure to disclose any corrective action prior to accepting an offer of transfer may also result in additional discipline, up to and including denial of the transfer and/or the termination of employment.

c. Employees with a final written warning are not eligible to apply for a transfer within six months of the date of issue of the final written warning. However, employees who are on a Final Written NOCA may apply for a posted position only if the position is the same as their current role, within the same department, and is only a status change. The position must be open and within the department's approved staffing budget. Eligibility to apply does not guarantee selection or approval for the transfer; selection is subject to the department's standard hiring process.

d. Prior to interview, the hiring ~~Director/Manger~~Leadership is encouraged to review the candidate's employee file and to have informal discussion with the candidates current ~~Director/Manager~~Leadership regarding the candidate's performance, skills, and abilities relevant to the position for which they are applying.

Human Resources will receive and forward application information for eligible employees to the hiring Unit/Department ~~Director~~ Leadership for their consideration and action. ~~As a courtesy, the employee's *current* Director will be informed that the employee has submitted a transfer request for consideration. The employee is given first opportunity to disclose their interest in the position. Otherwise, Human Resources will notify them during the recruitment process.~~

As a professional courtesy, Employees are encouraged to discuss a potential transfer with their current supervisor. If an offer is accepted by an employee, HR will notify the employee's supervisor that the employee has accepted another offer. HR in collaboration with the current supervisor will determine an appropriate timeline for the transfer to occur and 2-3 weeks is customary.

For key positions on a case-by-case basis, HR will notify a current supervisor if the employee has requested to transfer to another position and has applied via the SVMC job board.

Locum, travelers, agency and temporary staff may apply and be hired to help fill the vacancy during the open posting period.

REFERENCES:

- The Joint Commission (2018). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- STAFF RECRUITMENT, EMPLOYMENT, AND RETENTION
- PERFORMANCE ACCOUNTABILITY AND COMMITMENT

SUBJECT: **WORKPLACE VIOLENCE PREVENTION PLAN**	SECTION: ***Security Management*** **Page 1 of 15**

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

PURPOSE:

Violence is occurring all throughout the world and over time has filtered into the workplace. Overall, violent assaults remain fairly rare, although healthcare workers may be at higher risk for attacks compared to other professions. With this in mind, Sierra View Medical Center (SVMC) is committed to providing a work environment that is safe, and every effort is made to reduce or eliminate threats or acts of workplace violence.

In late 2016, the Cal/OSHA Standards Board adopted SB 1299, a new health care workplace violence prevention regulation. The first phase of the regulation went into effect on April 1, 2017 related to reporting requirements and recordkeeping, followed by the final phase that became fully effective April 1, 2018. The Workplace Violence Prevention Plan, assessments of the workplace, hazards identified, corrective measures put into place, and staff training was implemented by the 2018 due date.

The Workplace Violence Prevention Plan (WVPP) is part of the organization's Injury and Illness Prevention Plan (IIPP). The WVPP is in effect at all times in every unit (including Outpatient areas), services and operations.

Key Elements of the WVPP include:

1. Identifying management positions with the responsibility for administering the WVPP
2. Coordination with other employers of employees (contractors, registries, vendors) regularly working at SVMC
3. Identifying and evaluating safety and security risks
4. Investigating acts of violence/violent incidents
5. Hazards corrections/mitigations
6. Communication plan with employees and others
7. Designing, coordinating and implementing the training
8. Incident reporting by employees, contracted labor, registries, and regularly on-site vendors
9. Incident reporting to Cal/OSHA, Law Enforcement and the California Department of Public Health (CDPH)
10. Recordkeeping/Incident Log
11. Annual Program Review

A. DEFINITIONS:

1. Workplace Violence: Any act of violence, threat of violence or aggressive behavior that occurs in the work setting. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:

    a. The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;

    b. An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;

    c. Examples of violent acts may include, but are not limited to, assault, battery, beatings, stabbings, shooting, rape, psychological traumas, threatening or obscene phone calls, stalking, being sworn or shouted at, intimidation, or harassment of any kind

    d. Threat of violence means a statement or conduct that causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured, and that serves no legitimate purpose.

2. Four workplace violence types:

    a. “Type 1 violence” means workplace violence committed by a person who has no legitimate business in the worksite, and includes violent acts by anyone who enters the workplace with the intent to commit a crime

    b. “Type 2 violence” means workplace violence directed at employees by customers, clients, patients, students, inmates, or any other for whom an organization provides services

    c. “Type 3 violence” means workplace violence against an employee by a present or former employee, supervisor, or manager

    d. “Type 4 violence” means workplace violence committed in the workplace by someone who does not work there, but has, or is known to have had, a personal relationship with an employee

3. Risk Factors:

   a. Environmental risk factors in the facility or area in which health care services or operations are conducted may contribute to the likelihood or severity of a Workplace Violence incident. Environmental risk factors include risk factors associated with the specific task being performed.

   b. Patient specific risk factors are specific to a patient that may increase the likelihood or severity of a Workplace Violence incident, such as the use of drugs or alcohol, psychiatric condition or diagnosis associated with increased violence, and condition or disease process that would cause confusion and/or disorientation, or history of violence.

4. Work Practice Controls: Procedures, rules and staffing that are used to effectively reduce Workplace Violence hazards. Work practice controls include, as applicable, but are not limited to:

   a. Appropriate staffing levels.

   b. Provisions of dedicated safety personnel (e.g., Security Officers).

   c. Employee training on Workplace Violence prevention methods.

   d. Employee training on procedures to follow in the event of a Workplace Violence incident.

POLICY:

B. **RESPONSIBILITIES**

1. The Safety Officer is responsible to initiate, implement, maintain and administer the WVPP. The Safety Officer may delegate duties, tasks and assignments via the Environmental Safety Committee.

2. The Director of Quality & Patient Safety or designee is responsible to initiate, implement, maintain and administer the IIPP.

3. Each Department Director/Manager/Supervisor and Employers (On-site Contractors/Vendors) of other employees is responsible for implementing, complying and supporting the WVPP.

4. Each employee and other employees (contractors/vendors) are responsible for

implementing, complying and supporting the WVPP.

C. **PLAN DEVELOPMENT**

1. WVPP development requires a multidisciplinary team approach, which includes Leadership and Management, along with employees and their representatives in developing, implementing, and reviewing the plan.

2. The development, implementation, and annual review of the plan will be coordinated through the Environmental Safety Committee in conjunction with active involvement of employees and their representatives.

D. **COMMUNICATION**

WVPP information and updates are communicated through the following means:

1. Annual WVPP evaluation and review

2. Annual training (type of training is dependent on the roles, departments and specific risks associated with the job duties or environment)

3. Department Specific Training (example: CPI Non-Violent Crisis Intervention)

4. E-Learning self-learning module

5. Department Staff Meetings

6. SVMC will document and communicate to other employees, employers and between shift and units, information that may increase the potential for Workplace Violence incidents.

Employees are encouraged to report safety concerns to the Safety Officer, Security, Risk Management, Employee Health and their Director, Manager or Supervisor.

Attempts will be made throughout the year to solicit active participation of employees and their representatives in the review, creation, design and implementation of the WVPP and all training materials and sessions. The following methods will be used to solicit active participation:

1. E-Learning modules

2. Training session debriefings

3. Staff meetings

E. **TRAINING**

All employees working in the facility, units, service lines, or operations shall be provided initial

training, that includes an online module in E-Learning which covers the types of Workplace Violence, personal safety and reporting, followed by annual refresher training on the WVPP.

Initial employee training will address the workplace violence risks that the employees are reasonably anticipated to encounter in their jobs, the workplace violence hazards identified in the facility, unit, service or operation, and the corrective measures SVMC has implemented. The initial training was provided when the Workplace Violence Prevention Plan was first established and when an employee is newly hired, assigned to perform duties for which required training was not previously required, and new or reassigned employees.

Initial training includes:

1. An explanation of the Workplace Violence Prevention Plan, including the hazard identification and evaluation procedures, general and personal safety measures implemented, how the employee may communicate concerns about workplace violence without fear of reprisal, how workplace violence incidents will be addressed, and how employees can participate in reviewing and revising the plan.

2. How to recognize potential violence, factors contributing to the escalation of violence and how to counteract them, and when and how to seek assistance to prevent or respond to violence.

3. Strategies to avoid physical harm.

4. How to recognize alerts, alarms, or other warnings about emergency conditions and how to use identified escape routes or locations for shelters, as applicable.

5. The role of private security personnel, if any.

6. How to report violent incidents to law enforcement.

7. Resources available to employees for coping with incidents of violence, including but not limited to, critical incident stress debriefing or employee assistance program.

8. An opportunity for interactive questions and answers with a person on knowledge about the Workplace Violence Prevention Plan.

In addition to District employees, WVPP training is required for:

- Contracted/Contingent Workforce
- On-Site Contractors that conduct regular business on SVMC property (i.e., On-Site Security, Renovo)
- Licensed Independent Professionals not employed by the District and volunteers are not required to be trained by Cal/OSHA, but are highly encouraged to be familiar with the WVPP

The level of training on WVPP depends on the workplace or job position risk level:

- Low risk: E-Learning self-learning module
- High risk: Non-violent crisis intervention training

Employees performing patient care contact activities in higher-risk areas (example: Emergency Department), and those employees' supervisors are required to attend annual formal Non-Violent Crisis Intervention training. Non-Violent Crisis Intervention training (CPI) is a focused training on de-escalation techniques as well as restrictive and non-restrictive interventions. The training reviews the topics included in the initial training and the results of the annual Workplace Violence Prevention Plan review and/or any review conducted due to new procedures or new information.

Employees assigned to respond to alarms or other notifications of violent incidents or whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior (i.e., Security Officers) shall be provided training prior to initial assignment and at least annually thereafter that will include.

1. General and personal safety measures.

2. Aggression and violence predicting factors.

3. The assault cycle.

4. Characteristics of aggressive and violent patients and victims.

5. Verbal interventions and de-escalation techniques and physical maneuvers to defuse and prevent violent behavior.

6. Strategies to prevent physical harm.

7. Appropriate and inappropriate use of restraining techniques in accordance with Title 22.

8. Appropriate and inappropriate use of medication as chemical restraints in accordance with Title 22.

9. An opportunity to practice the maneuvers and techniques included in the training with other employees, including a meeting to debrief the practice session. Problems found are corrected.

SVMC provides additional training when new equipment, work practices or hazards are introduced, or when a new, or previously unrecognized, workplace violence hazard has been identified.

F. **RISK ASSESSMENTS**

1. A risk assessment is required for all departments, units, service lines, (including outpatient areas), and services that include:

   - Environmental risk factors;
   - Community-based risk factors;
   - Operation area surrounding the facility such as employee parking areas and other outdoor surroundings;

2. Include a review of workplace violence incidents that have occurred in each facility, department, unit, operations, (including outpatient areas), and services within the previous year, whether or not an injury occurred;

3. Risk assessments will be conducted annually or whenever conditions change that could affect safety;

4. The risk assessment shall be used to identify locations and situations where violent incidents are more likely to occur;

5. Active engagement of employees and their representatives.

Patient-Specific Risk Factors:

Create procedures to identify and evaluate factors specific to patients that may increase the likelihood or severity of violence or the threat of violence (e.g. alcohol, psychiatric condition or diagnosis associated with increased risk of violence, any condition or disease process that would cause confusion and/or disorientation, or history of violence.

1. Procedures for paramedics/emergency medical services to communicate with receiving facility to identify risk factors associated with patients being transported to the receiving facility

2. Procedures for receiving facilities to communicate with law enforcement and paramedics/emergency medical services to identify risk factors associated with patients being transported to the receiving facility.

Risk factors must include, but not limited to:

1. Patient's mental status and condition that may cause the patient to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively;

2. A patient's treatment and medication status, type, and dosage, as is known to the health facility and employees;

3. A patient's history of violence;

4. Any disruptive or threatening behavior displayed by the patient.

Visitors or Other Persons Who Are Not Employees

Create procedures to assess visitors or other persons who are not employees who display disruptive behavior or otherwise demonstrate a risk of committing workplace violence.

1. Policies outlining the circumstances under which a person will not be permitted to enter or remain in the facility. Hospital should train staff on what to do if such a person comes into the facility or becomes angry when asked to leave.

2. Develop criteria for discontinuing the flagging of a visitor for risk of violence potential if the risk is due to a temporary situation.

3. Develop process to credential and manage vendors.

4. Develop a plan to communicate the violence potential of a visitor to staff.

G. HAZARD CORRECTION

1. Engineering and work practice controls shall be used to eliminate or minimize employee exposure to the identified hazards to the extent feasible.

2. SVMC shall take measures to protect employees from imminent hazards immediately, and shall take measures to protect employees from identified serious hazards within seven business days of the discovery of the hazard.

3. When an identified corrective measure cannot be implemented within the seven business day timeframe, such as a project that requires OSHPD approval, SVMC shall take interim measures to abate the imminent or serious nature of the hazard while completing the permanent control measures.

4. Active engagement of employees and their representatives will be included in the hazard corrective measures whenever feasible. Employees will be informed of the results and corrective actions taken.

5. Examples of Hazard Corrections include, but are not limited to, the following:

    a. Emergency Department:

a. Electronic access control
b. Closed Circuit Television (CCTV) cameras
c. Security Officer Station – Posted 24 hours per day

b. Maternal Child Health Unit:

a. Electronic access control
b. Access Control System
c. CCTV
d. Department policy in place for identifying visitors
e. Department procedure for uniquely identifying mother-infants
f. Security Officer Station – Posted 24 hours per day

c. Pharmacy Department:

a. Electronic access control
b. CCTV

d. Human Resources department:

a. Access Control System
b. CCTV

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

PROCEDURE:

H. **VIOLENT INCIDENT REPORTING (Internal and External to Cal/OSHA)**

A. Internal reporting of workplace violence incidents may be accomplished by several means:

1. During normal business hours Monday – Friday, employees may contact Employee Health Services (EHS) by dialing ext. 6174 or visiting the EHS office. They may also contact the Environment of Care/Safety and Security Manager at ext. 6008.

2. After hours and weekends, incidents may be reported by using the electronic Incident Reporting System.

3. For serious incidents, such as a death or injury requiring hospitalization, the employees' supervisor, manager or director shall be contacted and that individual will immediately contact the administrator on-call and the Environment of Care/Safety and Security Manager or Safety Officer.

4. External reporting of workplace violence incidents to Cal/OSHA shall be completed for incidents involving any of the following:

   - The use of physical force against a hospital employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.

   - An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.

   - An incident involving the death of an employee, hospitalization greater than 24 hours, one or more days away from work (which includes the day of the incident), restricted work or transfer to another job, medical treatment beyond "First Aid", loss of consciousness, significant injury, or psychological trauma or stress as a result of the workplace violence incident.

5. Timeframes for reporting to Cal/OSHA:

   1) Shall be reported online to Cal/OSHA within 24 hours if the incident involves:

      a. A fatality or an injury that requires inpatient hospitalization for a period in excess of 24 hours.
      b. Any incidents involving a firearm, dangerous weapon, loss of limb, or serious degree of permanent disfigurement.
      c. An urgent or emergent threat to the welfare, health, or safety of hospital personnel (potential exposure to death or serious physical harm)

   2) Shall be reported online to Cal/OSHA within 72 hours if the incident involves:

      a. All other incidents not listed above in section 3.a. b. c.

      b. The hospital shall submit an initial report with all information available within the allotted timeframe. There are no obligations by Cal/OSHA for the hospital to update the report online if additional information is made available at a later date.

   3) Reports to Law Enforcement

      a. Within 72 hours of an incident, the employer must report acts of assault or battery against on-duty hospital personnel to the local law enforcement agency if the incident results in injury or

involves the use of a firearm or other dangerous weapon, even if there is no injury.

4) Reports to the California Department of Public Health (CDPH)

a. The death or significant injury of a staff member resulting from a physical assault that occurs within or on the grounds of a facility is an adverse event that must be reported to CDPH no later than five days after the adverse event has been detected. If the event is an ongoing urgent or emergent threat to the welfare, health or safety of patients, personnel or visitors, the report must be made not later than 24 hours after the adverse event has been detected.

6. Telephone reports to Cal/OSHA

The Cal/OSHA WVP regulations states that employers must continue to report immediately by telephone to the nearest District Office of the Division of Occupational Safety & Health any serious work-connected injury, illness or death as required by Title 8, California Code of Regulations, Section 342(a).

A. Local District Office:

Fresno District Office
2550 Mariposa St. Room 4000
Fresno, CA. 93721
Telephone: 559-445-5302

B. Cal/OSHA does not accept telephone reporting in place of the online reporting noted in 3.a.b. The telephone reporting is a separate requirement for incidents involving death or serious work-connected injury.

C. "Immediately" means as soon as practically possible, but no longer than 8 hours after the hospital knows of the death or serious injury. In extreme exigent circumstances, the timeframe for reporting to Cal/OSHA may be extended up to 24 hours maximum.

D. Information required when completing a telephone report:

1. Time and date of accident/event
2. Employer's name, address and telephone number
3. Name and job title of the person reporting the accident
4. Address of accident/event site
5. Name of person to contact at accident/event site
6. Name and address of injured employee(s)

7. Nature of injuries
8. Location where injured employee(s) was/were taken for medical treatment
9. List and identity of other law enforcement agencies present at the accident/event site
10. Description of accident/event and whether the accident scene or instrumentality has been altered.

B. VIOLENT INCIDENT LOG/RECORD KEEPING

1. Records of workplace violence hazards identification, evaluation, and correction shall be created and maintained in accordance with Title 8, California Code of Regulations, Section 3203(b) & 5120(e)(1)(B).

2. Training records shall be created and maintained for a minimum of 1 year. Per Title 8, California Code of Regulations, Section 3203(b). The records must include details with date of training, contents or summary of the training sessions, names and qualifications of persons conducting the training, and the names and job titles of all the persons attending the training sessions. In addition, Title 22, California Code of Regulations, Section 70214 states that orientation and competency validation must be documented in the employee's file for the duration of their employment.

3. Violent Incident Logs must be maintained for a minimum of five years, per Title 8, California Code of Regulations, Section 3342(h)(3). The Violent Incident Logs shall include:

1) The date, time, specific location and department of the incident.

2) A detailed description of the incident.

3) A classification of who committed the violence, including whether the perpetrator was a patient/client/customer, family/friend of a patient/client/customer, stranger with criminal intent, coworker, supervisor/manager, partner/spouse, parent/relative, or other perpetrator.

4) A classification of circumstances at the time of the incident, including whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, in a high-crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances.

5) A classification of where the incident occurred, including whether it was in a patient or client room, emergency room or urgent care, hallway, waiting room, rest room or bathroom, parking lot or other area outside the building, personal residence, break room, cafeteria, or other area.

6) The type of incident, including whether it involved:

a. Physical attack, including biting, choking, grabbing, hair pulling, kicking, punching, slapping, pushing, pulling, scratching or spitting;

b. Attack with a weapon or object, including a knife, gun, or other object;
c. Threat of physical force or threat of the use of a weapon or other object;

d. Sexual assault or threat, including rape/attempted rape, physical display, or unwanted verbal/physical sexual contact;

e. Animal attack;

f. Other

7) Consequences of the incident, including:

a. Whether medical treatment was provided to the employee;

b. Who, if anyone, provided necessary assistance to conclude the incident;

c. Whether security was contacted and whether law enforcement was contacted;

d. Amount of lost time from work, if any; and

e. Actions taken to protect employees from continuing threat, if any.

8) Information about the person completing the Log, including the person's name, job title, phone number, email address, and the date completed.
4.

5. All records required by this subsection shall be made available upon request to the Chief of the Division of Occupational Safety and Health or his/her representative (Cal/OSHA Investigators) for examination and copying.

6. All records required by this section shall be made available to employees and their representatives, on request, for examination and copying (at no charge to the employee).

C. **VIOLENT INCIDENT INVESTIGATION**

A. A post-incident response and investigation shall be completed for any employee, contractor, or other individuals that are covered by the WVPP, and have been involved in an act of violence or threat of violence. Steps that shall be taken in the event of an incident of violence (include, but not limited to):

1. Provide immediate medical care or first aid to employees or covered individuals who have been injured in the incident;

2. Identify all employees involved in the incident.

3. Making available individual trauma counseling to all employees affected by the incident.

4. Reviewing any patient-specific risk factors and any risk reduction measure that were specified for that patient.

5. Reviewing whether appropriate corrective measures developed under the Workplace Violence Prevention Plan were – such as adequate staffing, provisions and use of alarms or other means of summoning assistance, and response by staff or law enforcement were effectively implemented.

7. Soliciting from the injured employee and other personnel involved in the incident their opinions regarding the cause of the incident, and whether any measure would have prevented the injury.

8. Conduct a post-incident debriefing as soon as possible after the incident with all employees, supervisors, and security involved in the incident.

9. Completion of the Workplace Violent Incident Report form.

4. The Security Department will conduct a Security Incident Report for any incidents that cause injury or have a high probability of causing injury, psychological trauma or stress.

5. All violent incidents will be reviewed through the Environmental Safety Committee and reported to Senior Leadership, and finally up to the Board of Directors (annually).

D. **ANNUAL REVIEW OF THE WVPP**

A. An annual review of the WVPP must be completed at the end of each fiscal year. The goal of the annual evaluation is to evaluate the effectiveness of the plan and any actions implemented throughout the plan year. The annual review of the WVPP shall include:

1. Staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence;

2. Sufficiency of security systems, including alarms, emergency response, and security personnel availability;

3. Job design, equipment, and facilities;

4. Security risk associated with specific units, areas of the facility with uncontrolled access, late-night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas and other outdoor areas;

5. Review of the Violent Incident Log.

6. Additional limited review may be required following new procedures, processes

or information. An updated review of the plan shall be completed whenever necessary, as follows:

- To reflect new or modified tasks and procedures, changes in staffing, engineering controls, construction or modifications of the facilities, evacuation procedures, alarm systems and emergency responses;
- To include newly recognized workplace violence hazards;
- To review and evaluate workplace violence incidents that result in a serious injury or fatality; or
- To review and respond to information indicating that the WVPP is deficient in any area.

REFERENCES:

- The Joint Commission (20254). Hospital accreditation standards. EC.02.01.01, EC.04.01.01, HR.01.05.03, LD.03.01.01 Joint Commission Resources. Oak Brook, IL.
- Cal/OSHA Workplace Violence Prevention in Healthcare (2019).
- Title 8, California Code of Regulations, Section 3203(b); 5120(e)(1)(B); 3342(h)(3). (2019) Retrieved from https://www.dir.ca.gov/samples/search/query.htm.
- Title 22, California Code of Regulations, Section 70214 (2019). Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- California Hospital Association. (January 2017). Healthcare Workplace Violence Prevention: How to comply with the Cal/OSHA regulations. Retrieved from https://www.calhospital.org/sites/main/files/file-attachments/workplaceviolenceprevention_preview_0.pdf.

CROSS REFERENCES:

- SECURITY MANAGEMENT PLAN
- INJURY AND ILLNESS PREVENTION PROGRAM

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	11/05/2025
BOARD OF DIRECTORS APPROVAL	
	11/25/2025
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
November 25, 2025 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**
	• Administration of Measles, Mumps and Rubella Vaccine	1-3	
	• Assessment of Patients for CT Simulation	4	
	• Blood & Blood Components, Administration of	5-12	
	• Care Conference Multidisciplinary – Internal	13-14	
	• Discharge of Patient	15-17	
	• Electron Cutouts: Field Size Correction Factor	18-19	
	• Formulary	20-28	
	• Guidelines for Immunocompromised (Neutropenic) Patients	29-31	
	• High Radiation Areas	32	
	• Interdisciplinary Care Plan – Completion of	33-34	
	• Pain Management	35-40	
	• Pediatric Assessment and Nursing Standards	41-43	
	• Personnel Monitoring for Radiation Exposure	44	
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	• Point of Use: Instrument Cleaning and Transport	48-50	
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	• Radiation Safety	52-54	
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	• Tattooing Patients	57-58	
	• Therapeutic Phlebotomy	59-62	
	• Vascular Access Device Injections/Flushing	63-65	
	• Wasting or Returning Controlled Substances	66-68	
	• Pharmaceutical Waste	69-74	

SUBJECT:	SECTION:
ADMINISTRATION OF MEASLES, MUMPS, AND RUBELLA VACCINE	**Page 1 of 3**

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

POLICY

PURPOSE: Establish a population of health care professionals (HCPs), who will minimize the spread of measles, mumps and rubella in the healthcare setting.

The Advisory Committee on Immunization Practices (ACIP) recommends that HCP who do not have presumptive evidence of immunity to measles, mumps, and rubella should get vaccinated against these diseases with measles, mumps, rubella (MMR) vaccine or measles, mumps, rubella, varicella (MMRV) vaccine.

BACKGROUND: Measles, mumps and rubella are 3 highly contagious but preventable diseases that may result in severe complications including pneumonia, encephalitis, parotitis, lymphadenopathy, deafness and even death. Health care workers are about 18% more likely than the general public to become infected during their regular course of work. The asymptomatic rate for the 3 contagious diseases ranges from 20% to 50%, which means that an infected individual may not even know that they are contagious. In addition to a generalized rash, rubella may result in pregnancy complications up to and including miscarriage or stillbirth. These severe complications may be avoided simply through vaccination against measles, mumps and rubella.

A. **PREREQUISITES**: According to the Centers for Disease Control and Prevention (CDC), adults/HCP who meet the following criteria are eligible for MMR vaccination:

   a. Those with no history of acceptable evidence of immunity against measles, mumps or rubella including:

      i. Born after 1957
      ii. No written documentation of two doses of measles-containing vaccine administered after the first birthday
      iii. No laboratory evidence of immunity
      iv. No laboratory confirmation of disease

B. **PRECAUTIONS**: The following precautions should be considered prior to vaccination:

   a. Recent receipt (<11 months) of antibody containing blood product(s). The specific interval depends on the blood product received.
   b. A history of thrombocytopenia or thrombocytopenic purpura
   c. A recent moderate or severe acute illness with or without fever
   d. A clinical need for tuberculin skin testing or interferon gamma release assay (IGRA) testing. If active TB is suspected, MMR vaccination should be delayed
   e. A history (individual or family) of seizures

C. **PLAN**: Establish immunization against measles, mumps and rubella by vaccinating all adults, especially HCPs who are in need of vaccination and meet the criteria for vaccination

a. Treatment:
   i. Screen all adults for contraindications and precautions to measles, mumps and rubella vaccine
   ii. Provide a copy of the most current Vaccine Information Statement (VIS) to the vaccine recipient. You must document in the medical record or office log the publication date of the VIS and the date it was given. Provide non-English speakers with a copy of the VIS in their native language if available. These documents may be found at www.immunize.org/vis
   iii. Administer the manufacturer's recommended dose of MMR vaccine, subcutaneous (SC), using a 23-25g, 5/8-3/4 inch needle in the posterolateral section of the upper arm.
   iv. For adults in need of second doses of MMR, observe a minimum interval of 4 weeks between the first and second doses.

b. Documentation:

   i. Agility – record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine.
      1. **IMPORTANT** - If the vaccine was not given, record the reason(s) for non-receipt of the vaccine (e.g. medical contraindication, refusal).

D. PROFESSIONAL REQUIREMENTS FOR ADMINISTRATION:

a. Education: Licensed personnel (e.g. LVN, RN, MD)
b. Training: As required by initial and annual internal competencies
c. Experience: N/A
d. Initial Evaluation: Review of CDC immunization criteria, SBMC Standardized Procedures for immunization
e. Continuing Evaluation: Annually

REFERENCES:

Centers for Disease Control and Prevention. (2025, January 17). *Measles (Rubeola) vaccination.* Centers for Disease Control and Prevention. Accessed 2025, September 12th at https://www.cdc.gov/vaccines/vpd/mmr/public/

Centers for Disease Control and Prevention. (2021, January 26*). Routine MMR vaccination recommendations: For Providers.* Centers for Disease Control and Prevention. Accessed 2025, September 12th at https://www.cdc.gov/vaccines/vpd/mmr/hcp/recommendations.html#print

The Joint Commission (2024). Hospital Standards Manual accreditation standards. Joint Commission Resources. Oak Brook, IL. IC.01.05.01, EP1

SUBJECT: **ASSESSMENT OF PATIENTS FOR CT SIMULATION**	SECTION: **Page 1 of 1**

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

PURPOSE:

Patient assessment is made with the interdisciplinary approach of the Radiation Oncologist and Radiation Therapists to provide the most relevant information to allow for the optimum Computerized Tomography (CT) Simulation and treatment planning results.

POLICY:

Assessment of patients that will be receiving a CT Simulation at the Cancer Center shall take place in the following manner:

1. The patient's diagnosis should be relative to the CT Sim ordered by the Radiation Oncologist. An order from the Radiation Oncologist will be reviewed by the radiation therapist prior to the procedure.

2. The patient will be questioned about his/her condition and how positioning or the use of immobilization devices might be affected by their condition.
    a. For example: The patient might be claustrophobic and unable to tolerate a mask or the patient might not be able to lie flat.
        i. The information will be given to the Radiation Oncologist and solutions will be discussed to determine the most appropriate way treat the patient safely and accurately.

3. The Radiation Therapist performing the CT Simulation will also assess the patient during the study being performed. If the condition of the patient changes in an adverse manner, the Radiation Oncologist and/or the nurse will be notified immediately.

REFERENCE:

American Society for Radiation Oncology (ASTRO). Safety is No Accident: A Framework for Quality Radiation Oncology and Care. March 2019. Available at: https://www.astro.org/practice-support/quality-and-safety/safety-is-no-accident. Accessed September 11, 2025.

- "
- Dove APH et al. "Academic Patterns of Practice Regarding CT Simulation Scans and Radiology Review" October 2022. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10230158/. Accessed September 15, 2025

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

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

PURPOSE:

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

POLICY:

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

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

EQUIPMENT:

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

PROCEDURE:

PHYSICIAN RESPONSIBILITIES:

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

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

HOSPITAL PERSONNEL RESPONSIBLITIES:

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

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

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

COMPLETING THE HOSPITAL'S CONSENT FORM:

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

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

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

A. Ordering and Obtaining Blood Products

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

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

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

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

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

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

   a. Patient's name

   b. Identification number

   c. Blood group, Rh type and antibody screen,

   d. Donor number

   e. Donor blood group and Rh type

   f. Expiration date and time

   g. Blood product ordered

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

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

C. Preparing the patient

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

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

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

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

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

D. At the bedside

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

   a. Patient's name

   b. DOB

   c. Patient Account Number

   d. BBK#

   e. Blood unit number

f. Donor blood group and Rh type

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

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

E. Preparation for Transfusion

1. Wash hands thoroughly. Put on gloves.

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

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

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

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

F. Administration

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

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

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

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

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

G. Completion of Transfusion

1. Clamp blood component bag.

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

3. Remove blood products and tubing
   a. Dispose of blood bag and tubing in appropriate biohazard container.
   b. Return blood bags to the lab only when a reaction is suspected.
   c. The Unit Issue Card is affixed to the patient's lab sheet in the medical record.

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

PLATELETS

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

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

FRESH FROZEN PLASMA (FFP)

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

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

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

SPECIAL CONSIDERATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

DOCUMENTATION

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

REFERENCES:

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

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

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

CROSS REFERENCES:

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

SUBJECT: **CARE CONFERENCE MULTIDISCIPLINARY – INTERNAL**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define the process by which care will be coordinated among all disciplines for the purpose of providing comprehensive care for the Cancer Treatment Center (CTC) patient.

POLICY:

Patients receiving new treatment, experiencing problems that result in delay of treatment and those whose planned treatment has concluded, shall be discussed at a multi-disciplinary care conference. Care Conferences will occur at interval of no less than once per month. Attendees may include treating physicians, treatment personnel, dietary and social services etc. Participants may record their comments on the Care Conference Form. Orders and treatment plans will be documented in the electronic health record.

AFFECTED AREAS/ PERSONNEL: *CANCER TREATMENT CENTER STAFF*

PROCEDURE:

1. **Frequency of meeting**

   Care Conferences shall take place no less than once per month on dates arranged by the CTC Director or designee.

2. **Documentation**

   a. The Director or designee shall complete a Care Conference Form for every new patient under both radiation and chemotherapy treatment simultaneously.

   b. The treatment staff shall submit names for discussion at care conference when patients experience complications that preclude them from receiving therapy as planned and when active treatment is over. Documentation for these patients will occur in the electronic health record when warranted.

   c. Initiated Care Conference Forms shall be placed in a pre-designated area and will be discussed at the next scheduled Care Conference.

   d. Those involved in the care of the patient should document pertinent information on the Care Conference Form.

   e. If a referral for nutrition services and/or Social Services consultation is suggested, the physician shall submit an order for such consultation.

   f. Office nurse shall be responsible for communicating with nutrition services and or Social Services when order is received.

g. Completed Care Conference Forms shall be filed in the patient's medical record.

REFERENCES:

- ASRT The Practice Standards for Medical Imaging and Radiation Therapy, 2025 American Society of Radiologic Technologists
- ACR–ASTRO Practice Parameter for Radiation Oncology, 2019, American College of Radiology
- NCCN Guidelines https://www.nccn.org/guidelines/category_1 Accessed September 23, 2025

SUBJECT: **DISCHARGE OF PATIENT**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 3**

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

PURPOSE:

The discharge of the patient from the hospital should ensure continuity of care in the transition from hospital to home, or from hospital to another facility.

POLICY:

The staff nurse is responsible for seeing that the patient is discharged with appropriate instructions, all personal property and valuables. Other professional services, including Patient Registration,, Financial Services, Pharmacy, Social Services and Case Management, assist in the discharge planning. The staff nurse and social services is responsible for making sure that a patient has transportation to get home.

AFFECTED AREAS/PERSONNEL: *ALL INPATIENT CARE UNITS*

PROCEDURES:

Planning of Discharge:

1. Discharge planning begins upon admission and continues through the hospital stay.
2. Patient and family teaching are a part of this preparation and are included in the nursing care plan.
3. Social Services, Case Management and other staff are involved as appropriate and approved by the attending physician.

Discharge:

1. An order by the attending physician must be obtained prior to discharge.
2. At the time of discharge, nursing will complete the discharge instruction and a copy will be given to the patient.
3. It is the responsibility of the staff nurse to make certain that the patient is discharged with all of his/her personal effects.
    a. Make special note of the presence of eyeglasses, contact lenses, hearing aids and prosthesis.
    b. The nurse or aide must check dresser drawers, closet, over-bed table and bathroom.
    c. If the patient has valuables in the Admitting Safe, he/she will present the claim check and be given their belongings, in accordance with the "Valuables" policy.

4. All patients are to be escorted out of the hospital

5. At the time of actual discharge, notify appropriate departments.

6. Minor children are to be discharged to the custody of their legal guardian. *In the event the legal guardian is not available prior arrangements for discharge pick up need to be made. Upon pick up the authorized person must provide staff with proper identification before releasing the minor in to their custody. The identification should be copied and place in the medical record before discharge. Examples :of proper identification should include but not limited to driver license, passport, or picture identification)*

Medication:

1. All drugs brought in by the patient on his admission will be returned to him/her at the time of discharge.

2. Discharge prescriptions must be filled at an outpatient pharmacy of the patient's choice. The prescription will be electronically sent to the pharmacy of the patient's choice. If a prescription cannot be electronically sent, the patient will be given a prescription to take to their pharmacy.

3. Patient's will receive at the time of discharge drug information regarding their discharge prescriptions that will include; use, storage, relevant warnings, contraindications, drug interactions, and the importance of compliance with directions.

4. Upon discharge, unused medications in the patient's cassette or in the medication refrigerator will be returned to the pharmacy.

Home Health Care/Durable Medical Equipment:

1. If the patient is under the care of a particular home health agency, or equipment supplier, Social Services/Nursing will continue with those arrangements and notify the agency of the patient's discharge.

2. Patient will be asked about any preference of home health agency using the Outpatient Services preference form. If the patient has no preference, referral will be given to any available agency that can provide the requested service.

3. Social Services will maintain a list of home health agencies and suppliers of durable medical equipment and will coordinate arrangements and referrals as needed.

Documentation:

1. The nurse caring for the patient is responsible for documenting the following:

    a. Condition of patient including surgical wounds and decubiti, if present.

b. Prescription, dressing, or equipment sent with the patient.

c. Method of discharge, i.e. wheelchair or ambulance gurney.

d. Place discharged to:

- Home
- Name of Skilled/ of other Care Facility
- Name of Acute Care Hospital

e. Verification of patient's and or family member knowledge of home care and/or limitations.

f. Signature and date.

For family members or responsible party not present on the patients discharge steps include:

- Phone call to verbally explain all discharge and care instructions
- Ensure a copy of all discharge instructions including any follow up appointments is sent with the patient
- Verification of the patients, family member or responsible party's verbal understanding of all provided instructions is understood.
- Discharge nurse documents the name, of the family member or responsible party, date and time confirming phone instructions where given.

REFERENCES

- Pharmacy Law: California Edition (2019) San Clemente, California Law Tech Publishing Group.

CROSS REFERENCES:

- *Patient Belongings and Valuables* – SVMC Policies and Procedures

SUBJECT: **ELECTRON CUTOUTS: FIELD SIZE CORRECTION FACTOR**	SECTION: **Page 1 of 2**

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

PURPOSE:

To avoid underdose or overdose and account for the decrease in field size due to a costume electron cutout. The correction factor is measured with an open cone verses the cutout. The correction factor is then utilized in the formula to arrive at the correct mu's based on the machine output factor chosen for each energy.

POLICY:

The decrease in field size due to an electron custom made cut out must be accounted for in order to avoid an underdose or overdose. Measurements of individual cut outs can be made with the CNMC Model 10 Dosimetry System and lucite slab with probe centered in each field.

AFFECTED AREAS/ PERSONNEL: *RADIATION THERAPIST/AIDE*

PROCEDURE:

1. Measure the exposure for the open cone, delivering 100 mu. with the indicated energy.

2. Measure the exposure for the cutout, delivering 100 mu. with the same energy.

3. Divide the cutout quantity by the open quantity typically for a number less than one being your correction factor as a function of scatter.

e.g. $\frac{\text{cutout}}{\text{open}} \quad \frac{99.8}{104.9}$ = 0.951 correction factor

Application: $\frac{\text{DOSE}}{(\%DD)\ (\text{OUTPUT FACTOR})\ (CF)}$ = monitor units

e.g. $\frac{100}{(100)\ (.918)\ (.951)}$ = 114.5

Where Dose =100cGy and Output Factor = 0.918

4. Monitor units must be typically increased to compensate for the decrease in field size and decrease in scatter when using cutouts. Exceptions might apply.

5. Documentation of electron block output factors will be maintained in binder labeled Output Factors Custom Blocks

REFERENCES:

•

American Society of Radiologic Technologists. The Practice Standards for Medical Imaging and Radiation Therapy. Revised June 30, 2024. Available at: https://kbmirt.ky.gov/PublishingImages/Pages/Statutes-Admin-Regulations/The%20ASRT%20Practice%20Standards%20for%20Medical%20Imaging%20and%20Radiation%20Therapy%20%E2%80%93%20Mammography%20revised%20June%2030%202024.pdf Accessed September 11, 2025.

American College of Radiology (ACR) and American Society for Radiation Oncology (ASTRO). Practice Parameter for Radiation Oncology. Originally approved 2014; current version maintained by ACR–ARS Practice Parameter and Technical Standards Committee. Available at: https://www.acr.org/Clinical-Resources/Clinical-Tools-and-Reference/Practice-Parameters-and-Technical-Standards.Accessed September 11, 2025.

American Society for Radiation Oncology (ASTRO). Safety is No Accident: A Framework for Quality Radiation Oncology and Care. March 2019. Available at: https://www.astro.org/practice-support/quality-and-safety/safety-is-no-accident. Accessed September 11, 2025.

American College of Radiology (ACR) and American Society for Radiation Oncology (ASTRO). Practice Parameter for Intensity Modulated Radiation Therapy (IMRT). Amended 2014 (Resolution 39). https://gravitas.acr.org/PPTS/GetDocumentView?docId=122.Accessed September 15, 2025.

SUBJECT: **FORMULARY**	SECTION: **Page 1 of 9**

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

PURPOSE:

To provide an ongoing process whereby the Pharmacy Department and the medical staff of Sierra View Medical Center (SVMC), working through the activities of the Pharmacy and Therapeutics (P&T) Committee, evaluates and selects those drug products considered to be the most useful in patient care according to need, effectiveness, safety and cost.

DEFINITION:

Formulary: An approved list of medications that can be used in all patient care areas of Sierra View Medical Center.

POLICY STATEMENT:

It is the policy of Sierra View Medical Center that the maintenance and updating of the formulary of approved medications is the responsibility of the Department of Pharmacy Services via the Pharmacy and Therapeutics (P&T) Committee.

PROCEDURE:

A. The Formulary:

1. Will be compiled and maintained by the Pharmacy Service under the general direction of the Pharmacy and Therapeutics Committee.

2. Will be distributed appropriately to members of the medical staff, nursing staff and other professionals, so that it may be immediately available to them, either in printed form, via the SVMC intranet, or via SVMC website.

3. Will be revised, and approved by Pharmacy and Therapeutics Committee annually.

4. Will consist of a listing of all drugs and pharmaceutical agents, legend and non-legend, in general use in the Medical Center, which contains:
   a. An alphabetical listing with generic and trade name references
   b. A code key that will note use restrictions

When drugs are added to the SVMC formulary, they are approved for all FDA-approved indications and for all age groups.

B. Changes to the Formulary

1. Additions, deletions or other changes to the Formulary will be made only with the approval of the Pharmacy and Therapeutics Committee

2. Additions

- Persons desiring additions will complete a form, "Application for Addition to the Sierra View Medical Center Formulary"
- The request is submitted to the Committee through the Pharmacy or a Committee member. The requesting person may be required to appear before the Committee for clarification of the nature of the drug and its use.
- The medication request is read into the minutes of the Pharmacy and Therapeutics Committee.
- A subcommittee to review additions may be formed to consist of the sponsor, a Clinical Pharmacist and any other interested individuals.
- A review of the medication is required before medications will be added to the Formulary which consists of at least the following:

  1) Formulary Item
  2) Recommendation
  3) Pharmacological Action/Comparison
  4) Drug Interactions
  5) Formulary Impact
  6) Safety Data (including sentinel events)
  7) Economic Impact
  8) Summary
  9) References

The clinical summary may be used as a tool to inform the professional staffs of the Medical Center about the approved medications.

3. Deletions:

- Shall be made for drug items which are no longer used, which have become obsolete, which have been replaced with superior agents, or which should be deleted for other reasons, including newly discovered safety information.
- The Director or a senior pharmacist will bring such drugs to the attention of the Committee immediately for newly discovered safety issues, but no less than annually for all other time the entire formulary is reviewed.

4. Monitoring:

- Any new addition to the formulary will be monitored over the next 12 months for reports of untoward side effects or adverse reactions, which may require a re-evaluation of formulary status.

- New reports of adverse reactions, warnings, precautions, and other safety concerns for established formulary medications will be reviewed, and proactively identified for possible reevaluation of formulary status.

  Shortages to items on formulary will be evaluated by pharmacy personnel. An email with information on shortages & alternatives will be distributed to providers on an as needed basis.

5. Clinical Informatics/ACS will be notified of any formulary changes once they are approved and education has been provided, as appropriate, so the electronic pharmacy and ordering systems can be updated to reflect the changes/shortages.

ADDENDUMS:

"Application for Addition to the Sierra View Medical Center Formulary"

REFERENCES:

- Hospital accreditation standards. (2025). Oak Brook, IL: Joint Commission Resources.
  - MM.02.01.01 EP2
- American Society Hospital Pharmacists Best Practices.(2018). Retrieved from http://digital.ashp.org/ASHP_Best_Practices_2015-2016.
- American Society of Health-System Pharmacists. ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System. ASHP; 2019. Available from: ttps://www.ashp.org/-/media/assets/policy-guidelines/docs/guidelines/gdl-pharmacy-therapeutics-committee-formulary-system.ashx

Addendum A
PHARMACY AND THERAPEUTICS COMMITTEEAPPLICATION FOR ADDITION TO THE SIERRA VIEW MEDIAL CENTER FORMULARY

INSTRUCTIONS:

- Formulary application is restricted to medical and surgical staff members, and clinical pharmacists.
- Department chair or department director should be requester.
- Use sound sources of information. [Example: Review articles, drug information sources or practice guidelines]. Expert consultants in the therapeutic area of interest may also be very useful.
- Return this form to the Director of Pharmacy.
- The sponsoring member or clinical pharmacist must be present at the committee meeting for the request to be evaluated.

Pharmacy and Therapeutics Committee
Generic Name (Brand Name) Monograph

Operational Summary

1. **Description/Mechanism**
   a.

2. **FDA Labeled Indications**
   a.

3. **Non Labeled Indications**

4. **Dosing and Route of Administration**
   a. (pre-medications, if applicable)

5. **Preparation and Administration**
   a. (if applicable: vial size, diluent volume, pump bag or use pre-filled bag, add drug directly or remove volume first, pharmacy or nursing to prime line, what line, prime with diluent or active drug, protect from light and PVC requirements, duration of infusion, flushing instructions)

6. **Storage and stability** – should match IV room materials/product packaging/protect from light
   a.

7. **Monitoring considerations** –
   a. Monitoring –
   b. Adverse reactions –

8. **Warnings and Precautions** –
   a. Contraindications –
   b. Warnings and Precautions –
   c. Drug interactions –
   d. Special Populations –
      i. Pregnancy –
      ii. Breast feeding –
      iii. (others, like pediatrics, if applicable)

Executive Summary

Background and indication(s):

Efficacy:
[Include a brief description of the trials (i.e. randomized, placebo-controlled, etc) and a brief description of patients (# of patients, general age, % woman/men). The next sentence should explicitly state 'the primary outcome of xxxxx was seen in xx% of shingrix patients versus xx% of other group (p=x.xx).]

Safety:
[Common (>5%) adverse reactions were xx, xx, xx and xx. Adverse effects that lead to medication discontinuation included xx (xx%). State if the medication has a REMS program and why.]

Pharmacoeconomics:

Summary:
[One sentence about what the medication is and who it is used for. One sentence about the patients the medication has shown efficacy. One sentence about who is requesting and who (at UCSD) is planning to use. One sentence, without biased statements, about comparative efficacy to other treatments (if they exist) or efficacy in specific patient population. One sentence about cost to the organization.]

The Bottom Line:

Pro's	Con's

1. **Introduction:** [Brief discussion of the disease state and where this medication fits into the overall treatment scheme]

2. **FDA Approved Indication(s):** [include date of approval]

3. **Non-FDA Approved (Off-Label) Uses:** [per CMS-approved compendia, Clinical Pharmacology, Drugdex, NCCN, AHFS]

4. **Pharmacology/Pharmacokinetics:**
   4.1. Pharmacology:

4.2. **Pharmacokinetics:** [Please provide a brief summary, in sentence form, of the pharmacokinetic data related to the medication. Please specify if the data was collected in humans or non-human subjects.]

Table 1: Pharmacokinetics

Half-life (active metabolite)	
Bioavailability (Oral)	
Cmax	
Tmax	
Protein Binding (Albumin)	
Volume of distribution (Vd)	
Excretion	

5. **Dosage and administration:** [make sure to include additional information for IV products: standard concentration, preferred vehicle for mixing]
   - **5.1. Renal dosing:**
   - **5.2. Hepatic dosing:**
   - **5.3. Other dosing (if applicable) considerations:**

6. **Clinical Efficacy:** [summarize key findings from the highest level of evidence available and include an evidence table in the appendix]

7. **Guideline Recommendations:** [provide current guideline recommendations for use of the medication and it's place in therapy]

8. **Treatment/formulary Options:** [include all other comparator drugs available on formulary]

9. **Safety Considerations:**
   - **9.1 REMS:** [if yes, indicate medication guide, inpatient and/or outpatient prescribing requirements, registry requirements, etc.]
   - **9.2 Boxed Warnings:**
   - **9.3 Precautions/Contraindications:**
   - **9.4 Sentinel Event Advisory:**
   - **9.5 Adverse Effects:** [provide the most common and most serious adverse effects from package insert and/or clinical trials in a list or table format]

Table 2 (example): Adverse Events Reported by >2% of Patients in Clinical Trials

Event (examples)	Trial 1 *Dose 1* (N=633)	Trial 2 Dose 2 (N=410)	Trial 3 Dose 3 (N=194)
Headache	60 (9%)	34 (8%)	32 (16%)
Constipation			
Diarrhea			
Fatigue			
Insomnia			

9.6 Drug Interactions:

9.7 Potential For Error: [include any alerts from ISMP or FDA MedWatch]

9.7.1 High alert medication: [if yes, explain reason behind high alert]

9.7.2 Look alike/sound alike: [if yes, include what medication(s) it can be confused with]

9.8 Abuse potential:

10. **Special Populations**: [include pertinent information for pregnancy, lactation, geriatrics, pediatrics, renal dysfunction, hepatic dysfunction]
    - **10.1.** Pregnancy
    - **10.2.** Lactation
    - **10.3.** Geriatrics
    - **10.4.** Pediatrics
    - **10.5.** Renal Dysfunction
    - **10.6.** Hepatic Dysfunction

11. **Storage:** [include any special storage instructions, light protection, beyond use dating if applicable]
    - **11.1.**
    - **11.2. NIOSH Review: Circle one option below**
      - **11.2.1. Antineoplastic Non-Antineoplastic HD Reproductive t Risk NA**
    - **11.3. Hazardous Waste Review:**
      - **11.3.1. Circle appropriate final disposition of waste: RCRA Non-RCRA**

12. **Operational Considerations:** [institute specific considerations such as **necessary monitoring parameters**, smart pump guardrails, Meditech med record, etc]

13. **Pharmacoeconomic Analysis:** [cost analysis and how use of the medication may impact the hospital economically. May present data in any organized fashion]

14. **Conclusions and Recommendations:** [summarize the key points of the monograph, weighing the pros and cons. Make sure to include recommendation for formulary addition and/or restriction]

15. **References:**

Cite references in numerical order of mention in the monograph. Use format in http://www.icmje.org/

Clinical Trials:

[In this section, include a small paragraph outlining the total number of trials you identified, indicate the types of studies and focus on the highest quality. This will help the reader understand the total volume of articles available and which were the highest quality. Rank in order of (1) comparative efficacy (2) randomized controlled trials (3) placebo-controlled trials; include the most pivotal trials and include quality of life data if available for high cost, low-to medium impact drugs]

Study/Title/Journal	Study Design/Population Characteristics	Measures/Results	Adverse effects	Comments

SUBJECT: **GUIDELINES FOR IMMUNOCOMPROMISED (NEUTROPENIC) PATIENTS**	SECTION: **Page 1 of 3**

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

POLICY

INTRODUCTION:

SVMC will at the minimum utilize Standard Precautions and hand hygiene when caring for a patient who is known to be neutropenic or immunocompromised as these patients are at a greater risk for infectious diseases. The purpose of this policy then is to reduce the risk of the transmission of pathogens, especially within the immunocompromised patient population at SVMC.

PROCEDURE:

Patients who are immunocompromised are at greater risk for infection. This is because of the great reduction of circulating neutrophils 1,500 cells/μL which are the first line of defense against invading microorganisms. When the absolute neutrophil count (ANC) is less than or equal to 1,500 cells/μL, the patient is at high risk for infection.

When the ANC is less than 1,500 cells/μL, the following guidelines may be helpful in reducing the risk of infection for the immunocompromised patient:

1. Apply Standard Precautions.
2. Pay rigorous attention to hand washing.
3. Patient education: teach the patient about his/her condition and the measures that they can use to prevent the acquisition of pathogens during periods of neutropenia:
    a. Maintain an optimal nutritional status.
    b. Avoid cleaning of bird cages and cat litter boxes (home instruction).
    c. Avoid areas containing dog feces because feces can contain a high level of fungus and bacteria (home instruction).
    d. Maintain personal hygiene and cleanliness by showering/bathing daily.
    e. Prevent injury to the rectal mucosa by avoiding rectal thermometers, rectal suppositories, enemas, and straining when having a bowel movement.

f. Assess for signs of infection frequently by taking the temperature daily at the same time of the day, reporting a temperature of > 100°F, and reporting any signs and symptoms of infection (e.g., cough with or without sputum, fever, burning on urination, urgency, frequency of urination, cloudy urine.)

g. Use a soft toothbrush to clean the mouth and teeth after every meal.

h. Conserve energy and maintain adequate periods of sleep and rest.

i. Limit visitors, clearing visitors for communicable diseases.

j. Avoid crowded places.

k. Wash hands frequently using proper technique.

REFERENCES:

Aapro, M. (2022, May 12). Chemotherapy-Induced Neutropenia and Febrile Neutropenia in the US. *The Oncologist, Volume 27 (8)*: 625-636. Retrieved September 19, 2025, from https://pmc.ncbi.nlm.nih.gov/articles/PMC9355811/

Centers for Disease Control and Prevention. (2025, August 25). Staying healthy during cancer treatment. Centers for Disease Control and Prevention. Retrieved September 18, 2025, from https://www.cdc.gov/cancer-survivors/patients/staying-healthy-during-cancer-treatment.html

The Joint Commission (2024). Hospital Standards Manual accreditation standards. Joint Commission Resources. Oak Brook, IL. IC.01.03.01, EP1

The Joint Commission (2024). Hospital Standards Manual accreditation standards. Joint Commission Resources. Oak Brook, IL. IC.02.03.01

SUBJECT: **HIGH RADIATION AREAS**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose of this policy is to establish the requirements for High Radiation Areas and radiation machines capable of producing High Radiation Areas.

POLICY:

The department will comply with the California Radiation Control Regulations Title 17, Section 30279.

1. Each room capable of producing High Radiation shall be equipped with a control device which shall cause the level of radiation to be reduced below a level that an individual might receive a dose of 100 millirems in one hour upon entry into the area.

2. The room will also be provided with a conspicuous visible alarm signal, such that any individual at or approaching the tube head of radiation port is made aware that the machine is producing radiation. Such alarm signals shall be activated automatically only when radiation is being produced.

3. Caution signs and labels: The department will comply with California Radiation Control Regulations Title 17, Section 30278 by posting appropriate radiation signs on all rooms capable of producing or emitting radiation. Selection and usage of signs will be determined by the type of radiation source in the room.

4. Surveys and test: Each user shall make or cause to be made such surveys as are necessary for compliance with all applicable provisions of Title 17, Section 30275 of the California Radiation Control Regulations. Surveys and test will be completed by a licensed Radiation Physicist and by a licensed Radiation Therapist when regulations permit.

AFFECTED AREAS/ PERSONNEL: *CANCER TREATMENT CENTER STAFF*

REFERENCES:

- .

- American Society of Radiologic Technologists. The Practice Standards for Medical Imaging and Radiation Therapy. Revised June 30, 2024. Available at: https://kbmirt.ky.gov/PublishingImages/Pages/Statutes-Admin-Regulations/The%20ASRT%20Practice%20Standards%20for%20Medical%20Imaging%20and%20Radiation%20Therapy%20%E2%80%93%20Mammography%20revised%20June%2030%202024.pdf Accessed September 11, 2025.

- American College of Radiology. ACR-ASTRO practice parameter for intensity modulated radiation therapy (IMRT). Amended 2023 Retrieved September 15, 2025 from https://gravitas.acr.org/PPTS/DownloadPreviewDocument?DocId=119#:~:text=This%20ACR%E2%80%93AAPM%20Technical%20Standard,relevant%20practice%20accreditation%20program%20requirements.

SUBJECT:	SECTION:
INTERDISCIPLINARY CARE PLAN – COMPLETION OF	***Provision of Care, Treatment and Services (PC)***

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

PURPOSE:

Planning for care, treatment, and services is individualized to meet the patient's unique needs. The first step in the process includes creating an initial plan for care, treatment, and services that is appropriate to the patient's specific assessed needs. To continue to meet the patient's unique needs, the plan is maintained and revised based on the patient's response. The plan may be modified or terminated based on reassessment; the patient's need for further care, treatment, services; or patient's achievement of goals. The modification of the care plan for care, treatment, and services may result in planning for the patient's transfer to another setting or discharge.

POLICY:

There will be an interdisciplinary Care Plan developed for each patient in coordination with the total health care team.

1. Information generated through the analysis of assessment data is integrated into the Care Plan to identify and prioritize the patient's needs for care.

2. Assessment, planning and revision of the patient Interdisciplinary Care Plan may be documented by the physician, Registered Nurse, Social Worker, Dietician, Respiratory Therapist, Rehabilitation Professional, pastoral Care, Pharmacist or other professional staff on the patient care plan.

3. Intervention/reassessment and resolution of goals/problems will be documented in the patient's nursing, or appropriate discipline's, patient progress notes.

The plan will be based upon the age and developmental needs of all patients and will be consistent with the therapies of other disciplines. Communication among disciplines may occur by review of documentation, interdisciplinary meetings, direct conversation(s) or other appropriate means.

Expected patient outcomes (goals) will be realistic, measurable and consistent with the medical plan of care and available to all members of the interdisciplinary health care team.

1. Whenever possible, patient care goals/outcomes are mutually set with the patient and/or family.

2. Patient education and patient/family knowledge is given special consideration in the patient care plan.

3. In preparation for discharge, the patient care plan will address the assessment of continuing care needs and necessary referrals for such.

Care, treatment and rehabilitation are evaluated against the goals of the plan of care and are revised periodically as appropriate to the patient.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL DEPARTMENTS*

SUBJECT: **INTERDISCIPLINARY CARE PLAN – COMPLETION OF**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 2 of 2**

PROCEDURE:

1. Upon admission and within 4 hours, the licensed nurse will initiate the Interdisciplinary Plan of Care.
2. The Interdisciplinary Care Plan is reviewed every shift and updated and revised as the patient's condition warrants.
3. Other disciplines will update and revise the care plan as necessary. Any changes made to the plan of care will be communicated to the Registered Nurse of the patient.
4. Goals or expected outcomes must be realistic and measurable.
5. Interventions must be consistent with the medical plan of care by checking the appropriate action that will resolve or improve the problem.
6. The patient's psychosocial, spiritual concerns and developmental needs will be incorporated into the Interdisciplinary Plan of Care.
7. The Interdisciplinary Care Plan is reflected in all nursing documentation forms.
8. Upon discharge, the nurse will complete the Outcome Status of each problem as applicable to the patient.

CROSS REFERENCES:

- Nursing Documentation Policy
- The Joint Commission – 2023 Hospital Accreditation Standards; PC.01.03.01

SUBJECT: **PAIN MANAGEMENT**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 6**

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

PURPOSE:

To define the process of assessment, interventions and reassessment of pain in patient populations across the lifespan.

DEFINITIONS:

1. 0-10 Pain Scale (numeric scale) – Pain scale used for children older than 7 years of age and for adults who can understand abstract numbers (10 point scale).

2. Wong-Baker FACES Scale – Pain scale used for children or others whose developmental age is approximately 3-7 years, and who can communicate intensity and location of pain, but who do not understand abstract numbers (10 point scale).

3. FLACC Scale – Pain scale used primarily for infants and children on all units, nonverbal children, and the cognitively impaired. It measures Face, Legs, Activity, Cry, and Consolability on a scoring continuum from zero (0) to two (2). The total score (0-10) cannot be converted to the descriptive groupings of the 0-10 numeric pain scale, and should be contextualized to the particular patient, clinical setting and primary caregiver's perception of the patient's behavior when determining interventions needed.

4. Mild pain - Value of 1-3 on the numeric scale.

5. Moderate pain – Value of 4-6 on the numeric scale.

6. Severe pain – Value of 7-10 on the numeric scale.

7. Chronic Pain- Any pain persisting that occurs beyond the usual course of a disease or beyond the reasonable time for an injury to heal. It negatively impacts all aspects of an individual's life, including emotional, vocational, financial and social elements.

8. Critical Care Pain Observation Tool (CPOT)- Designed specifically to identify and assess the pain of critically ill patients that are otherwise unable to give report on their pain. Scoring takes place in multiple categories such as the following: Facial expression, body movements, muscle tension, compliance with ventilator or vocalization (extubated patients only). A score >2 suggesting patient is in pain.

POLICY:

A. Optimal management of pain is a primary goal of patient care and is crucial to quality patient care. Sierra View Medical Center (SVMC) recognizes that pain is a unique and individual experience for each patient. As such, staff will involve patients in management of their pain to the degree that patients have the capacity to participate. Healthcare professionals will assess pain using one of the developmentally appropriate tools mentioned in DEFINITIONS.

B. Staff Education, Orientation and Competency Validation

1. During the initial orientation period, all levels of staff who have direct patient care responsibilities, including contract/agency staff, are oriented to this policy and procedure and to appropriate pain management.

2. Competency validation related to pain management is documented in employee files.

C. Pain scores will be collected at the following times:

1. On admission

2. Each time vital signs are measured - this is not necessary if vital signs are being measured more frequently than every 30 minutes unless the patient is undergoing a painful procedure.

3. Whenever a patient complains of pain.

4. Reassessment within 60 minutes of intervention to treat pain unless patient is in surgery or a procedure during the 60-minute timeframe.

D. All patients capable of answering will be questioned regarding the presence of pain, what form of pain management is most effective for that type of pain, and how they would rate the pain using a standard scale. Information will be sought from family/significant others/caregivers, and physical assessments will be performed by nursing staff for patients without capacity to interact with the care team to manage pain.

E. Management of the patient's pain is an interdisciplinary process and will be included in the plan of care . Licensed clinical staff acting within their scope of practice will assess and reassess the patient for pain and responses to treatment interventions.

F. Licensed patient care providers will provide education to the patient and the patient's family/significant others/caregivers regarding pain management.

G. The use of placebos is appropriate only in clinical trial settings providing there is documented informed consent. Placebos will NOT be prescribed or administered outside of the clinical trial setting.

H. If it is determined that the facility is unable to manage a patient's pain, the patient will be referred to a facility that can meet that need.

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

PROCEDURE:

A. Initial Assessment

1. Upon admission, all patients will be assessed for the presence of pain. The most appropriate pain rating scale will be used to evaluate the patient's pain.

2. The initial assessment will also include the presence of chronic pain.

3. Pain assessment will include, but not be limited to, the following information:

   a. Location or site of pain (use a body chart for patients to locate)

   b. Use a pain intensity rating scale appropriate for the patient population

   c. What makes the pain worse, i.e. position, movement, time of day

   d. What makes the pain better, i.e. position, heat or cold, medication

   e. Effects of medication (relief, side effects), effects on activities of daily living, quality of life

   f. Description and quality of the pain (dull, sharp, aching, stabbing, cramping, etc.) in the patient's own words

4. The patient's cultural, spiritual, ethical, family and personal beliefs and values will be included in the assessment as appropriate.

5. The patient's/significant other's learning needs, abilities, preferences and readiness to learn will be assessed to include but not be limited to:

   a. Emotional barriers and motivations

   b. Financial implications of core choices

   c. Physical and cognitive limitations

   d. Educational level and language and literacy

   e. Beliefs and values

6. In addition, patients identified to have chronic pain will have the following assessment documented in the chart:

    a. Pharmacological and nonpharmacological modalities that are successful in relieving the patient's chronic pain.

B. Reassessment

1. The patient will undergo reassessment of pain during each designated vital sign assessment, when a patient complains of pain, during a painful procedure and after every pain control mechanism used by the patient care providers. Data collected will be documented in the electronic medical record. Pain control mechanisms include both pharmacological and nonpharmacological interventions, they include but are not limited to:

    a. Medications administered for the control or relief of pain and during the post-operative period (i.e. PCA pump; spinal/epidural/IV administration of medicine)

    b. Medications administered for the control or relief of anxiety

    c. Repositioning of the patient

    d. Ambulating of the patient

    e. Mild patient exercise

    f. Therapeutic massage (i.e. back rub)

    g. Bathing or sitz bath

    h. Diversion techniques (i.e. television or videotape viewing, reading)

    i. Therapeutic communication

    j. Spiritual counseling

    k. Visitation from family/significant others

2. Any patient care provider, from any department, that has implemented a pain control mechanism, will reassess the patient within 60 minutes of administration of medication to treat pain unless the patient is in surgery or a procedure in the 60-minute timeframe.

C. Patient Education

1. All patient care providers will provide information to the patient and the patient's family/significant other about pain management.

2. Patients will be taught that pain management is part of their treatment.

3. Patients will be instructed to keep their nurse informed about their pain so that they may receive interventions, including medications as ordered.

4. The patient and their family/significant others will receive education provided by licensed staff regarding management of the patient's pain. Education includes, but is not limited to:

   a. Types of pain the patient actually or potentially experienced

   b. Pain control mechanisms available and/or that have been employed

   a. Potential limitations of pain management and treatment

   c. Potential and/or actual side effects of pain management treatments

   d. Determination of the patient's acceptable level of pain, i.e. the terminally ill patient may wish complete relief from pain, knowing this may render him/her in a semi-somnolent state; or this patient may request relief from pain to the degree where pain may still be experienced, however his/her ability to remain mentally alert and relate to family/significant others remains intact

   e. Discharge planning process with emphasis on symptom management, i.e. pain, nausea, or dyspnea

5. Education will be documented in the electronic medical record.

D. High Risk Inpatients

E. When a physician identifies a patient as high risk, they may be monitored by CO_2 monitor or other appropriate equipment as directed by the physician.

F. Outpatient Referrals

1. Upon discharge, patients requiring continued pain management (e.g. palliative care), may be referred to appropriate service for care.

REFERENCES:

- The Joint Commission (2025). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- FLACC Scores. Retrieved on July 30, 2020 from https://www1.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-pain~triageqrg-FLACC.
- Wong-Baker FACES Pain Rating Scale. Retrieved on July 30, 2020 from https://wongbakerfaces.org/instructions-use/.

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

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

PURPOSE:

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

AFFECTED PERSONNEL/AREAS: *MEDICAL SURGICAL NURSING STAFF*

POLICY:

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

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

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

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

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

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

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

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

   g. The patient's immunization status

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

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

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

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

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

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

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

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

Cribs or beds:

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

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

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

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

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

NURSING STANDARDS – PEDIATRIC

A. The nursing staff shall be competent in:

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

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

3. Prevention of contamination and cross contamination.

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

REFERENCES:

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

SUBJECT: **PERSONNEL MONITORING FOR RADIATION EXPOSURE**	SECTION:

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

PURPOSE:

Radiation protection for patients and staff will be carried out as outlined in Title 17, California Administrative Code. In compliance with California Radiation Control Regulations Title 17, Sub-chapter 4, Chapter 5.

POLICY:

1. Personnel Monitoring: Cancer Treatment Center (CTC) shall supply appropriate personnel monitoring equipment to and shall require the use of such equipment by:

   a. Each individual 18 years of age or over who enters a controlled area under such circumstances that he is likely to receive in any calendar quarter a dose exceeding 300 millirems to the whole body; or 5 rems to the hands, forearms, feet, and ankles, or 2 rems to the skin of the whole body.

   b. Each individual under 18 years of age who enters a controlled area under such circumstances that he is likely to receive in any calendar quarter a dose exceeding 60 millirems to the whole body; or 900 millirems to the hands, forearms, feet, and ankles, or 400 millirems to the skin of the whole body.

   c. Each individual who enters a High Radiation Area.

   Personnel monitoring devices will be required and provided for each applicable staff member of the Cancer Treatment Center, through a licensed company of interpreting radiation exposure.

AFFECTED AREAS/ PERSONNEL: *CANCER TREATMENT CENTER STAFF*

REFERENCES:

- California Code of Regulations, Title 22, Radiation Therapy Service General Requirements, Section 70587.
- California Code of Regulations, Title 17, Standards for Protection Against Radiation, Section 30255.

American Society of Radiologic Technologists. *The ASRT Practice Standards for Medical Imaging and Radiation Therapy*. 2025 American Society of Radiologic Technologists. https://www.asrt.org/docs/default-source/practice-standards/asrt-practice-standards-for-medical-imaging-and-radiation-therapy.pdf (Accessed September 15, 2025).

- American College of Radiology (ACR) and American Society for Radiation Oncology (ASTRO). Practice Parameter for Intensity Modulated Radiation Therapy (IMRT). Amended 2014 (Resolution 39). https://gravitas.acr.org/PPTS/GetDocumentView?docId=122.Accessed September 15, 2025.

SUBJECT: **PHYSICIAN NOTIFICATION CRITERIA**	SECTION:

PURPOSE:

To define when treatment should be held pending provider notification.

POLICY:

Treatment shall be held and provider notified when patient presents with symptoms of being clinically unstable. Such symptoms may be:

1. Abnormal vital signs:
   a. Temperature: >100° Tympanic , or ≥ 100.4
   b. Blood Pressure: Systolic <85 >180, Diastolic <50
   c. Pulse: <50 (45 if on beta blocker)
   d. Respiration: >30
   e. SpO2 < 90
2. Changes in mental status:
   a. Lethargic
   b. Dizziness
   c. Confusion
   d. New onset agitation
3. Loss of function (eg. decrease in ADL from baseline)
4. Increased neuropathy such as numbness/tingling paralysis
5. Productive cough with yellow/green sputum
6. ↑ SOB over baseline (eg. sudden onset, with chest pain, interferes with ADL's)
7. Uncontrolled nausea and vomiting (eg. despite antiemetics)
8. Uncontrolled diarrhea >6 stools in 24 hours
9. Severe fatigue "3" on a scale of 0-3

10. Symptomatic anemia:
    a. ↑ Dizziness
    b. Fainting
    c. ↑ SOB
    d. Chest Pain
11. Bladder symptoms:
    a. Burning with urination
    b. ↑ Frequency
    c. Fever or flank pain
12. Skin alterations:
    a. Rash
    b. Infection
    c. Severe burn or laceration
13. Abnormal labs:
    a. Anc: <1.5
    b. Hgb: <8
    c. Plt: <100
14. Mucositis >1 on WHO scale

AFFECTED AREAS/ PERSONNEL: *CANCER TREATMENT CENTER STAFF*

PROCEDURE:

After physician notification, document actions taken in patient medical record.

REFERENCE:

- National Comprehensive Cancer Network. Antiememis Guidelines (Version 2.2025).
- https://www.nccn.org/professionals/physician gls/pdf/antiemesis.pdf Accessed November 30, 2023
- National Comprehensive Cancer Network. Cancer Related Fatigue Version 2.2024 https://www.nccn.org/professionals/physician_gls/pdf/fatigue.pdf Accessed November 30, 2023
- National Comprehensive Cancer Network. Prevention and Treatment of Cancer Related Infections (Version 3.2024). https://www.nccn.org/professionals/physician_gls/pdf/infections.pdf Accessed September 23, 2025ONS Symptom Intervention and Guidelines https://www.ons.org/clinical-tools/pep. Accessed September 23, 2025

SUBJECT: **POINT OF USE: INSTRUMENT CLEANING AND TRANSPORT**	SECTION: **Page 1 of 3**

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

PURPOSE:

This document provides guidance for **cleaning** surgical instruments, including point-of-use treatment, transport, **decontamination**, inspection, and general care of reusable medical devices (eg, surgical instruments).

POLICY:

All instruments used in a procedure will be cleaned of gross soil, sprayed with instrument spray post procedure and returned to the CPD in a puncture proof, locking container labeled as "Bio Hazardous."

AFFECTED PERSONNEL/AREAS: *ENDOSCOPY, SURGICAL SERVICES, AMBULATORY SURGERY, RADIOLOGY, UROLOGY CLINIC, WOUND CARE CLINIC, MEDICAL/SURGICAL UNIT, TELEMETRY UNIT, EMERGENCY DEPARTMENT, MATERNAL & CHILD HEALTH UNIT, INTENSIVE CARE UNIT, ENDO/FLEX CARE/PACU, CENTRAL PROCESSING DEPARTMENT, NICU, PHYSICAL THERAPY, CARDIAC CATH LAB, CDU, RENAL SERVICES, DP/SNF, SURGERY CLINIC, OB/GYN Clinic.*

EQUIPMENT:

- Biohazard red containers
- Enzymatic instrument spray
- Closed transport carts

PROCEDURE:

1. Wear appropriate personal protective equipment (PPE), per task.

2. Begin preparation for instrument decontamination at the point of use with water.

3. Pre-clean gross soil (to prevent the formulation of biofilm) at *point of use with water* (i.e., procedure room, operating room (OR), soiled utility room, etc.)per product recommendations and manufacturer's instructions for use (IFU).

4. After the procedure is complete, obtain instruments to be cleaned.

5. Sharp instruments must be separated from other instruments and confined in a puncture-resistant container before transport to the decontamination area.

6. Protect delicate instruments (eg, fiberoptic cords, endoscopes, microsurgical instruments, robotic instruments) from damage during transport to a decontamination area by segregating them into different containers or by placing them on top of heavier instruments.

7. Keep instruments moist until they are cleaned by using either saturation with an enzymatic pretreatment product or a towel moistened with water placed over the instruments. Do not use saline.

8. Per the Association for the Advancement of Medical Instrumentation (AAMI) Guidelines, a disposable sponge or brush soaked in water could be used to wipe gross soil.

9. All items will be placed in CPD-provided leak proof red container labeled as biohazardous, without water added.

10. Prior to transport, spray item with CPD-provided instrument spray

    a. Assure fully covered, especially around the hinges
    b. Hinged instruments to remain open

11. Arrange for transport to CPD

    a. Department with dirty instrumentation will ensure transport via CPD/courier to CPD in red biohazardous container for reprocessing.
    b. Each department will be given an appropriate quantity of red biohazardous containers to allow for an exchange from dirty to clean containers (indicated by blue containers).

12. CPD will receive items in biohazardous containers. CPD is responsible to monitor the process and assure items are received in an appropriate manner.

13. When instruments have been reprocessed, they will be delivered back to department by CPD/courier

REFERENCES:

- Association for the Advancement of Medical Instrumentation (AAMI) ST 79 (2017). *Comprehensive guide to steam sterilization and sterility assurance in healthcare facilities*. (pp.33-38).

- Disinfection (HLD) and Sterilization ~~2022~~ 2023. The Joint Commission. Sterilization, Retrieved from https://www.jointcommission.org/resources/patient-safety-topics/infection-prevention-and-control/disinfection-and-sterilization/

- Association of Operating Room Nurses. Guidelines. Instrument Cleaning. October 12, 2020. Retrieved from https://aornguidelines.org/guidelines/content?sectionid=173736661&view=book#173736661

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under

appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

SUBJECT: **PREGNANT PATIENT – RADIATION TREATMENT**	SECTION: ***Radiation Therapy*** Page 1 of 1

PURPOSE:

To define the process for considering pregnancy before and during radiation treatment.

POLICY:

Decisions regarding the use of radiation therapy during pregnancy, the delay of therapy, or pregnancy termination should be made by the patient and physician and be guided by the prognosis of the disease, the stage of gestation, the risk to the fetus from the expected fetal radiation dose, and the patient's ethical and religious beliefs.

During the informed consent process the Radiation Oncologist will review the following:

- Patients will be asked if they are pregnant prior to receiving radiation therapy.
- Patients will be asked to not become pregnant while receiving radiation treatment.
- Patients will be asked to report pregnancies or suspected pregnancies to the treatment team immediately.

If a patient reports being pregnant or is otherwise known to be pregnant prior to or during radiation treatment, do not proceed with treatment, notify the ordering physician immediately.

AFFECTED AREAS/ PERSONNEL: *CANCER TREATMENT CENTER STAFF*

REFERENCES:

American Association of Physicists in Medicine (AAPM). Task Group 36. Fetal Dose from Radiotherapy with Photon Beams. AAPM Report No. 50. College Park, MD: AAPM. Retrieved from https://www.aapm.org/pubs/reports/rpt_50.pdf (Accessed September 15, 2025).

American College of Obstetricians and Gynecologists (ACOG). Guidelines for Diagnostic Imaging During Pregnancy and Lactation. Committee Opinion No. 723. Obstet Gynecol. 2017;130:e210–e216. Retrieved from https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/10/guidelines-for-diagnostic-imaging-during-pregnancy-and-lactation. (Accessed September 15, 2025).

Centers for Disease Control and Prevention (CDC). Radiation and Pregnancy: Information for Clinicians. Atlanta, GA: CDC. Retrieved from https://www.cdc.gov/radiation-emergencies/hcp/clinical-guidance/pregnancy.html (Accessed September 15, 2025).

CROSS REFERENCES:

- Patient Pregnancy Risk – Imaging Policy & Procedure Manual

SUBJECT: **RADIATION SAFETY**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide a safe environment for patients and health care personnel by minimizing exposure to radiation.

SUPPORTIVE DATA:

Ionizing radiation can damage living tissues and may produce long-term effects.

POLICY:

Because of the effects of ionizing radiation exposure on tissue, patients and personnel will be protected from unsafe levels of radiation that are not medically indicated.

AFFECTED AREAS/PERSONNEL: *CANCER TREATMENT CENTER STAFF*

PROCEDURE:

Personnel Precautions:

1. All personnel should follow As Low as Reasonably Achievable (ALARA) principles when operating radiation generating machines or handling radioactive materials:

    a. Time: Minimize the time of a necessary exposure to radiation
    b. Distance: Maximize the distance to a radiation source
    c. Shielding: Use the maximum amount of shielding that does not impair operating personnel's functionality

2. When operating a Linear Accelerator or any other radiation generating machine, use precautions to ensure that the treatment room is clear of any operating personnel, the treatment room door is closed and only the prescribed radiation dose is delivered to the patient.

3. When operating a linear Accelerator or any other radiation generating machine, never bypass any of the safety or operational interlocks of the machine to provide functionality of the treatment unit.

4. Apply good communication practice to ensure that every member of the treatment team is aware of the locations and actions of all other members, especially in the treatment room.

5. Ensure correct patient position and condition via the Audio/Visual Communications System.

6. Before entering the room, ensure that the radiation indicator light is off.

7. Ensure that no minors under the age of 18 or pregnant women (other than therapists) are in the control area when operating the radiation generating machine.

8. In case both video systems for patient monitoring should fail, patient treatment is to be discontinued until the problem is fixed.

9. Report all safety related problems that involve both the patient and the operating personnel immediately to the Radiation Safety Officer.

Monitoring:

1. Film badges:

   a. All Cancer Treatment Center personnel who may be exposed to radiation will be provided with film badges.

   b. When at work, staff will continually wear the photon radiation monitoring badge. The badge should be left at the work place after the completion of a work day. Pregnant personnel will be required to wear 2 film badges. One a fetal monitor, worn at waist level and one in the usual chest area. Those film badges should be evaluated on a monthly basis.

   c. The film badges are evaluated according to the guidelines of the Imaging Department at Sierra View Medical Center. The Cancer Treatment Center will be supplied with read-out sheets concerning the amount of exposure each employee receives.

   d. In the event of an over exposure of an individual to radiation, that employee may not be assigned to radiation procedures until cleared by Employee Health.

   e. Over exposed employee situations will be investigated by the Cancer Treatment Center Director and Radiation Safety Officer.

   f. Area Monitoring and Control: Several radiation area monitors will be placed in the vicinity of the treatment vault as well as throughout the Radiation department for long-term radiation monitoring.

   g. Radiation Safety Training: For any new personnel, in case of new equipment, new procedures, and on an annual basis, Radiation Safety training will be provided to all technical staff at the Cancer Center. Such training will include radiation principles, types of radiation, effects of radiation on the human body, the ALARA principle, methods for protection from radiation, allowable radiation exposure limits, and state regulation.

REFERENCES:

- U.S. Nuclear Regulatory Commission. 10 CFR Part 20—Standards for Protection Against Radiation. Washington, DC: U.S. Nuclear Regulatory Commission. Retrieved from https://www.nrc.gov/reading-rm/doc-collections/cfr/part020/full-text. (Accessed September 15, 2025).

- Centers for Disease Control. "Guidelines for ALARA" February 2024. Retrieved from: G035101p01x.ukg.net/pages/utility/newsession.aspx. (Accessed September 15, 2025)

CROSS REFERENCES:

- Radiation Badge Policy

SUBJECT: **SIMULATION OF TUMOR LOCALIZATION**	SECTION: **Page 1 of 2**

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

PURPOSE:

Simulation of tumor localization is a procedure used to determine the location of the tumor and the size, in relation to other anatomical structures and organs in the body. Localization can be done by examining X-rays, CT scans, or by performing a treatment simulation.

POLICY:

Each patient who is to be treated will, with minor exceptions, undergo a treatment CT simulation. During simulation, optimal patient positioning is determined. Immobilization devices are created if needed or prescribed by the physician. Treatment parameters, including couch positioning, gantry angle and collimator angle, beam entry sites and field localization, are identified during the treatment planning. Digital photographs should be taken and patient fiduciary points are tattooed at this time.

AFFECTED AREAS/ PERSONNEL: *RADIATION THERAPY STAFF*

PROCEDURE:

1. Machine warm-up and checkout

   a. Prior to machine warm-up, the CT Scan will be started in accordance with the procedures listed in the operator's manual.

   b. For additional information on machine warm-up or morning checkout mode, consult the operator's manual.

2. Reportable Variances

   a. Variances in the results will be logged and reported to the department's physicist.

3. Simulations

   a. The patient will be positioned on the simulator table in a manner corresponding to the type of treatment desired and location of treatment area. Any immobilization devices such as aquaplast masks or vac locks will be created before the actual CT simulation. Fiducials will be placed on the patient's skin to mark the intersection of the lasers on the patient's skin.

   c. Upon completion of the scan, the technologist will mark the fiducial locations with permanent tattoos.

4. Images for each patient will be transferred to the treatment planning computer.

   a. Treatment information needed for plan running are recorded. These include:

      - Patient Name

- Patient Medical Record Number
- Date of CT
- Site and/or Plan Name
- Tumor Volume or Margin
- Critical Structures / Dose Limits
- Dose Fractions
- Technologist and/or Dosimetrist's Initials

5. Quality Assurance

   a. A record of all tests and surveys done on the CT Simulator will be kept for future reference. These records will consist of light field/radiation, field verification, morning checkout data sheets, listing of machine faults during each treatment or operational period during the day, all physics calibration, and surveys done on the equipment during a specific period of time.

6. Shutdown Procedures

   a. Shutdown procedures will be followed according to the operator's manual.

REFERENCES:

- American Society for Radiation Oncology (ASTRO). Safety is No Accident: A Framework for Quality Radiation Oncology and Care. March 2019. Available at: https://www.astro.org/practice-support/quality-and-safety/safety-is-no-accident. Accessed September 11, 2025.

- Dove APH et al. "Academic Patterns of Practice Regarding CT Simulation" October 2022. https://pmc.ncbi.nlm.nih.gov/articles/PMC10230158/. Accessed September 15, 2025

- . American Society of Radiologic Technologists. The Practice Standards for Medical Imaging and Radiation Therapy. Revised June 30, 2024. Available at: https://kbmirt.ky.gov/PublishingImages/Pages/Statutes-Admin-Regulations/The%20ASRT%20Practice%20Standards%20for%20Medical%20Imaging%20and%20Radiation%20Therapy%20%E2%80%93%20Mammography%20revised%20June%2030%202024.pdf Accessed September 11, 2025.

SUBJECT: **TATTOOING PATIENTS**	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 patients are tattooed in a consistent manner and only after an Informed Consent is obtained.

POLICY:

- Patients will be tattooed for a permanent documentation of the treatment fields.
- Patients will sign an Informed Consent providing permission for this procedure to be performed. This will become part of the patient's medical record.
- Tattoos will be documented in the treatment chart.

AFFECTED AREAS/ PERSONNEL: *RADIATION THERAPY STAFF*

PROCEDURE:

1. The tattoo procedure will be explained to the patient by the Radiation Therapist performing the procedure.
2. Field photos and/or treatment diagrams documenting patient positioning and location of tattoos will be placed in the electronic treatment chart.

RECOMMENDATIONS:

1. Tattoo at the time of CT simulation or clinical simulation. The patient's skin is less sensitive and less apt to bleed because of capillary dilation when tattoos are done before the start of radiation.
2. Tattoo only after all points of interest have been verified.
3. Warn the patient that they will be feeling a prick of pain.
4. Clean area with an alcohol swab prior to tattooing. Place a drop of ink on the area to be tattooed, pierce outer skin layer with a 21 gauge sterile needle, clean area of excess ink, and clean area again with an alcohol swab. Verify that tattoos are visible before releasing patient.
5. DO NOT puncture near the eyes or over the temporal area.
6. For patients receiving radiation to the head and neck area, aquaplast masks are used for immobilization. Marks representing the isocenter are marked on the mask, eliminating the need to tattoo these patients.
7. When tattooing near the spinous process or any other thin area, pull the skin aside, away from the thin area and then execute the tattoo.

REFERENCES:

- Agarwal, J.P. "Skin markings methods and guidelines: A reality in image guidance radiotherapy era" South Asian Journal of Cancer, 2012 Jul-Sep; 1(1): 27–29.

Stone S, et al. Improving the Practice of Tattooing in Radiation Oncology. American Journal of Infection Control (AJIC). 2014.

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Courtney Misher MPH, Allyson Van Horn MPH. Radiation Therapy Tattoos. OncoLink. March , 2024. https://www.oncolink.org/cancer-treatment/radiation/support/radiation-therapy-tattoos. Accessed September 15, 2025

SUBJECT: THERAPEUTIC PHLEBOTOMY	SECTION: Page 1 of 4

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

PURPOSE:

To provide guidelines for removal of excess peripheral blood volume for the treatment of Hemochromatosis, Polycythemia Vera (PV), Porphyria Cutanea Tarda and other hematologic disorders.

DEFINITIONS:

- ***Phlebotomy:*** Procedure to remove blood from a person, usually 250mL to 500mL.
- ***Hemochromatosis:*** Iron overload disorder or iron loading disorder.
- ***Polycythemia Vera:*** Chronic life-shortening Myeloproliferation disorder, characterized by an increased red cell mass (from a single cell clone).
- ***Porphyria Cutanea Tarda:*** Most common type or porphyria. Associated with chronic liver failure, characteristic skin lesions and blistering and erosions of sun-exposed areas.

POLICY:

Therapeutic phlebotomy will be performed at the Cancer Treatment Center by nursing staff under the direct supervision of a provider, qualified to assist in an emergency.

AFFECTED PERSONNEL/AREAS: CTC NURSING STAFF

EQUIPMENT:

- Blood collection kit with needle (16 or 17 gauge)
- Blood pressure assembly
- Tape
- Gauze dressing and tape
- Tourniquet
- Stress ball

SPECIAL PRECAUTIONS:

- Patients should be well hydrated prior to the procedure. Offer oral fluids.
- Withdrawal should not exceed a maximum of 500mL of blood (450mL = 1 pound or 1 unit) to be removed at any one time unless otherwise ordered by provider, with relevant supporting data. If more than one unit is to be removed during the procedure, consider obtaining an order for and starting an IV for fluid replacement.

- If systolic blood pressure is less than 90 mmHg and or pulse greater than 130 beats per minute, contact provider before proceeding with phlebotomy
- Relevant target levels as pertain to the diagnosis (i.e. hematocrit <45% for PV or ferritin <50-100 ng/mL for hemochromotosis) should be specified, obtain clarification from ordering provider if necessary, hold once target(s) achieved.
- Appropriate protective apparel should be donned while performing phlebotomy (gloves).

Adverse reactions include fainting, dizziness, nausea/vomiting, hyperventilation, hematoma, bleeding, convulsing, cardiac and respiratory difficulties. Observe the patient closely. DO NOT LEAVE the patient alone during or after the procedure for 15 minutes. In the event of an adverse reaction stop the procedure immediately, institute Basic Life Support (BLS) measures to sustain life if necessary. Summon backup help at the outset of any resuscitation effort and call 9-1-1 for patients with unstable vital signs.

PROCEDURE:

1. Obtain chart and supplies
2. Offer the patients fluids of choice, 500 mL pre-procedure unless contraindicated.
3. Obtain physician's order specifying amount to be withdrawn, frequency, and desired target levels.
4. Explain procedure to the patient.
5. Obtain written consent of the patient.
6. Collect vital signs prior to beginning procedure.
7. Place the patient on a stretcher chair (converts to supine position) or bed
8. Identify antecubital fossa or accessible vein and put on gloves.
9. Wipe phlebotomy site thoroughly with alcohol or chlorhexidine swabs using a circular motion from the center of the site out.
10. Insert needle into the vein and secure with tape. After the tubing is attached release the tubing. Blood should be flowing freely into the bag.

11. Monitor vital signs and observe patient throughout the procedure and 30 minutes after the procedure is over.

12. When the desired amount of blood has been withdrawn, clamp the tubing remove the needle and place gauze over the entry site, keeping constant pressure on the site for the next five minutes.

13. Hold unclamped tubing up to allow blood to drain by gravity into the bag, clamp tubing dispose of blood, bag tubing and needle in a small red hazardous waste container.

14. If there has been no bleeding at the venipuncture site for 5 minutes, apply a dressing Take care to maintain circulation and patient comfort. Patient should remain lying down for at least 10 minutes after phlebotomy.

15. Repeat vital signs.

16. Document phlebotomy site, vital signs before and after, amount of blood taken, patient tolerance of the procedure and any adverse reactions, the duration of the procedure, patient teaching.

17. Review After Phlebotomy discharge instruction with the patient.

INSTRUCTIONS TO PATIENT AFTER PHLEBOTOMY

1. If you experience bleeding from the needle site in your arm, apply firm pressure and raise your arm straight up for 5 to 10 minutes with your fingers over the bandage at the puncture site. If this does not stop the bleeding, you should proceed to the Emergency Department or consult a provider.

2. If you should feel faint, light "headed", or dizzy after leaving the Hospital, sit down immediately, and put your head lower than the rest of your body until the feeling disappears. If such feeling continues, call your provider or go to the Emergency Department.

3. You may resume your normal (non-strenuous) physical activities upon discharge from the Cancer Treatment Center. We advise you not to participate in any strenuous physical activity or return to hazardous occupation for at least 24 hours following phlebotomy.

4. You should avoid driving for at least 1 hour or until feeling fully alert

REFERENCES:

Infusion Nurses Society. Infusion Therapy Standards of Practice, 9th ed. J Infus Nurs. 2024;47(1S):S1–S224.

McMullin MF, et al. "Therapeutic phlebotomy." UpToDate. Accessed September 2025. https://www.uptodate.com

AABB Technical Manual, 21st , 2023

American Red Cross. "What to do Before, During, and After Your Donation." Updated 2024. https://www.redcrossblood.org

Centers for Disease Control and Prevention (CDC). "Iron overload and hemochromatosis." Reviewed 2023. https://www.cdc.gov/hemochromatosis/

CROSS REFERENCES:

Physician Notification Criteria Policy
Emergency Response and Transfer Policy

SUBJECT:	SECTION:
VASCULAR ACCESS DEVICE INJECTIONS/FLUSHING	***Provision of Care, Treatment & Services (PC)***

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

PURPOSE:

Short-term venous access for administration of IV therapy, usually on outpatient basis. Also to ensure patency of catheter during periods of non-use by flushing with heparized saline every four to eight weeks.

POLICY:

As most chemotherapy causes peripheral venous sclerosis, peripheral IV access is limited and questionable for vesicant administration. Patency of the vascular access device must be maintained and complications from long-term vascular access device use should be prevented.

AFFECTED AREAS/ PERSONNEL: *REGISTERED NURSES (RN)*

EQUIPMENT NEEDED:

- One pair non-sterile gloves
- Three alcohol wipes
- One chloraprep applicator
- "Gripper" non-coring needle with attached extension tubing
- One pair sterile gloves
- 1 sterile 2x2 gauze pack
- 1 occlusive dressing
- Two 10 ml syringes filled with normal saline
- One 5ml syringe filled with Heparin 100u/ml
- One Band-Aid or adhesive bandage
- Primary IV solution with tubing attached and primed (if applicable)

SUBJECT:	SECTION:
VASCULAR ACCESS DEVICE INJECTIONS/FLUSHING	***Provision of Care, Treatment & Services (PC)***

PROCEDURE:

1. Observe and palpate vascular access device site for post septum. Observe site for possible complications such as: edema, erosion of tissue over port, signs of infection and dislodgment of port within subcutaneous pocket.

2. Explain procedure to patient. Have patient report any change in sensation during infusion. Stop infusion if any changes are noted, and request X-ray confirmation of port functional capability. Patient may experience slight discomfort when port is accessed.

3. Prepare the injection site:

   a. Don non-sterile gloves.

   b. Cleanse area thoroughly with chloraprep applicator starting over the port and moving outward in a spiral motion to cover an area five inches in diameter and let dry.

4. Prepare a sterile site by opening the sterile gloves. (Do not don.)

5. If the VAD will be used for a push or other infusion, the device will need to be secured by using a sterile 2x2 and an occlusive dressing. Steps 6 & 7.

6. Open the sterile 2x2 and drop on the sterile field.

7. Open the occlusive dressing and drop on the sterile field.

8. Open the non-coring needle pack only so far as to access the cap. Do not touch the cap, instead hold the neck of the cap securely by using the outside of the package wrap. With your other hand, twist off the blue cap, taking care not to touch the tubing. Discard the blue cap.

9. Attach the N.S. syringe and prime the tubing. Leave the syringe attached. Pull from wrap and place needle device and tubing on prepared sterile area. Don sterile gloves.

10. Use the first and second fingers of one hand and place on either side of port to stabilize it during puncture. Insert the non-coring needle perpendicular to the septum and push it firmly through the skin and port septum until it makes contact with bottom part of the port chamber. It should make a "click" sound as the metal needle contacts the metal base of the port.

11. Open clamp and pull slightly on attached syringe plunger. If blood return is present, flush catheter with entire 10ml of normal saline and re-clamp tubing while maintaining positive pressure on syringe plunger as the last ml of saline is injected. To flush port only to maintain patency, proceed directly to step 15.

12. Remove insertion clip from head of needle device. Secure the needle and attached tubing by placing a sterile 2x2 folded into a triangle onto the patient's skin on either side of the needle. Place the occlusive dressing over the site.

13. Remove N.S. syringe and attach the primary IV line using sterile technique.

14. Open all clamps to start the primary IV flowing.

15. After infusion flush with 10ml N.S. using positive pressure technique as noted in step 10.

16. Attach 5ml syringe filled with Heparin 100u/ml. Open clamp, flush extension tubing slowly. Reclamp tubing while maintaining positive pressure.

17. Withdraw needle while firmly stabilizing port with two fingers of other hand.

18. Remove chloraprep solution from patient's skin with alcohol wipes. Apply Band-Aid.

REFERENCES:

- Access Device Standards of Practice for Oncology Nursing (Fourth Edition), 2023, ONS Publications.
- Oncology Nursing Society Chemotherapy and Immunotherapy Guidelines and Recommendations for Practice,(Second Edition) 2024, Oncology Nursing Press, Inc.

CROSS-REFERENCES:

- Patient Care Services Policy - Vascular Access Device (Port-A-Cath) Bolus Injections
- Patient Care Services Policy - Vascular Access Device (Port-A-Cath) Continuous Infusion

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

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

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

POLICY:

1. Upon hire, all Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) will receive training on medication management policies and procedures at the responsibility of the unit manager.

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

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

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

5. ONLY the following practitioners and employees are authorized to waste and witness the wasting of medications per their scope of practice:
   a. Registered Nurses (RNs) & Licensed Vocational Nurses (LVN)
   b. Pharmacists
   c. Licensed Independent Practitioners (Includes all advanced practice practitioners)

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

PROCEDURE:

1. Wasted controlled substances will be deposited into the nearest *Cactus Smart Sink®.*
   a. Dispose of any extra medication while being observed by a physically present witness.

2. Solid controlled medications (tablets, capsules) will be wasted into the left hand opening, labeled "Solids Only".
   a. Remove the solid controlled substance from the Pyxis ® Automated Dispensing Cabinet.
   b. Obtain the ordered dose of medication, using the closest unit dose and a clean pill cutter when necessary.

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

3. Liquid controlled medications (injectable and oral) will be wasted into the right hand opening, labeled "Liquids Only".
   a. Remove the liquid controlled substance from the Pyxis ® Automated Dispensing Cabinet.
   b. Draw up or pour the ordered dose of liquid medication.
   c. Empty the liquid out of the syringe into the receptacle.
   d. Do not insert the syringe or needles.
   e. In the event that the wasted amount is greater in volume than 30mL(for example a 'morphine drip' with 100mL remaining) the following procedure will be followed:
      i. Wasted controlled substance volume remaining, as reflected on the Alaris Infusion Pump, will be witnessed and recorded as the waste amount.
      ii. Note that infusion must remain on the pump until waste amount is witnessed.

4. Topical patches (i.e., fentanyl/Duragesic ®, etc.) will be wasted into the center opening slot, labeled "Patches Only".
   a. Fold the used patch, sticky sides together and place over the center opening slot.
   b. Use the provided tool to push the patch into the *Cactus Smart Sink*®.

5. Documentation of witnessed wasted narcotics without visual verification is not permitted and will result in disciplinary action for both parties involved.
   a. For all controlled medication removed from the Pyxis ® with the exception of the PCA and controlled medication infusions such as epidurals or pain management IV drips sent from pharmacy, waste is documented in the Pyxis ® Automated Dispensing Cabinet with the appropriate witness co-signing the waste.
   b. For all PCA syringes and controlled medication infusions sent up from pharmacy and NOT removed from the Pyxis, the name of the wasted controlled substance and remaining volume will be recorded and co-signed on a Sierra View Medical Center Controlled Substance Log (Pink Sheet).

6. Returning Controlled Medications that were not used to the Pyxis machine
   a. A witness is required to return a controlled substance in Pyxis
   b. Choose the return function
   c. Choose patient name
   d. Choose medication to be returned

e. Check that the amount that you are returning is accurately reflected on the screen or edit as needed and then select the "accept" button on the Pyxis screen.

f. Place medication in return slot. Turn the wheel to ensure that the medication drops securely into the return bin. The return bins are labeled to remind users to execute this step.

g. Pharmacy will run a Return Bin Activity Report twice a day to monitor return activity.

7. Discontinued individual patient's drugs not supplied by the hospital may be sent home with the patient. Those that remain in the hospital after discharge shall be destroyed in the following manner.

   a. Drugs listed in Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall be destroyed in the presence of two pharmacists or a pharmacist and a registered nurse employed by the hospital. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the witnesses required above shall be recorded in the patient's medical record or in a separate log. Such log shall be retained for at least three years.

   b. Drugs not listed under Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall be destroyed in the presence of a pharmacist.

REFERENCES:

- California Board of Registered Nursing. Nursing Practice Act. California Board of Registered Nursing. Accessed October 2, 2025. https://www.rn.ca.gov/practice/npa.shtml
- California Code of Regulations, Title 22, § 51237. Medi-Cal Coverage of Physician Services. Sacramento, CA: Office of Administrative Law. Available at: https://govt.westlaw.com/calregs/Document/IB0E3FEDC5B6111EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default). Accessed October 2, 2025.
- Clark J, Fera T, Fortier C, Gullickson K, Hays A, Murdaugh L, Ogden R Jr, O'Neal B, Rush J, Vest T, Hawkins B. ASHP guidelines on preventing diversion of controlled substances. *Am J Health-Syst Pharm.* 2022;79(24):2279-2306. doi:10.1093/ajhp/zxac246.
- U.S. Government Publishing Office. Title 21, Chapter II, Code of Federal Regulations. 2025. Accessed October 2, 2025. https://www.ecfr.gov/current/title-21/chapter-II

CROSS REFERENCE:

- Controlled Substances Policy

SUBJECT: **PHARMACEUTICAL WASTE**	SECTION: ***Medication Management (MM)*** **Page 1 of 6**

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

PURPOSE:

To outline the methods used at Sierra View Medical Center (SVMC) to comply with federal & state regulations on the appropriate segregation and handling of pharmaceutical waste.

DEFINITIONS:

1. Hazardous Waste Pharmaceutical- means a pharmaceutical that is a solid waste, as defined in § 261.2, and exhibits one or more characteristics identified in part 261 subpart C or is listed in part 261 subpart D. A pharmaceutical is not a solid waste, as defined in § 261.2, and therefore not a hazardous waste pharmaceutical, if it is legitimately used/reused (*e.g.,* lawfully donated for its intended purpose) or reclaimed. An over-the-counter pharmaceutical, dietary supplement, or homeopathic drug is not a solid waste, as defined in § 261.2, and therefore not a hazardous waste pharmaceutical, if it has a reasonable expectation of being legitimately used/reused (*e.g.,* lawfully redistributed for its intended purpose) or reclaimed.

2. Non-creditable hazardous waste pharmaceutical- means a prescription hazardous waste pharmaceutical that does not have a reasonable expectation to be eligible for manufacturer credit or a nonprescription hazardous waste pharmaceutical that does not have a reasonable expectation to be legitimately used/reused or reclaimed. This includes but is not limited to, investigational drugs, free samples of pharmaceuticals received by healthcare facilities, residues of pharmaceuticals remaining in empty containers, contaminated personal protective equipment, floor sweepings, and clean-up material from the spills of pharmaceuticals.

3. Pharmaceutical Waste- means a prescription or over the counter drug that cannot be dispensed, repackaged and sold, redistributed, or returned for credit.

4. Potentially creditable hazardous waste pharmaceutical- means a prescription hazardous waste pharmaceutical that has a reasonable expectation to receive manufacturer credit and is—
(1) In original manufacturer packaging (except pharmaceuticals that were subject to a recall);
(2) Undispensed; and
(3) Unexpired or less than one year past expiration date. The term does not include evaluated hazardous waste pharmaceuticals or nonprescription pharmaceuticals including, but not limited to, over-the-counter drugs, homeopathic drugs, and dietary supplements.

5. Reverse Distributor- means any person that receives and accumulates prescription pharmaceuticals that are potentially creditable hazardous waste pharmaceuticals for the purpose of facilitating or verifying manufacturer credit. Any person, including forward distributors, third-party logistics providers, and pharmaceutical manufacturers, that processes prescription pharmaceuticals for the facilitation or verification of manufacturer credit is considered a reverse distributor.

6. Resource Conservation and Recovery Act (RCRA): Federal law that governs the management of solid and hazardous waste, including pharmaceutical waste in hospital pharmacies. It establishes waste classification whereby a pharmaceutical waste is considered hazardous if it is listed in of

the EPA's four lists (P, U, F, and K) or if it exhibits one of four characteristics (ignitability, corrosivity, toxicity, or reactivity).

7. RCRA Black Bin: Receptacle for designated pharmaceutical waste that is acutely hazardous (P-Listed waste); toxic (U-Listed waste); ignitable (flammable); corrosive; reactive; has toxicity characteristics; or is an endocrine (hormone) disrupter (D-Listed waste).

8. Cactus Sink: Designated pharmaceutical waste container for all controlled substances.

9. Chemotherapy/Trace Yellow Bin: Receptacle for designated pharmaceutical waste including all chemotherapy infusion containers, syringes, and vials that contain are "empty". Also for disposal of all Personal Protective Equipment (PPE) used in preparation and administration of these medications.

10. Sewer: Pharmaceutical waste method for IV fluids containing dextrose, saline, sterile water or lactated ringer's solution as a base solution and may contain potassium (K^{+}), calcium (Ca^{++}) or magnesium (Mg^{++}) salts.

11. Pharmaceutical Comingle Blue Bin: Designated pharmaceutical waste container for all medications that cannot be disposed of in the previously listed option (black or yellow).

12. Empty: is defined by the Medical Waste Management Act as follows:

    1. A condition achieved when tubing, a container, or inner liner removed from a container that previously contained liquid or solid material, including, but not limited to, a chemotherapeutic agent, is considered empty. The tubing, container, or inner liner removed from the container shall be considered empty if it has been emptied so that the following conditions are met:

    (a) If the material that the tubing, container, or inner liner held is pourable, no material can be poured or drained from the tubing, container, or inner liner when held in any orientation, including, but not limited to, when tilted or inverted.

    (b) If the material that the container or inner liner held is not pourable, no material or waste remains in the container or inner liner that can feasibly be removed by scraping.

POLICY:

A. Sierra View Medical Center staff will maximize pharmaceutical safety of patients, staff and community members by ensuring that pharmaceutical waste generated by Sierra View Medical Center shall be segregated, contained, transported, treated and disposed of in accordance with federal & state regulations.

B. Each patient care unit and department is responsible for appropriate training, handling, storage and disposal of pharmaceutical waste products that are generated from the medication use process.

C. Disposal of Chemotherapy Yellow bins, Pharmaceutical Blue bins, and Biohazard/Sharps Red bins are managed by a medical waste contractor who will haul these to a medical waste incinerator, where the contents are burned to ash and dumped into a lined non-hazardous waste landfill. In event the Chemotherapy Yellow bins are unavailable, RCRA Black bins should be used to dispose of those materials.

D. Disposal of RCRA Black bins are managed by a medical waste contractor who will dispose of these into a federally permitted hazardous waste incinerator, where the contents are burned to ash and dumped into a special lined hazardous waste landfill.

AFFECTED PERSONNEL/AREAS: *ALL NURSING, PHARMACY, RESPIRATORY THERAPY, RADIOLOGY, LABORATORY, AND ENVIRONMENTAL HEALTH SERVICES STAFF.*

EQUIPMENT:

- Blue Pharmaceutical Waste Container "comingle": Rigid blue plastic container labeled "Pharmaceutical Waste High Heat or Incineration Heat Only".
- Yellow Trace Chemotherapy Container (antineoplastic)
- Black Hazardous Drug Container
- Red Sharps Container

FROM THIS POINT ON, ONLY PHARMACEUTICAL WASTE WILL BE DISCUSSED. SEE ENVIRONMENTAL SERVICES POLICIES ON WASTE MANAGEMENT.

PROCEDURE:

A. Each nursing unit and department is responsible for the appropriate disposal of pharmaceutical waste products that are generated from the medication use process.

B. Sorting of the pharmaceutical waste products shall be as follows:

1. Controlled Substance Cactus Sink or other bin such as CsRx: All controlled substances (tablets/capsules/injectable and oral liquids/suppositories/patches) will be placed in the Cactus Sink and witnessed as per the Wasting Controlled Substances policy. If the Cactus is full and unavailable, the medication may be wasted in the blue pharmaceutical waste bin. If the medication falls under RCRA it must be wasted in the appropriate black bin.

2. Chemotherapy Yellow Bin: All empty vials, ampules, syringes, IV containers of chemotherapy and all personal protective equipment used to administer the chemotherapy.

3. Sewer/Toilet: The following pharmaceuticals may be disposed of through flushing down the sewer:

   a. IV fluids: Dextrose, Saline, Sterile Water, Lactated Ringer's solutions

   b. IV fluids as above and containing potassium, calcium or magnesium salts

4. RCRA Black Bin AERO: All pharmaceutical items in an aerosol form (usually labeled "contents under pressure") should be returned to Pharmacy in a sealed biohazard bag for separate black bin disposal labeled AERO; medication such as but not limited to:

   a. Albuterol (Proventil/Ventolin/ProAir) & Advair inhalers
   b. Ipratropium (Atrovent) inhaler
   c. Levalbuterol (Xenopex) inhalers
   d. Albuterol and ipratropium (Combivent) inhalers
   e. Beclomethasone (QVAR) inhalers
   f. Fluticasone (Flovent) inhalers
   g. Benzocaine (Americaine, Dermoplast or Hurricaine) sprays

5. Pharmaceutical RCRA Waste- Black Bin
   a. Medications which must be disposed of according to the Resource Conservation Recovery Act of 1976. This includes pharmaceutical wastes that are characteristically hazardous: toxic, flammable, reactive or corrosive.
      i. A Pharmaceutical Waste Categorization file has been developed based on the formulary & is available on the intranet.

6. Pharmaceutical blue waste containers: All other medications that do NOT meet the above requirements. That is, the medication must be Non-Black, Non-Yellow, Non-Controlled Substance and Non-Drain/Sewer to be put in Blue bins.

7. Sharps Waste: The comingle blue pharmaceutical waste containers may be used for disposal of sharps waste. If comingled sharps/pharmaceutical waste containers are not available in the area, red sharps waste containers should be used.

C. Staff shall ensure the bins remain closed, not sealed, when not in active use. Bins must be stored in areas that prevents unauthorized access to its contents such as medication room, soiled utility room.

D. Pharmaceutical waste in form of suspensions, solutions, or emulsions may be discarded in original container into the blue pharmaceutical waste container.

E. Pharmaceutical waste in form of tablets, capsules, or suppositories do not need to be taken out of original packaging and the entire contents may be placed into the blue pharmaceuticals waste container.

F. Pharmaceutical waste in form of cream, ointment, gel or lotion do not need to be taken out of original packaging and the entire contents may be placed into the blue pharmaceuticals waste container.

G. Pharmaceutical waste originating from an isolation room shall be taken to the appropriate pharmaceutical waste bin where it may then be disposed of as described within this policy. Staff should take care to prevent the waste from touching any other surface during disposal. Gloves used to transport the item from isolation should be discarded after waste disposed of & staff shall then perform hand hygiene.

H. Environmental Services (EVS) will obtain and store pharmaceutical waste bin supplies, and replace the bins as needed & be responsible for designating them as Hazardous Pharmaceutical Waste bins as well as documenting the date when the container began accumulating, starting from the date it first becomes a waste.

I. When the pharmaceutical waste container is ¾ full, EVS should be contacted and will seal it with the provided seals and move the container to the secured storage area for removal and incineration by an outside vendor.

The sealed pharmaceutical waste containers shall only be removed by certified/authorized personnel and relocated to designated holding areas. The designated areas are to be locked at all times and may only be accessed by authorized staff & certified third party contractors authorized to collect and package waste for destruction. Pharmaceutical waste not accepted by the primary vendor will be removed by a vendor designated by Environmental Services.

REFERENCES:

- American Society of Health-System Pharmacists Council on Pharmacy Practice Guideline on Pharmaceutical Waste. (2013). *Best practices for hospital and health-system pharmacy, 2013-2014 edition.* Bethesda, Maryland: American Society of Health-System Pharmacists, page 74.
- Johnson, J., Bount, G, Clemons, C, & Williams, H. (2012). Challenges in pharmaceutical waste management: "First, do no harm". *Natural Resources & Environment, 26*(4), pages 1-5. (Published by the American Bar Association.)
- Medical Waste Management Act (2024). California Health and Safety Code Sections 117600-118360.
- Code of Federal Regulations Title 40: Protection of the Environment, parts 261, 262. 266. Retrieved on January 18, 2024 from http:// www.ecfr.gov/cgi-bin/
- EPA website. Retrieved on January 17th, 2024 from https://www.epa.gov/system/files/documents/2022-10/10_step_blueprint_guide_final_9-22.pdf

- Hospital Accreditation Standards. (2025). Oak Brook, IL: Joint Commission Resources, Inc.

CROSS REFERENCES:

- Hazardous Materials and Waste Management Plan
- Pharmaceutical Services policy on WASTING OR RETURNING CONTROLLED SUBSTANCES

SIERRA VIEW
MEDICAL CENTER

MEETING MINUTES

MINUTES FROM PREVIOUS MEETING SUBMITTED FOR APPROVAL

MEETING MINUTES

BOARD OF DIRECTORS REGULAR MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly **October 28, 2025 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman Lomeli called the meeting to order at 5:01 p.m.

Board Attendance:

- Liberty Lomeli, Chair - Present
- Bindusagar Reddy, Vice Chair - Arrived at 5:05
- Areli Martinez, Secretary – Present
- Hans Kashyap, Director – Present
- Zone 2 Vacant

Others Present: Donna Hefner, President/Chief Executive Officer, Craig McDonald, Chief Financial Officer, Ron Wheaton, Vice President of Professional Services & Physician Recruitment, Melissa Crippen, Vice President of Quality and Regulatory Affairs, Tracy Canales, Vice President of Human Resources & Marketing, Brandy Irwin, Chief Nursing Officer, Kim Pryor-DeShazo, Director of Marketing, Silvia Roberts, Director of Care Integration, Jennifer Regalado, Compliance Privacy Manager, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff, Martha A. Flores, Dawn Bennett and Charles Whisnand.

I. Approval of Agenda:

Chair LOMELI inquired if there was a motion to approve the agenda. Director MARTINEZ moved to approve the agenda, the motion was seconded by Director KASHYAP. The motion was carried with the following vote:

KASHYAP	Yes
MARTINEZ	Yes
REDDY	Absent
LOMELI	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:02 p.m. to discuss the following items:

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

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

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

Vice Chair Reddy arrived to the meeting at 5:05pm

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Financial Audit and Strategic Planning (1 Item). Estimated date of disclosure October 29, 2025.

D. Pursuant To Gov. Code Section 54956.9(D)(2), Conference With Legal Counsel About Recent Work Product (B)(1) And (B)(3)(F): Significant Exposure To Litigation; Privileged Communication (1 Items).

E. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation; Anticipated Litigation; BETA Claim 25-001937: Conference with Legal Counsel; (1 Item). Estimated Disclosure: 3 years after completion of matter.

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning concerning new service line (1 Item). Estimated date of disclosure July 1, 2027.

G. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning. Estimated date of disclosure September 1, 2026.

H. Pursuant To Gov. Code Section 54956.9(D)(2), Conference With Legal Counsel About Recent Work Product (B)(1) And (B)(3)(F): Significant Exposure To Litigation; Privileged Communication (1 Items).

III. Open Session: Chair LOMELI adjourned Closed Session at 5:32 p.m., reconvening in Open Session at 5:33 p.m.

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

A. Chief of Staff Report

Information Only; No Action Taken.

Pursuant to Evidence Code Section 1156 and 1157.7:

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

Following review and discussion, Director MARTINEZ made a motion to approve the Quality of Care/Peer Review/Credentials as presented. The motion was seconded by Director Kashyap. The motion was carried with the following vote by the Board:

KASHYAP Yes
MARTINEZ Yes

REDDY	Abstain
LOMELI	Yes

B. Quality Division Update

Pursuant to Evidence Code Section 1156 and 1157.7:

2. Quality Division Update

Following review and discussion, Vice Chair REDDY made a motion to approve the Quality Division Update as presented. The motion was seconded by Director MARTINEZ. The motion was carried with the following vote by the Board:

KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

C. Discussion Regarding Trade Secrets Pertaining to Financial Audit
Information Only; No Action Taken.

D. Conference with Legal Counsel
Information Only; No Action Taken.

E. Discussion of Significant Exposure to Litigation; Anticipated Litigation BETA Claim 25-001937

Following review and discussion, Vice Chair REDDY made a motion to reject BETA Claim 25-001937 as presented. The motion was seconded by Director MARTINEZ. The motion was carried with the following vote by the Board:

KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

F. Discussion Regarding Trade Secrets Pertaining to New Service Line
Information Only: No Action Taken

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

IV. Public Comments

Letter from Patricia P. Dowling was given to the Board for review regarding her positive patient experience.

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). Director KASHYAP pulled the following three policies for further clarification: Environmental Tours, Food Purchasing and Receiving and Food Service Emergency Plan. Following review and discussion, it was moved by Director KASHYAP, seconded by Director MARTINEZ, and carried to approve the Consent Agenda with the exception of the three that were pulled. The vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director MARTINEZ and seconded by Director KASHYAP to approve the September 23, 20205 Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

VII. Business Items

A. Single Audit Review

A virtual presentation was given by Brian Conner, Bradyn Stowe and Justen Gomes of Moss Adams via Zoom.

Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Director Kashyap and carried to approve single audit review as presented. The vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

B. September 2025 Financials

Craig McDonald, CFO presented the Financials for September2025.

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

KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

C. Capital Budget Report Quarter 1

Craig McDonald, CFO presented the Capital Budget Report for Quarter 1.

Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Director MARTINEZ and carried to approve the Capital Budget Report for Quarter 1 as presented. The vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

D. Investment Report Quarter 1

Craig McDonald, CFO presented the Investment Report for Quarter 1.

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

KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

E. Resolution 10-28-2025/01 Free Standing Mental Health Hospital

A resolution is needed as part of a requirement to submit an application for a Behavioral Health Continuum Infrastructure Program (BHCIP) grant. If awarded, grant money would go towards a free-standing psychiatric hospital, with outpatient clinic and urgent care.

Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Director MARTINZ and carried to approve Resolution 10-28-2025/01 as presented. The vote of the Board is as follows:

KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

F. Vote to Appoint Director to Fill Vacancy for Zone 2. Review of Applications and Interview Applicants who are Present Prior to Vote

Two applications were received by the Clerk of the Board for the Zone 2 vacancy. Both candidates were confirmed to reside within Zone 2, and each appeared in person for an interview with the Board. Martha A. Flores and Dawn Bennett were invited to join the Board at the conference table for the interview process. Board members took turns asking questions, focusing on topics such as current healthcare trends, relevant experience, and healthcare gaps within the community.

Following review and discussion, each of the four Board members cast their vote for whom they felt was more qualified to fill the vacancy, the vote of the Board is as follows:

KASHYAP	Martha A. Flores
MARTINEZ	Martha A. Flores
REDDY	Martha A. Flores
LOMELI	Abstain

G. Administer Oath of Office to Director Appointed to Fill Zone 2

Oath of office was administered to Martha A. Flores by CEO, Donna Hefner and Chairman Liberty Lomeli.

VIII. SVLHCD Board Chair Report
No Report was Given

IX. CEO Report

Donna Hefner, President/CEO provided a report of current activities and legislative report that impact Sierra View Medical Center.

IX. Announcements:
A. Regular Board of Directors Meeting – November 25, 2025 at 5:00 p.m.

XII. Adjournment

The meeting was adjourned at 7:33 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

SIERRA VIEW MEDICAL CENTER

FINANCIALS

FINANCIAL REPORTS FROM THE PREVIOUS MONTH

FINANCIAL PACKAGE
Oct-25

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
October 2025

Statistic	Oct-25 Actual	Budget	Over/ (Under)	% Var.	YTD Actual	Budget	Over/ (Under)	% Var.	Fiscal 25 YTD	Increase/ (Decrease) Oct-24	% Change
Utilization											
SNF Patient Days											
Total	31	-	31	0.0%	88	-	88	0.0%	116	(28)	-24.1%
Medi-Cal	31	-	31	0.0%	88	-	88	0.0%	116	(28)	-24.1%
Sub-Acute Patient Days											
Total	1,011	1,073	(62)	-5.8%	4,112	4,261	(149)	-3.5%	4,071	41	1.0%
Medi-Cal	458	538	(80)	-14.9%	1,850	2,205	(355)	-16.1%	2,107	(257)	-12.2%
Acute Patient Days	1,599	1,746	(147)	-8.4%	6,410	6,688	(278)	-4.2%	6,308	102	1.6%
Acute Discharges	440	463	(23)	-5.0%	1,840	1,773	67	3.8%	1,773	67	3.8%
Medicare	151	177	(26)	-14.7%	652	693	(41)	-5.9%	693	(41)	-5.9%
Medi-Cal	230	225	5	2.2%	933	850	83	9.8%	850	83	9.8%
Contract	56	60	(4)	-6.7%	241	217	24	11.1%	217	24	11.1%
Other	3	1	2	200.0%	14	13	1	7.7%	13	1	7.7%
Average Length of Stay	3.63	3.77	(0.14)	-3.7%	3.48	3.77	(0.29)	-7.6%	3.56	(0.07)	-2.1%
Newborn Patient Days											
Medi-Cal	156	177	(21)	-11.8%	651	652	(1)	-0.1%	639	12	1.9%
Other	40	34	6	17.1%	166	137	29	20.8%	150	16	10.7%
Total	196	211	(15)	-7.1%	817	789	28	3.5%	789	28	3.5%
Total Deliveries	111	107	4	3.7%	455	401	54	13.5%	403	52	12.9%
Medi-Cal %	79.28%	83.43%	-4.15%	-5.0%	78.85%	83.43%	-4.58%	-5.5%	82.18%	-3.32%	-4.0%
Case Mix Index											
Medicare	1.6838	1.6368	0.0470	2.9%	1.6187	1.6368	(0.0181)	-1.1%	1.6051	0.0136	0.8%
Medi-Cal	0.9969	1.1975	(0.2006)	-16.8%	1.0181	1.1975	(0.1794)	-15.0%	1.1836	(0.1655)	-14.0%
Overall	1.2363	1.3724	(0.1361)	-9.9%	1.2836	1.3724	(0.0888)	-6.5%	1.3468	(0.0632)	-4.7%
Ancillary Services											
Inpatient											
Surgery Minutes	9,116	7,863	1,253	15.9%	31,315	31,451	(136)	-0.4%	31,182	133	0.4%
Surgery Cases	87	90	(3)	-3.7%	355	365	(10)	-2.9%	367	(12)	-3.3%
Imaging Procedures	1,467	1,506	(39)	-2.6%	6,218	6,023	195	3.2%	5,883	335	5.7%
Outpatient											
Surgery Minutes	15,461	14,118	1,343	9.5%	60,113	56,473	3,640	6.4%	54,848	5,265	9.6%
Surgery Cases	195	196	(1)	-0.3%	771	783	(12)	-1.5%	763	8	1.0%
Endoscopy Procedures	216	187	29	15.8%	795	746	49	6.5%	741	54	7.3%
Imaging Procedures	4,564	4,194	370	8.8%	17,249	16,777	472	2.8%	16,522	727	4.4%
MRI Procedures	349	304	45	14.9%	1,309	1,215	94	7.8%	1,217	92	7.6%
CT Procedures	1,566	1,262	304	24.1%	5,834	5,047	787	15.6%	4,963	871	17.5%
Ultrasound Procedures	1,679	1,360	319	23.5%	6,120	5,438	682	12.5%	5,404	716	13.2%
Lab Tests	35,958	32,307	3,651	11.3%	141,734	129,230	12,504	9.7%	127,276	14,458	11.4%
Dialysis	11	3	8	226.3%	26	13	13	92.8%	10	16	160.0%

Sierra View Medical Center
Financial Statistics Summary Report
October 2025

	Oct-25				YTD					Increase/	
Statistic	**Actual**	**Budget**	**Over/ (Under)**	**% Var.**	**Actual**	**Budget**	**Over/ (Under)**	**% Var.**	**Fiscal 25 YTD**	**(Decrease) Oct-24**	**% Change**
Cancer Treatment Center											
Chemo Treatments	2,009	2,014	(5)	-0.2%	8,138	8,055	83	1.0%	8,614	(476)	-5.5%
Radiation Treatments	2,118	1,920	198	10.3%	7,213	7,680	(467)	-6.1%	7,823	(610)	-7.8%
									0.0%		
Cardiac Cath Lab									0.0%		
Cath Lab IP Procedures	14	14	0	0.1%	59	56	3	5.4%	45	14	31.11%
Cath Lab OP Procedures	31	33	(2)	-6.9%	127	133	(6)	-4.6%	142	(15)	-10.56%
Total Cardiac Cath Lab	45	47	(2)	-4.8%	186	189	(3)	-1.7%	187	(1)	-0.53%
Outpatient Visits											
Emergency	3,504	3,426	78	2.3%	13,863	13,753	110	0.8%	13,740	123	0.9%
Total Outpatient	15,768	14,313	1,455	10.2%	60,466	57,253	3,213	5.6%	56,854	3,612	6.4%
Staffing											
Paid FTE's	871.82	900.16	(28.34)	-3.1%	885.09	900.16	(15.07)	-1.7%	873.07	12.02	1.4%
Productive FTE's	765.87	772.13	(6.26)	-0.8%	760.77	772.13	(11.36)	-1.5%	741.45	19.32	2.6%
Paid FTE's/AOB	4.93	5.11	(0.18)	-3.5%	5.02	5.20	(0.18)	-3.5%	5.18	(0.16)	-3.1%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,364	10,887.84	477	4.4%	11,249	11,106	143	1.3%	11,212	37	0.3%
Cost/Adj.Patient Day	2,819	2,823	(5)	-0.2%	2,879	2,870	8	0.3%	2,740.00	139	5.1%
Revenue/Adj. Discharge	54,370	53,683	687	1.3%	51,709	55,236	(3,527)	-6.4%	52,832	(1,123)	-2.1%
Cost/Adj. Discharge	13,485	13,921	(436)	-3.1%	13,233	14,276	(1,043)	-7.3%	12,912	322	2.5%
Adj. Discharge	1,145	1,107	38	3.4%	4,715	4,278	437	10.2%	4,397	319	7.2%
Net Op. Gain/(Loss) %	0.84%	-1.15%	2.00%	-173.0%	1.92%	-1.15%	3.07%	-266.0%	-2.43%	4.35%	-178.8%
Net Op. Gain/(Loss) $	131,204	(175,856)	307,060	-174.6%	1,219,155	(756,201)	1,975,356	-261.2%	(1,346,967)	2,566,122	-190.5%
Gross Days in Accts Rec.	99.76	95.03	4.74	5.0%	99.76	95.03	4.74	5.0%	84.65	15.11	17.9%
Net Days in Accts. Rec.	45.02	57.75	(12.73)	-22.0%	45.02	57.75	(12.73)	-22.0%	43.91	1.11	2.5%

Sierra View Local Health Care District
Balance Sheet

	Oct-25	Sep-25
Assets		
Current Assets:		
Cash & Cash Equivalents	16,318,806	11,714,050
Short-Term Investments	-	-
Assets Limited As To Use	2,499,722	2,017,463
Patient Accounts Receivable	198,102,457	195,832,362
Less Uncollectables	(12,858,367)	(13,870,339)
Contractual Allowances	(162,568,816)	(158,344,409)
Other Receivables	26,004,867	29,237,801
Inventories	4,509,502	4,488,101
Prepaid Expenses and Deposits	3,125,921	2,842,153
Less Receivable - Current	301,020	301,020
Total Current Assets	**75,435,113**	**74,218,204**
Assets Limited as to use, Less		
Current Requirements	32,457,422	32,375,105
Long-Term Investments	141,252,321	140,787,029
Property, Plant and Equipment, Net	71,088,250	69,965,032
Intangible Right of use Assets	230,946	243,006
SBITA Right of use Assets	2,776,487	2,925,915
Lease Receivable - LT	607,682	632,608
Other Investments	250,000	250,000
Prepaid Loss on Bonds	1,174,858	1,195,838
Total Assets	**325,273,080**	**322,592,737**
Liabilities and Funds Balances		
Current Liabilities		
Bond Interest Payable	405,883	304,412
Current Maturities of Bonds Payable	4,235,000	4,235,000
Current Maturities of Long Term Debt	599,282	684,544
Account Payable and Accrued Expenses	7,383,624	5,880,843
Accrued Payroll and Related Costs	8,320,887	7,886,959
Estimated Third-Party Payor Settlements	4,455,134	4,294,112
Lease Liability - Current	130,871	132,614
SBITA Liability - Current	1,474,274	1,476,328
Total Current Liabilities	**27,004,955**	**24,894,812**
Self-Insurance Reserves	2,114,815	2,130,222
Capital Lease Liab LT	0	0
Bonds Payable, Less Curr Reqt	29,040,000	29,040,000
Bonds Premium Liability - LT	1,896,496	1,942,016
Lease Liability - LT	122,581	133,200
SBITA Liability - LT	1,771,472	1,890,110
Other Non Current Liabilities	-	-
Deferred Inflow - Leases	848,042	872,539
Total Liabilities	**62,798,360**	**60,902,900**
Unresticted Fund	258,350,395	258,350,395
Profit or (Loss)	4,124,324	3,339,442
Total Liabilities and Fund Balance	**325,273,080**	**322,592,737**
	-	-

Sierra View Local Health Care District
Income Statement

For Period **Oct-25**

	ACTUAL	BUDGET	VARIANCE	% VARIANCE	ACTUAL YTD	BUDGET YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	5,441,457	5,590,232	(148,775)	(3%)	21,850,145	21,374,029	476,116	2%
Inpatient - Ancillary	18,563,054	19,264,931	(701,877)	(4%)	73,630,114	76,559,027	(2,928,913)	(4%)
Total Inpatient Revenue	**24,004,511**	**24,855,163**	**(850,652)**	(3%)	**95,480,259**	**97,933,056**	**(2,452,797)**	(3%)
Outpatient - Ancillary	38,252,696	34,570,726	3,681,970	11%	148,339,600	138,385,192	9,954,408	7%
Total Patient Revenue	**62,257,208**	**59,425,889**	**2,831,319**	5%	**243,819,859**	**236,318,248**	**7,501,611**	3%
Medicare	(18,743,979)	(19,568,846)	824,867	(4%)	(72,378,187)	(77,807,294)	5,429,107	(7%)
Medi-Cal	(21,062,121)	(18,297,729)	(2,764,392)	15%	(85,191,012)	(72,753,342)	(12,437,670)	17%
Other/Charity	(7,611,427)	(6,958,496)	(652,931)	9%	(22,917,086)	(27,759,950)	4,842,864	(17%)
Discounts & Allowances	(149,679)	(18,597)	(131,082)	705%	(394,334)	(73,956)	(320,378)	433%
Bad Debts	(39,957)	(237,704)	197,747	(83%)	(2,364,759)	(945,273)	(1,419,486)	150%
Total Deductions	**(47,607,161)**	**(45,081,372)**	**(2,525,789)**	6%	**(183,245,378)**	**(179,339,815)**	**(3,905,563)**	2%
Net Service Revenue	**14,650,046**	**14,344,517**	**305,529**	2%	**60,574,481**	**56,978,433**	**3,596,048**	6%
Other Operating Revenue	922,323	889,614	32,709	4%	3,043,878	3,343,731	(299,853)	(9%)
Total Operating Revenue	**15,572,369**	**15,234,131**	**338,238**	2%	**63,618,359**	**60,322,164**	**3,296,195**	5%
Salaries	6,100,785	6,139,344	38,559	1%	24,368,459	24,077,686	(290,773)	(1%)
S&W PTO	633,107	726,875	93,768	13%	2,666,404	2,852,332	185,928	7%
Employee Benefits	1,411,237	1,460,204	48,967	3%	5,879,215	5,840,816	(38,399)	(1%)
Professional Fees	1,539,428	1,905,782	366,354	19%	7,787,415	7,578,316	(209,099)	(3%)
Purchased Services	1,149,724	904,743	(244,981)	(27%)	3,846,818	3,634,406	(212,412)	(6%)
Supplies & Expenses	2,627,029	2,298,157	(328,872)	(14%)	9,718,270	9,174,361	(543,909)	(6%)
Maintenance & Repairs	312,587	303,754	(8,833)	(3%)	1,233,029	1,215,016	(18,013)	(1%)
Utilities	294,086	306,217	12,131	4%	1,445,656	1,224,868	(220,788)	(18%)
Rent/Lease	34,870	30,041	(4,829)	(16%)	145,649	120,164	(25,485)	(21%)
Insurance	97,762	122,727	24,965	20%	475,394	490,908	15,514	3%
Depreciation/Amortization	806,420	811,079	4,659	1%	3,270,257	3,244,316	(25,941)	(1%)
Other Expense	434,130	401,064	(33,066)	(8%)	1,562,638	1,625,176	62,538	4%
Impaired Costs	-	-	-	0%	-	-	-	0%
Total Operating Expense	**15,441,165**	**15,409,987**	**(31,178)**	(0%)	**62,399,203**	**61,078,365**	**(1,320,838)**	(2%)
Net Gain/(Loss) From Operations	**131,205**	**(175,856)**	**307,061**	**(175%)**	**1,219,156**	**(756,201)**	**1,975,357**	**(261%)**
District Taxes	138,477	138,477	-	0%	553,908	553,908	-	0%
Investment Income	593,695	488,226	105,469	22%	2,088,379	1,952,904	135,475	7%
Other Non - Operating Income	28,005	40,308	(12,303)	(31%)	114,206	161,232	(47,026)	(29%)
Interest Expense	(71,194)	(70,649)	(545)	(1%)	(291,240)	(282,596)	(8,644)	(3%)
Non-Operating Expense	(63,252)	(39,853)	(23,399)	(59%)	(168,543)	(159,413)	(9,130)	(6%)
Total Non-Operating Income	**625,730**	**556,509**	**69,221**	12%	**2,296,710**	**2,226,035**	**70,675**	3%
			-				-	
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	**756,935**	**380,653**	**376,282**	**99%**	**3,515,866**	**1,469,834**	**2,046,032**	**139%**
Net Incr/(Decr) in the Fair Value Invstmt	27,947	162,500	(134,553)	(83%)	608,458	650,000	(41,542)	(6%)
Net Gain/(Loss)	**784,882**	**543,153**	**241,729**	45%	**4,124,324**	**2,119,834**	**2,004,490**	95%

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SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
October-25

	Current Month	YTD
Cash flows from operating activities:		
Operating Income/(Loss)	131,205	1,219,156
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation/Amortization	806,420	3,270,257
Provision for bad debts	(1,011,972)	(1,362,430)
		-
Change in assets and liabilities:		-
Patient accounts receivable, net	1,954,312	(1,916,503)
Other receivables	3,232,935	(5,736,411)
Inventories	(21,401)	(16,592)
Prepaid expenses and deposits	(283,768)	(506,003)
Advance refunding of bonds payable, net	20,980	83,918
Accounts payable and accrued expenses	1,502,781	1,885,676
Deferred inflows - leases	(24,497)	(97,988)
Accrued payroll and related costs	433,928	(874,548)
Estimated third-party payor settlements	161,022	46,421
Self-insurance reserves	(15,407)	(14,274)
Total adjustments	6,755,332	(5,238,476)
Net cash provided by (used in) operating activities	6,886,537	(4,019,320)
Cash flows from noncapital financing activities:		
District tax revenues	138,477	553,908
Noncapital grants and contributions, net of other expenses	(49,790)	(118,442)
Net cash provided by (used in) noncapital financing activities	88,687	435,466
Cash flows from capital and related financing activities:		
Purchase of capital assets	(1,917,577)	(2,862,871)
Proceeds from sale of assets	-	-
Proceeds from debt borrowings	-	-
Proceeds from lease receivable, net	24,926	98,953
Principal payments on debt borrowings	-	(4,235,000)
Interest payments	(701)	(696,856)
Issuance of bonds payable and bond premium liability	-	-
Net change in notes payable and lease liability	(68,889)	(271,983)
Net changes in assets limited as to use	(564,576)	2,820,979
Net cash provided by (used in) capital and related financing activities	(2,526,817)	(5,146,778)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(437,345)	(1,588,135)
Investment income	593,695	2,088,379
Net cash provided by (used in) investing activities	156,350	500,244
Net increase (decrease) in cash and cash equivalents:	4,604,756	(8,230,390)
Cash and cash equivalents at beginning of month/year	11,714,050	24,549,196
Cash and cash equivalents at end of month	16,318,806	16,318,806
	16,318,806	16,318,806
	(0.00)	(0.00)

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
October 2025

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Nov-24	11,872,571	1,402,779	13,275,350
Dec-24	13,002,191	6,026,303	19,028,494
Jan-25	12,353,155	4,293,154	16,646,309
Feb-25	9,516,870	8,335,277	17,852,147
Mar-25	13,111,820	451,259	13,563,079
Apr-25	13,460,422	8,143,789	21,604,211
May-25	12,344,513	9,292,615	21,637,128
Jun-25	10,549,177	4,753,556	15,302,733
Jul-25	13,219,919	932,239	14,152,158
Aug-25	9,922,993	1,161,531	11,084,524
Sep-25	12,323,268	233,998	12,557,266
Oct-25	**12,181,755**	**7,001,985**	**19,183,740**

NOTE:

Cash receipts in "Other Activity" include the following:

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

- Non-Operating Revenues - rental income, property tax revenues, sale of assets

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

October 2025 Summary of Other Activity:

34,555	Beta Healthcare Group Dividend 1st Installment
16,010	Cal Viva DHDP FY23 Phase 2
2,647,159	Health Net DHDP CY23 Phase 2
90	Health Net DHDP CY23 Phase 2
554	LA Care Healthplan DHDP CY23 Phase 2
92	Contra Costa County DHDP CY23 Phase 2
470,424	M-Cal IP DSH 07/25 - 09/25
253,428	M-Care interim payments
2,903,655	Anthem Blue Cross DHDP CY23 Phase 2
30,919	M-Care Temporary Allowance Cost Report FY15
160,103	M-Care Temporary Allowance Cost Report FY24
484,996	Miscellaneous
7,001,985	10/25 Total Other Activity