SIERRA VIEW
MEDICAL CENTER

SVLHCD BOARD AGENDA

JULY 22, 2025

MEETING LOCATION:
Sierra View Medical Center
Board Room
465 W Olive Avenue
Porterville, CA 93257

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SIERRA VIEW
MEDICAL CENTER

AGENDA

LIST OF ITEMS TO BE DISCUSSED

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

AGENDA
July 22, 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

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

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

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

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2027

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

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

B. Quality Review

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

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

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Recommended Action: Information Only; No Action Taken

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

VI. Public Comments

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

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

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

VIII. Approval of Minutes

A. June 24, 2025 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove June 24, 2025 Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

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

B. Capital Report – Quarter Ending June 30, 2025
Recommended Action: Approve/Disapprove Capital Report as Presented

C. Investment Report – Quarter Ending June 30, 2025
Recommended Action: Approve/Disapprove Investment Report as Presented

X. SVLHCD Board Chair Report

XI. SVMC CEO Report

XII. Announcements:

Regular Board of Directors Meeting – August 26, 2025 at 5:00 p.m.

XIII. 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

Senior Leadership Team	7/24/2025
Board of Director's Approval	
Liberty Lomeli, Chairman	7/24/2025

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
July 24, 2025
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	Action
Policies:		Approve ↓
• 014104 Authorization of PHI - English	1-3	
• 014107 Authorization of PHI – Spanish	4-6	
• 027047 SPANISH IUD Informed Consent	7-8	
• 027055 OB History Form – Spanish	9-16	
• 027060 Urology Clinic Discharge Spanish*****	17-18	
• Anti-Discrimination, Harassment & Non-Retaliation Policy	19-23	
• Care Management Plan	24-26	
• Contaminated Instrument Transportation*****	27-29	
• Employee Education Assistance	30-39	
Reports:		
• Human Resources Quarter 2 Report	40-76	
• Marketing Quarter 2 Report	77-105	

***** These polices were approved by the Medical Executive Committee, but were left out of the MEC consent agenda so they have been included here.

SIERRA VIEW MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION: (Please use full legal name, no nicknames)

Patient Name: _____ **Social Security Number:** XXX-XX-_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____/_____/_____ **Phone:** (_____) _____-_____

Email: _____

RELEASE RECORDS TO: (Where do you want records sent?)

I authorize _____ **to release my medical records to**

Name of Hospital/Clinic/Person: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____

Email: _____

RELEASE RECORDS TO: (Who do you want to recieve the records?)

If you would like a designee to pick up your records, please fill out section below:**

I authorize _____ **to pick up my medical record copies.**

Relationship to patient: _____

****Note: Designee must provide valid photo ID**

DELIVERY INSTRUCTIONS: (Please select one)

☐ **CD** ☐ **Email (email will be encrypted)** ☐ **Paper Copy**

Purpose (what is the purpose of this release?)

State reason: _____

_____

HEALTH INFORMATION TO BE RELEASED: (What records are being released?)

☐ **Billing Statements**	☐ **Emergency Reports**	☐ **Pathology Reports**
☐ **Consultations**	☐ **History & Physical Exams**	☐ **Progress Notes**
☐ **Discharge Summary**	☐ **Radiology CD**	☐ **EEG**
☐ **Laboratory Reports**	☐ **EKG**	☐ **Operative Reports**
☐ **Radiology Reports**	☐ **Mental Health**	

☐ **Other:** _____

SENSITIVE INFORMATION:
(Sensitive information will not be released unless specifically authorized below:)

☐ **Drug and Alcohol Abuse Results** ☐ **Genetic Testing Information** ☐ **HIV/AIDS Test Results**

SPECIFY DATE / TIME PERIOD

Specify date / time period for information selected above

From _____ To _____

EXPIRATION OF AUTHORIZATION

If no date is indicated this Authorization will expire 12 months after the date signed.

SIGNATURE(S)

Patient Name: _____ **Date:** _____

Printed Name: _____

Phone: (_____) _____-_____

If signed by someone other than the patient, indicate relationship to the

patient: _____

Signature of Witness (only if patient unable to sign): _____

Date: _____

COMPLETING AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

To protect our patient's confidential medical information we must have a valid, complete and legible authorization to disclose their health information.

All sections of this authorization must be completely filled out before SVMC is permitted to disclose your protected health information.

NOTICE

SVMC and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

REVOCATION

I may revoke this authorization at any time, provide that I do so in writing and submit it to:

SVMC
Health Information Management
465 W Putnam Avenue
Porterville, California 93257

The revocation will take effect when SVMC receives it, except to the extent that SVMC or others have already relied on it.

I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for:

1) conducting research-related treatment,
2) obtaining information in connection with eligibility or enrollment in a health plan,
3) determining an entity's obligation to pay a claim, or
4) creating PHI to provide to a third party.

I am entitled to receive a copy of this Authorization.

OFFICE USE ONLY

Date request filled: _____ **Time:** _____ **By:** _____

INFORMACIÓN DEL PACIENTE: (Utilice el nombre legal completo, sin apodos)

Nombre del paciente: _____ **Número de seguro social:** XXX-XX-_____

Dirección: _____

Ciudad: _____ **Estado:** _____ **Código postal:** _____

Fecha de nacimiento: _____/_____/_____ **Teléfono:** (_____) _____-_____

Correo electrónico: _____

ENTREGAR REGISTROS MÉDICOS A: (¿A dónde desea que se envíen los registros?)

Autorizo a _____ **a divulgar mis registros médicos a**

Nombre del hospital/clínica/persona: _____

Dirección: _____

Ciudad: _____ **Estado:** _____ **Código postal:** _____

Teléfono: _____ **Número de fax:** _____

Correo electrónico: _____

ENTREGAR REGISTROS MÉDICOS A: (¿Quién desea que reciba los registros?)

Si desea que una persona designada recoja sus registros, complete la sección a continuación:**

Autorizo a _____ **a recoger copias de mis registros médicos.**

Relación con el/la paciente: _____

****Nota: El designado debe proporcionar una identificación con fotografía válida.**

INSTRUCCIONES DE ENTREGA: (Por favor seleccione una)

☐ **CD** ☐ **Correo electrónico (correo electrónico será cifrado)** ☐ **Copia en papel**

Propósito (¿con qué propósito comparte sus registros?)

Indique su motivo/razón: _____

_____

INFORMACIÓN DE SALUD QUE SE DIVULGARÁ: (¿Qué registros se divulgarán?)

☐ **Facturas**
☐ **Consultas**
☐ **Resumen de Alta**
☐ **Informes de Laboratorio**
☐ **Informes de Radiología**
☐ **Informes de Emergencia**
☐ **Historial y Exámenes Físicos**
☐ **Radiología, CD**
☐ **ECG**
☐ **Salud Mental**
☐ **Informes de Patología**
☐ **Notas de Evolución**
☐ **EEG**
☐ **Informes Operativos**
☐ **Otros:** _____

INFORMACIÓN SENSIBLE:
(No se divulgará información sensible a menos que se autorice específicamente a continuación:)

☐ **Resultados de abuso de drogas y alcohol** ☐ **Información sobre pruebas genéticas**

☐ **Resultados de prueba de VIH/SIDA**

ESPECIFICAR FECHA / PLAZO DE TIEMPO

Especifique la fecha y el plazo de tiempo para la información seleccionada anteriormente

De _____ **hasta** _____

VENCIMIENTO DE LA AUTORIZACIÓN

Si no se indica ninguna alguna fecha, esta Autorización se vencerá 12 meses después de la fecha de la firma.

FIRMA(S)

Nombre del paciente: _____ **Fecha:** _____

Nombre impreso: _____

Teléfono: (_____) _____-_____

Si firma otra persona que no sea el paciente, indique su parentesco con el

paciente: _____

Firma del testigo (solo si el paciente no puede firmar): _____

Fecha: _____

CÓMO COMPLETAR LA AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN MÉDICA PROTEGIDA

Para proteger la información médica confidencial de nuestros pacientes, debemos contar con una autorización válida, completa y legible para divulgar su información médica.

Todas las secciones de esta autorización deben completarse en su totalidad antes de que SVMC pueda divulgar su información médica protegida.

AVISO

SVMC y muchas otras organizaciones e individuos, como médicos, hospitales y planes de salud, están obligados por ley a mantener la confidencialidad de su información médica. Si usted ha autorizado la divulgación de su información médica a alguien que no está legalmente obligado a mantenerla confidencial, es posible que está ya no esté protegida por las leyes estatales o federales de confidencialidad.

REVOCACIÓN

Puedo revocar esta autorización en cualquier momento, siempre que lo haga por escrito y lo envíe a:

SVMC
Health Information Management
465 W Putnam Avenue
Porterville, California 93257

La revocación surtirá efecto cuando SVMC la reciba, salvo en la medida en que SVMC u otros ya hayan confiado en ella.

Entiendo que esta autorización es voluntaria. El tratamiento, la inscripción en el pago o la elegibilidad para los beneficios no pueden estar condicionados a la firma de esta autorización, excepto si la autorización es para:

1) realizar un tratamiento relacionado con la investigación,

2) obtener información relacionada con la elegibilidad o la inscripción en un plan de salud,

3) determinar la obligación de una entidad de pagar una reclamación, o

4) crear PHI para proporcionarla a un tercero.

Tengo derecho a recibir una copia de esta autorización.

SOLO PARA USO DE OFICINA

Fecha de llenado de la solicitud: _____ **Hora:** _____ **Por:** _____

Consentimiento y Riesgos Indicados a Continuación:

- Se analizó la indicación para la colocación del dispositivo intrauterino (DIU) como método anticonceptivo.
- Se explicó el procedimiento en detalle, incluyendo los pasos previstos: colocación del espéculo, limpieza cervical, colocación del tenáculo (si es necesario), sondeo uterino e inserción del DIU.
- Se mencionaron las sensaciones esperadas durante la inserción, incluyendo cólicos y molestias.
- Se detallaron los riesgos:
  - Riesgo de perforación:
    - Se explicó que la perforación uterina es una complicación poco frecuente, pero grave.
    - Se estima una incidencia de aproximadamente 1 a 2 por cada 1000 inserciones.
    - La perforación puede ocurrir en el momento de la inserción si el dispositivo atraviesa la pared uterina.
    - Los factores de riesgo incluyen el posparto reciente, la lactancia materna, el útero en retroversión y la experiencia del médico.
  - Síntomas de perforación
    - Dolor abdominal agudo, intenso o persistente.
    - Hilos del DIU anormales o ausentes.
    - Sangrado inexplicable.
- Cuidados en caso de una perforación, según lo indicado:
  - Si se sospecha una perforación, se pueden solicitar imágenes (ecografía o radiografía) para localizar el DIU.
  - Si el DIU ha migrado fuera del útero, generalmente se requiere extirpación quirúrgica.
    - La cirugía puede consistir en laparoscopia (cirugía mínimamente invasiva) o laparotomía (cirugía abierta), dependiendo de la ubicación del dispositivo.
    - Se analizaron los riesgos asociados con la cirugía, incluyendo los riesgos de la anestesia, las infecciones y las lesiones en los órganos adyacentes.
- Se revisaron otras posibles complicaciones de la colocación del DIU, entre ellas:
  - Expulsión (eliminación parcial o total del DIU).
  - Infección (especialmente en los primeros 20 días tras la inserción).
  - Cambios en los patrones de sangrado (según el tipo de DIU: hormonal o de cobre).
- La paciente expresó su comprensión de los riesgos, incluyendo la rara pero posible necesidad de intervención quirúrgica en caso de perforación.
- Se le dio a la paciente la oportunidad de hacer preguntas; todas fueron respondidas.
- La paciente consiente en proceder con la colocación del DIU.

Firma de la Paciente _____

Fecha _____ Hora _____

Firma del Médico _____

Fecha _____ Hora _____

PATIENT'S LABEL

INTERPRETER'S STATEMENT

I have accurately and completely read the foregoing document to (patient or patient's legal representative) _____ in the patient's or legal representative's primary language (identified language) _____ . He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

_____

Signature of interpreter, or remote interpreter's number *Date/Time*

_____

Print Name

PATIENT'S LABEL

Si prefiere no responder alguna pregunta, déjela en blanco; puede discutirlas con su médico o enfermera.

Nombre: _____
APELLIDO PRIMERO SEGUNDO NOMBRE PREFERIDO

_____
IDENTIDAD DE GÉNERO (p.ej., MUJER, HOMBRE TRANSGÉNERO) PRONOMBRES (por ejemplo, ELLA/ELLA, ELLOS/ELLOS, ÉL/ÉL) ORIENTACIÓN SEXUAL (p. ej., HETEROSEXUAL, QUEER, PANSEXUAL

Pediatra Elegido: _____ Atención primaria/Grupo: _____ Recomendado por: _____

Dirección PCP: _____

Fecha de nacimiento: _____ Edad: _____
MONTH/DAY/YEAR

Estado Civil: ❒ Soltero ❒ Casado ❒ En pareja
❒ Viudo ❒ Divorciado ❒ Separado

Raza: _____

Etnicidad: _____

Ocupación: _____

Educación _____
(ÚLTIMO GRADO COMPLETADO)

Idioma: _____

Pareja: _____ Teléfono: _____

Persona de apoyo
durante el embarazo: _____ Teléfono: _____

Dirección del paciente: _____

Estado: _____ Código postal: _____

Teléfono: _____ Correo electrónico: _____

Compañía de seguros/Medicaid #: _____

Contacto de emergencia: _____

Teléfono: _____

Embarazo total: ____ Ab Espontáneo: ____ Embarazo ectópico: ____

Nacimientos múltiples: _____ Vivos: _____ Plazo Completo: _____

Prematuro: _____ Ab, inducido: _____

Su embarazo actual fue resultado de un tratamiento de infertilidad? ❒ Sí ❒ No

En caso afirmativo ❒ IUI ❒ IVF ❒ Other Se realizó el PGTA ❒ Sí ❒ No

Historial del Embarazo

Primer día de última menstruación:
Existen varias opciones durante el embarazo. ¿Estás considerando:

❒ Continuar el embarazo con intención de ser padre.
❒ Continuar el embarazo con intención de adopción.
❒ Aborto
❒ Otro; (gestación subrogada, etc.)

¿Si pudiera cambiar el momento de este embarazo, le gustaría?

❒ más temprano?
❒ más tarde?
❒ nunca?
❒ no responder?

Historial Menstrual

LMP

❒ Definido
❒ Desconocido
❒ Final: _____
❒ Fecha estimada de parto: _____

❒ Aproximado (Mes conocido)
❒ Cantidad/Duración normal
Duración: _____ Días
Menstruaciones previas: _____

Frecuencia: _____ Días
Anticoncepción durante el embarazo: ❒ Sí ❒ No
Menarquia: (Edad de inicio)
Hcg + ____/____/____

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
OB HISTORY FORM
Form # 027055 REV 06/25

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

PATIENT'S LABEL

Embarazos Previos (últimos cinco)

Fecha Mes/ Año	Semanas de Gestación	Duración del parto	Peso al nacer	Género M/H	Tipo de parto ❒ vaginal ❒ ventosa ❒ fórceps ❒ cesárea	Anes.	Lugar de parto	Duración de amamantamiento	¿Necesita consulta de lactancia? Sí/No	Comentarios/ Complicaciones

Historial de Salud Personal

1. Alguna vez ha tenido reacción alérgica a:

Penicilina?	❒ Sí	❒ No	❒ No lo se
Un medicamento o una vacuna?	❒ Sí	❒ No	❒ No lo se
Mariscos?	❒ Sí	❒ No	❒ No lo se
Látex?	❒ Sí	❒ No	❒ No lo se

En caso afirmativo, enumere las alergias y describa la reacción alérgica (por ejemplo, picazón, sarpullido, urticaria, anafilaxia [cierre de garganta]):

_____

_____

¿Alguna otra alergia o reacción?

_____

_____

2. Marque cualquier afección que tenga o haya tenido en el pasado:

- ❒ Anemia Ansiedad
- ❒ Anxiety
- ❒ Artritis o lupus
- ❒ Trastorno de la coagulación sanguínea (p. ej., flebitis/trombofilia)
- ❒ Transfusión de sangre
- ❒ Enfermedad mamaria
- ❒ Cáncer
- ❒ Depresión/depresión posparto
- ❒ Diabetes (tipo 1 o 2)
- ❒ Trastorno alimentario
- ❒ Epilepsia
- ❒ Infecciones frecuentes
- ❒ Enfermedad/afección gastrointestinal (p. ej., SII, enfermedad celíaca, enfermedad de Crohn)
- ❒ Diabetes gestacional
- ❒ Estreptococo del grupo B en antecedentes Embarazo
- ❒ Dolores de cabeza
- ❒ Enfermedad cardíaca
- ❒ Hepatitis
- ❒ Herpes
- ❒ VIH/SIDA
- ❒ Presión arterial alta
- ❒ Enfermedad renal
- ❒ Preeclampsia
- ❒ Parto prematuro previo
- ❒ Enfermedad psiquiátrica
- ❒ Infecciones recurrentes del tracto urinario
- ❒ Infecciones de transmisión sexual
- ❒ Trastornos de la piel
- ❒ Trastorno de la tiroides
- ❒ Tuberculosis
- ❒ Enfermedad de Von Willebrand u otros trastornos hemorrágicos
- ❒ Otro:

describa, si necesario: _____

3. Indique cualquier cirugía u hospitalización que haya tenido y la fecha:

4. Describa cualquier problema o síntoma de salud que tenga en este momento:

5. ¿Tiene usted o algún miembro de su familia antecedentes de problemas con la anestesia? ❒ Sí ❒ No

6. ¿Tiene alguna objeción a cualquier forma de tratamiento médico (por ejemplo, transfusión de sangre)? ❒ Sí ❒ No

Exposiciones que Afectan la Salud

1. Actualmente o durante el último año ha fumado, masticado, ¿usado cualquier tipo de sistema de suministro de nicotina (ENDS) o vapeado? ❒ Sí ❒ No Caso afirmativo, ¿cuántos paquetes o cartuchos por día?_____
   ¿Actualmente fuma, vapea, dabbea o come marihuana o la ha consumido durante el último año? ❒ Sí ❒ No

2. ¿Bebe bebidas alcohólicas ahora o lo hacía antes de quedar embarazada?? ❒ Sí ❒ No
   Caso afirmativo, por favor indique el número de bebidas por semana:
   Qué tipo de bebidas?

3. Enumere todos los medicamentos que ha tomado desde su última menstruación, incluidos los medicamentos recetados, los medicamentos de venta libre, los multivitamínicos, otros suplementos y cualquier medicamento a base de hierbas:

4. ¿Ha consumido alguna droga sin receta o recreativa desde su última menstruación (por ejemplo, cocaína, opioides)? ❒ Sí ❒ No
   Caso afirmativo, por favor indique el número de usos por semana:
   Qué tipo de drogas?

5. Tiene alguna razón para creer que usted o su(s) pareja(s) sexual(es) pudieron haber estado expuestos al VIH/SIDA? Esto puede incluir antecedentes de transfusiones de sangre, consumo de drogas por vía intravenosa, relaciones sexuales con hombres que tienen relaciones sexuales con otros hombres o con hombres bisexuales, o relaciones sexuales con alguien que haya consumido drogas por vía intravenosa.
   ❒ Sí ❒ No

6. Ha estado expuesta a productos químicos (por ejemplo, pesticidas, plomo, materiales/agentes peligrosos) o radiación (por ejemplo, rayos X) desde que quedó embarazada? ❒ Sí ❒ No
Caso afirmativo, descríbalo:

7. ¿Tiene alguna restricción dietética? ❒ Sí ❒ No
Caso afirmativo, descríbalo:

8. ¿Usted o su(s) pareja(s) han viajado recientemente (por ejemplo, en los últimos 3 meses) fuera de los Estados Unidos? ❒ Sí ❒ No
¿Caso afirmativo, a dónde fue el viaje y quién viajó?

Historial de Salud Ginecológica

1. ¿Cuándo fue su última prueba para detectar cáncer de cuello uterino (por ejemplo, Papanicolaou u otra prueba)?
¿Alguna vez ha tenido un resultado anormal en una prueba de Papanicolaou u otra prueba de cáncer de cuello uterino? ❒ Sí ❒ No
Caso afirmativo, ¿cuándo y cómo fue atendido?
¿Cuál fue el diagnóstico?
¿Le realizaron algún procedimiento en el cuello uterino para su tratamiento (por ejemplo, LEEP [procedimiento de escisión electroquirúrgica con asa] o conización con bisturí frío o láser)? ❒ Sí ❒ No
Alguna vez has tenido VPH? ❒ Sí ❒ No
Ha recibido la serie completa de la vacuna contra el VPH? ❒ Sí ❒ No

2. ¿Alguna vez ha tenido uno o más de los siguientes?: ❒ Gonorrea ❒ Clamidia ❒ Enfermedad inflamatoria pélvica
Caso afirmativo, cuando fue atendido?

3. ¿Alguna vez has tenido herpes? ❒ Sí ❒ No
¿Caso afirmativo, en qué parte del cuerpo tiene brotes? ¿Con qué frecuencia?
Alguna vez ha tenido sífilis? ❒ Sí ❒ No
Caso afirmativo, ¿cómo, ¿cuándo y dónde fue atendido?

4. ¿Estaba usando un dispositivo intrauterino (DIU) como método anticonceptivo cuando quedó embarazada?

5. ¿Ha recibido tratamiento para la infertilidad? ❒ Sí ❒ No
Caso afirmativo, describa cuándo y el tratamiento recibido:

6. ¿Tiene alguna otra preocupación relacionada con su historial de salud pasado? ❒ Sí ❒ No
Caso afirmativo, por favor enumere:

Antecedentes Familiares y Pruebas de Detección Genética

1. Las siguientes preguntas se refieren a la composición genética del embarazo actual. Responda "sí" si alguna de las siguientes preguntas aplica a alguna persona con parentesco genético con el bebé.
Con qué etnia/raza se identifica usted? (Enumere una o más, según corresponda).
Cuál es la etnia/raza paterna? (Enumere una o más, según corresponda).

Indique si el bebé tiene alguno de los siguientes antecedentes genéticos:

Ashkenazi	❒ Sí	❒ No	❒ No lo sé
Negro/Afroamericano	❒ Sí	❒ No	❒ No lo sé
Ascendencia Mediterránea o Sur Asiática	❒ Sí	❒ No	❒ No lo sé
Ascendencia Francesa Canadiense o Cajún	❒ Sí	❒ No	❒ No lo sé

¿Se han realizado pruebas para las siguientes afecciones en algún familiar genético del bebé? Es posible que se hayan realizado en un embarazo anterior o que estén relacionadas con antecedentes familiares de estas afecciones.

Enfermedad de Tay-Sachs	❒ Yo	❒ Otro pariente genético	Relación:
Enfermedad de Canavan	❒ Yo	❒ Otro pariente genético	Relación:
Disautonomía familiar	❒ Yo	❒ Otro pariente genético	Relación:
Drepanocítico (anemia falciforme)	❒ Yo	❒ Otro pariente genético	Relación:
Formas hereditarias de anemia (talasemia)	❒ Yo	❒ Otro pariente genético	Relación:
Fibrosis quística	❒ Yo	❒ Otro pariente genético	Relación:
Atrofia muscular espinal	❒ Yo	❒ Otro pariente genético	Relación:
Prueba de detección de portadores genéticos	❒ Yo	❒ Otro pariente genético	Relación:

Caso afirmativo, ¿cuándo y dónde se realizó y cuál fue el resultado?

Fecha: _____ Resultado: _____

Fecha: _____ Resultado: _____

Fecha: _____ Resultado: _____

Fecha: _____ Resultado: _____

2. ¿Tiene el bebé algún pariente genético que haya nacido con algún defecto congénito? ❒ Sí ❒ No Caso afirmativo, por favor describa:

_____

_____

3. Describa cualquier necesidad especial que hayan tenido los familiares genéticos del bebé (p. ej., retraso del desarrollo, deterioro cognitivo o discapacidad intelectual, muerte infantil prematura, educación especial, afecciones genéticas como hemofilia, anemia falciforme o fibrosis quística). Si hay alguna persona, indique su afección y su parentesco con usted o con el padre del bebé.

Qué relación tiene este(a) niño(a)/persona con usted?

4. ¿Existen antecedentes de pérdida de embarazo (abortos espontáneos o muertes fetales)? ❒ Sí ❒ No
¿En caso afirmativo, ha recibido asesoramiento genético? ❒ Sí ❒ No
¿En caso afirmativo, se han realizado pruebas genéticas relacionadas con el historial de pérdida de embarazo? ❒ Sí ❒ No
Si es así, sabe cuáles fueron los resultados y dónde/cuándo se realizó esta prueba? _____

_____

5. Tiene antecedentes familiares de síndrome del cromosoma X frágil, discapacidades intelectuales/retrasos cognitivos, autismo o insuficiencia ovárica prematura? ❒ Sí ❒ No En caso afirmativo, ¿cuáles fueron los resultados y cuándo y dónde se realizaron estas pruebas?
Prueba de detección:_____ Fecha: _____ Resultado: _____

6. Enumere cualquier otra inquietud que tenga sobre defectos de nacimiento o trastornos hereditarios:

_____

_____

7. ¿Quiere realizarse pruebas de detección para buscar problemas genéticos o cromosómicos como el síndrome de Down durante su embarazo?? ❒ Sí ❒ No ❒ No lo sé

Nombre del paciente: Fecha de nacimiento: N.º de identificación: Fecha:

Antecedentes Familiares y Pruebas de Detección Genética

	P*	F*	Detalle Comentarios Positivos Incluir fecha y tratamiento
A. Alergias/reacciones a medicamentos y látex	❒	❒	
B. Alergias (alimentarias, estacionales, ambientales)	❒	❒	
1. Neurológica/Epilepsia	❒	❒	
2. Disfunción tiroidea	❒	❒	
3. Enfermedad mamaria/Cirugía de los senos	❒	❒	
4. Pulmonar (TB, Asma)	❒	❒	
5. Cardiopatía	❒	❒	
6. Hipertensión	❒	❒	
7. Cáncer	❒	❒	
8. Trastornos hematológicos	❒	❒	
9. Anemia	❒	❒	
10. Trastornos gastrointestinales	❒	❒	
11. Hepatitis/Enfermedad hepática	❒	❒	
12. Enfermedad renal/ITU	❒	❒	
13. Trombosis venosa profunda	❒	❒	
14. Diabetes (tipo 1 o tipo 2)	❒	❒	
15. Diabetes gestacional	❒	❒	
16. Trastornos autoinmunes	❒	❒	

	P*	F*	Detalle Comentarios Positivos Incluir fecha y tratamiento
17. Trastornos dermatológicos	❒	❒	
18. Operaciones/Hospitalizaciones (año y razón)	❒	❒	
19. Cirugía ginecológica (año y razón)	❒	❒	
20. Complicaciones anestésicas	❒	❒	
21. Antecedentes de transfusiones de sangre	❒	❒	
22. Infertilidad	❒	❒	
23. Arteria (FIV o TEC)	❒	❒	
24. Antecedentes de Papanicolaou anormal	❒	❒	
25. Enfermedad psiquiátrica	❒	❒	
26. Depresión/Depresión posparto	❒	❒	
27. Trauma/Violencia	❒	❒	
28. Tabaco (fumado, masticado, ENDS, vapeado) (cantidad/día)	❒	❒	Prepreg. / Preg. / No. Years Use
29. Alcohol (cantidad/semana)	❒	❒	
30. Consumo de drogas (incluidos opioides) (consumo/semana)	❒	❒	
31. Síndrome de ovario poliquístico	❒	❒	
32. Otros	❒	❒	

*P= Personal, F= Family

Pre-embarazo/Durante embarazo/N.° de años de uso: _____

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

OB HISTORY FORM

Form # 027055 REV 06/25

PATIENT'S LABEL

Prueba Genética*

Afección	Paciente	Pareja	Otro	Relación
Defectos cardíacos congénitos	❒	❒	❒	
Defectos del tubo neural	❒	❒	❒	
Fibrosis quística	❒	❒	❒	
Anomalía cromosómica	❒	❒	❒	
Enfermedad de Tay-Sachs	❒	❒	❒	
Hemofilia	❒	❒	❒	
Discapacidad intelectual	❒	❒	❒	
Autismo	❒	❒	❒	
Pérdida recurrente del embarazo/ Nacimiento sin vida	❒	❒	❒	
Otros defectos congénitos estructurales	❒	❒	❒	
Otras enfermedades genéticas (p. ej., fenilcetonuria, enfermedad metabólica, distrofia muscular)	❒	❒	❒	

Exposición a Teratógenos Desde el Última Menstruación /Embarazo

Afección	Sí	No	Detalles/Fecha	RESULTADOS/COMENTARIOS/ASESORAMIENTO:
Medicamentos con receta	❒			
Medicamentos de venta libre	❒			
Alcohol	❒			
Drogas ilegales, recreativas o de otro tipo	❒			
Diabetes pregestacional materna	❒		HGB A1C	
Otros	❒			
DES	❒			

Nombre del paciente: Fecha de nacimiento: N.º de identificación: Fecha:

Historial de Infecciones

Afección	Sí	No	COMENTARIOS:
1. Vive con alguien con tuberculosis o ha estado expuesto a ella.	❒	❒	
2. El paciente o su pareja tienen antecedentes de herpes genital.	❒	❒	
3. Sarpullido o enfermedad viral desde su última menstruación.	❒	❒	
4. Hijo con infección previa por estreptococo del grupo B	❒	❒	
5. Antecedentes de ITS: (Marque todas las que correspondan) ❒ Gonorrea ❒ Clamidia ❒ VPH ❒ Sífilis ❒ Enfermedad inflamatoria pélvica (EIP)			
7. Antecedentes de hepatitis	❒	❒	
8. Historial de viajes recientes o viajes de su pareja fuera del país	❒	❒	
9. Exposición reciente al virus del Zika, incluso por su pareja	❒	❒	
10. Infección por COVID-19	❒	❒	

INTERPRETER'S STATEMENT

Interpreter services have been provided to the consent giver in the language of their choice: _____ (Identify language).

Signature: _____ Date: _____ Time: _____ AM/PM

(Interpreter, or remote interpreter's number)

Name: _____

(print)

386 N. Villa St., Ste. B • Porterville, CA 93257 (559) 791-3914

Siga las instrucciones de Cuidados Posteriores marcadas a continuación.

❑ **Procedimiento de Termoterapia Fría**
❑ Haga arreglos con alguien que lo lleve a casa hoy.
❑ Debe tomarse el resto del día libre del trabajo.
❑ Se irá a casa con un catéter y recibirá instrucciones del médico encargado del cuidado del catéter
❑ No levante objetos pesados ni realice trabajos extenuantes durante las próximas 24 horas
❑ Llame al consultorio si tiene fiebre de más de 101°.
❑ Llame al consultorio si el catéter no drena.

❑ **Cistoscopia**
❑ Haga arreglos con alguien que lo lleve a casa hoy.
❑ No tener relaciones sexuales durante 1 semana.
❑ Beba al menos 8 (8 onzas) de líquidos todos los días durante los próximos días.
❑ Debe tomarse el resto del día libre del trabajo.
❑ No levante objetos pesados ni realice trabajos extenuantes durante las próximas 24 horas.
❑ Experimentar sangre en la orina, urgencia urinaria y ardor al orinar es normal después de un procedimiento de cistoscopia durante los próximos dí
❑ Llame al consultorio si tiene fiebre de más de 101°. o si tiene sangrado persistente.
❑ Si está tomando anticoagulantes, reanude su consumo una vez que su orina esté libre de sangre

❑ **Evaluación de Vejiga interStim®**
❑ Mantenga seco el lugar de la implantación.
❑ No hay restricciones en su actividad.
❑ Registre los resultados en el diario proporcionado por su médico, según las indicaciones.
❑ Llame al consultorio si tiene fiebre más de 101°.
❑ Llame al consultorio si uno de los alambres se sale.

❑ **Ecografía y Biopsia de Próstata**
❑ Haga arreglos con alguien que lo lleve a casa hoy.
❑ Complete su receta de Bactrim DS.
❑ Es normal encontrar sangre en la orina, las heces y el semen después de una biopsia.
❑ Debe tomarse el resto del día libre del trabajo.
❑ No levante objetos pesados ni realice trabajos extenuantes durante las próximas 24 horas.
❑ Llame al consultorio si tiene fiebre de más de 101°.
❑ Llame al consultorio si tiene sangre y coágulos persistentes en la orina 48 horas después del procedimiento.
❑ Beba al menos 8 (8 onzas) de líquidos todos los días durante los próximos días.
❑ Si está tomando anticoagulantes, reanude su uso una vez que su orina y/o heces estén libres de sangre.

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
The content of this form was developed solely by Virinder J. Bhardwaj, MD
UROLOGY CLINIC DISCHARGE INSTRUCTIONS
Form # 027060 REV 6/25
Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

❑ **Vasectomía**
❑ Haga arreglos con alguien que lo lleve a casa hoy.
❑ Puede haber un pequeño sangrado, suficiente para manchar los vendajes.
❑ Experimentará una leve molestia e hinchazón en el área de la incisión, que debería desaparecer en 72 horas.
❑ Ocasionalmente, la piel del escroto y la base del pene se vuelve negra y azulada. Esto dura solo unos días y desaparece sin tratamiento.
❑ Tome sus medicamentos según las indicaciones.
❑ Regrese al trabajo después de dos (2) días.
❑ Evite el ejercicio intenso y levantar objetos pesados durante los primeros tres (3) días después de la vasectomía.
❑ Posponga la actividad sexual durante siete días después de la vasectomía y continúe con los métodos anticonceptivos hasta que dos análisis de esperma consecutivos den resultados positivos.

Firma: _____ Fecha: _____ Hora: _____ AM/PM
(paciente/padres/conservador/tutor)

Si firma otra persona que no sea el paciente, indique el nombre y la relación: _____

Firma del/de la enfermero(a): _____ Nombre: _____
(print)

INTERPRETER'S STATEMENT

Interpreter services have been provided to the consent giver in the language of their choice: _____ (Identify language).

Signature: _____ Date: _____ Time: _____ AM/PM
(Interpreter, or remote interpreter's number)

Name: _____
(print)

The content of this form was developed solely by Virinder J. Bhardwaj, MD

PATIENT'S LABEL

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

SUBJECT: **ANTI-DISCRIMINATION, HARASSMENT & NON-RETALIATION POLICY**	SECTION: **Page 1 of 5**

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

PURPOSE:

Sierra View Medical Center (SVMC) is committed to providing a work environment free from all unlawful discrimination, harassment and retaliation. The Fair Employment & Housing Authority (FEHA) prohibits coworkers, third parties, supervisors and managers from engaging in discriminatory, harassing, or retaliatory conduct. To the extent possible, SVMC will protect its employees from harassment and/or discrimination retaliation.

POLICY:

DEFINITIONS:

DISCRIMINATION - the unlawful and intentional act of unfair treatment of a person based on a protected class, such as, race, color, religion, sex, sexual orientation, gender expression, national origin or ancestry, age, genetics (results of genetic testing), medical condition, marital status, registered domestic partner status, pregnancy, childbirth, physical or mental disability or veteran/military status, with respect to the terms, conditions, or privileges of employment including, but not limited to hiring, promoting, firing, disciplining, scheduling, training or deciding how to compensate that employee.

HARASSMENT - Harassment occurs when an employee is subjected to unwelcome verbal or physical conduct because of a protected class, such as, race, color, religion, sex, sexual orientation, gender expression, national origin or ancestry, age, genetics (results of genetic testing), medical condition, marital status, pregnancy, childbirth, physical or mental disability or veteran/military status.

HOSTILE WORK ENVIRONMENT: Hostile work environment sexual harassment occurs when unwelcome comments or conduct based on sex unreasonably interfere with an employee's work performance or create an intimidating, hostile or offensive work environment.

SEXUAL HARASSMENT – The unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when: (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, (2) submission to or rejection of such conduct by an individual is used as a basis for employment decisions affecting such individual, (3) the unwelcome sexual advances disrupt a reasonable person's emotional tranquility or (4) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

RETALIATION - Is any adverse action taken against an individual (applicant or employee) because he or she filed a charge of discrimination, or made a formal complaint to the hospital about discrimination on the job, or participated in an employment discrimination proceeding (such as an internal investigation or lawsuit), including as a witness. Examples of retaliation include termination, demotion, refusal to promote, or any other adverse action that would discourage a reasonable person from opposing perceived discrimination.

SVMC is committed to maintaining an environment which respects the dignity of all individuals. Accordingly, SVMC will not tolerate harassment or discrimination based on a protected class, such as, race, color, religion, sex, sexual orientation, gender expression, ancestry, national origin, age, genetics (results of genetic testing),medical condition, marital status, pregnancy, childbirth, physical or mental disability , veteran/military status, or any other basis protected by federal, state, or local law, ordinance, or regulation by or if its patients, patient's family members or staff.

No employee of SVMC shall engage in discrimination or harassment in any program, activity or place in which the hospital exercises control. Sexual harassment is prohibited whether it's between members of the opposite sex or members of the same sex. It is expected that every employee will take responsibility for reporting any incident that is made known, will cooperate in preventing such behavior, and will assist with investigation procedures when requested.

Examples of behavior which may constitute sexual harassment include, but are not limited to:

1. Unwelcome verbal or physical advances of a sexual nature.
2. Requests or subtle pressure, overt or implied, for sexual favors.
3. Remarks, jokes, comments or observations of a sexual nature which demean or offend individuals, provided, that such expressions were not discussed for a valid treatment purposes of a patient.
4. Gestures or other nonverbal behavior of a sexual nature.
5. Display or distribution of offensive materials of a sexual nature provided that the information discussed/used was for valid patient treatment or staff educational purposes.

All complaints made in good faith will be taken seriously and no one reporting harassment or discrimination will suffer retaliation. Complaints of harassment and/or discrimination will be treated in confidence to the fullest extent possible, taking into consideration the need to conduct a thorough investigation, and to take corrective action if warranted. If it is determined through an investigation that harassment or discrimination has occurred, effective corrective action will be taken to stop the conduct and to attempt to ensure that it does not reoccur. Depending on the circumstances and the severity of the conduct, disciplinary action could result up to and including termination of the employee(s) involved in initiating the harassment and/or discrimination.

Every employee has a role in the implementation of this policy.

It is a violation of this policy to retaliate in any way against someone who has in good faith filed a complaint about discrimination or harassment, participated in any manner in proceedings under this policy, or opposed the alleged discrimination or harassment. Retaliation subjects the retaliator to disciplinary action up to and including termination.

Knowingly making false allegations of harassment or discrimination or providing evidence with the knowledge that it is false is also a violation of policy and will subject a person to disciplinary action up to and including termination.

Not all situations in which an individual is offended or uncomfortable will be considered a violation of this policy. Personality clashes, clashes of beliefs or lifestyles alone will not be violations of this policy nor will conduct that reflects socially acceptable behavior.

Reporting patient complaints of sexual abuse or misconduct by a licensed health care practitioner:

Upon receiving an allegation of sexual abuse or misconduct by a licensed healthcare practitioner, a report will be filed by the Chief Nursing Officer or authorized designee within fifteen (15) days of receiving the written allegation to the practitioners licensing board.

Licensed healthcare practitioners refer to employees whose license are held with any of the following licensing boards:

- Medical Board of California
- Podiatric Medical Board of California
- Board of Psychology
- Osteopathic Medical Board of California
- Board of Registered Nursing
- Board of Vocational Nursing
- State Board of Optometry
- Board of Behavioral Sciences
- Physical Therapy Board of California
- California Board of Pharmacy
- Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board
- Board of Occupational Therapy
- Physician Assistant Board

Management's Responsibility:

All levels of supervision are responsible for assuring harassment in any form is prohibited at SVMC, and all allegations of discrimination, harassment and retaliation will be fully investigated and prompt and appropriate action will be taken to ensure future violations are not repeated.

All levels of supervision are required to report any known or alleged incidents of harassment, discrimination and/or retaliation to their next level up and to the Human Resources Department upon knowledge of the incident. Non-employees (medical staff, etc.) will be reported by the Compliance Department. Failure to engage in or properly report violations under this policy will be taken seriously and may be grounds for disciplinary action, up to and including separation of employment from SVMC.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES AND CONTINGENCY EMPLOYEES*

COMPLAINT PROCEDURES:

Any employee who believes he or she has been the subject of harassment and/or discrimination or who has witnessed harassment and/or discrimination should report the alleged incident immediately.

Complaints may be submitted through any of the following channels at SVMC:

- The employee's immediate supervisor or next supervisory level, if complaint is due to actions of the employee's immediate supervisor.
- Any member of Senior Management.
- The Human Resources Department.
- The Compliance Hotline at (559) 791-4777
- The Department of Fair Employment & Housing (DFEH) http://www.dfeh.ca.gov/Complaints_ComplaintProcess.htm
- The Equal Employment Opportunity Commissions Office (EEOC) https://www.eeoc.gov/employees/charge.cfm

The Human Resource Department will initiate an investigation of the allegation within three (3) working days of the formal complaint filing date. The investigation will be conducted thoroughly and in a timely manner. Employees will not be subject to retaliation as a result of filing a complaint of discrimination or harassment. Following completion of the investigation by Human Resources, a report will be provided to the Director and/or Vice President of the department, detailing the findings along with any recommendation for appropriate action as necessary. The Director/Vice President, upon reviewing the report, may approve the recommended action or recommend an alternate resolution. If discrimination, harassment, or retaliation is found to have occurred, disciplinary action up to and including termination may result.

The accused offender(s) will be notified of the final decision. The complainant will be notified when the investigation has been completed and a determination has been made as appropriate. The complainant will not be notified of the disciplinary actions, if any, taken against the offender(s). Instead, he/she will be notified of actions taken to prevent future incidents.

Training

All staff will be trained on this policy and advised of the zero tolerance for harassment, discrimination and retaliation. Training will occur during the initial orientation period and on a biannual basis. All supervisory-level employees will be required to complete the mandatory two-hour harassment training every two years based on California AB-1825.

Confidentiality

All parties involved in the investigation are asked to uphold the integrity of the process by maintaining confidentiality of the incident during the investigation as well as once the investigation has been completed. To the extent possible, SVMC will preserve the confidentiality of any employee filing a complaint, as well as any person involved in the investigative process. Employees of SVMC will not be subject to retaliation if filing a complaint under this policy.

REFERENCES:

- Civil Rights Act, Title VII
- Equal Employment Opportunity Commission
- Federal Employment & Housing Act - ARTICLE 1. Unlawful Practices, Generally [12940 - 12953]
- Business and Professions Code BPC § 16721

CROSS REFERENCES:

- PERSONAL CONDUCT
- CODE OF CONDUCT
- NON RETALIATION - COMPLIANCE ISSUE REPORTING
- COMPLAINTS AND GRIEVANCES, HANDLING OF
- SERIOUS CLINICAL ADVERSE EVENT

SUBJECT: **CARE MANAGEMENT PLAN**	SECTION: **Page 1 of 3**

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

PURPOSE:

The Care Management Program at Sierra View Medical Center (SVMC) is a collaborative process which assesses plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health care needs through communication and available resources to promote quality cost-effective outcomes.

AFFECTED AREAS/PERSONNEL: *CARE MANAGEMENT AND NURSING*

OBJECTIVES:

- To maximize efficiency in utilization of available resources.
- To collaborate with the patient and their family, physician(s) and other hospital resource staff to implement a plan of care which meets the individual health care needs.
- To objectively provide educational information related to identified health care knowledge deficit.
- To promote the optimal expenditure of health care dollars through effective and efficient utilization of resources.

GOALS:

- To promote an optimal state of patient wellness, as appropriate to the individual, though assessment, monitoring and coordination of the patient's health care needs.
- To ensure that all services are necessary and beneficial to the patient, and are provided in a timely and cost-effective manner.
- To assist the patient to achieve an optimal level of wellness and functioning through facilitation of necessary health care services and needs.
- To encourage and assist patients to appropriately assume an active role in the health care, through acceptance and understanding of self-advocacy.
- To facilitate and maintain cost-effectiveness in all areas of health care delivery.

SCOPE:

- The scope of care management plan encompasses those important processes necessary to provide a system of health care delivery that leads to optimal wellness for each patient, at their highest level of achievable functioning. These processes are direct and indirect clinical assessment, problem identification, outcome identification, planning, monitoring and evaluating. Inclusive in the case management scope of services are the tenants of patient advocacy, quality of care and service, health team collaboration and optimum preparation to manage clinical, psychosocial and other social determinants of health.

- Care mManagement will be conducted in accordance with all legal mandates while supporting the patient's ethical and moral directives. Care mManagement services are available to all patients and families, regardless of age, sex, nation origin, race and sexual orientation and are admitted to Sierra View Medical Center for their health care needs.

METHODOLOGY:

Care MManagement Selection Procedure

- The Care Management selection process includes inpatients and outpatients.
- For the purposes of this plan, all individuals, whether inpatient or outpatient, will be referred to as patients.
- Patients selected for Care Management will be identified through referral patterns, direct provider referral, specific case review and referral from any source, dependent upon case manager approval.
- A criteria list specifying acute, severe diseases and long term, chronic disease entities which, by nature, are known to require an increased level of medical management, will serve as a review tool for patient identification in the case management program. The care integration teamse manager will review all inpatient admissions on a working day (Monday –Friday 0800-1630, excluding holidays) basis against the list to determine if any admitted patients meet the criteria for placement on case management.
- A criteria list including, but not limited to: those diseases entities which are known to be chronic, impact other bodily systems or organs, require a high degree of resources usage, impact quality of life and functioning, and/or can directly or indirectly affect the patient's psychosocial outlook, will serve as a review tool for patient identification in the case management program.

Implementation of Care Management

1. Care management is initiated upon identification and selection of a patient who meets criteria for care management.
2. The care integration teamCare Manager performs a thorough assessment of the patient, family and support system. The assessment includes:
    a. Collection, aggregation and analysis of all relevant clinical information, functional status, situation status and personal history;
    b. Identification of family members, friends or key individuals who are able to provide support or direct care for the patient;
    c. Review and analysis of the current plan of care to determine patterns or trends in care, alternative treatment programs, revisions necessary to reduce resource usage and increase patient satisfaction;

d. Communication with designated family members to identify specific needs versus perceived needs and to work with the patients' family in coordinating care and achieving an agreed goal.

REFERENCE:

- California Code of Regulations. (2025). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I6F56A7E1D4B611DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=%28sc.Default%29&bhcp=1.
- The Joint Commission (2025~~19~~). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- ~~California Code of Regulations. (2019). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I6F56A7E1D4B611DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=%28sc.Default%29&bhcp=1.~~

SUBJECT:	SECTION:
EXTERNAL CONTAMINATED INSTRUMENT TRANSPORTATION	**Page 1 of 3**

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

PURPOSE:

Define the processes of decontamination and transport of surgical instruments between the point of use and Central Processing Department, to minimize the spread of potentially infectious microorganisms.

POLICY:

~~Instruments should be kept free of gross soil during surgical procedures.~~

~~2.~~1. All instruments, sterile or decontaminated, must be in solid closed containers for transport between buildings.

~~3.~~2. All decontaminated instruments ~~must~~ will be transported ~~as soon as possible~~at the end of the day from the point of use to the Central Processing Department.

~~4.~~3. Hospital vehicles ~~may be~~are to be used for transport.

AFFECTED AREAS/ PERSONNEL: *CPD, ~~MAIN OR, OB OR~~, ASD, WOUND CLINIC, UROLOGY CLINIC, ~~GENERAL & COLORECTAL~~ SURGERY CLINIC, OB/GYN Clinic, Rural Health Clinic*

PROCEDURE:

1. ~~Instruments will be wiped and soaked with sterile water during the procedure.~~ Instruments with lumens should be irrigated with sterile water to remove obstructive organic material.

   ~~. (Corrosion, rusting or pitting may occur when saline, blood or debris are allowed to dry on surgical instruments. Subsequent decontamination and sterilization may not be achieved)~~

2. Immediately after use and prior to transport, instruments are pre-treated to ensure excess bio-burden is removed. This will occur in the decontamination or workroom area of each point-of-use location.

3. Instruments will be placed in a rigid, puncture resistant, covered transport container and kept moist ~~by adding a towel dampened with sterile water, or~~ by the use of an enzymatic foam product.

4. Never allow free fluid to remain in the tray/biohazard container as it may spill during transport. ~~Clean items should be separated from dirty, and when possible instruments shall be returned together as sets. If the instruments are soaked in water from the back table or an enzymatic solution, the liquid should be discarded by properly attired personnel before transport.~~

5. If the external surfaces of the transport container are contaminated, the container will be placed in a red biohazard plastic bag for transport. Items will be labeled "biohazard" before being transported to the CPD.

6. Carts, reusable covers, bins and other transport containers should be decontaminated after every use with an EPA-registered intermediate level disinfectant.

~~6. The designated soiled lift between Surgery and Decontamination in CPD is considered to be a closed cart for transporting soiled instruments. The lift should be decontaminated once per month, and as needed with an EPA-registered intermediate-level disinfectant.~~

7. Staff carrying containers with soiled instruments will enter the hospital through the loading dock and go immediately to the Decontamination area of CPD. Instruments will be logged in upon receipt. Containers should be maintained in a horizontal position during transport to prevent dislodging or potential damage during transport.

8. A log is maintained at the remote facilities and the CPD documenting instruments transported and received between the two locations. The log is to show the name of the person sending the instruments, the receipt of the instruments and that the (for sterile packages) sealing tape is intact.

~~9.~~ Sterile items will also be placed in rigid, ~~sealed~~ closed containers for transport. ~~Containers will be sealed with tape, to assure the integrity of sterility during transport, and marked with the initials of the person who is sending the instruments.~~

9.

~~10. Sterile items must never be transported in the same cart or container as dirty items and are never in the soiled lift.~~ All medical devices being transported will be labeled to identify clean, sterile versus contaminated content to assure they remain separate during transport.

10. Transport carts used as transport carriers should be decontaminated and dried before they are reused and at the end of the shift.

11. Routine decontamination of the transport vehicle will be completed and logged daily.

12. A vehicle used to transport soiled items should contain a hazard spill kit and PPE in case a breach of containment occurs.

13.

REFERENCES:

- ~~ANSI/AAMI ST79, 2019.~~ AAMI TIR109: 2025 External transport of reusable medical devices for processing

- ~~OSHA Blood Borne Pathogen regulation (29 CFR 1910.1030)~~

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- ~~Guideline for Cleaning and Care of Surgical Instruments. AORN Standards and Recommended Practices, 2019. Accessed 3/16/2019.~~

SUBJECT: **EMPLOYEE EDUCATION ASSISTANCE**	SECTION: **Page 1 of 10**

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

PURPOSE:

To define the process by which eligible employees may receive education assistance or reimbursement for tuition for approved academic programs or courses and to encourage employee self-development.

To provide employees with support for outside education and/or certification that will enhance competency within an employee's present Sierra View Medical Center (SVMC) position or offer growth toward a SVMC position to which an employee may transfer or progress in the future.

POLICY:

A. Sierra View Medical Center (SVMC) encourages the development of an educated, highly skilled workforce. Each fiscal year, funds will be budgeted for Education Assistance purposes. SVMC reserves the right of fund discretion.

B. Education Assistance should be considered as a privilege rather than a right of a staff member. If Educational Assistance is approved, it will be considered as an interest-free loan and will be forgiven when the staff member has met the required work time payback and/or other criteria as outlined in this policy**.**

C. Approved courses: Courses must be academic courses toward an undergraduate degree or higher level and not continuing education units (CEU), workshops, or general education classes.

D. Approved certifications are awarded by a national, professional organization. The certification awarded denotes that the participant possesses a minimum educational level, licensure and experience, plus additional knowledge, skills, or competencies.

DEFINITIONS:

1. Academic courses: Courses taught by education institutions for which credit may be given towards a degree, ~~diploma,~~ or approved certificate.

2. Professional certifications: Certifications address a professional body of knowledge, which typically has been defined in a scope and standards of practice. Professional certification is a voluntary process by which a non-governmental body grants time-limited recognition and use of a credential to individuals who have demonstrated that they have met predetermined and standardized criteria for required knowledge, skill, or competencies. The certification is available at a national level (i.e., it is not a state-based or system-based certification). Skill-based and technical certificates or provider cards such as Advanced Cardiac Life Support (ACLS), Basic Life Support (BLS), Pediatric Advanced Life Support (PALS), Neonatal Resuscitation Program (NRP), etc., do not meet this requirement.

AFFECTED AREAS/PERSONNEL: *ALL ELIGIBLE SVMC PERSONNEL*
(RESIDENTS: REFER TO YOUR SPECIFIC GME RESIDENCY POLICIES.)

PROCEDURE:

A. Academic Course Selection, Approved Schools & Professional Organizations

1. Education institutions approved for this program may include any accredited public or private secondary school~~, junior college~~, university, scientific or technical institute, vocational, correspondence, extension, or business school. Online programs offered by these institutions are also acceptable.

2. Correspondence courses given by an accredited school may be included.

3. Recognized professional organizations offering concentrated courses of instruction are acceptable. Conference or conventional activities are NOT included.

4. Employees receiving college credit by challenge exam for a course that would have been approved for tuition assistance may submit proof of credit and receive reimbursement for the challenge examination fee with the same limits as applied to regular course work.

5. Certifications must be attained from a professional certification program.

6. Courses and Certifications must meet one or more of the following criteria:

   a. Provide/demonstrate particular knowledge, skills, or competencies directly applicable to present position

   b. Prepare an individual for career advancement at SVMC

   c. Be a required part of a degree program which is directly applicable to present position or area of work

   d. Prepare an individual for another position within SVMC

B. Eligibility

1. All regularly scheduled full-time SVMC employees are eligible to apply for education assistance based on their course of study. Staff must have successfully (no corrective actions in file) completed a full year of active employment prior to applying to the employee education assistance program.

2. All regularly scheduled full-time SVMC employees are eligible to apply for education assistance (reimbursement) for a first-time (one time only) completion of a qualified

professional certification. Staff must have successfully (no corrective actions in file) completed a full year of active employment prior to applying.

2.

4.3. ~~Staff must have successfully completed a full year of active employment prior to applying to the employee education assistance program~~Employees must remain in full time status throughout the time taking courses and during the work payback period.~~.~~

5.4. Employees will be disqualified from the Education Assistance Program and any monies paid in assistance by SVMC must be repaid by the employee if any of the following occur:

a. Grade below "C" or "Fail" if "Pass/Fail" for any course work or a withdrawal from a course

b. A grade of "incomplete" will be considered a "Fail" if not corrected within 60 days of the end of the course

c. An overall rating below 2% of eligible points on their most recent work performance evaluation

d. Is within the Disciplinary Action Process and has received a written warning or higher

e. Any type of Personal Leave of Absence (PLOA) from SVMC during the school term

f. Termination of employment prior to completion of the course work and/or prior to submitting grades and receipts

g. Changes to less than full time employment status.

~~f.~~h.

6.5. If the employee terminates employment and/or is disqualified from the Education Assistance Program for any reason, he/she will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the work payback period as defined below in Section C.2.

6. SVMC has the right to select applicants based on the course of study and their tenure with SVMC. (See Education Assistance Programs available on page 7-8.)

7. SVMC Nursing School with Unitek: ~~Per Diem and~~ Full-Time employees are eligible for sponsorship after 1 year ~~6 months~~ of hire, at the time of application ($10,000 per year, up to 3 years if attend all three years towards a BSN degree, OR, ~~Per Diem and~~ Full-Time

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employees after 1 year ~~6 months~~ of hire, prior to submitting an application, of tuition reimbursement up to 3 years in the BSN program. Grades have to be consistently at the "C" level or better to receive sponsorship or tuition reimbursement. SVMC reserves the right to determine the number of sponsored and tuition reimbursement selected students for each cohort.

C. Application Process for Educational Assistance - Degree

1. Staff must apply for assistance and complete the *Education Assistance Application Form* available in Education Department.

2. Employees applying for the program must agree to a work payback period for SVMC for no less than 12 months for each year reimbursed but not more than 12 months after receiving reimbursement.

3. Applications will be accepted twice per year in the months of May and November.

4. Employees who terminate or are terminated from employment with SVMC for any reason before the required ~~payback work~~work payback time is completed will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the payback period.

~~4.~~5. Employees who change employment status to less than full time before the required work payback time is completed will be required to repay a prorated amount of costs reimbursed based on the amount of time left in the payback period.

~~5.~~6. The *Contingent Repayment Authorization Form* must be signed by the employee at the time tuition reimbursement is distributed.

~~6.~~7. The Education Coordinator will forward copies of the *Contingent Repayment Authorization Form* as follows: one (1) copy to the employee; one (1) copy to the Education Department; one (1) copy to HR for the employee's personnel file; and one (1) copy for the employee's Department Director.

~~7.~~8. The *Employer Provided Educational Assistance Form* must be signed by the employee and Director upon application for Education Assistance. The Department Director is responsible for identifying the job-related or non-job-related areas. This form must be sent with the *Education Assistance Application Form* to the Education Department. Federal and Social Security taxes will be deducted from the reimbursed amount for those courses which are non-job related.

~~8.~~9. The *Education Assistance Application Form* must be completed and signed by the staff member's Department Director with a letter of recommendation and forwarded to the respective Vice President (VP) for signature before routing to the Education Assistance Committee for final approval and processing.

~~9.~~10. Applicants will be required to indicate their education goals.

~~10.~~11. The Director and respective VP have the right to deny requests from staff members with performance problems and/or attendance problems. (See B. Eligibility)

12. Requests for tuition reimbursement will be considered for any coursework completed within the last six months of the application deadlines.

~~11.~~13. SVMC School of Nursing with Unitek – prospective student must register with Unitek College. Options for selecting sponsorship or tuition reimbursement is part of the registration process. The SVMC Education Department has additional templates and documents for prospective students to use in the application process to SVMC.

D. Approval Process for Professional Certification Reimbursement:

1. Staff planning on sitting for national professional certification must submit a request for reimbursement and receive approval from their Director and the Selection Committee. If staff have already taken a certification exam, they will still be considered for reimbursement if they have taken the exam within 6 months from submitting for reimbursement.

2. Only one time/first time certification will be reimbursed. Certification renewal fees are not reimbursable.

3. The Director and respective Vice President have the right to deny requests from staff members with performance problems and/or attendance problems. (See B. Eligibility)

4. Employees requesting reimbursement for a professional certification must agree to a work payback period for SVMC for not less than twelve (12) months.

5. Employees who terminate or are terminated for any reason before the required ~~payback~~ work time is completed will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the payback period.

~~5.~~ Employees who change employment status to less than full time before the required work payback time is completed will be required to repay a prorated amount of costs reimbursed based on the amount of time left in the payback period.

6.

~~6.~~7. The *Contingent Repayment Authorization* must be signed by the employee at the time tuition reimbursement is distributed.

8. The Education Coordinator will forward copies of this form as follows: one (1) copy to the employee; one (1) copy to the Education Department; one (1) copy to HR for the employee's personnel file; and one (1) copy for the employee's Department Director.

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~~7.~~9. SVMC School of Nursing with Unitek – SVMC will use a grading rubric, documents submitted from the student, along with a personal interview in the decision-making process for sponsored and tuition reimbursement. Sponsored and Tuition Reimbursement programs required a 1:1 year of payback working at SVMC full-time after graduation. Failure to finish the program and graduate, will be a required payback of any financial assistance/support to SVMC

E. Department Director Responsibility

1. In determining whether to approve a request for tuition/certification reimbursement, Department Directors and Vice Presidents will consider the necessity of the "Job Enhancement", the priority of the position to be achieved, as well as the length of service of the staff member (minimum of 12 months) and their job performance and/or attendance.

2. A letter of recommendation for degree completion (not certification reimbursement) written by the Department Director must accompany the employee's application when forwarded to the respective VP or Employee Education Assistance Committee (EEAC) for review.

3. Department Directors will notify staff that has been denied eligibility due to these factors.

F. Employee Education Assistance Committee (EEAC)

1. The EEAC shall consist of the following members:

   a. Vice President of Finance

   b. Vice President Patient Care Services

   c. Vice President of Human Resources

   d. Director of Nursing Education

2. The EEAC will be responsible for reviewing all applications presented looking at the following factors:

   a. Completeness of application packet

   b. The nature and purpose of the course of study

   c. The benefits to be derived by the staff member and by the District

3. Only those applications with all required information will be considered.

4. The EEAC will make the decision for final approval prior to processing.

   The Education Department will notify the employee and the employee's Department Director of the EEAC's decision.

G. Reimbursement

1. At successful completion of their course of study, and after receiving approval from the EEAC, staff members must submit receipts for approved expenses to the Education Department for reimbursement.

NOTE: Employees will only receive reimbursement upon successful completion of the course or first time approved certification.

2. The Education Department will then ensure that reimbursement is based upon actual receipts that are attached to the original form and forwarded for processing.

3. Costs excluded from the program are:

   a. Insurance

   b. Seminars and conventions

   c. Institutions/programs not approved by the District

   d. Report preparation

   e. Supplies (i.e., pens, pencils, calculators, recording devices, notebooks, etc.)

   f. Uniforms

   g. Transportation/mileage

   h. Parking expense

   i. Meals and lodging

   j. Skill-based and technical certificates or certification tuition such as ACLS

4. After successful completion of EACH grading period with a course grade, or passing a "pass-fail" course, or completion of a recognized professional certification, the staff member will submit the transcript of the grades received or copy of the certification and receipts to the Education Department.

   a. Future reimbursement will not be made until this information is received

b. Anything lower than a grade of "C", "Fail", or "Incomplete" will not be reimbursed

5. To be eligible for reimbursement, the receipt must be turned in within thirty (30) days after completion of the course, or it will not be paid.

6. The Education Department will submit a Check Request to the Accounting Department along with the required supporting documents to have a check issued as follows:

   a. If the courses or certification exam taken were job-related, so that there are no payroll deductions, separate checks will be sent to the employee's Department Director for distribution to the employee

   b. If the courses or certification exam taken were not job-related, or otherwise subject to payroll deductions, the reimbursement money will be included in the employee's bi-weekly payroll check

Note: All checks will be processed according to current Accounts Payable and Payroll Policies and Procedures.

H. Miscellaneous

1. Class attendance, completion of study assignments, and certification exam preparation will be accomplished outside of the staff member's regularly scheduled working hours.

2. It is expected that educational activities/preparation will not interfere with the staff member's work. However, exceptions will be decided on a case-by-case basis by the respective Department Director and VP.

3. Any unsatisfactory job performance or attendance issues during enrollment may result in termination of education assistance, as well as affecting the individual's employment status, as it would for employees who are not receiving educational assistance.

4. Employees will be reimbursed for up to 2 years maximum for an undergraduate degree and up to 2 years maximum for a graduate degree and higher. However, in the SVMC School of Nursing with Unitek, the sponsorship or tuition reimbursement is for up to 3-years.

I. Education Assistance Programs Available:

ANNUAL TUITION REIMBURSEMENT	
Career Goals	**All Eligible Employees**
Bachelors, Masters, Post Graduate Certificate, Doctorate ~~of Pharmacology~~ ~~Doctorate of Nursing (DNP or PhD)~~	Up to $3,000/~~-~~fiscal year. Last day of course determines which year reimbursement will apply (max 2-years) SVMC School of Nursing with Unitek – Sponsored program for up to 3-years of $10,000 or up to 3-years for Tuition Reimbursement program. Requires at least 6 months of FT or PD status prior to application to the program.

ANNUAL TUITION REIMBURSEMENT	
Career Goals	**All Eligible Employees**
Professional Certification which addresses a professional body of knowledge, defined in a scope and standards of practice.	Up to $500 x one (1) time reimbursement of certification exam fee – First time only!

NOTE: Annual reimbursement of costs are based on a fiscal year and divided into two 6-month periods beginning on July 1st and January 1st.

J. Terms and Conditions

1. It is naturally expected that staff members who have received education assistance will remain with SVMC and will apply their acquired skills and knowledge to improve SVMC's overall performance.

2. A staff member who voluntarily leaves SVMC's employment or who is terminated for cause prior to completing the course or who does not complete their course will be expected to repay monies per contractual provisions.

K. Disclaimer

1. Nothing in this program represents an assurance of continued employment with SVMC.

2. Employment is at the mutual consent of the employee and SVMC and is entirely at will. No one is authorized to modify this Program without the consent of the Board of Directors.

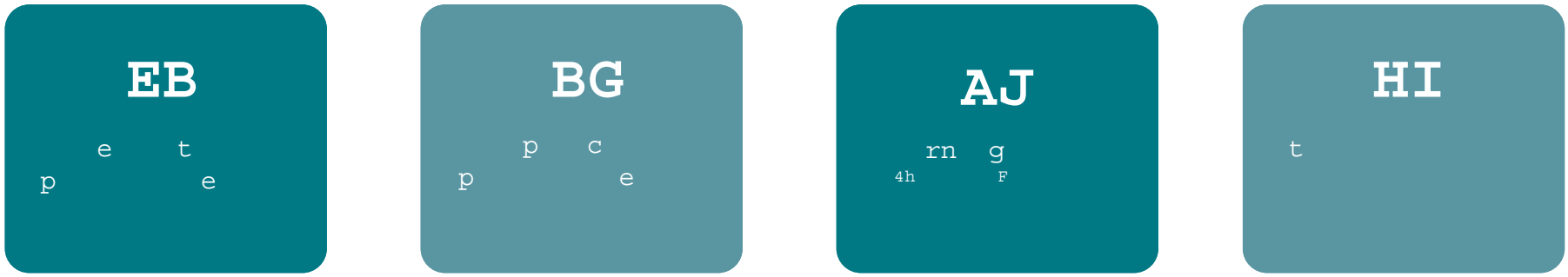

SIERRA VIEW
MEDICAL CENTER
HR Report 2025 QTR 2

Dashboard

Measurement	QTR 1	QTR 2	QTR 3	QTR 4	YTD	Annualized	Goal	Variance
EE Referral Rate	10%	14%			12%	12%	NA	NA
Geofencing Rate	0%	0%			0%	0%	NA	NA
Timely Eval	63%	67%			66%	66%	90%	-24.0%
Turnover	3.9%	3.2%			7%	14%	10%	-3.8%
RN Turnover	5.3%	3.8%			9%	18%	11%	-7.2%
Employee Retiention >5 Years	45%	45%			45%	45%	50%	-5.0%

SVMC RECRUITMENT

Recruitment Update – Q1



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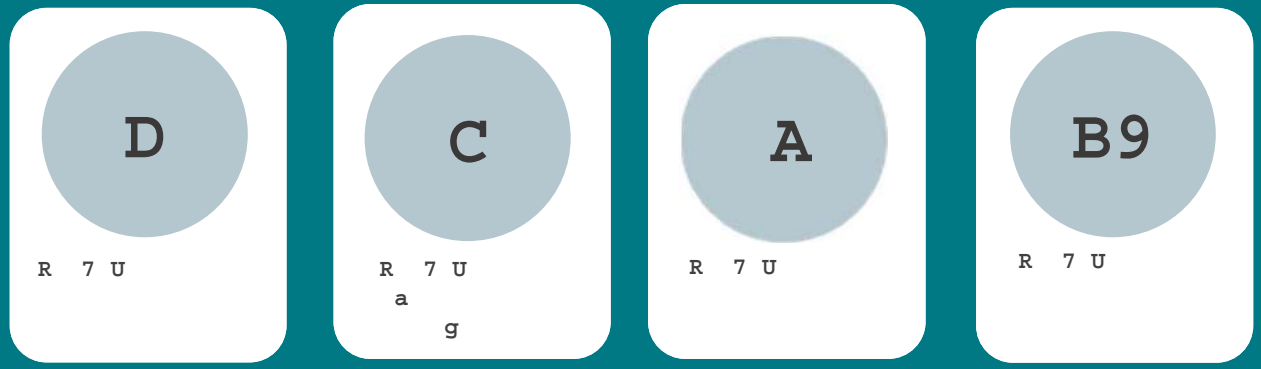

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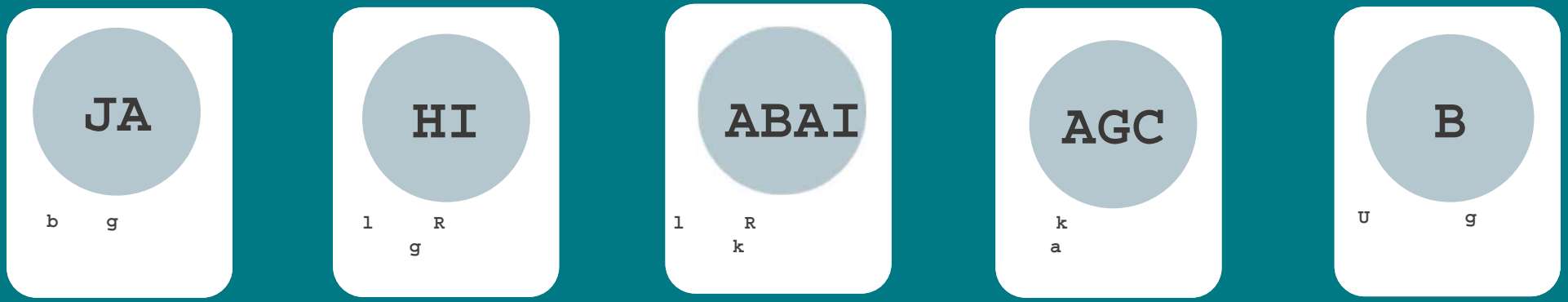

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Recruitment Events/Projects

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Recruitment Events/Projects

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ONBOARDING UPDATE

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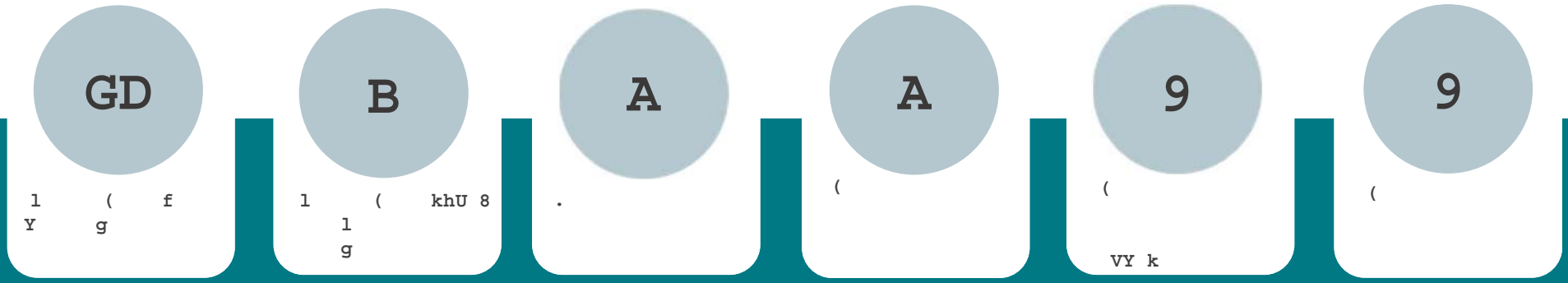

EMPLOYEE RELATIONS

Employee Relations Activity

Human Resources

Performance Management Activities

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9

Progressive Disciplinary Action

d r

Unemployment Insurance Activity

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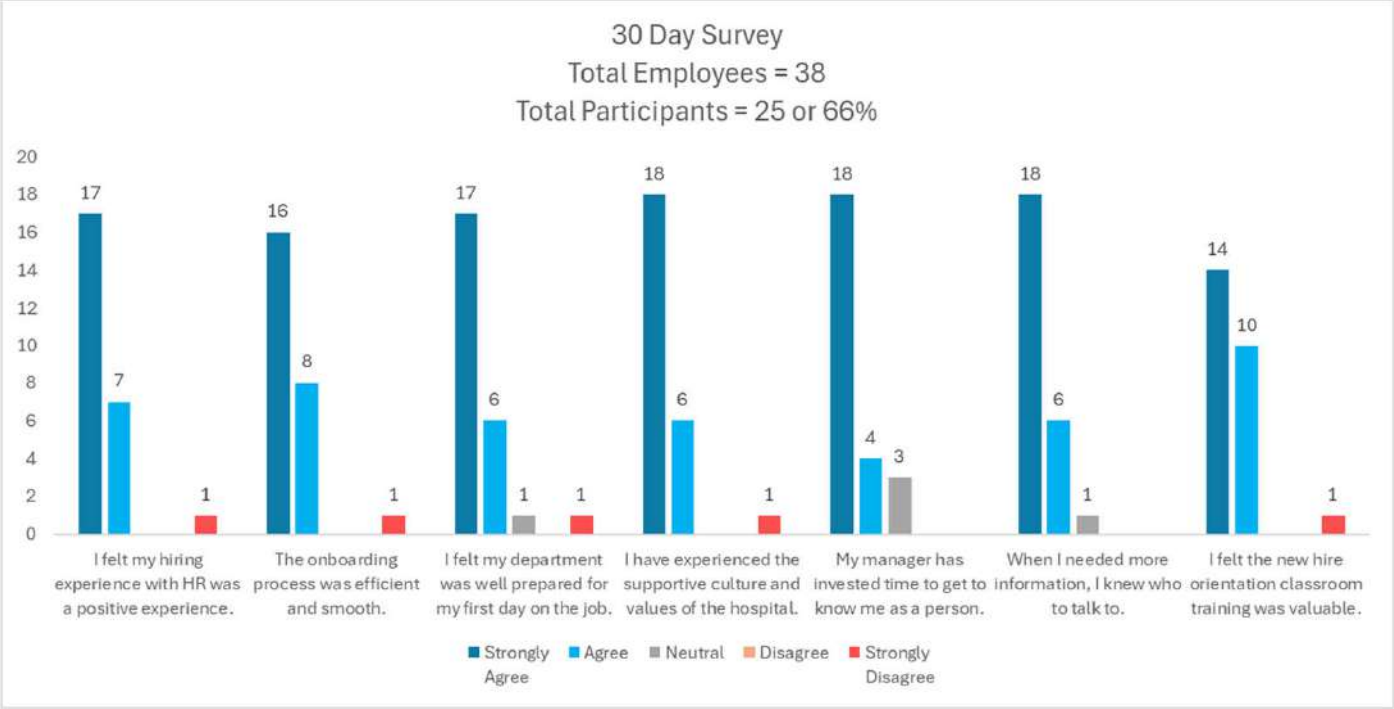
SIERRA VIEW MEDICAL CENTER

Training & Development

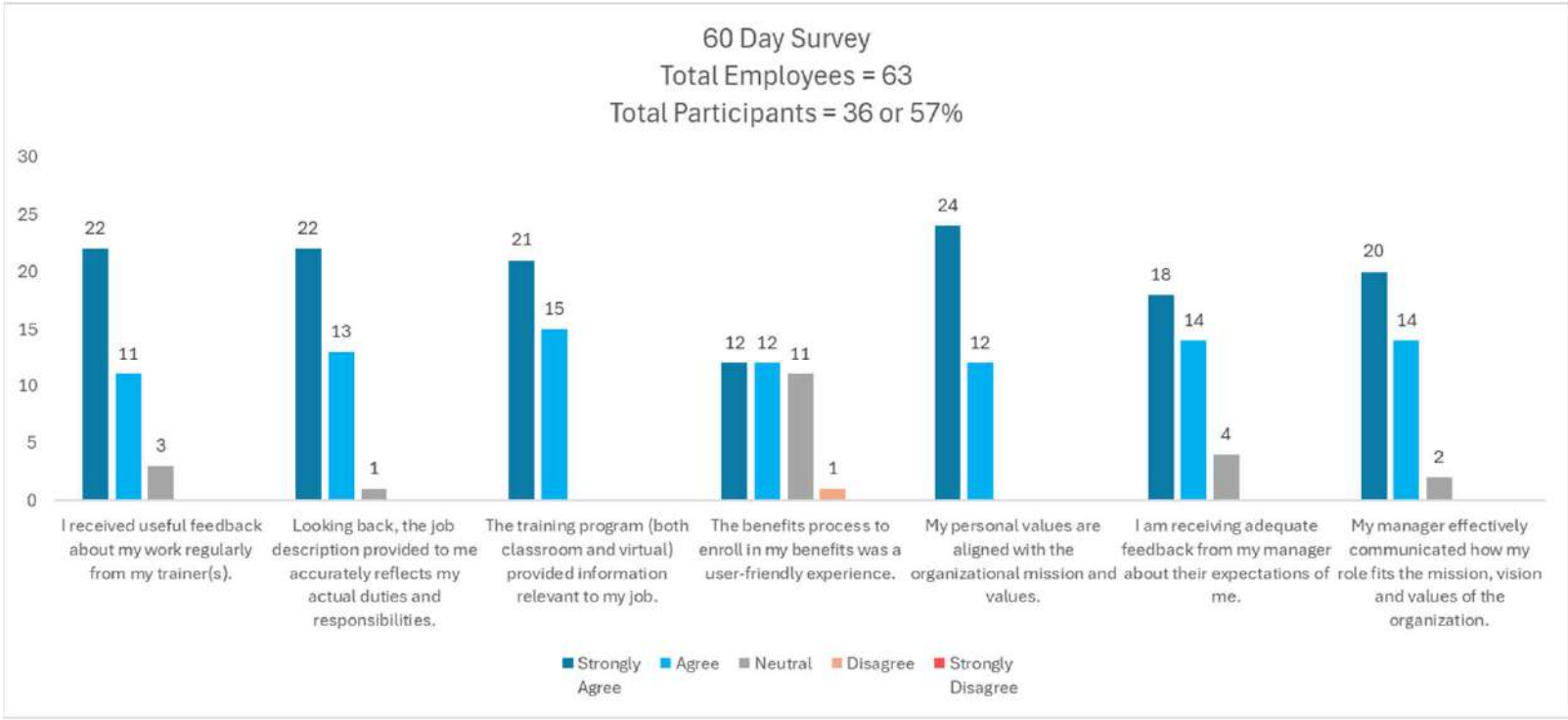
- ✓4 NHO Sessions Facilitated
- ✓55 New Hires Trained

EMPLOYEE ENGAGEMENT

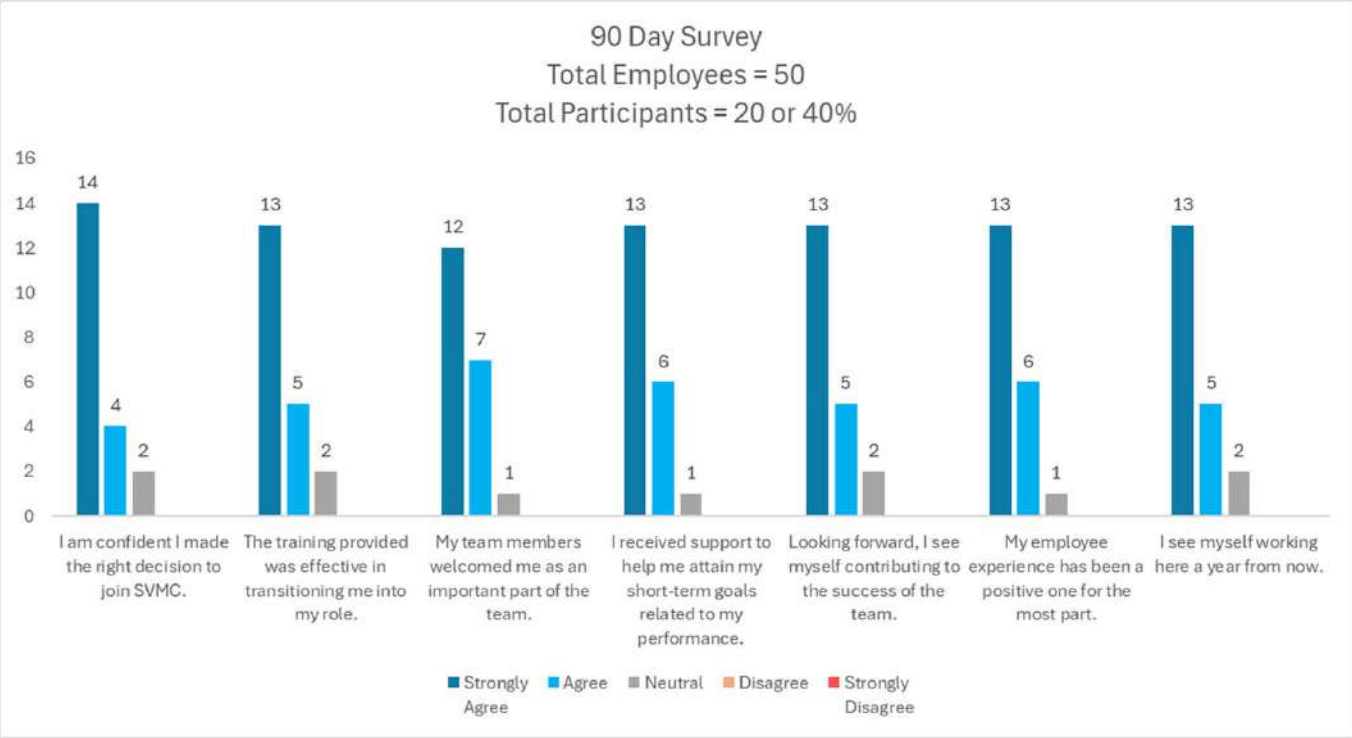
New Hire Survey



New Hire Survey



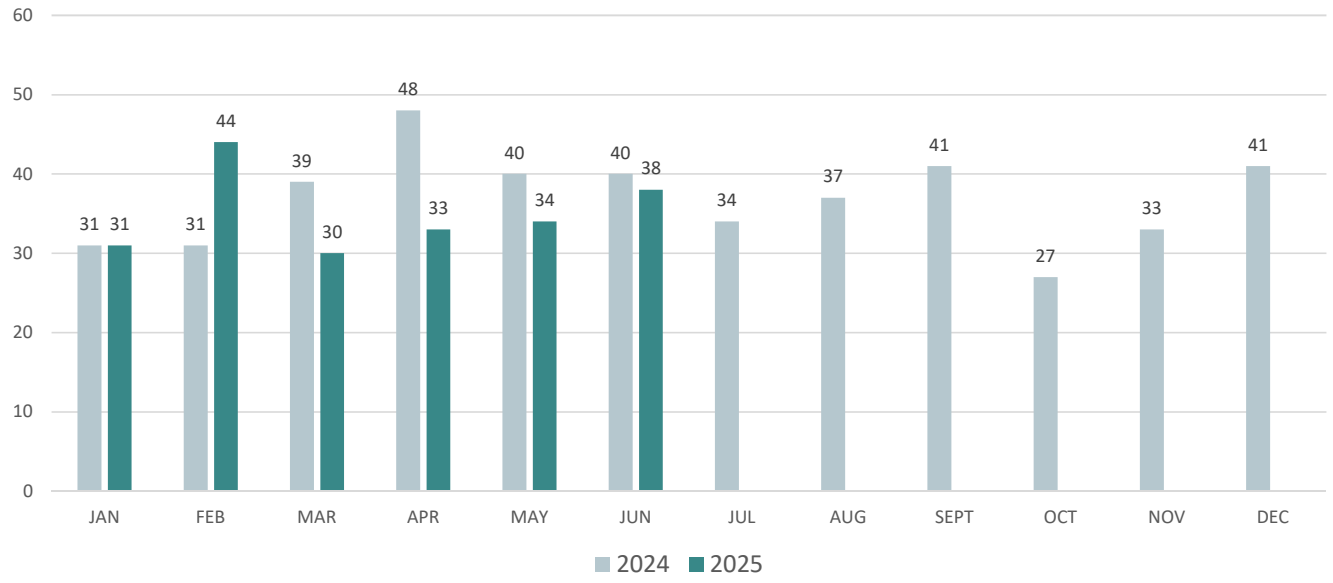
New Hire Survey



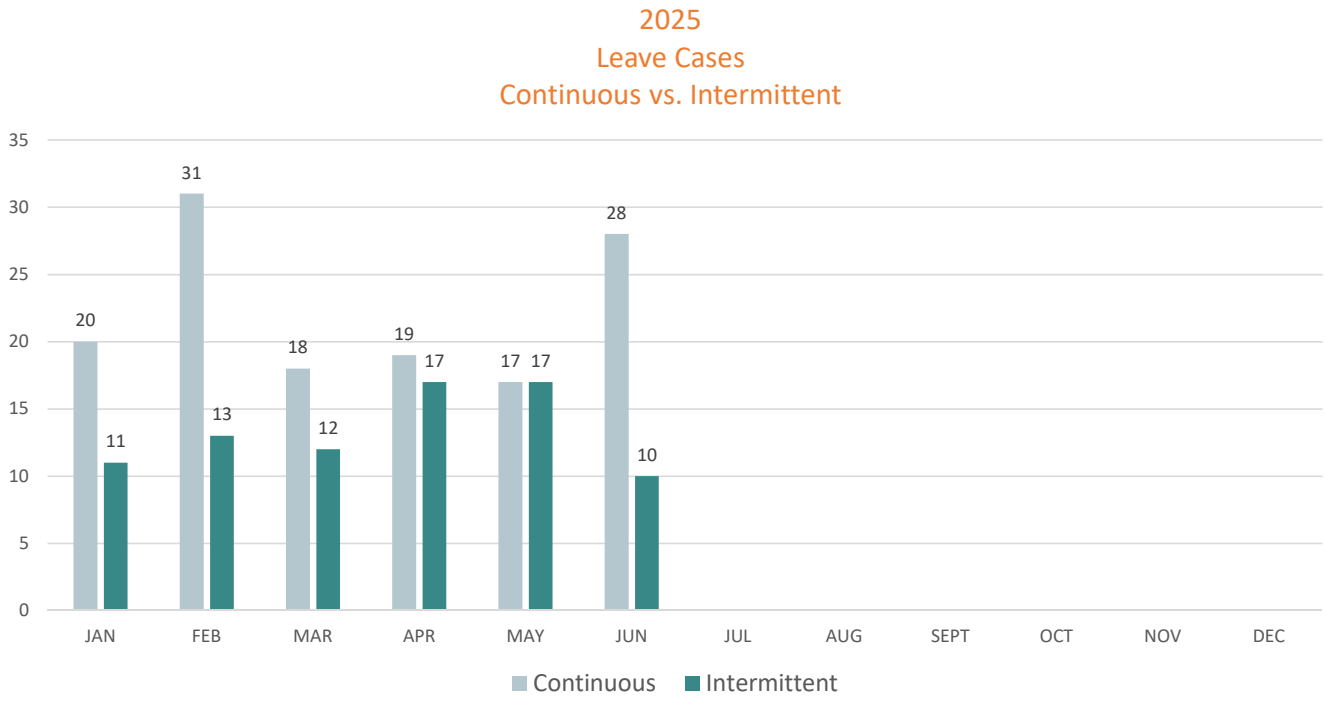
LEAVE OF ABSENCE UPDATE

Leave of Absence Update

Leave Cases
2024 vs. 2025
CY25: Q1 = 105 | Q2 =105 | Q3 = |Q4 =



Leave of Absence Update



Leave of Absence & Accommodations

Leave Designation & Totals

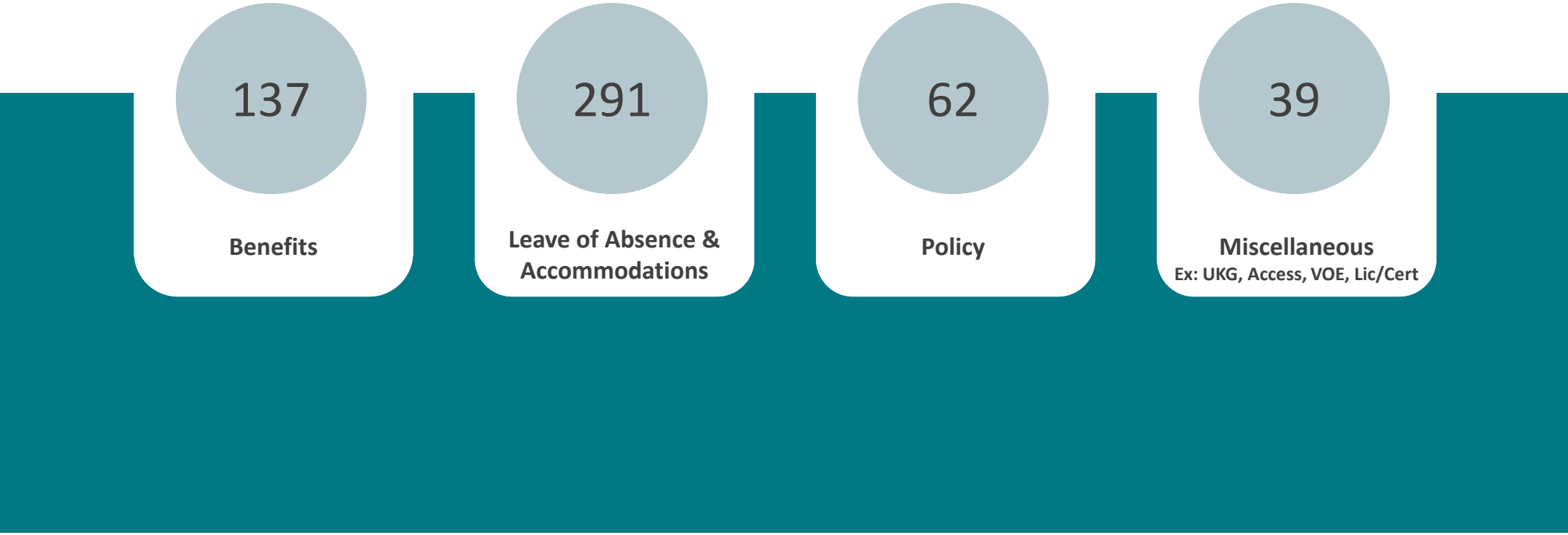
- FMLA- **45**
- FMLA Intermittent- **41**
- ADA Accommodation- **15**
- Personal- **0**
- Administrative- **4**
  - Expired licensure/certification- **4**
  - Expired I-9 documentation- **0**
- Workers Compensation- **5**
- Extensions- **40**
- Return to Work- **63**
- Total of ALL Leaves- **105**

Accommodations Requests

- Light Duty/Modified Duty- **8**

Consultations with Benefits/Leave Coordinator

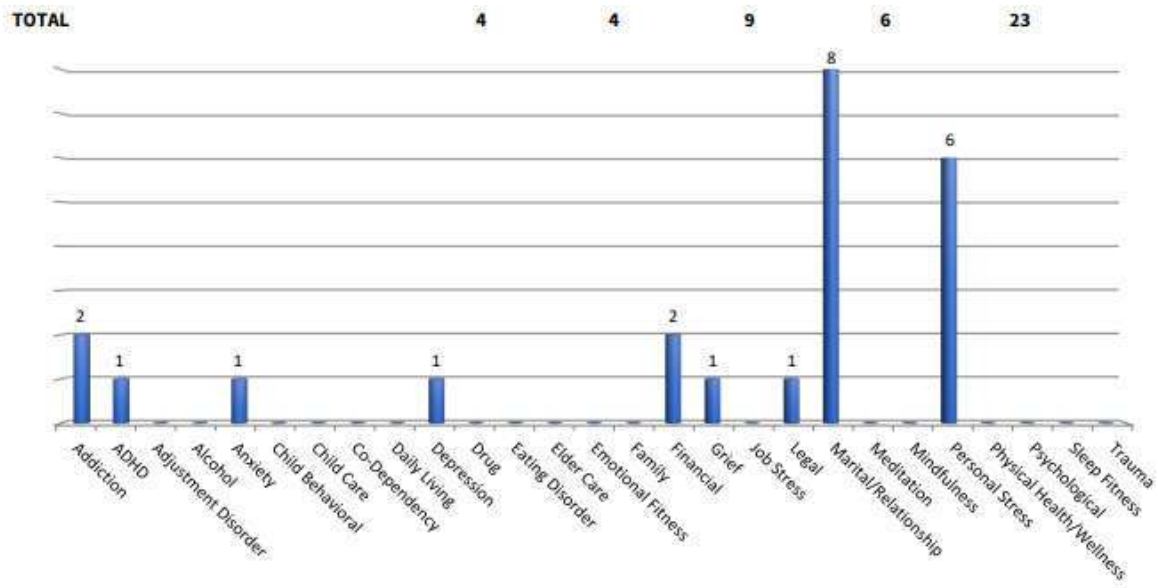
Q4 Total= 529



BENEFITS UPDATES

4 V qtr

Simple Therapy- EAP



a b r 4 V qtr


Sofia Conversational Report
Sierra View Medical Center : 01-01-2025 to 03-31-2025
Hi! Sofia here, your friendly personal benefits assistant. I've put together some helpful insights for you. This report can help you understand my overall engagement and interactions with your team.
Conversations with Sofia
Total conversations with Sofia this time period: 262
% of Sofia chats that occurred after hours or on the weekend: 38%
% of chats that did not result in a conversation with a live representative in the same day: 86%
% of chats that did not result in a conversation with a live representative within the next 7 days: 81%
Conversations Across Platforms
Mobile 32%
Phone 48%
Web 20%
Sofia Usage
70 users
Active employees: (~800)
Percentage of Sofia Chats by Employment Status
96% Full-time
3% Part-time
2% Terminated
% of Chats depicted by Skill
40% Benefits: Questions about what benefits are offered, elections, and plan specific information.
13% Insurance Card: Questions about Insurance ID cards.
11% Spending Account: Questions about spending accounts including balances, contributions, claims, debit cards, etc.
8% Verification: Questions about Dependent and Event Verification. Sofia can answer questions about status, due dates, required documents, and more.
8% Enrollment: Questions about how to enroll including when annual enrollment is and how to add or change an election.
*Note: The numbers represented in this report are rounded to the nearest whole number.
Based on your size and benefit offerings, clients like you have these Top 5 Skills...
Benefits
Spending Account
Insurance Card
Enrollment
Transfer
businessolver
PAGE 1

HR POLICY REVIEW

h

HR Policies

Rhjad SgRjU RhhjgnRdk

- Employee Parking

eRr SgRjU RhhjgnRdk

- Licensure, Registration, Certification
- On-Call, Call Back

bmfV SgRjU RhhjgnRdk

- Personal Conduct
- Property, Privacy & Searches
- Reduction in Force (RIF) Selection and Severance Pay
- Transitional Return to Work
- Voluntary Reduction in Force-Separation

REGULATORY COMPLIANCE AUDIT UPDATES

Regulatory Audits/Internal Audits

a

h V B

aflVjfRd RmUalk TgfUmTlVU

- EE Audited Changes 4/1/25
- Rate Audit Var from pay grade 4/16/25
- Rate Audit Var From Pay grade 5/27/25
- EE Audited Changes 6/19/25

jVXmdRlgjr kmjnVrk TgfUmTlVU

- CDPH 5/24/25 Complaint
- CDPH 6/3/25 Complaint

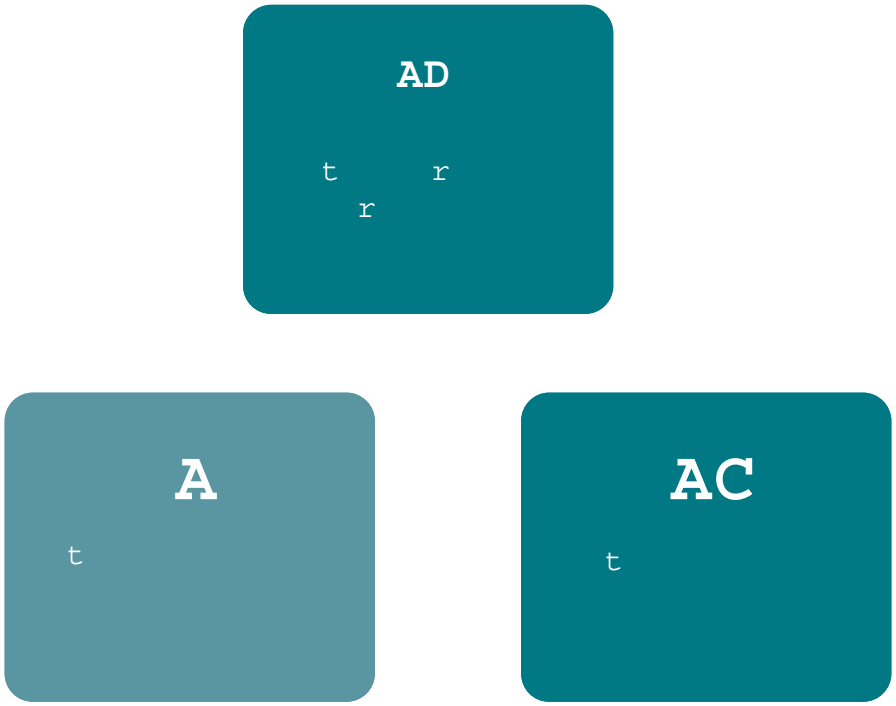
Regulatory Compliance

HR PROJECT UPDATES

HRIS Project Update

- k R
  - FY25-26 Salary adjustments distributed
- TYR T k
  - Submitted
- mcX h e
  - Implementation in progress, go-live set for 1/1/2026
- RTR Y a
  - Interface file created, pending validation

Report Requests



HR KEY ACCOMPLISHMENTS

- Completion of 2025 Strategic Session/Goals
- EE Handbook completed/launched
- Restructure
- Created telework cancellation form on form stack
- Launched Bio Metric Screening campaign
- Automated Port/Convert forms with BSC and VOYA
- Completed TB Non-Compliance
- Successfully onboarded and oriented 17 new Resident Physicians

Marketing Report

Quarter 2

SIERRA VIEW
MEDICAL CENTER

Social Media

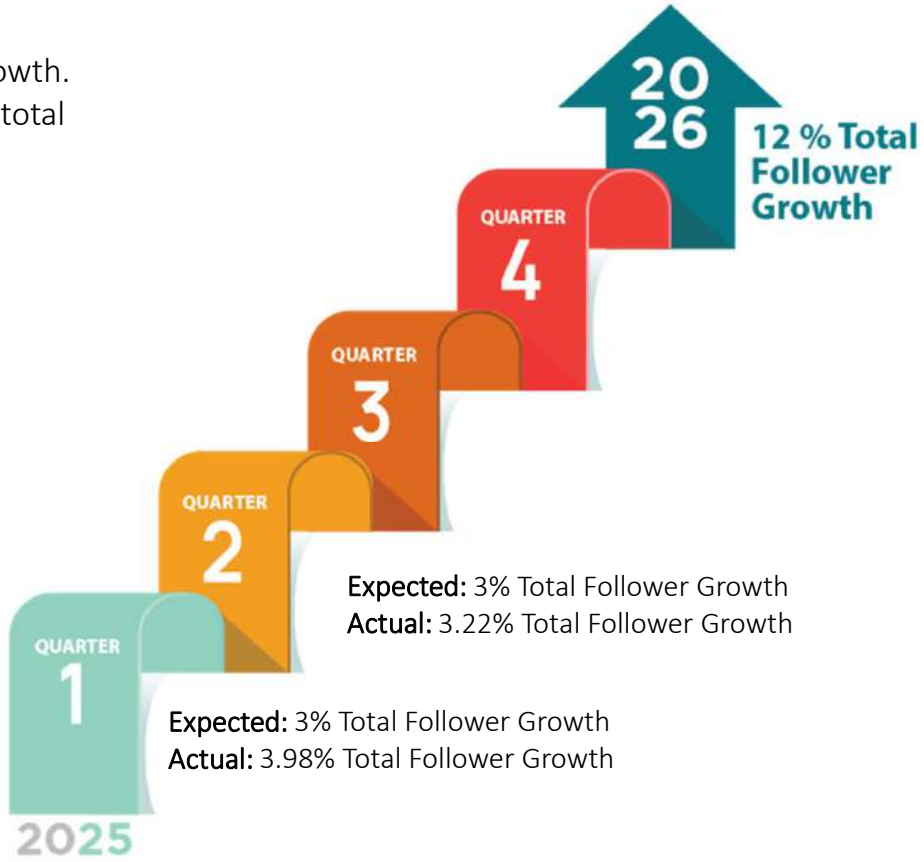
SIERRA VIEW
MEDICAL CENTER

Quarter 2

Social Media Growth

SVMC social media platforms continue to experience a steady growth. Average growth for Q2 was 3.22% in overall audience net gain. A total of 315 new followers was gained across the three platforms.

Followers by Platform				
Platform	**2025 Q1**	2025 Q2	Followers Gained	Growth Percentage
Facebook	**5,387**	5,493	106	2%
Instagram	**2,042**	2,103	61	3%
LinkedIn	**2,347**	2,495	148	6.3%



Quarter 2

Social Media Analytics

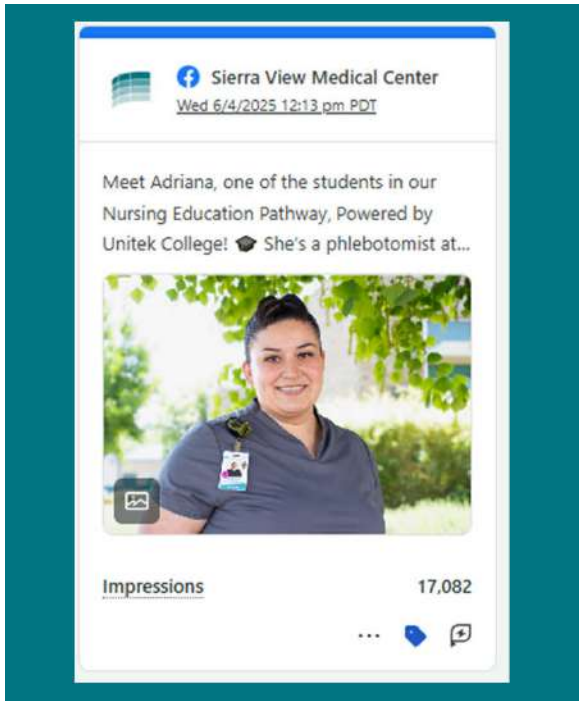
	Facebook	Instagram	LinkedIn	Overall Total for Q2	Social Media Quarterly Goals
# of Posts	96	129	69	294 	250 per quarter
Impressions	706,087	176,789	28,966	911,842 	625,603
Engagements	52,513	3,671	4,555	60,739 	48,587
Engagement Rate	7.4%	2.1%	15.7%	6.7% 	8.4%

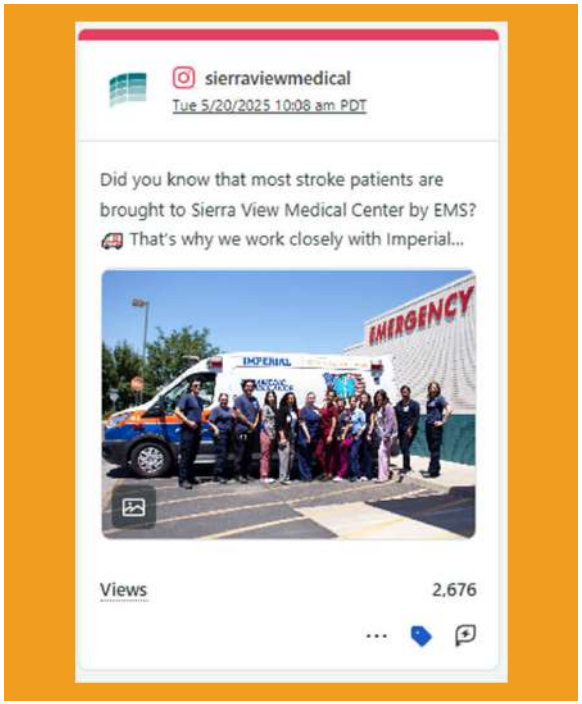
Social Media Quarterly Goals Explained:

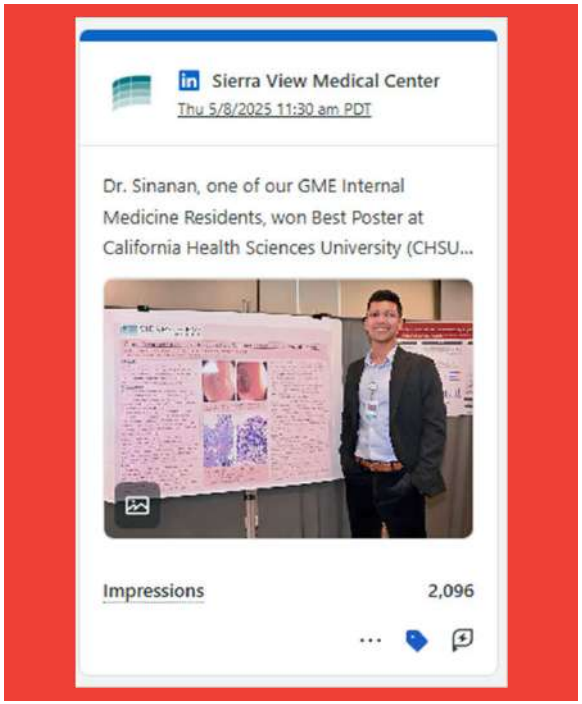
- **# of Posts (250 per quarter):** Realistic goal for SVMC that keeps up with industry standards
- **Impressions Goal (625,603 per quarter):** 10% growth from previous year-to-date
- **Engagements Goal (48,587 per quarter):** 10% growth from previous year-to-date
- **Engagement Rate Goal (8.4% per quarter):** 7.5% growth from previous year-to-date

Quarter 2

Top Three Stories By Platform (Impressions)

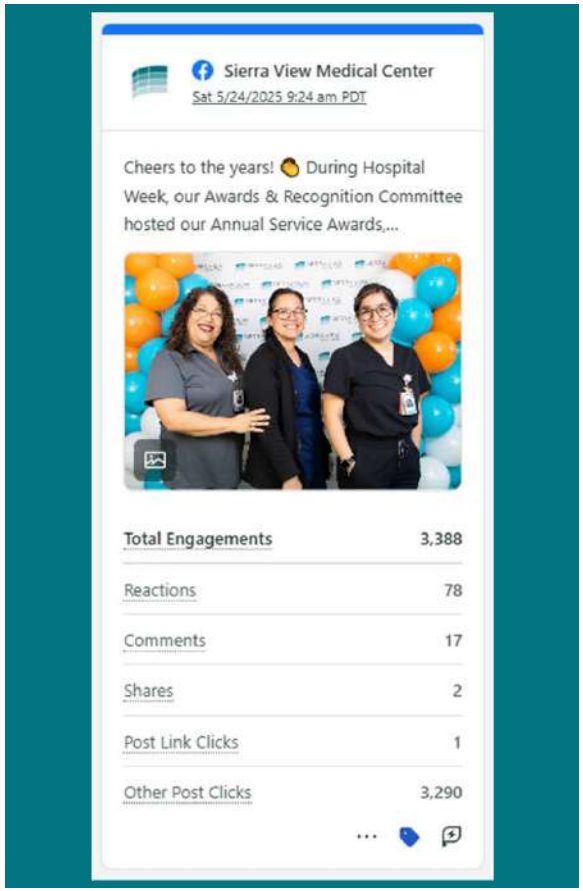


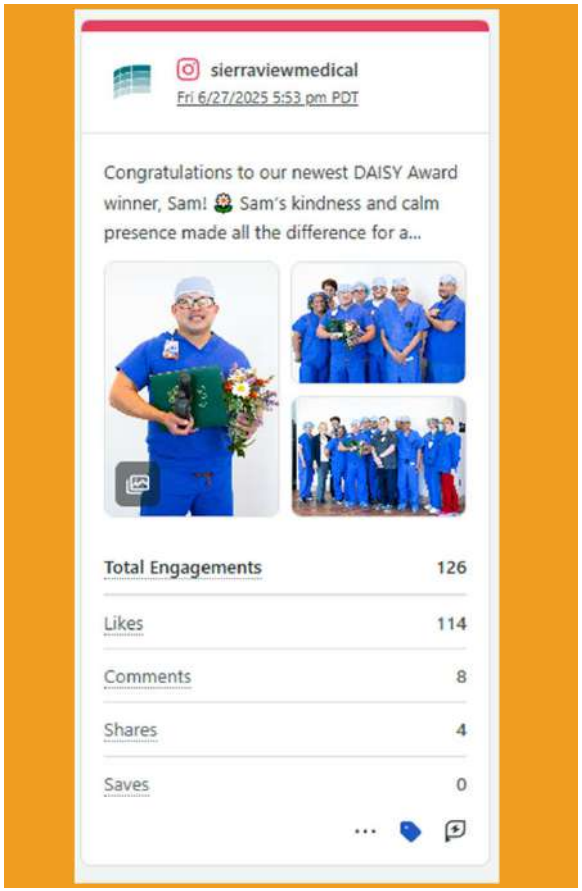


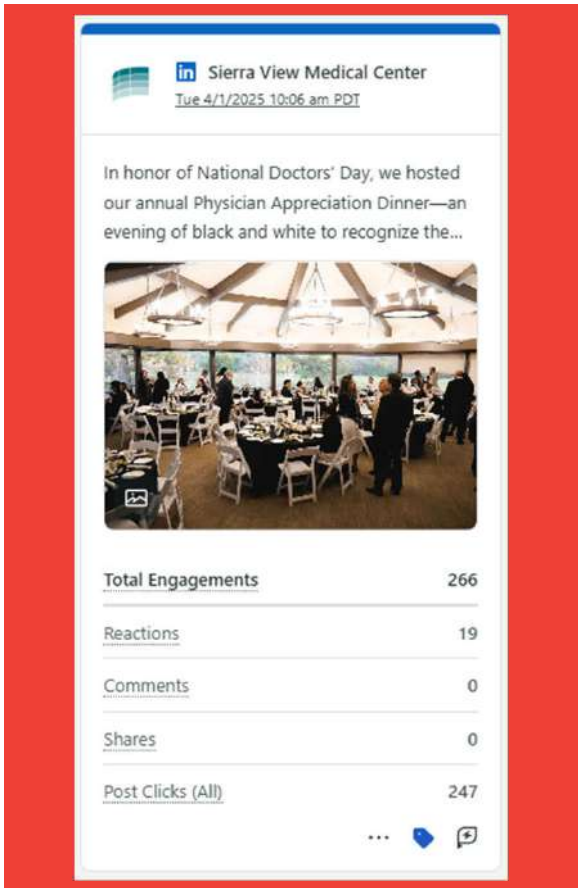


Quarter 2

Top Three Stories By Platform (Engagements)







Quarter 2

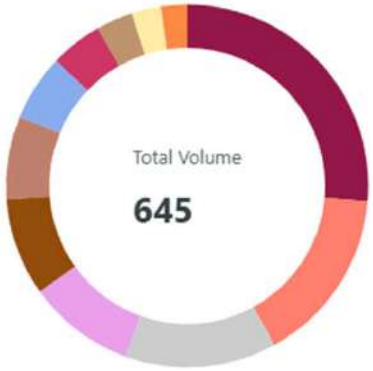
Top Paid Advertisements

Platform	Post	Date	Link Clicks	Reach
Facebook	Inspired By Care	May 9 for 52 days at $300	904	37,205

Quarter 2

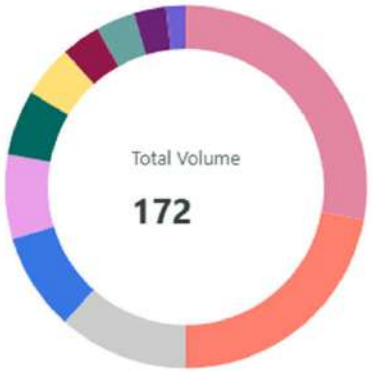
Category Breakdown for Social Media Posts

All Tags



Employees	26.4%
Holiday & Observances	15.7%
partnerships	9.6%
events	8.7%
Senior Team	7.4%
Nursing Services	5.9%
Awards	4.7%
recruitment	3.3%
Updates	2.6%
CTC	2.3%
All Other Tags	13.5%

Service Lines Only



Senior Team	27.9%
Nursing Services	22.1%
CTC	8.7%
SV Foundation	7.6%
GME	5.8%
Stroke Center	4.7%
ICU/Tele	3.5%
Wound Healing	3.5%
Maternal Child Health	2.9%
ASD	1.7%
All Other Tags	11.6%

Quarter 2

Competitive Analysis

Facebook	Kaweah Health	Sierra View Medical Center
# of Posts	61	96
Follower Growth	+52	+107
Engagements Per Post (Average)	52.70	64.59
Published photos	44	82

Instagram	Kaweah Health	Sierra View Medical Center
# of Posts	58	95
Follower Growth	+104	+68
Engagements Per Post (Average)	78.59	35.32
Published photos	33	51

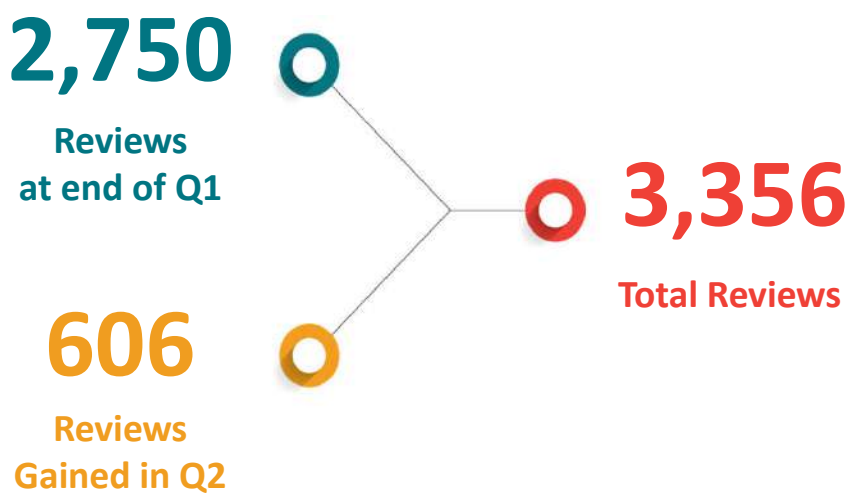
Reputation Management

SIERRA VIEW MEDICAL CENTER

Quarter 2

Reputation Management

SVMC launched our Reputation Management software (Reputation) in January 2024 to improve our online brand health and gain more insights into the patient experience at our hospital. Reputation sends patients a text/email after they are discharged from SVMC, asking them to leave a Google Review about their experience.



Google Star Rating by Location	
Sierra View Medical Center	3.7 Stars
SVMC Urology Clinic	4.5 Stars
SVMC Medical Office Building	4.6 Stars
Roger S. Good Cancer Treatment Center	4.7 Stars
SVMC Physical Therapy	4.7 Stars
Sierra View Community Health Center – Terra Bella	4.7 Stars
Sierra View Hip & Knee Center	4.8 Stars
SVMC Ambulatory Surgery Center	4.8 Stars
SVMC Wound Healing	4.9 Stars

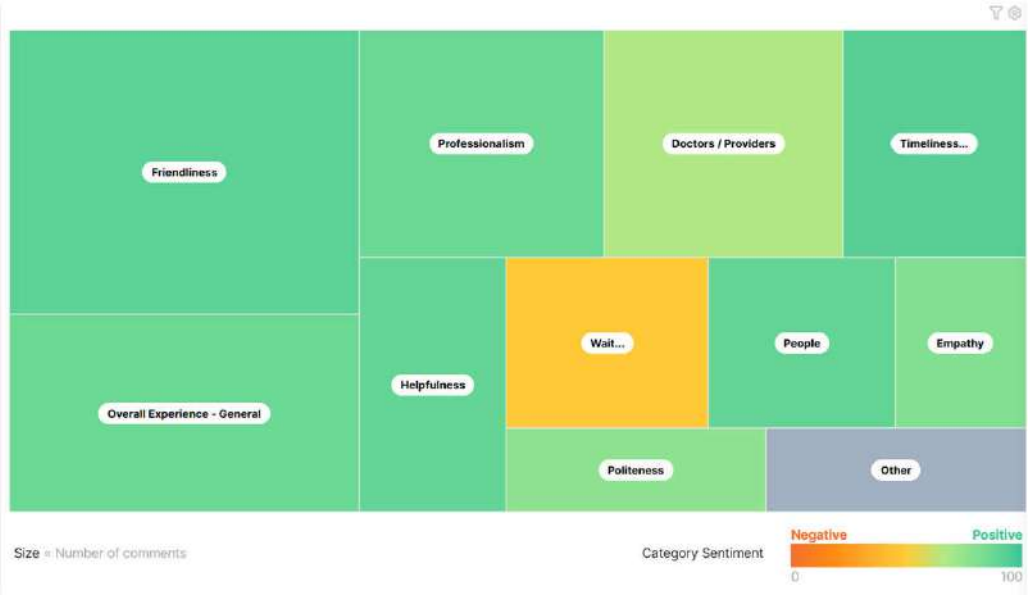
Quarter 2

What Our Patients Are Saying

Word Cloud

*The word cloud displays the frequency and sentiment of patient reviews. Larger words were mentioned more frequently. Green words indicate positive feedback, yellow represents neutral feedback, and orange signifies negative feedback.

Sentiment Map



Quarter 2

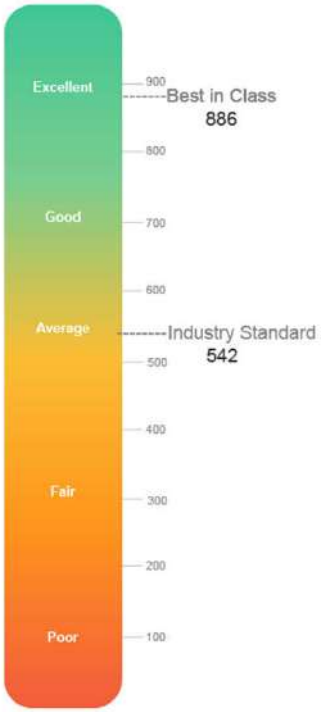
Reviews & Average Ratings

Location (9)	Total Reviews	Average Rating
SVMC Medical Office Building (SVMC_MOB)	334 6% | 3% | 91%	4.6 /5
Sierra View Medical Center (SVMC)	278 19% | 7% | 74%	4.0 /5
SVMC Roger S. Good Cancer Treatment Center (SVMC_CTC)	44 2% | 2% | 96%	4.8 /5
Sierra View Hip & Knee Center (SVMC_Hip_Knee)	36 0% | 3% | 97%	4.9 /5
SVMC Ambulatory Surgery Center (SVMC_ASC)	30 0% | 7% | 93%	4.7 /5
Sierra View Medical Center Urology Clinic in alliance with Keck Medicine of USC (SVMC_Urology_Clinic)	27 4% | 4% | 92%	4.6 /5
Sierra View Physical Therapy (SVMC_PT)	25 12% | 4% | 84%	4.4 /5
SVMC Wound Healing Center (SVMC_Wound_Healing)	11 0% | 0% | 100%	4.9 /5
Sierra View Community Health Center – Terra Bella (SVMC_Terra_Bella_Clinic)	6 17% | 0% | 83%	4.0 /5

SIERRA VIEW MEDICAL CENTER

Quarter 2

Reputation Scores



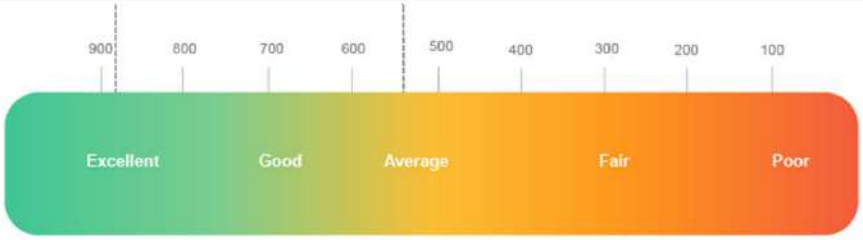
Location (9)	Reputation Score	Review Sentiment	Review Volume	Review Recency	Review Quality	Review Spread	Review Response	Search Impressions	Listing Completeness	Social Score
Sierra View Medical Center (SVMC)	625	44%	52%	100%	68%	52%	100%	74%	92%	96%
Sierra View Community Health Center – Terra Bella (SVMC_Terra_Bella_Clinic)	697	72%	52%	100%	19%	52%	94%	59%	84%	-
SVMC Medical Office Building (SVMC_MOB)	725	72%	52%	100%	61%	52%	100%	74%	80%	-
Sierra View Medical Center Urology Clinic in alliance with Keck Medicine of USC (SVMC_Urology_Clinic)	737	83%	52%	100%	25%	52%	100%	31%	84%	-
Sierra View Physical Therapy (SVMC_PT)	784	85%	52%	100%	50%	52%	99%	74%	84%	-
SVMC Roger S. Good Cancer Treatment Center (SVMC_CTC)	791	86%	52%	100%	58%	52%	100%	74%	84%	-
SVMC Ambulatory Surgery Center (SVMC_ASC)	819	92%	52%	100%	54%	52%	100%	74%	84%	-
SVMC Wound Healing Center (SVMC_Wound_Healing)	845	99%	52%	100%	25%	52%	100%	74%	84%	-
Sierra View Hip & Knee Center (SVMC_Hip_Knee)	868	97%	52%	100%	69%	52%	100%	91%	95%	-

SIERRA VIEW MEDICAL CENTER

Quarter 2

Competitive Analysis of Patient Reviews

Location (4)	Total Reviews	Average Rating	Reputation Score
Sierra View Medical Center (SVMC)	278 19% | 7% | 74%	4.0 /5	626
Adventist Health Hanford	277 11% | 4% | 85%	4.4 /5	851
Dignity Health - Memorial Hospital	200 14% | 3% | 83%	4.3 /5	706
Kaweah Health Medical Center	26 27% | 4% | 69%	3.7 /5	624



Website

SIERRA VIEW
MEDICAL CENTER

Quarter 2

Session Durations

122,262 Sessions

(Up 2,384)

A session represents a single visit to the website, including all user interactions within a given time frame, typically 30 minutes.

1.4 Pages Per Session

(Down 0.1)

The average number of pages a visitor views during a single session.

2M 49S Average Engaged Duration

(Up 6S)

The average time users were actively interacting with your website, not just passively viewing.

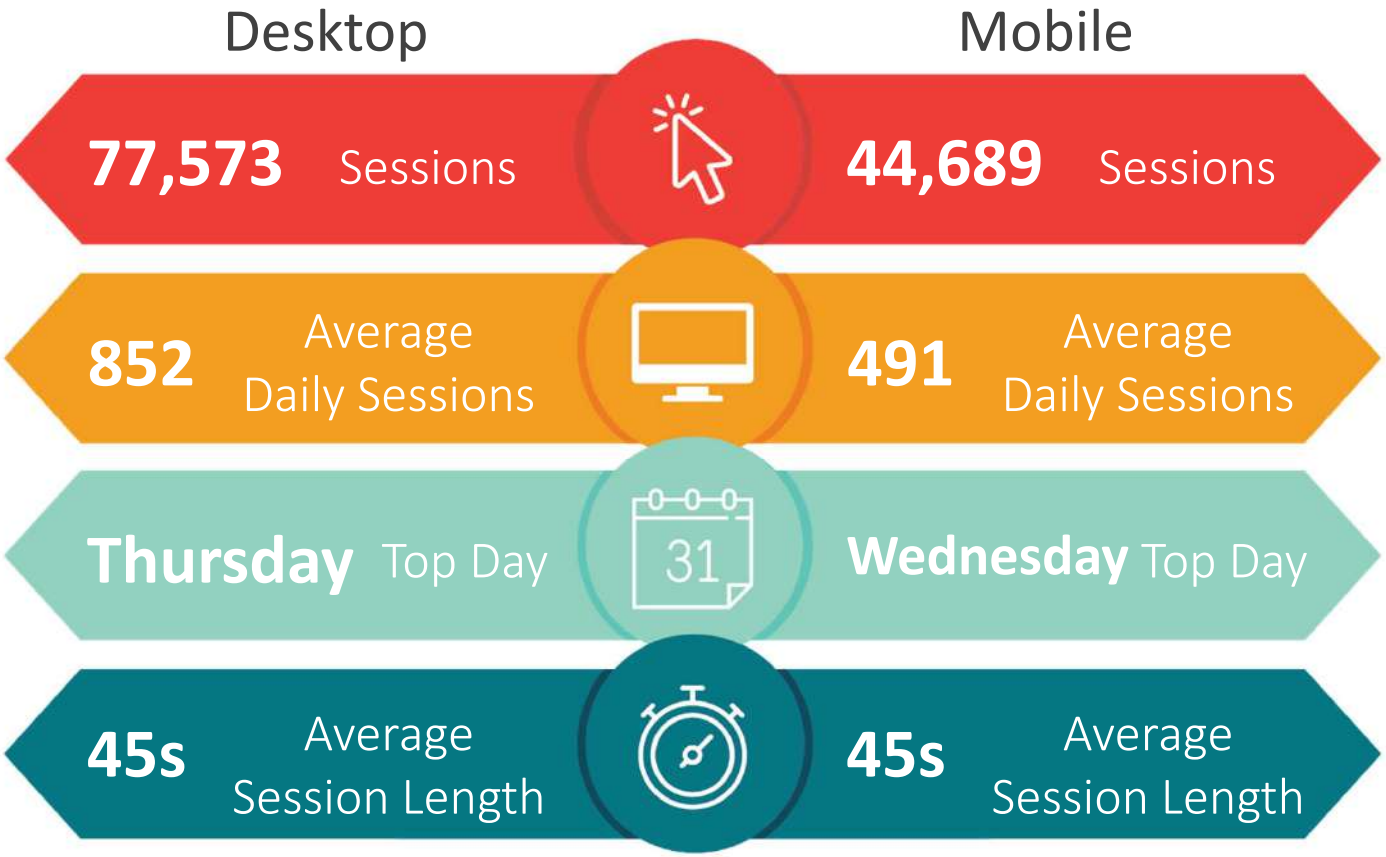
45S Average Session Duration

(Down 6S)

The average amount of time users spend on your website during a session.

Quarter 2

A Snapshot of Our Users



Quarter 2

Top Pages

Page	Sessions	Bounce Rate
Home page	30,990	60.7%
Welcome	23,856	99.5%
Careers	15,901	26.9%
Locations: Sierra View Medical Center	6,995	27.3%
Patient Portal	5,880	11.7%
Remote Access	4,194	17.7%
Physician Directory	3,252	36.7%
Locations	2,747	38.5%
Pay My Bill	1,419	48.5%
Press Room	1,388	55.6%

Sessions: A session represents a single visit to your website, including all user interactions within a given time frame, typically 30 minutes of activity

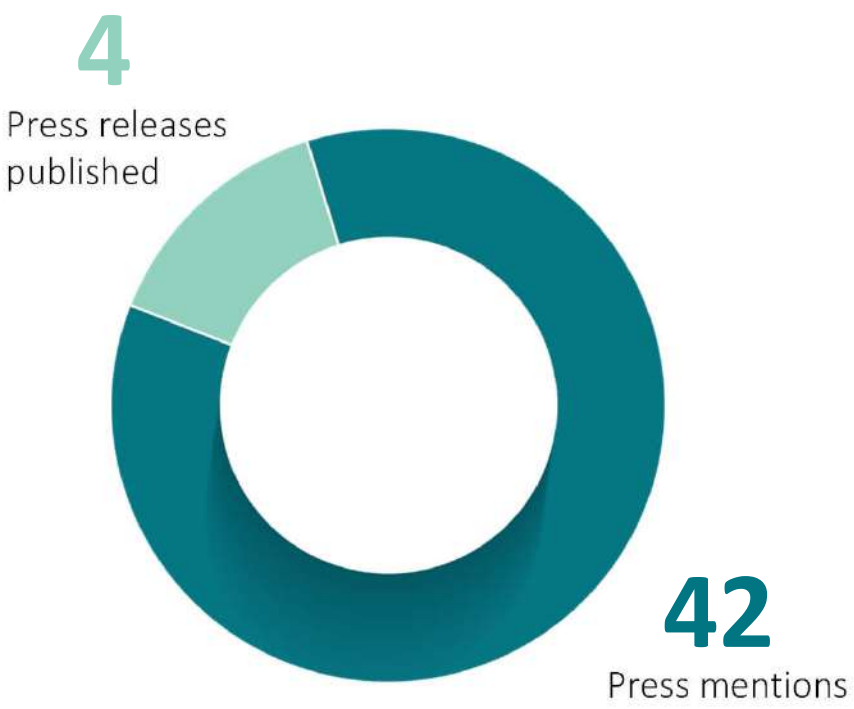
Bounce Rate: The percentage of website sessions where a user leaves after viewing only one page, without taking further action. A high bounce rate isn't always bad—it can mean the visitor quickly found the information they needed.

Public & Media Relations

SIERRA VIEW MEDICAL CENTER

Quarter 2

SVMC In the Headlines



Top Articles

1. Medicare/Medicaid Cuts Looming
2. Sierra View Medical Center Launches Emergency Department Improvement Initiative
3. Let Life Sing_Sierra View Medical Center Honors National Donate Life Month
4. Sierra View receives B Grade for Safety
5. Fitch Affirms Sierra View Local HC District, CA's Revs at 'A-'; Outlook Stable
6. Health Insights Spring Edition

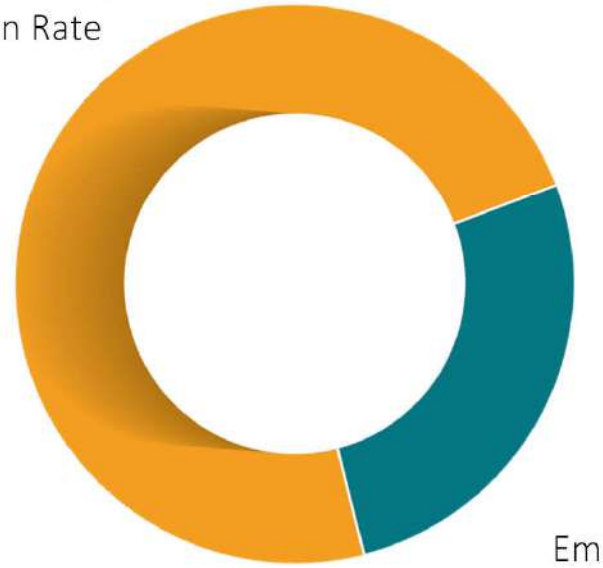
Quarter 2

SIERRA VIEW MEDICAL CENTER

INSIDE View

SIERRA VIEW MEDICAL CENTER

60%
Open Rate



3
Emails Sent

Sierra View Medical Center delivered 3 installments of our digital newsletter Inside View to those who sign up. This publication gives an Inside View of everything happening at and around our hospital. Our monthly emails will keep you up-to-date on the latest Sierra View news, events, career openings, and more.

Community Relations, Events, & Fundraising

SIERRA VIEW MEDICAL CENTER

Quarter 2

Community Events

In quarter two, Sierra View hosted, sponsored or was present at the following community events:

April

- Donate Life Month Flag Raising
- Donate Life Donor Tabling
- Foundation Golf Tournament
- Porterville Spring Festival
- Wear Green and Blue Day

May

- Cinco De Mayo Parade
- Strathmore Football Golf Tournament
- Summit Charter Intermediate Academy Greeting Card Donation to the CTC
- Blood Drive

June

- Porterville Chamber Golf Tournament
- City of Porterville- Freedom Fest
- United Way of Tulare County- Power of the Purse
- CTC Survivor's Day

Quarter 2

Community Relations Outreach

April

- MTA Pathway Advisory Board Meeting
- Public Information All Hazards Incident Training
- Access To Care Committee Meeting (Tulare County)
- Porterville Government Affairs Committee Meeting
- ABC 30 Advisory Council Meeting

May

- MTA Pathway Advisory Board Meeting
- Access To Care Committee Meeting (Tulare County)
- Porterville Government Affairs Committee Meeting

June

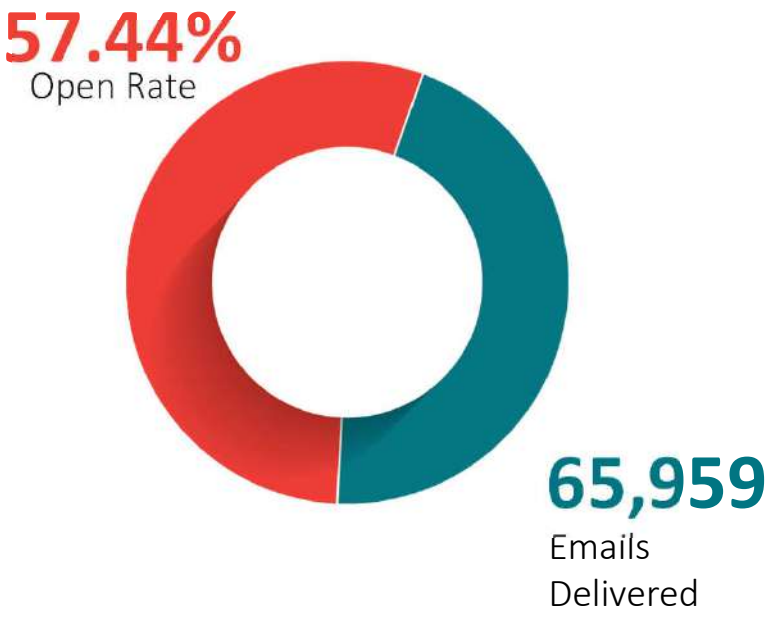
- Bank of the Sierra Grant Check Presentation
- Access To Care Committee Meeting (Tulare County)
- Porterville Government Affairs Committee Meeting
- BUSD Emergency Evacuation Lockdown Drill
- National Dairy Month Celebration

Internal Communication Strategy

SIERRA VIEW MEDICAL CENTER

Quarter 2

Internal Communications



Industry Standard: 28.06% (open rate)
(Approx.. Expected open rate for health care and wellness newsletter.
Source: Constant Contact(Parent company for our vendor, Emma)

Email	Open Rate
GME Graduation Reminder	86.36% Open Rate
5/8 Bi-Weekly Leadership Email	84.31% Open Rate

Types of Internal Communication:

- Weekly Update
- Quality Updates
- Leadership Updates
- Software Updates
- Benefits, HR, and Services
- Chaplaincy Services
- Events

Get In Touch With Marketing

Address

444 West Putnam Avenue

Porterville, CA 93257

General Email

Marketing@sierra-view.com

General Line

(559)791-3922

Thank You

SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED AT MEC MEETING (JUNE)

MEDICAL EXECUTIVE COMMITTEE	06/04/2025
BOARD OF DIRECTORS APPROVAL	
	07/22/2025
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
July 22, 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**
	• Allergy Documentation/Communication	1-2	
	• Annual Infection Prevention Plan	3-30	
	• Bland Aerosol Administration	31-34	
	• Handwashing	35-38	
	• High-Alert Medications and Look Alike Sound Alike Medications	39-51	
	• Medical Screening and Triage in the Emergency Department	52-58	
	• Modified Allens Test	59	
	• Nursing Care of Ventilator Patients on the Medical-Surgical Unit	60-63	
	• Patient Identification	64	
	• Pharmacy Organization	65-66	
	• Prescriber Dispensing for Discharges After Community Pharmacy Hours	67-70	
	• Procedural Sedation	71-92	
	• Pyxis Access	93-95	
	• Pyxis Medication Overrides and Discrepancy	96-109	
	• Quality Improvement – Radiology and Lab Variances	110-111	
	• Registration Process in the Emergency Department	112	
	• Targeted Temperature Management (TTM) – Therapeutic Hypothermia	113-115	
II.	**Forms**:		
	• Medicare Change of Status Notice – English	119-120	
	• Medicare Change of Status Notice – Spanish	121-122	

SUBJECT:	SECTION:
ALLERGY DOCUMENTATION/ COMMUNICATION	***Nursing Procedures (NR)*** **Page 1 of 2**

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

PURPOSE:

To establish standard guidelines for the documentation and communication of patient allergies.

POLICY:

Patient allergy information will be entered and maintained in the electronic health record and a red "Allergy" band will be placed on the patient's wrist in accordance with hospital policy (Color-coded Wristband Use policy).

***Exception**: Cancer Treatment Center maintains paper records, so allergy information is documented on appropriate forms.*

AFFECTED AREAS/PERSONNEL:

ALL PATIENT CARE AREAS, MAY INCLUDE, BUT IS NOT LIMITED TO RNs, LVNs, REGISTERED DIETITIANS

PROCEDURE:

1. Allergy information will be obtained upon initial intake in both outpatient and inpatient areas of the hospital by the Registered Nurse (RN), Licensed Vocational Nurse (LVN) or Registered Dietitian.

2. Allergy information obtained will include food, medication and environmental (i.e. latex, tape, bees, etc.) allergies.

3. The nurse or dietitian may obtain allergy information from the patient, a family member, patient friend, guardian, care giver, conservator, agent, patient's other care providers, other facility documentation (i.e. skilled nursing facility), the patient's electronic health record or medical jewelry (i.e. allergy bracelet).

4. If the patient has no allergies, the nurse will use the "NKA" button on the allergy screen to enter this information in the electronic health record.

5. If allergy information is unable to be obtained due to patient condition and unavailability of additional information sources, the nurse will use the "Unable to Obtain" button on the allergy screen.

6. If the patient has allergies, the nurse or dietitian will enter the allergen name; the type of reaction (allergic or adverse); the severity of the reaction; and the signs and symptoms into the electronic health record.

   NOTE: Registered Dietitian will only enter food-related allergies.

7. The nurse or dietitian should enter "coded" allergies into the electronic health record whenever possible. A "coded" allergy will trigger an auto-alert to physicians, pharmacists and dieticians in the event that a medication or food allergen is inadvertently entered/ordered in the patient's electronic health record. To enter a "coded" allergy, the nurse, dietitian or technologist will begin typing part of the allergen name (i.e. "sul" for sulfa) in the search field and then select the appropriate allergen from a drop down menu.

8. If an allergen is not found in the drop down menu, the nurse or dietitian will type in the full name of the allergen and this will be entered as an "uncoded" allergy. Both coded and uncoded allergies appear in the patient header of electronic health record screens.

9. With each patient visit, the nurse is responsible for reviewing and updating the patient allergy information. All allergies listed will be reviewed for accuracy with the patient or from other appropriate sources as listed above. For allergies already listed, the nurse will confirm accuracy by clicking the "Confirm" button on each allergy. Any new allergies will be entered as outlined above. If any allergies listed are inaccurate, the nurse will delete the allergen.

10. A red allergy band will be placed on patients with allergies and the nurse will document verification of the band placement every shift in the electronic health record.

11. If an allergic reaction occurs during the patient's hospital stay, the nurse or dietitian will enter the new allergen in the electronic health record. If the allergic reaction is related to a medication, the nurse will complete an adverse drug reaction report in Meditech.

DP/SNF Considerations

The DP/SNF unit receives the majority of patient medications from a contracted pharmacy. In order to communicate patient allergies to this external source, nursing staff are responsible for writing patient allergies on the physician's order and faxing to the contracted pharmacy. Additionally, for internal documentation and communication of allergy information, nursing staff of DPSNF will follow the same procedures as outlined above.

TRAINING AND COMPETENCY

Upon hire, all RNs, LVNs and Registered Dietitians will receive training in allergy communication/management as outlined in this policy.

CROSS-REFERENCE:

- Color-Coded Wristband Use

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

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

PURPOSE:

The goal of the Annual Infection Prevention Plan is to establish a comprehensive Infection Prevention (IP) and Control Program. By doing so, SVMC will continue to have a functioning, coordinated process in place to reduce the risks of endemic and epidemic healthcare-associated infections (HAIs) in patients, personnel, volunteers, independent licensed practitioners, and the community.

The update of the Annual Infection Prevention Plan is based on current epidemiological principles and methods. This will ensure appropriate standards and measures are set to maintain awareness and working knowledge of guidelines and recommendations that are published by regulatory and accrediting agencies (such as The Joint Commission and others), professional allied health organizations (APIC, SHEA, AORN and others) that provide current, evidence-based infection control services. The Infection Prevention Manager, under the guidance of the Pharmacy, Therapeutics and Infection Prevention Committee (P&T/IPC) and the IP Chairperson, will develop and conduct infection surveillance, prevention and control to promote optimal health of patients, personnel and the community surrounding Sierra View Medical Center (SVMC).

The Infection Prevention and Control Program will incorporate the following items in a continuing series within this policy:

- Surveillance, prevention and control of infections throughout the organization, in both inpatient and outpatient areas (IC.06.01.01. EP3).
- Screening and surveillance of diseases with pandemic potential (e.g., Ebola, Zika, COVID-19, Mpox)
- Develop alternative techniques to address real and potential exposures
- Select and implement the best interventions to minimize adverse processes/outcomes
- Evaluate and monitor the results and revise techniques as needed

DEFINITIONS:

Centers for Disease Control and Prevention (CDC) – The nation's leading science-based, data-driven, service organization that protects the public's health which in addition to other departments, houses DHQP and NHSN.

Division of Healthcare Quality Promotion (DHQP) – This organization is a division of the CDC and works to protect patients and healthcare workers through safe healthcare delivery systems in the U.S. Among its other activities, the DHQP oversees NHSN activities.

Healthcare-associated infection: Infection acquired while receiving care in a healthcare facility.

Infection prevention and control committee: A multidisciplinary group that functions as the central decision-making and policymaking body for infection prevention and control in the healthcare setting. Its decisions and policies are guided by data and evidence-based practice.

Pharmaceutical and Therapeutics/Infection Prevention committee: A multidisciplinary group that functions as the central decision-making and policymaking body for infection prevention and control in the healthcare setting. Its decisions and policies are guided by data and evidence-based practice.

Infection prevention and control program: Comprehensive strategy for preventing and controlling infections using a combination of policies, procedures, and actions.

Infection prevention and control risk assessment: A detailed list of potential infectious risks to the healthcare setting that are prioritized to provide direction to the infection prevention and control department.

Infection preventionist: Someone who is qualified through education, training, experience, or certification in infection prevention and control.

Infection surveillance: Systematic method of identifying infections that is used to measure the success of infection prevention and control measures and to meet reporting mandates.

National Healthcare Safety Network (NHSN) – Oversees a national database which is the nation's most widely used healthcare-associated infection tracking system

OVERVIEW:

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

All personnel, in partnership with medical staff, are responsible for the safety and health of all patients, residents, visitors, and hospital staff while at SVMC. The responsibility may be met by working together to promote safe infection prevention practices, observing all rules, regulations and procedural guidelines, and continually striving to improve the quality of patient care. For those reasons, SVMC has established an Infection Prevention Program that requires the participation, support and cooperation of all personnel.

Each department, in partnership with medical staff, will be responsible and held accountable for its role in SVMC's Infection Prevention Program. Each department will be responsible for reporting any IP concerns to the Manager of Infection Prevention. Each department will be responsible for full and timely cooperation with the Pharmacy & Therapeutics/Infection Prevention and Control Committee (P&T/IPC). Individuals within each department may be given specific assignments or assigned to IP-related committees. When assigned, completion of assignments in a timely and thorough manner is expected. To coordinate infection prevention and control activities, infection prevention management functions are delegated to the Infection Prevention Manager and the P&T/IPC Committee to investigate and follow-up on clinical issues.

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

POLICY:

1. IP Policy Foundation
    a. Infection Prevention and Control policies are based on recognized guidelines, applicable laws and regulations at the local, state and federal. The policies address measures to prevent the transmission of infections among patients, employees, medical staff, volunteers, visitors, and the general public. Policies have been developed that define surveillance, prevention and control measures in all patient care, support and service areas, and identify methods effective in reducing the risk of transmission of microorganisms, while increasing patient safety.
    b. Policies are reviewed and revised by Infection Prevention and contributing departments at least every three years and as needed. New policies and those policies with major revisions are approved by the P&T/IP Committee. Hospital-wide policies include those that are general, which are followed throughout the hospital, and are located on the SVMC intranet in the Policy Library. Department-specific policies may include policies for tasks or IP measures unique to that particular area. Many of the IP approved practices are integrated into department policies that are kept by the Director/Manager of the department, and Infection Prevention is consulted for input and revisions.
2. Oversight of the Infection Prevention and Control Program
    a. Qualified individuals implement the infection prevention program. A full-time Infection Prevention Manager, an Infection Prevention Registered Nurse, Infection Prevention Analyst, and the P&T/IP Committee (including the ID Specialist) oversee the Infection Prevention program. The Infection Prevention Manager reports to the Vice President of Quality & Regulatory Affairs.
    b. Employee Health, the Education Department and Infection Prevention collaborate to develop policies and provide education to staff. Policies and educational offerings are created collaboratively with the goal to reduce infections.
    c. The P&T/IP Committee assists with the development and approves all Infection Prevention activities and the surveillance program. This approval process considers the following elements:
        i. Criteria used for defining a hospital acquired infection (HAI) and for differentiating them from community-acquired infections. The National Healthcare Safety Network (NHSN) definitions for HAI are utilized.
        ii. Rationale for selecting a specific approach or combination of approaches, and the time frame for using that approach. Targeted surveillance for NHSN and SVMC–specific indicators are used, as described below:
            1. Patient population to be studied
            2. Data collection methods employed
            3. Quality control procedures for ensuring accuracy and completeness of case findings

4. Assignment or responsibility for data evaluation and follow-up
5. Method for reporting and follow-up
6. Reporting of infections to public health as required
7. Documentation of infections of epidemiological significance among healthcare personnel

3. Risk Assessment (Appendix A)
    a. At least once a year, P&T/IP Committee completes a risk assessment, evaluates, revises as necessary, and approves the type and scope of surveillance activities by reviewing the following items:
        i. Data trend analysis generated by surveillance activities during the past year
        ii. Effectiveness of prevention and control intervention strategies in reducing the HAI risk
        iii. Services instituted, procedures performed, priorities of significant community and world health, and problems identified during the past year
4. Resources for Infection Prevention and Control Program
    a. SVMC provides resources for the program through MEDITECH Expanse Live computer services, laboratory services, equipment, supplies and personnel.
5. Healthcare-Associated Infection Surveillance Overview
    a. The SVMC Infection Prevention Program is responsible for monitoring HAIs. Since July 2008, the SVMC Infection Prevention Program has been an active participant in the CDC NHSN program using NHSN infection indicators, definitions, and methodologies for data collection and analysis. Data is entered into the Infection Prevention Database regularly and electronically transmitted into an Infection Prevention Database maintained by NHSN.
    b. Since 2003, a targeted surveillance program for an HAI has been utilized at SVMC. With targeted surveillance, infection prevention outcome objectives are determined, priorities are established, and resources are allocated to the major types of infections and the patient populations at highest risk of acquiring an HAI. Numerators and denominators are clearly established with the focus on procedures that have preventable risk factors that may contribute to the development of an HAI.
    c. In addition to the infection types specified in the targeted surveillance plan, non-targeted infections, single occurrences, and/or outbreaks of an HAI related to any unusual or virulent pathogenic organism are evaluated. The Infection Prevention Manager, Vice President of Patient Care Services, and P&T/IP Committee determine interventions.
6. Definitions for Healthcare-Associated Infections (HAI)
    a. Determination of an HAI depends on evaluation of clinical, laboratory and other diagnostic information gathered on the patient. Consistency in determining HAIs within the healthcare setting is necessary to compare infection rates from one evaluation period to the next. When comparing

hospital infection rates to a national infection rate, consistent determination of HAIs from all participating hospitals is essential.

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

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

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

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

   c. Central Venous Catheter-Associated Blood Stream Infections (CLABSI) (: Nationally, bloodstream infections associated with central venous catheters are often preventable and have a high mortality rate. It is a high priority to reduce risk factors leading to these infections. Patients in the ICU who develop a BSI are 2-3 times more likely to stay in the hospital an average number of 24 days and/or die (https://www.cdc.gov/clabsi/about/?CDC_AAref_Val=https://www.cdc.gov/HAI/bsi/CLABSI-resources.html). Estimates of added costs attributed to CLABSIs is over $40 million annually. At SVMC, CLABSIs are monitored house-wide and reported on an ongoing basis to P&T/& IP Committee and to the appropriate clinical units.

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

8. Surveillance Documentation of All Infections

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

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

c. Surveillance includes, but is not limited to, surgical procedures, obstetric procedures, catheterization procedures, and antibiotic resistant bacteria (MDROs).

9. Infection Control Reports

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

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

10. Surveillance Strategies

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

b. Surgical Site Infection Components:

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

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

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

2. Surgical Wound class

3. Whether the operation was performed as an emergency or as a result of trauma

4. If multiple procedures were performed through the same incision

c. Surgical Surveillance:

i. Objectives:

1. Establish a baseline for HAI of 0 incidences following procedures at SVMC
2. Evaluate procedures, policies, and practices, looking for preventable risk factors when infection trends are identified
3. Reduce infection by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis
2. Numerator: Number of patients developing surgical site infection following surgery
3. Denominator: Total number of patients undergoing surgery

iii. Data Sources:

1. Daily surgery schedule
2. Monthly report of all procedures
3. Daily census report from the computer data systems
4. Concurrent and/or retrospective chart review by Infection Prevention if there is an occurrence of infection
5. Communication from the surgical staff
6. Post discharge communication is monthly from surgeons to Infection Prevention via a follow-up letter

iv. Defining Indicators for Infections:

1. Infections occurring following surgery at SVMC
2. NHSN definition for surgical site infection

v. Follow-up:

1. Reports are provided quarterly to P&T/IPC, participating surgeons, and other committees with a vested interest in these rates
2. When SVMC rates increase, Infection Prevention makes a determination as to significance
3. If the infection rate is significant, an evaluation of relevant procedures, policies and practices is undertaken by Surgical Services and Infection Prevention
4. Information is shared with Surgical Services and the Performance Improvement/Patient Safety (PIPS) Committee

5. A report is presented by Infection Prevention to P&T/IPC the Performance Improvement/Patient Safety (PIPS) Committee
6. describing the result of the evaluation
7. If preventable risk factors are identified, an action plan outlining ways to reduce risk is included in this report

d. Ventilator Associated Pneumonia (VAP)

i. Objectives:

1. Evaluate procedures, policies and practices, looking for preventable risk factors when infection trends are identified
2. Maintain goal of "0" VAP
3. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects VAP data on an ongoing basis
2. Reports are provided quarterly to P&T/IPC and appropriate Directors and Clinical Managers, as indicated
3. Numerator: Number of patients who develop pneumonia following placement on a ventilator
4. Denominator: Number of ventilator days

iii. Data Sources:

1. Monthly number of ventilator days
2. Daily sputum gram stain and culture and sensitivity (C&S) reports from Microbiology Laboratory
3. Daily admission report from computer data system
4. Communication from staff to Infection Prevention
5. Communication from physicians to Infection Prevention
6. Concurrent and/or retrospective chart review

iv. Defining Indicators for Infections:

1. Patient developing pneumonia following placement on ventilator
2. NHSN definitions for pneumonia

v. Follow-up

1. Reports are presented quarterly to the P&T/IP Committee, Clinical Director and Managers for presentation to appropriate staff
2. When SVMC rates increase , a determination is made by Infection Prevention as to significance
3. If it is determined that the pneumonia rate is significant, evaluation of relevant procedures, policies and practices is undertaken by P&T/IP Committee
4. A report is presented by Infection Prevention to the P&T/IP Committee and the Performance Improvement/Patient Safety (PIPS) Committee describing the result of the evaluation.
5. If preventable, risk factors are identified and an action plan outlining ways to reduce risks is developed, with a schedule for implementation.

e. Central Line Associated Blood Stream Infections (CLABSI)

i. Objectives:

1. Establish a baseline for HAI of 0 incidences following procedures at SVMC
2. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
3. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis.
2. Reports are provided quarterly to the P&T/IPC and Clinical Directors and Managers.
3. Numerator: Number of episodes of CLABSI infections
4. Denominator: Number of CVC days

iii. Data Sources:

1. Monthly report of number of CVC days
2. Daily microbiology reports of blood, site, gram stain and C&S
3. Concurrent and/or retrospective chart review of patients with CVCs

iv. Defining Indicators for Infection:

1. Patient with CVC and a bloodstream infection
2. NHSN definitions for BSI

v. Follow-up:

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

2. When the SVMC rate increases, a determination is made by Infection Prevention as to significance.
3. A report is presented by Infection Prevention to the P&T/IP Committee and the Performance Improvement/Patient Safety (PIPS) Committee describing the result of the evaluation.
4. If preventable risk factors are identified, an action plan outlining ways to reduce risks, with a schedule for implementation

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

i. Objectives:

1. Establish a baseline for HAI of 0 incidences following procedures at SVMC
2. When SVMC rates increase , a determination is made by Infection Prevention as to significance
3. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
4. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis
2. Reports are provided quarterly to the P&T/IPC, Infection Prevention and clinical directors and managers
3. Numerator: Number of episodes of CAUTI in patients
4. Denominator: Number of urinary catheter days in patients.

iii. Data Sources:

1. Daily catheter report generated electronically
2. Daily microbiology reports of urine analysis, urine gram stain and C&S
3. Daily admission reports from the computer data system
4. Communication from nursing staff to Infection Prevention
5. Concurrent and/or retrospective chart review of patients with indwelling urinary catheters

iv. Defining indicators for infection:

1. Patients with indwelling urinary catheter
2. NHSN definitions for CAUTI

v. Follow-up:

1. Reports are presented quarterly to the P&T/IPC and nursing units
2. When the SVMC rate exceeds NHSN or SVMC benchmark rates, a determination is made by Infection Prevention as to significance.
3. If it is determined that the infection rate is significant, an evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors.
4. A report is presented by infection prevention to the P&T/IPC, describing the result of the evaluation.

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

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

a. Housewide Bloodstream Infections (BSI) with MRSA, VRE, CRE:

i. Objectives:

1. Establish a baseline for HAI of 0 incidences following procedures at SVMC
2. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
3. Reduce infections by reducing risk factors

ii. Methodology:

1. Infection Prevention collects data on an ongoing basis
2. Reports are provided quarterly to the P&T/IPC and nursing units
3. Numerator: Number of bloodstream infections in SVMC patients
4. Denominator: Number of patient days

iii. Data Sources:

1. Quarterly report of the number of bloodstream infection days from the Infection Prevention Department
2. Daily microbiology reports of blood cultures
3. Daily census reports from the computer data system
4. Communication from nursing staff to Infection Prevention
5. Concurrent and/or retrospective chart review of patients with bloodstream infections

iv. Defining Indicators for Infection:

1. Bloodstream infections will meet the NHSN definition for bloodstream infection

v. Follow-up:

1. Reports are presented quarterly to the P&T/IPC and nursing units. When the rate increases, a determination is made by Infection Prevention as to significance
2. If Infection Prevention determines that the rate is significant, this information is shared with the P&T/IPC
3. An evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors. The Infection Prevention Department reviews identified infections and assists in investigation.
4. A report is presented by Infection Prevention describing the result of the evaluation
5. If preventable risk factors are identified, an action plan outlining ways to reduce risks is developed, with a schedule for implementation

b. MRSA, VRE and *C. difficile* colonization and infections:

i. Objectives:

1. Establish a baseline for HAI of 0 incidences at SVMC
2. Evaluate procedures, policies and practices, looking for preventable risk factors, when infection trends are identified
3. Reduce infections by reducing risk factors

ii. Methodology:

1. Data is collected on a daily basis
2. Reports are provided quarterly to the P&T/IPC, nursing units, and other committees as necessary
3. Numerator: Number of episodes of HAI
4. Denominator: Number of patient days

iii. Follow-up:

1. Reports are presented quarterly to the P&T/IP Committee and nursing units. When the rate exceeds SVMC benchmark rates, a determination is made by Infection Prevention as to significance.
2. If Infection Prevention determines that the rate is significant, this information is shared with the P&T/IP Committee.

3. An evaluation of relevant procedures, policies and practices is begun by Infection Prevention, looking for preventable risk factors. The Infection Prevention Department reviews identified infections and assists in investigation.
4. A report is presented by Infection Prevention describing the result of the evaluation.
5. If preventable risk factors are identified, an action plan outlining ways to reduce risks is developed, with a schedule for implementation.

12. Requirements for Surveillance of All Infections:

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

13. Precautions:

    Transmission-based precautions to protect against exposure to a suspected or identified pathogen are utilized. Based on the transmission of a specific pathogen, precautions are selected. Contact, droplet, airborne or a combination is used, depending on the pathogen. Standard precautions are always used with all patients. Personal Protective Equipment (PPE) is used specific to the precaution to reduce the risk of infection.

14. Hand Hygiene Compliance:

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

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

    Infection Prevention and Employee Health are responsible for many other activities to prevent and control infection transmission in the hospital and outpatient areas. The following reports are submitted to the P&T/IP Committee on a regular basis or if a substantial change in occurrence is observed.

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

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

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

iii. There was a 85% vaccination rate in the 2023-2024 influenza season with 15% of all staff declining vaccination (see Table below) as indicated by the signed letter of declination. There was an 88% vaccination rate in the 2024-2025 influenza season with 12% of all staff declining vaccination.

Respiratory Disease Season	Vaccinated (%)	Declined (%)
2022 – 2023	78%	22%
2023 - 2024	85%	15%
2024 - 2025	88%	12%

iv. Improvements in the vaccination rate will be made through the use of education, the requirement that unvaccinated staff wear masks while working, and by making vaccine available frequently by taking the vaccine to the staff as well as continuing the present vaccine program.

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

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

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

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

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

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

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

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

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

16. Additional Infection Prevention Activities

Infection Prevention is responsible for many other activities to prevent and control infection transmission in the hospital and outpatient areas which include:

a. Healthcare Personnel and Public Education: Government regulations, bioterrorism, and unusual microorganisms such as H1N1 influenza, Ebola, Coronavirus (SARS-CoV-2), etc., have greatly increased the need for education and training. Infection Prevention will continue to update and present information when necessary to keep healthcare personnel, volunteers, and the public informed. Annual requirements for healthcare personnel education is maintained in Human Resources.

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

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

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

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

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

g. Environmental Cleanliness: Working with environmental services, clinical departments, and hospital leadership, the IP Clinical Workgroup was established to better serve the hospital and to meet CMS standards. The IP Clinical Workgroup has many other responsibilities, such as determining needed competencies by staff in infection prevention.

17. Unscheduled Reports

a. Focused Studies: Focused studies and identification of infection prevention measures occurs from data generated from targeted hospital surveillance, government regulations, and the recommendations of recognized experts in Infection Prevention such as APIC and the CDC. Focused studies include retrospective and concurrent chart reviews, literature reviews and surveys of clinical procedures and observations of clinical practices. Infection prevention measures include employee education, revision of policies and procedures when indicated, evaluation and modification of hospital equipment, disinfectants and work practices. Ongoing evaluation and monitoring of infection rates is required to determine the effectiveness of infection prevention measures.

18. Risk Assessment and Prioritization of Goals: (IC.06.01.01. EP1, see Appendix A)

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

a. Geographic Location and Community Environment

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

developmentally disabled clients on site and in group homes in the area. (Information from: Tulare County Community Health Assessment (CHA), https://tchhsa.org/eng/community/community-health-assessment-cha-community-health-improvement-plan-chip/)

b. Characteristics of the Population Served

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

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

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

d. Care, Treatment and Services Provided

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

e. Employee Health

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

f. Emergency Preparedness

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

Table of Goals for 2025

Goal #1: Limiting unprotected exposure to pathogens throughout the hospital (NPSG.07.01.01, IC.06.01.01. EP3)

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Result**
Improve Hand Hygiene Compliance	Achieve 70% hand hygiene compliance through 2025. Achieve 80% compliance for proper hand hygiene	Education Surveillance to monitor compliance On-the-spot reminder when needed	Monitor hand hygiene of staff with data upload to reporting software (Huron) to generate weekly reports	Unit Directors, Managers, IPs, HCW and Medical Staff.	Increase Department Hand Hygiene participation and compliance to 70% Obtain a realistic report

	technique	Provide regular compliance reports and feedback to leadership and staff Regular reminders for staff, visitors and other HCWs	Generate quarterly reports for distribution at committee meetings and hospital physician leadership		for "no hand hygiene displayed"

Goal #2: Implement evidence-based practices to prevent HAIs due to community acquired MDRO infections in the hospital

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Results**
Implement evidence-based practices to reduce spread of MDROs throughout the hospital (HAIs)	Reduce the incidence of HAI MDROs below1% through 2025	Identify patient on admit or transfer – take appropriate specimen, for laboratory evaluation. Educate staff, patients and families as appropriate to prevent spread. Remind HCW of hand hygiene, standard precautions and contact	Document and Report on education of staff and patients Monitor hand hygiene and report data for further hand hygiene compliance analysis. Dept. leadership will supervise surveillance to monitor isolation precautions compliance.	IPs, department directors and managers, staff, medical staff services director.	Observe evaluation and testing of qualified patients within the 72-hour time window. Observe a reduction of HAIs overall, but specifically MRSA

		precautions. Conduct appropriate cleaning and disinfecting of patient's environment; use dedicated equipment Use signage, posters and pamphlets to remind those in contact with patient.	Report any infractions to directors, managers, etc. for corrective action and on-the-spot advisement		

Goal #3: Minimize the risk of infection transmission associated with procedures, the use of medical equipment and devices

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Result**
Reduce Central Line-associated Bloodstream Infection (CLABSI) in patients	Reduce incidence of CLABSIs to below current incidence rate (see Expected Result)	Collect and analyze surveillance data. Provide feedback via reports to committees, directors, managers, etc. for distribution to HCW. Provide evidence-based catheter placement checklist for staff. Review current	Monitor changes in CLABSI incidence rates of infections Monitor adherence to placement checklist. Report CLABSI rates to Committees quarterly. Conduct annual risk assessment for compliance with evidence-based practices	IPs, Medical staff, central line insertion staff	Reduce incidence of CLABSIs to below 1% through the end of the fiscal year

		surveillance tool; compare to currently recommended surveillance tools, if necessary, update and implement.	hospital wide. Strive for 100% compliance rate.		
Reduce catheter-associated urinary tract infections (CAUTIs) in patients	Maintain CAUTIs at or below 0.5% (see Expected Result)	Conduct regular surveillance of catheters; provide annual education of staff to keep catheter usage at a minimum	Monitor CAUTIs. Report to P&T IP committee, IP and clinical unit directors and managers	Clinical departments that utilize catheters, physicians, IPs	Reduce incidence of CAUTIs to below 0.5% through the end of the 2025 fiscal year
Reduce surgical site infections (SSIs)	Maintain incidence of SSIs below 1% (see Expected Result)	Education of staff involved in surgical procedures upon hire, conduct annual competency reviews, and whenever surgical procedures are added to an individual's job responsibilities. Educate patients and/or patient family about infection prevention after a surgical procedure.	Monitor and report education sign in sheets to support completion of required education. Review nursing care plans for patient education.	Surgical staff, IPs, surgical nursing department, nursing staff and performance improvement.	Maintain incidence of SSIs below 1% through the end of the 2025 fiscal year

Goal #4: Limiting unprotected exposure to pathogens throughout the hospital

Infection Prevention Goal	Measurable Objective	Strategies	Evaluation	Responsibility	Expected Result
Prepare to respond to an influx or risk of influx of infectious patients	Meet 90% or more of the Influx of Infectious Patients Contingency Plan requirements	Provide IP representation on the Emergency Preparedness Team. Provide input on IP issues during emergencies, establish communication with local health dept. Utilize resources of the County Health Department, the State Department, and the Public Health System Maintain and/or revise policies and procedures for influx of patients, outbreaks, emerging infection and bioterrorism.	Perform observation during drills. Report compliance to Hospital Emergency Incident Command System, to Safety Committee, hospital leadership and P&T IP Committee.	Infection Prevention Committee	Maintenance and revision of contingency plan policies as needed to be prepared for influx of infectious patients.

REFERENCES:

- *Bloodstream Infection Event in Central Line-Associated Bloodstream Infection and Non-central Line Associated Bloodstream Infection* (January 2024). Accessed 06 December 2024.: https://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf

- Centers for Disease Control and Prevention: National Healthcare Safety Network (NHSN), *Patient Safety Component Manual* (January, 2024). Accessed 06 December 2024. https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf
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- Centers for Disease Control and Prevention. Guidelines for environmental infection control in health-care facilities: recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee. From 2003; Accessed 06 December 2024https://www.cdc.gov/infection-control/hcp/environmental-control/?CDC_AAref_Val=https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.Updated 10 September 2024. modified on September 10, 2024. Retrieved on December 6, 2024 from: https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-aquired-conditions-hac
- *Surgical Site Infection Event (SSI)*, January 2024. Accessed 06 December 2024https://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf .
- The Joint Commission (2024). Hospital Accreditation Standards Manual. Joint Commission Resources. Oak Brook, IL.
- Urinary Tract Infection (Catheter-Associated Urinary Tract Infection [CAUTI] and Non-Catheter-Associated Urinary Tract Infection [UTI] Events, January 2024. Accessed 06 December 2024https://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf.

Cross Reference:

- Influx Of Infectious Patients Contingency Plan
- Surge Capacity Plan

Risk Assessment for the Infection Prevention and Control (IP&C) Program
Annual Infection Control Risk Assessment 2024
Year: 2024_
Organization Name: ___Sierra View Medical Center____
Date of Report: ___Dec. 6, 2024_____

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Geography, Community & Populations served													
Increasing Incidence of TB		2				2					1		5
POTENTIAL HAIs / INFECTIOUS DISEASE													
Surgical Site Infection SSI		2			3						1		6
Ventilator Associated Pneumonia VAP			1		3						1		5
Central Line-Associated Blood Stream Infection CLABSI			1		3							0	4
Clostridioides difficile		2				2						0	4

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Infection CDI													
Catheter-associated Urinary Tract Infection CAUTI			1			2						0	3
MRSA (Hospital acquired)			1			2						0	3
VRE (Hospital acquired)			1			2						0	3
Exposure - specific infection													
Influenza (Seasonal)	3					2					1		6
Emergency Management - Influx of Infectious Patients		2				2					1		5
Infectious Disease Outbreak		2				2					1		5
Ebola Outbreak			1		3						1		5
COVID-19 Outbreak		2				2					1		5

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Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
COMMUNICATION													
HAI – Lack of Timely Notification (internal information flow)			1				1					0	2
Employee Illness – Lack of Timely Notification			1				1				1		3
Personnel, lips, Volunteers Surveillance and screening													
Poor Hand Hygiene Compliance		2				2					1		5
Sharps Injury (HCW)		2				2					1		5
Poor TB Screening (Hospital)			1			2						0	3
Poor TB Screening (LIP)		2				2					1		5
Inappropriate Use of Isolation		2				2						0	4
Ineffective Screening of Employees/Contract			1				1					0	2

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SUBJECT: **ANNUAL INFECTION PREVENTION PLAN**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 26 of 28**

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

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Staff/LIPs, Volunteers and Students													
Ineffective Fit Testing (Hospital)			1				1					0	2
Environment of care													
Inappropriate Handling of Biohazard Waste		2			3						1		6
No or Ineffective Preconstruction IC Planning (ICRA meeting)			1				1					0	2
Ineffective Notification or Communication for Applicable Utilities Issues/Shutdowns (HVAC, etc.)			1				1					0	2
Major Biohazard Spill			1			2						0	3
Failure of Appropriate Air Exchange or Air Pressure			1					1				0	2

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SUBJECT: **ANNUAL INFECTION PREVENTION PLAN**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 27 of 28**

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

Event or Condition	**What is the Probability of Occurrence?**				**Potential Severity, Risk Level of Failure**				**What is organization's preparedness to deal with this event/condition?**				**Numerical risk level**
	High (3)	**Med (2)**	**Low (1)**	**None (0)**	**Life Threat (3)**	**Perm Harm (2)**	**Temp Harm (1)**	**None (0)**	**None (3)**	**Poor (2)**	**Fair (1)**	**Good (0)**	**Total**
Monitoring in Isolation Rooms, ORs or Other Critical Environments													
Improper Cleaning or Disinfection of Environment of Care		2				2					1		5
supply storage, instrument & medical device cleaning, disinfection & handling													
Improper Storage or Disposal of Supplies			1			2						0	3
Ineffective Reprocessing of Devices		2			3						1		6
Improper Sterilization (Including Positive Biological Controls) of Supplies and Equipment		2			3							0	5

1. **Probability of the event/condition occurring**: determined by evaluating the risk of the potential threat actually occurring. Information regarding historical data, infection surveillance data, the scope of services provided by the facility, and the environment of the surrounding area (topography, interstate roads, chemical plants, railroad, ports, etc.) are considered when determining this score.
2. **Potential Severity, Risk Level of Failure:** determined by review of historical data and infection surveillance data.
3. **Organization's preparedness to deal with the event/condition**: determined by considering policies and procedures already in place, staff experience and response to actual situations, and available services and equipment.

(Developed by and modified from: K. Arias, M. Patrick, K. Delahanty and S. Odachowski)

SUBJECT: **BLAND AEROSOL ADMINISTRATION**	SECTION:

PURPOSE:

To define a consistent and safe method for administering aerosols (without measurements) for the purpose of humidification.

AFFECTED PERSONNEL/AREAS: *RESPIRATORY CARE PRACTITIONER*

PROCEDURE:

1. Verify physician's order.
2. Assemble equipment.
3. Wash hands and wear gloves.
4. ID patient with two patient identifiers.
5. Explain procedure to patient.
6. Connect aerosol devices to water and gas sources; turn on flow.
7. Connect to patient with large bore aerosol tubing.
    a. Insert drain cup mid distance
    b. Attach patient with aerosol, trach mask on T-tube.
    c. Adjust flow to obtain correct FiO_2 if on supplemental O_2.

INDICATIONS:

- The presence of upper airway edema - cool bland aerosol
    - Laryngotracheobronchitis
    - Subglottic edema
    - Postextubation edema
    - Postoperative management of the upper airway
- The presence of a bypassed upper airway
- The need for sputum specimens

CONTRAINDICATIONS:

- Bronchoconstriction

- History of airway hyper responsiveness

ASSESSMENT OF NEED:

- The presence of one or more of the following may be an indication for administration of a water or isotonic or hypotonic saline aerosol:

  - Stridor
  - Brassy, croup-like cough
  - Hoarseness following extubation
  - Diagnosis of LTB or croup
  - Clinical history suggesting upper airway irritation and increased work of breathing (e.g., smoke inhalation)
  - Patient discomfort associated with airway instrumentation or insult

- The presence of the need for sputum induction (e.g., for diagnosis of Pneumocystis carinii pneumonia tuberculosis) is an indication for administration of hypertonic saline aerosol.

ASSESSMENT OF OUTCOME:

- With administration of water or hypotonic or isotonic saline, the desired outcome is the presence of one or more of the following:

  - Decreased work of breathing
  - Improved vital signs
  - Decreased strider
  - Decreased dyspnea
  - Improved arterial blood gas values
  - Improved oxygen saturation as indicated by pulse oximetry (SpO2)

- With administration of hypertonic saline, the desired outcome is a sputum sample adequate for analysis.

RESOURCES:

Equipment - Depending upon the specific application, components may include:

- Aerosol generator

  - Small volume nebulizer
  - Large volume nebulizer
  - Barrel nebulizer
  - Bubble humidifier

- Heater or cooling device

- Patient application device
  - Mouthpiece
  - Mask
  - T-piece
  - Face tent
  - Tracheostomy collar or T-piece
- Corrugated aerosol tubing and water trap
- Tissues and emesis basin or container for collecting or disposing of expectorated sputum
- Gloves, goggles, gown, and mask
- Suction device and catheters

MONITORING:

The extent of patient monitoring should be determined on the basis of the stability and severity of the patient's condition. Patients receiving Bland Aerosol Therapy should be monitored at least Q 12 hours.

- Heart rate
- Respiratory Rate
- SpO2
- Breath Sounds
- Sputum Production

INFECTION CONTROL:

Universal Precautions

Management of the Bland Aerosol delivery system is performed in order to limit the occurrence of nosocomial infections and to assure that the circuit maintains its physical integrity.
Aerosol set up, including tubing, drain cup and suction will be changed weekly and PRN, documented at the time of the change, on the Respiratory Care Practitioner oxygen assessment. In addition, the new circuit will be dated at the time of change, usually on the drain cup itself.

REFERENCES:

- AARC Clinical Practice Guideline: Managing oxygen in acute care. (2022). https://www.aarc.org/wp-content/uploads/2022/10/cpg-clinical-mangement-adult-o2-acute-settings.pdf

- AARC Clinical Practice Guidelines: Bland Aerosol Administration-2003 Revision and Update. (n.d.). Retrieved 5/13/2025 from https://www.aarc.org/wp-content/uploads/2014/08/05.03.529.pdf

SUBJECT: HANDWASHING	SECTION: Page 1 of 4

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PURPOSE:

Handwashing is considered the single most important measure a healthcare worker can do to reduce the risks of transmitting microorganisms. The purpose of handwashing is to remove dirt, organic material, and transient microorganisms, thereby reducing the risk of healthcare acquired transmission of infection. The Handwashing policy and procedure establishes handwashing guidelines that are to be practiced throughout the facility.

POLICY:

All employees, volunteers, contractors, medical staff, students, and instructors shall wash their hands frequently with soap, friction, and running water or alcohol-based hand rub/sanitizer to minimize the likelihood of hands serving as a mode of transmission for ***healthcare acquired infections*** (HAIs).

**** Handwashing Indications (soap and water or, if appropriate, with alcohol-based hand rub/sanitizer):***

1. Upon arriving at work
2. Before and after performing invasive procedures
3. Healthcare Personnel (HCP) need to perform hand hygiene before and after all patient contact
4. Before and after taking care of particularly susceptible patients such as those who are severely immunocompromised and newborns
5. Before and after touching wounds
6. After contact with potentially infectious material in situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood, body fluids, secretions, excretions, and/or other potentially infectious materials (OPIM).
7. After touching inanimate sources that are likely to be contaminated with virulent or epidemiologically important microorganisms (i.e. Clostridium difficile, COVID-19).
8. After taking care of an infected patient or one who is likely to be colonized with microorganisms of special clinical or epidemiologic significance (i.e. must use soap and water when caring for patient with Clostridium difficile).
9. Before eating or drinking.
10. Before preparing or serving meals, drinks, or tube feedings
11. After using the restroom

12. After blowing one's nose

13. After the work shift

14. After handling patient equipment

15. When hands are visibly soiled or contaminated with infectious material (soap and water)

AFFECTED AREAS/PERSONNEL: *ALL STAFF*

PROCEDURES:

Handwashing with soap and water

1. Stand near the sink avoiding direct contact.

2. Turn on the water to a comfortable temperature.

3. Wet hands and wrists with running water.

4. Obtain handwashing agent from the dispenser and apply to hands. Thoroughly distribute over hands.

5. Vigorously rub hands together for 20-30 seconds, generating friction on all surfaces of the hands and fingers. Pay particular attention to nail beds and underneath the fingernails.

6. Rinse hands thoroughly with running water to remove residual soap.

7. Obtain paper towel and dry hands thoroughly.

8. Discard paper towel.

* Please note that the CDC has guidelines for "hand hygiene in health care settings". Studies have indicated that an alcohol-based hand rub is an alternative to the traditional approach of handwashing with soap and water in some situations. These are listed below:

Hand Hygiene Indications (alternative to soap and water with an alcohol-based waterless hand rub)

1. If hands are **not** visibly soiled, use an alcohol-based hand rub/sanitizer for routinely decontaminating hands in all other clinical situations.

2. Decontaminate hands after contact with a patient's intact skin (as in taking a pulse or blood pressure, or lifting a patient).

3. Decontaminate hands if moving from a contaminated body site to a clean body site during patient care.

4. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.

5. Decontaminate hands before caring for patients with severe neutropenia or other forms of severe immune suppression.

6. Decontaminate hands before donning sterile gloves when inserting a central intravascular catheter.

7. Decontaminate hands before inserting indwelling urinary catheters or other invasive devices that do not require a surgical procedure.

8. Decontaminate hands before donning (putting on) and after doffing (removing) gloves and reused PPE (mask, goggles/face shields and gowns).

Hand Hygiene with waterless antiseptic agent such as an alcohol-based hand rub (at least 60% alcohol)

Procedure:

1. Apply product to palm of one hand. Adequate volume of an alcohol-based hand rub to last approximately 20 seconds for hands to dry.

2. Rub hands together.

3. Rub hands together, covering all surfaces of hands and fingers, until hands are dry. (If an adequate volume of an alcohol-based hand rub is used, it should take approximately 20 seconds for hands to dry). Apply more hand sanitizer if needed to complete required time.

Monitor and measure staff adherence to proper hand hygiene practice:

- Make use of "secret shoppers" to monitor staff.

- Conduct adherence monitoring and provide coaching and feedback to frontline staff on regular basis to assess improvement over time, increase compliance, and prevent HAIs.

Patient Handwashing

Patients shall be given the opportunity to wash their hands before eating, after using the restroom, and any other time the hands are visibly soiled.

Visitor Handwashing

Visitors shall be encouraged to wash their hands before and after visiting patients.

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- "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings." Centers for Disease Control and Prevention. April 12, 2024. Accessed 01 May 2025. https://www.cdc.gov/infection-control/hcp/core-practices/index.html
- "Hand Hygiene in Healthcare Settings." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 27 February 2024., Accessed 01 May 2025 https://www.cdc.gov/handhygiene/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fhand-hygiene.html .
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SUBJECT: **HIGH-ALERT MEDICATIONS AND LOOK ALIKE SOUND ALIKE MEDICATIONS**	SECTION: **Page 3 of 12**

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

PURPOSE:

To establish a process for the identification of high-alert or high risk medications and provide methods to be utilized to promote the safe administration of these medications and help prevent adverse drug events.

POLICY:

1. It is the policy of Sierra View Medical Center (SVMC) to administer medications in a safe manner by placing safeguards into the entire medication delivery system. These safeguards are especially crucial when considering the administration of high-alert or high-risk medications including look-alike, sound-alike drugs.

2. The medications listed on Addendum A are considered high-alert or high-risk medications at Sierra View Medical Center. Also, refer to Addendum A for a listing of the risk reduction measures taken to prevent adverse drug events for those identified medications.

3. Addendum C details the list of hazardous drugs that may or may not be handled, prepared, or administered at Sierra View Medical Center. A significant number of medications are limited to the Cancer Treatment Center, such as those classified as high-risk. However, some hazardous drugs may be addressed at SVMC provided that all elements of the assessments of risk are followed.

AFFECTED PERSONNEL/AREAS: *PHARMACY; NURSING*

PROCEDURE:

1. The medications listed on Addendum A are considered high-alert or high-risk medications at Sierra View Medical Center. Also, refer to Addendum A for a listing of the risk reduction measures taken to prevent adverse drug events for those identified medications. Addendum B address Look-a-Like/Sound-a-Like Medications and risk reduction measures. Addendum C reviews SVMC's list of Hazardous drugs. A hyperlink is available within this policy to the standard operating procedures file on the hazardous drugs that have an associated assessment of risk.

2. At minimum, anyone who deals with a hazardous drug (Addendum C) will check ancillary information in the electronic health record, the assessments of risk or with Pharmacy prior to administration.

3. The lists in Addendums A, B, and C will be updated no less than annually at P&T Committee. New issues, new concerns, or newly identified trends in medication errors made at Sierra View will be considered by the P&T Committee when reviewing, modifying, and approving these lists.

4. These lists should be posted in medication rooms and/or near Pyxis Med Stations for easy review by nursing personnel that administer medications.

ADDENDUM A

2025 HIGH ALERT MEDICATIONS AND RISK REDUCTION MEASURES

Medication	Standard Dosage Form	Automated Dispensing Cabinet Alert	Nursing Double Check	Pharmacist Double Check	Warning Label on container	Only stocked in Pharmacy	Not on override list
IV Adrenergic Agonists	X	X			X		
IV Adrenergic Antagonists	X	X					
IV Anesthetics	X	X	X (drips: new bags on start)				
IV Antiarrhythmics	X	X					
Chemotherapy			X	X			X
Concentrated K+, Mg, NaCl, and Dextrose	X					X	
Dextrose, Hypertonic, ≥20%						X	
Parenteral Nutrition Preps						X	
NaCl for injection, hypertonic, greater than 0.9%	X	X	X (drips: new bags on start)				
Digoxin	X	X					
Insulin		X	X (drips: new bags on start)				
Injectable Antithrombotics	X	X	X				
Oral Antithrombotics		X					
Neuromuscular Blocking Agents		X	X (drips: new bags on start)		X		
Sulfonylureas		X					
IV Opioid/Sedative Drips	X	X	X (drips: new bags on start)				

ADDENDUM B

2025 LOOK ALIKE SOUND ALIKE AND RISK REDUCTION MEASURES

Medications	Tall-Man Lettering in CPOE	Separation on Shelving in Pharmacy	Separation in Pyxis	Clinical Screen in Pyxis
Alprazolam lorazepam	X		X	X
Amitriptyline Azathioprine		X		
Buproprion Buspirone	X			X
Captopril Carvedilol	X	X	X	X
Carboplatin Cisplatin	X	X		X
Clonazepam Lorazepam	X			X
Dexamethasone Diphenhydramine		X		
Dobutamine Dopamine	X	X	X	X
Duloxetine Fluoxetine	X	X	X	X
Fluoxetine Paroxetine	X	X	X	X
Glipizide Glyburide	X	X	X	X
Infliximab Rituximab	X	X		
Lamotrigine Levetiracetam	X			X
Levofloxacin Linezolid		X		
Nicardipine Nifedipine	X			X
Midazolam (Versed) Vecuronium*		X	X	X
Rifampin Rifamixin	X		X	X
Tramadol Trazodone	X		X	X

- Repackaged in Pyxis and auxiliary label on package "Caution Neuromuscular Blocker"

ADDENDUM C

Sierra View Medical Center Pharmacy – NIOSH Hazardous Drug List

Group 1 - Antineoplastic		
Generic Name	Dosage Form	AOR
ABIRATERONE	TABLET	X
AFATINIB	TABLET	X
ADO-TRASTUZUMAB EMTANSINE INJ	VIAL	
ANASTRAZOLE	TABLET	X
ARSENIC TRIOXIDE INJ	VIAL	
AXITINIB	TABLET	X
AZACITIDINE INJ	VIAL	
BELANTAMAB INJ	VIAL	
BELINOSTAT INJ	VIAL	
BENDAMUSTINE HCL INJ	VIAL	
BEXAROTENE	TABLET	X
BICALUTAMIDE	TABLET	X
BLINATUMOMAB INJ	VIAL	
BLEOMYCIN SULFATE INJ	VIAL	
BORTEZOMIB INJ	VIAL	
BOSUTINIB	TABLET	X
BRENTUXIMAB VEDOTIN INJ	VIAL	
BUSULFAN INJ	VIAL	
CABAZITAXEL INJ	VIAL	
CABOZANTINIB	TABLET	X
CAPECITABINE	TABLET	X
CARBOPLATIN INJ	VIAL	
CARFILZOMIB INJ	VIAL	
CARMUSTINE INJ	VIAL	
CERITINIB	TABLET	X
CHLORAMBUCIL INJ	VIAL	
CHLORAMBUCIL	TABLET	X
CISPLATIN INJ	VIAL	
CLADRIBINE INJ	VIAL	
COBIMETINIB	TABLET	X
CRIZOTINIB	TABLET	X
CYCLOPHOSPHAMIDE	CAPSULE	X
CYCLOPHOSPHAMIDE INJ	VIAL	
CYTARABINE INJ	VIAL	
DABRAFENIB	TABLET	X
DACARBAZINE INJ	VIAL	
DASATINIB	TABLET	X
DACTINOMYCIN INJ	VIAL	
DAUNORUBICIN INJ	VIAL	

DECITABINE INJ	VIAL	
DEGARELIX ACET INJ	KIT/ INJ	
DOCETAXEL INJ	VIAL	
DOXORUBICIN INJ	VIAL	
DOXORUBICIN LIPOSOMAL INJ	VIAL	
ENFORTUMAB VEDOTIN	VIAL	
ENZALUTAMIDE	TABLET	X
ERLOTINIB	TABLET	X
EPIRUBICIN INJ	VIAL	
ERIBULIN MESYLATE INJ	VIAL	
ERLOTINIB HYDROCHLORIDE	TABLET	X
ESTRAMUSTINE PHOSPHATE SODIUM	CAPSULE	X
ETOPOSIDE	CAPSULE	X
ETOPOSIDE INJ	VIAL	
EXEMESTANE	ORAL	X
EVEROLIMUS	TABLET	X
FAM-TRASTUZUMAB DERUXTECAN INJ	VIAL	
FLOXURIDINE	VIAL	
FLUDARABINE PHOS INJ	VIAL	
FLUTAMIDE	TABLET	X
FLUOROURACIL INJ	VIAL	
FULVESTRANT INJ	PREFILLED SYRINGE	X
GEMCITABINE INJ	VIAL	
GEMTUZUMAB OZOGAMICIN INJ	VIAL	
GOSERELIN INJ	PREFILLED SYRINGE	X
HISTRELIN INJ	PREFILLED IMPLANT	X
HYDROXYUREA	CAPSULE	X
IDARUBICIN INJ	VIAL	
IFOSFAMIDE INJ	VIAL	
INOTUZUMAB OZOGAMICIN INJ	VIAL	
IMATINIB MESYLATE	TABLET	X
IPILIMUMAB	VIAL	
IRINOTECAN INJ	VIAL	
IXABEPILONE INJ	VIAL	
IXAZOMIB	TABLET	X
LENALIDOMIDE	TABLET	X
LETROZOLE	TABLET	X
LEUPROLIDE ACET INJ	KIT	X
LENVATINIB	TABLET	X
LONCASTUXIMAB TESIRINE INJ	VIAL	
LOMUSTINE	TABLET	X
LURBINECTEDIN INJ	VIAL	
MECHLORETHAMINE	TOPICAL	X
MEGESTROL ACETATE	TABLET SUSPENSION	X

MELPHALAN	TABLET	X
MERCAPTOPURINE	TABLET	X
METHOTREXATE SOD	TABLET	X
METHOTREXATE SOD INJ	VIAL	
MIRVETUXIMAB SORAVTANSINE INJ	VIAL	
MITOMYCIN INJ	VIAL	
MITOMYCIN FOR BLADDER INSTILLATION	PREFILLED SYRINGE	X
MITOTANE	TABLET	X
MITOXANTRONE INJ	VIAL	
NILOTINIB	TABLET	X
NELARABINE INJ	VIAL	
OLAPARIB	TABLET	X
OXALIPLATIN INJ	VIAL	
PACLITAXEL, PROTEIN-BOUND INJ	VIAL	
PACLITAXEL, SEMI-SYNTHETIC INJ	VIAL	
PANOBINOSTAT	TABLET	X
PAZOPANIB	TABLET	X
PEMETREXED INJ	VIAL	
PENDOSTATIN INJ	VIAL	
POLATUZUMAB VEDOTIN INJ	VIAL	
POMALIDOMIDE	TABLET	X
PONATINIB	TABLET	X
PRALATREXATE INJ	VIAL	
PROCARBAZINE	TABLET	X
RALOXIFENE	TABLET	X
REGORAFENIB	TABLET	X
ROMIDEPSIN INJ	VIAL	
SACITUZUMAB GOVITECAN INJ	VIAL	
SONIDEGIB	TABLET	X
SORAFENIB	TABLET	X
SUNITINIB	TABLET	X
STREPTOZOCIN INJ	VIAL	
TAMOXIFEN CITRATE	TABLET	X
TEMOZOLOMIDE INJ	VIAL	
TEMOZOLOMIDE	TABLET	X
TEMSIROLIMUS INJ	VIAL	
THIOGUANINE	TABLET	X
THIOTEPA INJ	VIAL	
TISOTUMAB-VEDOTIN INJ	VIAL	
TOPOTECAN INJ	VIAL	
TOREMIFENE	TABLET	X
TRABECTEDIN INJ	VIAL	
TRAMETINIB	TABLET	X
TRIFLURIDINE OPTH	OPTHALMIC	X
TRIPTORELIN INJ	VIAL	

VALRUBICIN INTRAVESICAL	VIAL	
VANDETANIB	TABLET	X
VEMURAFENIB	TABLET	X
VINBLASTINE INJ	VIAL	
VINCRISTINE INJ	VIAL	
VINORELBINE INJ	VIAL	
VISMODEGIB	TABLET	X
VORINOSTAT	TABLET	X
ZIV-AFLIBERCEPT INJ	VIAL	

Medications that are listed as part of group 1 shall may only be compounded in the SVMC Cancer Treatment Center Hazardous Compounding Suite for patients of the Cancer Treatment Center, if compounding is required.

Group 2 – Non-antineoplastic hazardous drugs

Generic Name	Dosage Form	AOR
ABACAVIR	TABLET	X
APOMORPHINE	TABLET	X
AXITINIB	TABLET	X
AZATHIOPRINE	TABLET	X
CARBAMAZEPINE	TABLET SUSPENSION	X
CIDOFOVIR	VIAL	X
CYCLOSPORINE	CAPSULE	X
DEFERIPRONE	TABLET	X
DEXRAZOXANE HYDROCHLORIDE	VIAL	X
ENTECAVIR	TABLET	X
ESTRADIOL	PATCH	X
ESTROGENS, CONJ	TABLET	X
ESTROGENS, CONJ	VAGINAL CREAM	X
ESTROGENS, CONJ INJ	VIAL	X
EXENATIDE INJ	VIAL	X
FINGOLIMOD	CAPSULE/TABLET	X
FOSPHENYTOIN SOD INJ	VIAL	X
GANCICLOVIR INJ	VIAL	X
LIRAGLUTIDE	PREFILLED SYRINGE	X
METHIMAZOLE	TABLET	X
MYCOPHENOLATE MOFETIL	CAPSULE	X
NEVIRAPINE	TABLET	X
OSPEMIFENE	TABLET	X
OXCARBAZEPINE	TABLET	X
PALIFERMIN INJ	VIAL	X
PHENOXYBENZAMINE	CAPSULE	X
PHENYTOIN	CAPSULE SUSPENSION	X
PHENYTOIN INJ	VIAL	X
PROGESTERONE INJ	VIAL	X
PROGESTINS	ORAL/VIAL	X
PROPYLTHIOURACIL	TABLET	X
RALOXIFENE	TABLET	X
RASAGILINE	TABLET	X
SIROLIMUS	TABLET	X
SPIRONOLACTONE	TABLET	X
TACROLIMUS	CAPSULE	X
TERIFLUNOMIDE	TABLET	X
TOFACITINIB	TABLET	X
VALGANCICLOVIR	TABLET	X
ZIDOVUDINE	CAPSULE	X

Group 3 – Non-antineoplastic (Reproductive risk only)

Generic Name	Dosage Form	AOR
ACITRETIN	TABLET	X
ALITRETINOIN	TABLET	X
AMBRISENTAN	TABLET	X
BEXAROTENE	CAPSULE	X
BOSENTAN	TABLET	X
BOSUTINIB	TABLET/CAPSULE	X
CABERGOLINE	TABLET	X
CETRORELIX	SUBQ KIT	X
CHORIOGONADOTROPIN	VIAL	X
CLOBAZAM	SUSP	X
CLOMIPHENE	TABLET	X
CLONAZEPAM	TABLET	X
COLCHICINE	TABLET	X
DIHYDROERGOTAMINE INJ	VIAL	X
DINOPROSTONE	VAG.SUPP	X
DIVALPROEX SOD	CAPSULE TABLET	X
DRONEDARONE HYDROCHLORIDE	TABLET	X
DUTASTERIDE	CAPSULE	X
ERGOTAMINE/ CAFFEINE	SUPPOSITORY	X
ESLICARBAZEPINE	TABLET	X
FINASTERIDE	TABLET	X
FLUCONAZOLE	TABLET	X
FLUCONAZOLE INJ	PREMIX BAG	X
GANIRELIX INJ	PREFILLED KIT	X
ICATIBANT	PREFILLED SYR	X
ISOTRETINOIN	CAPSULE	X
IVABRADINE	TABLET	X
LEFLUNOMIDE	TABLET	X
LOMITAPIDE	CAPSULE	X
MEDROXYPROGESTERONE	VIAL	X
MENOTROPINS	VIAL	X
METHYLERGONIVINE	TABLET	X
METHYLERGONIVINE INJ	VIAL	X
METHYLTESTOSTERONE	CAPSULE/TABLET	X
MIFEPRISTONE	TABLET	X
MILTEFOSINE	CAPSULE	X
MISOPROSTOL	TABLET	X
NAFARELIN	NASAL SPRAY	X

OXYTOCIN	VIAL OR PREMIX BAG	X
PAMIDRONATE INJ	VIAL	X
PAROXETINE HYDROCHLORIDE	TABLET	X
PASIREOTIDE	PREFILLED SYR	X
PLERIXAFOR INJ	VIAL	X
RIBAVIRIN	TABLET	X
RIOCIGUAT	TABLET	X
TELEVANCIN	VIAL	X
TEMAZEPAM	CAPSULE	X
TESTOSTERONE CYPIONATE	VIAL	X
TOPIRAMATE	TABLET	X
TRETINOIN	CAPSULE	X
ULIPRISTAL	TABLET	X
VALPROATE SOD INJ	VIAL	X
VALPROIC ACID DIVALPROEX SODIUM	TABLET SPRINKLES SUSPENSION	X
VIGABATRIN	TABLET	X
VORICONAZOLE	TABLET	X
VORICONAZOLE INJ	VIAL	X
WARFARIN SODIUM	TABLET	X
ZIPRASIDONE	CAPSULE	X
ZIPRASIDONE INJ	VIAL	X
ZOLEDRONIC ACID INJ	VIAL PREMIX BAG	X
ZONISAMIDE	CAPSULE	X

Note: Assessments of Risk (AOR) can be located in Policy Library software via the following hyperlink: https://powerdms.com/link/sierraview/document/?id=2755269

Personal Protective equipment and engineering controls for working with hazardous drugs in healthcare settings.

Formulation	Activity	Double chemo-therapy gloves	Protective gown	Eye/face protection	Respiratory protection	Ventilated engineering control
All types of hazardous drugs	Receiving, unpacking, and placing in storage	no (single glove can be used, unless spills occur)	yes, when spills and leaks occur	no	yes, when spills and leaks occur	no
Intact tablet or capsule	Administration from unit-dose package	no (single glove can be used)	no	no	no	N/A
Tablets or capsules	Cutting, crushing, or manipulating tablets or capsules; handling uncoated tablets	yes	yes	no	yes, if not done in a control device	yes†
	Administration	no (single glove can be used)	no	yes, if vomit or potential to spit up[‡]	no	N/A

†It is recommended that these activities be carried out in a control device, but it is recognized that under some circumstances, it is not possible

Formulation	Activity	Double chemo-therapy gloves	Protective gown	Eye/face protection	Respiratory protection	Ventilated engineering control
Solution for irrigation	Compounding	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes, BSC or CACI; use of CSTD recommended
	Administration (bladder, HIPEC, limb perfusion, etc.)	yes	yes	yes	yes	N/A
Powder/solution for inhalation/ aerosol treatment	Compounding	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes, BSC or CACI
	Aerosol administration	yes	yes	yes	yes	yes, when applicable
	Administration	yes	yes	yes, if liquid that could splash[‡]	yes, if inhalation potential	N/A
Drugs and metabolites in body fluids	Disposal and cleaning	yes	yes	yes, if liquid that could splash	yes, if inhalation potential	N/A
Drug-contaminated waste	Disposal and cleaning	yes	yes	yes, if liquid that could splash	yes, if inhalation potential	N/A
Spills	Cleaning	yes	yes	yes	yes	N/A

Formulation	Activity	Double chemo-therapy gloves	Protective gown	Eye/face protection	Respiratory protection	Ventilated engineering control
Oral liquid drug or feeding tube	Compounding	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes[†]
	Administration	yes	yes	yes, if vomit or potential to spit up[‡]	no	N/A
Topical drug	Compounding	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes[†], BSC or CACI (Note: carmustine and mustargen are volatile)
	Administration	yes	yes	yes, if liquid that could splash[‡]	yes, if inhalation potential	N/A
Subcutaneous/ intra-muscular injection from a vial	Preparation (withdrawing from vial)	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes, BSC or CACI
	Administration from prepared syringe	yes	yes	yes, if liquid that could splash[‡]	no	N/A
Withdrawing and/or mixing intravenous or intramuscular solution from a vial or ampoule	Compounding	yes[§]	yes	no	no	yes, BSC or CACI; use of CSTD recommended
	Administration of prepared solution[¶]	yes	yes	yes; if liquid that could splash[‡]	no	N/A; CSTD required per USP 800 if the dosage form allows

REFERENCE:

1. The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
2. NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2024. https://www.cdc.gov/niosh/docs/2025-103/pdfs/2025-103.pdf?id=10.26616/NIOSHPUB2025103. Accessed February 11, 2025.
3. ISMP List of High-Alert Medications in Acute Care Settings, 2024. https://www.ismp.org/system/files/resources/2024-01/ISMP_HighAlert_AcuteCare_List_010924_MS5760.pdf

Link to associated assessments of risks:

https://powerdms.com/link/sierraview/document/?id=2755269

SUBJECT:	SECTION:
MEDICAL SCREENING AND TRIAGE IN THE EMERGENCY DEPARTMENT	***Patient Rights and Organizational Ethics (RI)***

PURPOSE:

To establish the guidelines for the medical screening/triage in the Emergency Department.

POLICY:

The Emergency Department will ensure that an emergency medical condition is determined prior to the discharge or transfer of patients presenting to the Emergency Department for care.

All Triage Nurses must have ACLS certification.

Explanation of Terms:

A. EMERGENCY MEDICAL CONDITION

A medical condition manifested by acute symptoms of sufficient severity (including severe pain, psychiatric emergencies and symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

1. The placing of the health of the individual in serious jeopardy, serious impairment to bodily functions, or
2. Serious dysfunction of any bodily organ/part, or
3. With respect to a woman who is having contractions:
    a. That there is inadequate time to effect a safe transfer to another hospital before delivery, or
    b. That transfer may pose a threat to the health and safety of the woman or unborn child.

Examples of psychiatric emergency medical conditions include, but are not limited to:

1. History of drug ingestion in a patient with coma or impending coma
2. Depression with feelings of suicidal hopelessness
3. History of recent suicide attempt or suicide ideation
4. Delusions, severe insomnia, and helplessness
5. History of recent assaultive, self-mutilative, or destructive behavior

6. Objective documentation of inability to maintain nutrition in a patient with altered mental status

7. Impaired reality testing accompanied by disordered behavior (psychotic)

8. Detoxification

9. Seizure (withdrawal or toxic)

B. MEDICAL SCREENING EXAMINATION

An evaluation of the patient presenting to the Emergency Department with a medical complaint to determine whether or not an emergency medical condition exists, and if one exists, to provide for medical management and stabilization. This screening is available to every individual, regardless of financial status, diagnosis, race, color, national origin, handicap, or similar factors, who comes to the Emergency Department requesting examination and/or treatment for a medical condition. The MSE is performed by the physician or Allied Health Professional (AHP) in the Emergency Department.

C. STABILIZE

With respect to an emergency medical condition, that no medical deterioration of the condition is likely, within reasonable medical probability, to result from or occur during transfer or discharge of the patient.

With respect to the woman in labor, delivery of the child, including the placenta, with no ensuing complications to mother or child.

D. TRIAGE

The act of ranking of patients, who may or may not have an emergency medical condition, according to the seriousness of their condition in order of access to the Medical Screening Examination and stabilizing treatment.

E. TRANSFER

To transport a patient to another health care facility, including another hospital, doctor's office, or clinic, consistent with relevant federal and state regulations.

Triage Examinations:

A. Qualifications for Performing Triage Examination

1. Possess a valid current California RN License

2. Be currently certified in Basic Life Support.

3. Have a minimum of 3 months experience in the Sierra View Medical Center Emergency Department.

4. Complete Sierra View Medical Center Emergency Department orientation to triage, demonstrating understanding of the triage process, categories, examination components, protocols, and state and federal regulations as they relate to the MSE and transfer requirements.

B. Components of the Initial Triage Examinations

1. ***Documentation*** of the chief complaint, including pertinent past medical history, medications and allergies, ability to ambulate.

2. Vital signs (including pulse oximetry for any suggested pulmonary complaint, glucose for altered mental status).

3. Respiratory Status – airway and breathing.

4. Circulatory Status – skin signs.

5. Mental Status – noting change from baseline.

6. Degree of pain/discomfort.

7. Gastrointestinal (GI), genitourinary (GU), musculoskeletal, and integumentary examination, as appropriate to patient's complaint.

C. Responsibility:

1. The Triage Nurse is responsible to the Shift Charge Nurse.

2. Assignment of the Triage Nurse is made each day. The Registration Clerk is responsible for alerting the Triage Nurse or relief of the presence of a new patient at any time they are not immediately available at the window.

3. The Triage Nurse is responsible for the following:

   a. ***Evaluate/Observe*** all persons reporting ambulatory to the Emergency Department and initiating an Emergency Department Medical Record.

   b. Document all patient contacts on the Emergency Department Electronic Health Record.

c. Assign an appropriate Emergency Severity Index Triage Category based on ***documented*** observations according to department guidelines.

d. Provide all appropriate first-aid measures as appropriate (emergency airway management, bleeding control, splinting, etc.)

e. ***The Triage Nurse will utilize the following Standing Order Protocols, within the level of their scope of practice, to expedite patient flow throughout the Emergency Department.***

f. Review charts of discharged patients for completeness.

g. Make follow-up calls for x-ray and/or lab variances or positive culture results.

4. The Nursing Staff in the Treatment area is responsible for the triage evaluation on all patients arriving by ambulance.

D. Emergency Severity Index Triage Categories:

ESI- I

Patient requires immediate life-saving intervention

ESI-II

High risk situation, confused, lethargic, disoriented, severe pain, distress

ESI- III

Does not meet ESI II, requires 2 or more resources. (See Emergency Severity Index training material)

ESI IV

Does not meet ESI II, requires one resource (See Emergency Severity Index training material)

ESI V

Does not meet ESI II, requires no resources (See Emergency Severity Index training material)

E. Standing Order Protocols:

1. Advanced Cardiac Life Support (ACLS) or (BLS) according to their scope of practice

2. Management of Altered Level of Consciousness

3. Administration of Antipyretics

4. Chest Pain

5. Multiple Trauma

6. Administration of Tetanus Prophylaxis

7. Diagnostic Tests: Urinalysis

8. Ordering of x-rays

F. Triage – General Standards

1. Initial ***examination*** of each individual presenting for assistance for the presence of an emergency medical condition, including a woman having contractions, shall be rendered as soon as possible upon arrival.

   a. The triage observations and ***evaluation*** will be documented. The appropriate triage category will be assigned. *(Refer to D. above)*

   b. Immediate life-saving and first aid measures will be rendered as appropriate.

2. The Triage ***examination*** and the provision of the MSE and necessary stabilizing treatment may not be delayed in order to inquire about the patient's method of payment or insurance status.

   a. If the patient inquires about hospital charges, acceptance of HMO patients or other financial matters, their questions may be answered. However, the patient must be advised that they will be provided with a MSE and appropriate medical stabilization regardless of the authorization/denial of the PCP or Managed Care Plan, or any other financial considerations.

   b. If the patient indicates authorization has been granted, this will be documented on the chart.

3. Maintain awareness of patients arriving to the Emergency Department and evaluate whether a patient can wait to be triaged or if the patient needs immediate attention ahead of others in the waiting area.

4. Inform Emergency Department Treatment Nurse or Physician of all ESI I or II patients taken to the treatment area. Remain with the patient until relieved.

5. Patients initially triaged as ESI III who are waiting for treatment in the waiting room will need to be monitored for changes in condition. Such as:

a. Cuts which may bleed

b. Chest discomfort

c. Patients with pain

d. Suspected fractures

e. Children with fevers

f. Any patient who looks ill and may need to lie down

g. Any patient who wants to leave without treatment

h. Any patient or visitor who is unhappy or causing problems in the waiting room

i. Any allergic reactions

6. Assist family members and friends with questions and concerns about patient care or progress in the system.

7. Practice effective communicable disease/infection control measures during the evaluation, waiting and bed assignment processes.

8. All patients presenting to the Emergency Department will be logged at registration.

Medical Screening Examination

A. Qualifications for performing the MSE:

Emergency Department Physician or Emergency Department physician extender possessing a valid and current California License and staff privileges at SVMC. *(See Physician Extender Protocols).*

B. The MSE will be provided to any individual (regardless of ability to pay) who comes to the Emergency Department and requests examination or treatment of a medical condition within the capability of the hospital's Emergency Department and including ancillary services routinely available to the Emergency Department such as lab, x-ray, CT, MRI, ultrasound, FBC, and the Operating Room.

C. The MSE shall include an investigation of all patient complaints and ordering all appropriate diagnostic tests, and will include documentation of the patient's condition at the time of discharge/transfer and documentation of the required patient consents.

D. The MSE may include consultation with specialty physicians by phone or at the bedside when jointly determined to be medically necessary.

E. The MSE is an ongoing process. The record must reflect ongoing monitoring in accordance with the individual's needs and must continue until the individual is stabilized or appropriately transferred.

Physician Telephone Orders

The requirement for performing an adequate MSE to rule-out the existence of an emergency medical condition prior to the patient's discharge from the Emergency Department also applies to all patients.

Patients Refusal of Further Medical Treatment – Against Medical Advice (AMA)

Patients have the right to refuse evaluation, the MSE and stabilizing treatment and leave Against Medical Advice (AMA). Hospital and Emergency Department policies must be followed in determining a patient's competence to refuse such evaluation and treatment. The patient will be asked to sign a form explaining the patient's right to a MSE and appropriate medical stabilization, the risks involved in that refusal, alternatives available for care, and proper physician and staff documentation of the patient's actions of refusal.

Chart Flow

All patients will be tracked on the electronic health record system.

AFFECTED AREAS/PERSONNEL: *EMERGENCY DEPARTMENT*

REFERENCES:

- Title 42 United States Code, sections 1395 cc and dd (COBRA/EMTALA). (2011). https://www.law.cornell.edu/uscode/text/42/1395dd.
- Gilboy N, Tanabe P, Travers D, Rosenau, (2020) Implementation Handbook 2020 Edition ESI Emergency Severity Index v4, Emergency Nurses Association (ENA).

CROSS REFERENCES:

- Emergency Department Structure Standards:
  "EMTALA- Interfacility Transfers, MSE, Emergency Care and Stabilization"
  "Emergency Department Patients Requiring Diagnostic Tests at Other Facilities"
  "Emergency Assessment and Reassessment"
- Emergency Department Standing Order Protocols

SUBJECT: **MODIFIED ALLENS TEST**	SECTION: **Page 1 of 1**

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

POLICY:

It is the policy of Respiratory Care Services to provide a method for verifying collateral arterial circulation to the hand via the ulnar artery, prior to an arterial puncture of the radial artery.

AFFECTED PERSONNEL/AREAS: *RCPs*

PROCEDURE:

Alert Patient

1. Ask the patient to make a tight fist.
2. Block blood flow to the patient's hand by occluding both radial and ulnar arteries.
3. Ask the patient to relax his/her hand.
4. Release the occlusion of the ulnar artery. If color returns to the patient's hand within 5-15 seconds, the collateral circulation is adequate.

Comatose Patient

1. Raise the patient's hand above the level of his/her heart.
2. When the color disappears from the patient's hand, block blood flow to the patient's hand by occluding both the radial and ulnar arteries.
3. Lower the patient's hand below the level of his/her heart.
4. Release the occlusion of the ulnar artery. If color returns to the patient's hand within 5-15 seconds, the collateral circulation is adequate.

REFERENCES:

- Beutel, B.G., Worley, C. Zisquit, J., & Nedeff, N. (2024). *Allen Test*. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK507816/#:~:text=Modified%20Allen%20Test,-The%20MAT%20differs&text=The%20elbow%20is%20extended%20to,pressure%20on%20the%20radial%20artery.
- The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT:	SECTION:
NURSING CARE OF VENTILATOR PATIENTS ON THE MEDICAL-SURGICAL UNIT	***Provision of Care, Treatment and Services (PC)***

PURPOSE:

To assure safe, comprehensive quality care to patients requiring continuous ventilator assistance outside of the critical care setting.

POLICY:

Patients who are ventilator dependent will be cared for in a safe and competent manner outside the critical care setting.

Patient Eligibility:

- Does not meet criteria for weaning parameters
- Full DNR (No Code)
- Does not require cardiac monitoring (i.e. Telemetry)

AFFECTED AREAS / AUTHORIZED PERSONNEL: *MED-SURG UNIT; TELEMETRY*

EQUIPMENT REQUIRED:

- Ambu bag with adult mask at bedside at all times
- **2** Spare Trach sets with ties (Trached patients only) at bedside at all times (same size and size smaller) – RT accountable to ensure availability
- Continuous Pulse Oximeter

PROCEDURE:

1. Upon the attending physician's order, a patient who is dependent on ventilator assistance but does not require critical care services may be placed on the medical unit.
2. Licensed nurses rendering care to these patients will be able to demonstrate competence in:
   a. Mechanical ventilator operations
   b. Basic lung auscultation; and
   c. Closed continuous tracheal suction systems.
   d. Be familiar with and competent in all other policies and procedures associated with the care of this particular patient.

3. Nursing personnel will be aware of ventilator parameters as ordered by the physician.

4. Nursing will notify Respiratory Therapy (RT) personnel should ventilator alarms continue to alarm. Nursing will remove the patient from the ventilator and apply bag-valve ventilation if:

   a. Ventilator continues to show low pressure alarm;

   b. Ventilator is in-operative or indicates gas pressure alarm; or

   c. If there is a deterioration of the patient's condition and/or status.

5. Patient assessments will be done minimally once every 12 hours and documented in the 24-hour record.

6. In accordance with established Respiratory Therapy Department policies and procedures:

   a. R.T. personnel will regulate ventilator settings – NO EXCEPTIONS!

   b. All patients on ventilators will be monitored by R.T. at least every 4 hours per their departmental policies.

   c. Maintenance of ventilator equipment and supplies is the responsibility of the RT department.

NURSING INTERVENTIONS

1. Maintain endotracheal tube and/or trach tube are maintained securely.

2. Suction and clean airway apparatus as indicated to maintain patency. Suction patient every 2 hours and PRN. Only suction for a 15-second period at any one time.

3. Prior to suctioning the patient, the nurse must:

   a. Instruct the patient on procedure to be performed.

   b. Comply with established suctioning policies and procedures regarding special instructions

   c. Keep water emptied from tubing and trap. (Never turn patient without emptying first.)

   d. Evaluate ventilatory pattern for rate, quality, signs of respiratory distress, or inappropriate inspiratory to expiratory ratio (should be at least 1:1).
   NOTE: patient chest movement needs to be equal for both sides of the chest. Be aware if patient has any spontaneous respirations.

e. Monitor patient for signs of fighting the ventilator, which indicates that the patient's respiratory cycle is inconsistent with the mechanical cycle; may be due to pain, hypoxia, secretions, fear or anxiety.

SOLUTION: clear airways as indicated or give sedatives as ordered.

f. Ensure that the alarms are always turned on. NO EXCEPTIONS!

g. Carefully check all connections of the ventilator tubings to assure that they are tightly secured.

h. Notify the R.T. department if alarms continue to be set off. If RT is unable to respond immediately or if any concerns arise as to the effectiveness or operations of the ventilator, remove the patient from the ventilator and manually ventilate the patient with an ambu resuscitation bag.

i. Assure at all times that the ventilator is plugged into a red outlet (due to the emergency generator system). NO EXCEPTIONS!

j. Position patient so that all lobes of the lungs are adequately ventilated and perfused.

k. Reposition patient every 2 hours; rotate positioning from right to left lateral positions to a semi-fowler's position.

l. Monitor breath sounds for presence and quality. Assess patient's lung fields for rales, rhonchi, wheezing, etc. every 4 hours being alert to any changes in the lung field.

m. Assure patient that he/she is not alone. Let the patient know that people are near and if they need assistance, nurses will respond rapidly.

- Provide call bell for immediate access.
- Assure patient that adequate ventilation is being provided.
- Provide means for patient to write messages as appropriate.

PATIENT EDUCATION

- Explain all procedures to the patient and why.
- Answer their questions.
- Involve family when applicable.

DOCUMENTATION

1. In the nursing notes:
    a. Problems identified.
    b. Interventions given.
    c. Evaluation of treatment(s).
    d. Document respiratory assessment and characteristics of sputum.
2. On Patient Care Profile
    a. Document type of ventilator with settings and frequency of suctioning.

REFERENCES:

Nettina, S. M. (2019). *Lippincott Manual of Nursing Practice*. Wolters Kluwer.

CROSS REFERENCE:

- TRACHEOSTOMY CARE

SUBJECT: **PATIENT IDENTIFICATION**	SECTION: **Page 1 of 1**

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

PURPOSE:

To ensure all Emergency Department patients are properly identified.

POLICY:

All patients presenting to the Emergency Department will have an identification (ID) band applied to their person as soon as possible. No treatment will be given until a patient's identity has been verified. If the patient's identity can't be verified due to medical condition, a Patient Access generated, unknown ID name and number will be assigned to the patient to ensure patient recognition.

AFFECTED PERSONNEL/AREAS: *EMERGENCY DEPARTMENT DIRECTOR/EMERGENCY DEPARTMENT STAFF, PATIENT ACCESS DIRECTOR /PATIENT ACCESS STAFF*

PROCEDURE:

1. All patients receiving care in the Emergency Department will be identified with an ID band which contains the following information, as available.
    a. Full name
    b. Date of Birth
    c. Medical Record number
    d. Blood Bank Number (BBK#)
2. Placement of the ID band on the patient's arm or leg must be accomplished as soon as possible upon escorting the patient into a treatment area, and in all cases prior to receiving treatment.
3. This procedure is essential for patient safety. The identification band must be checked prior to administration of medications, blood transfusions, radiological procedures, and other emergency department treatment procedures.

REFERENCE:

- The Joint Commission (2020). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- The Joint Commission (2020). Joint Commission National Patient Safety Goal NPSG.01.01.01. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2020/simplified_2020-hap-npsgs-eff-july-final.pdf.

SUBJECT: **PHARMACY ORGANIZATION**	SECTION: **Page 1 of 2**

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

POLICY:

The Sierra View Medical Center (SVMC) Hospital Pharmacy is under the direction of a licensed pharmacist with the responsibility to meet standards of care for pharmaceutical services. The Pharmacy is charged with responsibilities assigned by the Sierra View Local Health District Board of Directors through the hospital's Vice President of Professional Services & Physician Recruitment.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

The Director of Pharmacy, in conjunction with the Pharmacy and Therapeutics Committee & PIC, will initiate and develop policies and procedures pertaining to the pharmaceutical services of the hospital. These policies and procedures will meet the approval of Administration, the Medical Staff, and Board of Directors.

Standards of care for pharmaceutical services are those defined by nationally recognized organizations with expertise in medication preparation and administration. Examples of this organizations include but are not limited to the following: *American Society of Health-System Pharmacist, Institute for Safe Medication Practices, U.s Pharmacopeia.* These standards, in conjunction with State and Federal Law, will be used to develop all procedures pertaining to the acquisition, distribution, storage, dispensing and use of pharmaceuticals within the organization.

The chain of command is as follows:

- Sierra View Medical Center Board of Directors
- Chief Executive Officer
- Vice President of Professional Services
- Director of Pharmaceutical Services
- Pharmacy Clinical Coordinator & PIC
  - Maintains oversight over pharmacists and technicians as they relate to the practice of pharmacy ensuring they follow proper procedures and protocols.
- 340B Program Coordinator
- Clinical/Staff Pharmacist
  - Day to day oversight of technician activities, including review and sign off of their work involving stocking medications for Pyxis & preparation of compounds.
- Licensed Pharmacy Technicians

SUBJECT: **PHARMACY ORGANIZATION**	SECTION: **Page 2 of 2**

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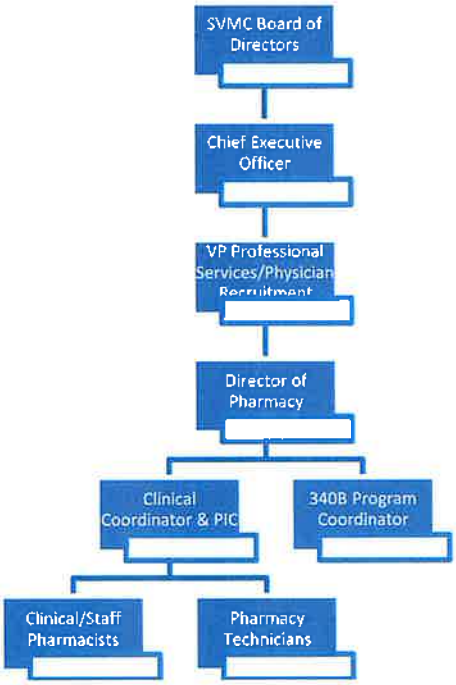
Department of Pharmaceutical Services – Organizational Chart



REFERENCES:

- Pharmacy Law: California Edition.(2025) San Clemente, California: LawTech Publishing Group.
- Title 42 CFR 482.25 Condition of Participation: Pharmaceutical Services. Accessed February 29, 2024. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482.
- Hospital Accreditation Standards. (2025). Oak Brook, IL: Joint Commission Resources, Inc.
  - MM.03.01.01, EP 19

SUBJECT: **PRESCRIBER DISPENSING FOR DISCHARGES AFTER COMMUNITY PHARMACY HOURS**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide a policy and procedure for patients to receive limited and specified, medications during hours in which all community pharmacies within the local area are closed for emergency room patients.

POLICY:

A small supply of a limited number of prepackaged medications may be dispensed directly to a patient by a prescriber to an emergency room patient. Dispensing and labeling is done in accordance with applicable laws and regulations and meets all requirements for prescriber dispensing as required within those applicable laws and regulations.

AFFECTED AREAS/PERSONNEL: *MEDICAL STAFF, PHARMACY, NURSING*

PROCEDURE:

1. Whenever possible, a prescription for anticipated medications should be given to the patient's family to be filled at a local, community pharmacy during business hours, PRIOR to discharge of the patient.

2. A prescriber may dispense a dangerous drug to an emergency room patient if all of the following apply:

   a) The hospital pharmacy is closed and there is no pharmacist available in the hospital

   b) The dangerous drug is acquired by the hospital pharmacy

   c) The dispensing information is recorded and provided to the pharmacy when the pharmacy reopens

   d) The pharmacies outside the hospital are not available or accessible (closed) at the time of dispensing to the patient.

   e) The quantity of drugs dispensed to any patient pursuant to this section are limited to that amount necessary to maintain uninterrupted therapy during the period when pharmacy services outside the hospital are not readily available or accessible (closed) but shall not exceed a 72-hour supply.

   f) The prescriber shall ensure that the label on the drug contains all the information required by BPC Section 4076.

   g) The prescriber shall be responsible for any error or omission related to the drugs dispensed.

3. Dispensing from SVMC: To assure that when medications are dispensed directly to the patient by Physicians during the hours in which all community pharmacies are closed; dispensing and

labeling is done in accordance with applicable laws and regulations and meets all requirements for prescriber dispensing as required within those applicable laws and regulations. The following conditions must be met:

a. The physician has examined the patient.

b. It is documented in the patient's record that the medication is necessary in the treatment of the condition presented to the physician.

c. Circumstances preclude the patient obtaining the medication from an outside pharmacy (i.e. patient's condition, all community pharmacies are closed).

d. The Physician dispenses only properly-labeled prescriber dispensing packs (as described in the procedure below) to include:

- Name of the medication
- Name of the manufacturer
- Directions for the use of the medication
- Patient's name
- Physician's name
- Date of issue
- Name, address, and telephone number of the hospital emergency department
- Prescription number or other means of identifying the prescription
- Strength of the medication or medications
- Quantity of the medication
- Expiration date
- Condition (e.g. "for pain")

e. The medication is not furnished by a nurse or attendant, but directly by the Physician. However, the nurse is required to sign out the appropriate medication from the Pyxis inventory, inclusive of all information and documentation required, to give to the Physician for dispensing to the patient.

f. The Physician offers to give the patient a written prescription for the medication to be filled at a pharmacy of the patient's choosing.

g. Documentation will be present in the electronic health record that indicated that the patient acknowledges:

- The fact that they could go to any pharmacy, when the pharmacy reopens
- That they have been counseled by the physician

h. Upon request of the patient or patient's representative, a translated directions for use will be provided on a supplemental document.

i. The prescriber will also verbally counsel the patient on the medication's indication, directions, side effects, precautions, interactions, and storage.

j. The quantity dispensed shall not exceed 72 hours.
Prescriptions dispensed will be in child-proof containers. If non-safety caps are used, provider is to document in the Medical Record.

k. Sierra View Medical Center will not dispense controlled substances for this purpose.

l. Pharmacy to input discrepancies & errors into electronic reporting system. Pharmacy will also investigate and document to report to the Board of Pharmacy as part of Quality Assurance requirements for ADDS License.

m. Pharmacy personnel perform monthly inspection for expiration, blind counts, and cleanliness.-see Medication Procurement, Storage, Distribution and Control Policy.

n. Personnel with access to Pyxis will be trained on system use on new hire & annually.

o. Medication will only be dispensed from a validly licensed ADDS Pyxis machine. Copy of valid license & policy will be displayed by AUD.
(a) Currently licensed Pyxis machines: EDEA-DT

REFERENCE:

- Automated Drug Delivery System License Application. California State Board of Pharmacy. https://www.pharmacy.ca.gov/forms/adds_app.pdf. Accessed April 28
- Direct Dispense Application. California Prescription Drug Monitoring Program (PDMP). https://oag.ca.gov/cures. Accessed April 28, 2025

- Pyxis Access. Medication Management. Patient Care Services Policy & Procedure Manual.
- https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I1164F3305A1E11EC8227000D3A7C4BC3&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default) Accessed April 28, 2025.

- California Business & Professions Code, Article 12, Section 4170 (a – c). Retrieved from http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4170.&lawCode=BPC.

- 2025 Lawbook for Pharmacy. https://www.pharmacy.ca.gov/laws_regs/lawbook.pdf. Accessed May 9, 2025.

SUBJECT: **PROCEDURAL SEDATION**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 22**

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

PURPOSE:

To establish appropriate standards for administering and monitoring patients receiving procedural sedation.

POLICY:

All patients at Sierra View Medical Center receiving procedural sedation, IV/PO/IM, for short term diagnostic, therapeutic or invasive procedures will be cared for as stated in this policy.

Exceptions:

This policy applies to the use of analgesia and/or sedation in all hospital departments and areas except as stated below:

1. Those patients in the Intensive Care or Post Anesthesia Care Unit under a 1:2 nurse to patient ratio who are mechanically ventilated or whose cardiovascular and respiratory status are continuously monitored by the same monitoring devised as specified in this policy. These patients are excluded because their care always includes continuous monitoring of vital signs and are documented according to ICU and/or PACU protocol based on patient acuity.

2. Single dose drugs used as pain control and anxiolysis (where the patient retains a normal response to verbal stimulation and airway ventilation is unaffected) with a local infiltration analgesia to perform minimal procedures, e.g. episiotomies, simple lacerations, closed reductions, lumbar puncture, dressing change, bone marrow aspiration.

3. Medications given for procedure-related anxiolysis or deep sedation.

4. Those patients requiring emergency tracheal intubation.

5. An adult patient receiving strictly a one time pre-diagnostic PO sedative will be exempt from the documentation and monitoring of this policy if in the judgment of the prescribing physician, the dosage and drug given would not result in impairment of protective or airway reflexes. The provider assumes responsibility of ensuring the patient is accompanied by an escort, instructions are given regarding when the patient may resume normal activities, and counseling regarding possible side effects is given. This exception does NOT apply to children. It also does not apply if any additional PO, IM or IV sedation/analgesia is given.

6. Pre-operative medications, pre-procedural management of anxiety or pain management medications.

7. Deep sedation under by IV Ketamine administered by physicians or IM Ketamine.

DEFINITIONS:

Levels of Sedation:
Sedation occurs in a dose related continuum, is variable, and depends on each patient's response to various drugs. The definitions below progress on a continuum from a high state of consciousness to unconsciousness.

Table 1. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia (2014)

	Minimal Sedation (Anxiolysis)	**Moderate Sedation/ analgesia (Conscious Sedation)**	**Deep Sedation/ Analgesia**	**General anesthesia**
Responsiveness	Normal response to verbal stimulation	Purposeful* response to verbal or tactile stimulation	Purposeful* response following repeated or painful stimulation	Unarousable, even with painful stimulation
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous Ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular Function	Unaffected	Usually maintained	Usually maintained	May be impaired
*Reflex withdrawal from a painful stimulus in NOT considered a purposeful response. American Society of Anesthesiologists. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/ Analgesia, 2014.				

NOTE: Anesthesiologists, CRNA's or physicians who are residency trained and board certified in Emergency Medicine or emergency physicians with 10+ years active practice in a current emergency room environment or physician assistant in the ED may provide sedation for patient's assessed as being ASA Class 4 or 5 and any patient requiring deep sedation. ***EXCEPT in emergent situations with an ER physician present.***

AFFECTED AREAS/PERSONNEL: *MAIN OPERATING ROOM (OR); OBSTETRICS (OB)OR; ENDOSCOPY SUITE; EMERGENCY DEPARTMENT; INTENSIVE CARE UNIT (ICU);INTERVENTIONAL RADIOLOGY; POST ANESTESIA CARE UNIT (PACU), AMBULATORY SURGERY DEPARTMENT (ASD), CARDIAC CATHETERIZATION LAB*

MEDICATIONS APPROVED FOR PROCEDURAL SEDATION:
(See Addendum A for Procedural Sedation Dosing Guidelines)

1. Minimal or Light Sedation
    a. Ativan
    b. Diazepam (Valium)
2. Moderate Procedural Sedation
    a. Midazolam (Versed)
    b. Fentanyl (Sublimaze)
    c. Meperidine (Demerol)
    d. Morphine Sulfate
3. Reversal Agents
    a. Benzopdiazepines – Flumazenil (Romazicon)
    b. Opiods – Naloxone (Narcan)

Only anesthesiologists, anesthesia providers (i.e. Certified Registered Nurse Anesthetists), physicians who are residency trained and board certified in Emergency Medicine or emergency physicians with 10+ years active practice in a current emergency room environment may administer the following (deep sedation) anesthetics:

- Ketamine
- Sodium Thiopental
- Propofol
- Etomidate
- Nitrous Oxide

PATIENT ASSESSMENT AND CRITERIA FOR SELECTION:

1. Registered Nurses who have successfully completed the Moderate Procedural Sedation competency may provide care to the following types of patients:

   a. Patients who are to have minimal or moderate sedation.

   b. Patients who are assessed as ASA 1, ASA 2, or ASA 3 as designated by the American Society of Anesthesiologist (ASA) Classifications. (Note: ASA 3 patients may be appropriate, but need to be evaluated on an individual basis.):

      - *ASA 1: A normal healthy patient.*
      - *ASA 2: A patient with mild systemic disease.*
      - *ASA 3: A patient with severe systemic disease.*
      - *ASA 4: A patient with severe systemic disease that is a constant threat to his/her life.*
      - *ASA 5: A moribund patient who is not expected to survive 24-hours with/without an operation.*

2. Anesthesiologists, CRNAs or physicians who are residency trained and board certified in Emergency Medicine or emergency physicians with 10+ years active practice in a current emergency room environment are required to provide care to the following types of patients:

   a. Patients who are to have deep sedation or analgesia

   b. Patients who are assessed as ASA 4 or ASA 5

3. It is the responsibility of the physician to select only those patients who can safely undergo the required procedure with the use of moderate sedation.

4. An anesthesiologist or anesthetist should be consulted for the following patients:

   a. Significantly compromised patients; e.g., severe obstructive pulmonary disease, coronary artery disease, congestive heart failure
   b. Morbid obesity

   c. Significant risk of aspiration

   d. Pregnancy

   e. Difficult airway

f. If it appears likely that sedation to the point of unresponsiveness or general anesthesia will be necessary to perform the procedure

g. History of symptoms of obstructive sleep apnea (OSA), or diagnosed OSA.

5. Patients must be screened for potential risk factors of receiving any pharmalogical agents selected. The decision as to which agent and dosage to use, will be based on the goals of sedation, the type of procedure being performed, and the age and physiologic condition of the patient.

6. NPO Guidelines:

a. Clear liquids(not to include alcohol) > 2 hours is advisable

b. Solids > 6 hours is advisable

Fasting recommendation to reduce the risk of pulmonary aspiration:

- Clear liquids(not to include alcohol) 2 hours
- Breast milk 4 hours
- Infant formula 6 hours
- Non human milk 6 hours
- Light meal 6 hours
- Regular meal 8 hours

NOTE: NPO status exempt in emergency situations.

PROCEDURE:

PRE-PROCEDURE PREPARATION:

1. Physician's responsibility

a. Prior to the procedure, it is the physician's responsibility to complete and record the following in the patient's medical record

- Focused physical examination (performed within 30 days and 24 hour update), including pertinent medical history, auscultation of the heart and lungs, and evaluation of the airway.
- Indicated diagnostic test(s), including pregnancy test for female patients between the onset of menses and post-menopause, typically between the ages of 10-55 years, unless sterilized
-
- Informed consent of sedation risks, benefits and options as discussed with the patient and/or family prior to administration.
- Pre-procedure diagnosis
- Pre-sedation assessment and ASA category;
- Order for sedation medications
- Procedure/sedation plan.
- Sedation goal using the Ramsay Sedation Scale below;
  - Anxious and/or restless
  - Cooperative, oriented, tranquil
  - Responds to commands
  - Brisk response to stimulus
  - Sluggish response to stimulus
- Determination of patient's appropriateness for the planned sedation, and
- Time-Out with RN and team prior to sedation to confirm patient identity, procedure and site, plus agreement on patient status, planned sedation level and recommended dosages of medications.

2. RN Responsibilities:

a. Two perioperative RNs will be assigned to care for the patient receiving procedural sedation. One RN will administer the sedation medication and monitor the patient and the other RN will perform the circulator role.

b. During Cardiac Cath Lab procedures requiring moderate sedation, in addition to the Cardiologist, one RN is continuously present to monitor the patient and assist with minor, interruptible tasks that do not interfere with the ability to monitor the patient. In addition, immediately available is another RN readily available to go into procedure.

c. Validate the following:

- Physician orders for sedation medications
- Presence of the current H&P, updated if not done on day of procedure
- Signed Informed Consent for procedure and moderate sedation

d. Provide pre-procedural patient education, including the following:

- To anticipate drowsiness/sleep lasting a short time
- That conscious awareness of activity will be limited
- That ability to hear will remain; nurse will communicate throughout procedure
- That BP cuff and pulse oximeter will remain on during the procedure
- To advise the nurse if pain, itching, or difficulty breathing occurs
- To advise nurse if pain is not tolerated
- That recovery period will remain relatively short
- Addressing any questions the patient may have at that time

e. Confirm patent IV access

f. Validate presence of emergency equipment:

- Oxygen set-up with tubing and face mask/nasal cannula
- Suctioning equipment
- Pulse oximetry

- Cardiac monitor
- Non-invasive, automatic blood pressure cuff/machine
- Code cart immediately accessible
- Sedative and analgesic antagonists

3. All team members participate in pre-procedure Time Out (following Universal Protocol) to confirm patient identity, procedure and site, plus agreement on patient status, planned sedation level and recommended dosages of medications.

IMMEDIATELY PRIOR TO DRUG ADMINISTRATION

1. RN conducts and documents a baseline assessment to include the following:
   a. Respiratory rate;
   b. Oxygen saturation via pulse oximetry;
   c. Blood Pressure;
   d. Heart rate;
   e. Pain assessment
   f. Level of consciousness
2. Physician delivers or directs the RN to deliver the initial and subsequential doses of moderate sedation medications.
3. Immediately prior to start of procedure, the RN verbally confirms drug and dosage with physician, repeating sedation medication orders prior to administration.

THROUGHOUT THE ADMINISTRATION OF THE AGENT(S) AND DURING THE PROCEDURE

1. During the procedure with sedation the physician must be present and continuous monitoring will begin at the time the sedation medication is administered. Every 5 minutes throughout the procedure and for at least 15 minutes after the last dose of medication, the patient will be monitored , and the following will be documented:
   a. Oxygen saturation (pulse oximetry);

b. End Tidal CO2;

c. Blood pressure;

d. Rate and quality of respirations;

e. Level of consciousness;

f. Response to verbal commands;

g. ECG Monitoring;

h. Vital signs.

2. Verbally confirm drug and dosage with physician, repeating sedation medication orders prior to administration.

3. Notify physician if patient-specific maximum dosage of sedative or analgesic has been administered. (Note: Administration of procedural sedation medication above the recommended dosages for the patient's age, status and desired level of sedation (as outlined by the Procedural Sedation Dosing Guidelines, Appendix A) will be done at the physician's discretion and documented as such.

4. During the procedure and during post-procedure observation, the RN will verbally notify the physician of any signs or symptoms of adverse reaction or physiologic compromise. These include, but are not limited to:

a. Variation of 20% in blood pressure or heart rate

b. Oxygen saturation drops more than 2% from baseline.

c. Dyspnea, apnea or hypoventilation

d. Chest pain or cardiac arrhythmia

e. Diaphoresis

f. Inability to arouse the patient

g. The need to maintain the patient's airway mechanically

h. Any other untoward or unexpected patient responses.

5. The RN must have no other responsibilities that would leave the patient unattended or would compromise continuous monitoring until the patient recovers.

IMMEDIATELY POST PROCEDURE:

1. The physician and team do a "Sign-Out", reviewing the name of the procedure, specimens are identified and labeled, equipment problems are addressed, and any concerns for the continued management of the patient to be communicated to the next care-providers

2. The physician will remain available (within hearing distance) and the pulse oximeter and ECG monitor will remain in place until the patient recovers protective airway reflexes, responds to verbal stimulation and moves extremities appropriately.

3. The physician will complete the Post Procedure Assessment Note including: procedure performed, post-operative diagnosis, findings, EBL, specimens removed and if there was an assistant.

4. One set of vital signs will be recorded in the procedural area before transfer to the PACU or immediate post-procedure area for continued recovery from procedural sedation if the patient remains in the procedural area longer than 15 minutes.

5. Patient status will then be monitored for a minimum of 30 minutes after the last dose of medication by a qualified RN until the patient has reached baseline status or acceptable level according to the Aldrete scoring system in the following parameters:

   a. Level of consciousness;

   b. Oxygen saturation;

   c. Movement of extremities;

   d. Vital signs stable for 30 minutes;

   e. Maintenance of airway; and

   f. Pain assessment.

6. The Aldrete score is to be recorded in the immediate post-procedure recovery period, repeated every 15 minutes until criteria is met. (see below)

ALDRETE SCORE

SCORE	ADD 2	ADD 1	ADD 0
Activity	Moves 4 extremities voluntarily or upon command.	Moves 2 extremities voluntarily or upon command.	Moves 0 extremities voluntarily or upon command.
Respiration	Deep breathe or cough on command.	Limited or difficult respiration.	Apnea.
Circulation	BP +/- 20 mm Hg of pre-anesthetic level	BP +/- 20-50 mm Hg of pre-anesthetic level.	BP +/- 50 mm Hg or more of pre-anesthetic level.
Consciousness	Fully awake.	Responsive to voice stimuli.	Not responsive.
Oxygenation	Maintain SaO2 > 92%.	Maintain SaO2 > 90%	Sa02 < 90% even with $O^{2.}$

7. IV access will be maintained throughout the post-procedure recovery until the LOC returns to the baseline, unless otherwise ordered by the MD.

8. A physician will be available to discharge the patient in accordance with hospital policy.

9. Patients may be recovered in the following areas only:

   a. PACU

   b. ICU/CCU

   c. ER

   d. Radiology

   e. Endoscopy

   f. ASD

   g. Cardiac Catheterization Lab

10. The patient must be accompanied by an RN if transported prior to the return to baseline status with O2 available. Transportation mode is determined based upon patient status and need.

11. Patients may be discharged from the recovery phase after the hospital-approved discharge criteria is met.

Inpatients:

a. It has been at least 30 minutes since the last dose of sedation (or *1 hour if a reversal agent was used.*)
b. The patient has an Aldrete score within 2 points of pre-procedure baseline level.

EXCEPTION: Patient admitted to or currently in ICU.

c. Vomiting is absent or controlled with ordered medications.

d. Pain is managed via ordered medications after alternative methods are attempted; i.e., repositioning.

Outpatients

a. Discharge criteria (Post-Anesthesia Recovery or PAR), including level of consciousness, should be met for a 30 minute period before discharge. (See Outpatient Discharge Criteria Standardized Procedure.)

b. It has been at least 30 minutes since last dose of sedation medication and 2 hours after a reversal agent was used.

c. The patient has an Aldrete score within 2 points of pre-procedure level.

d. Pain and nausea are controlled.

e. The patient is able to ambulate with assistance consistent with age and procedure.

f. The patient will be accompanied by a responsible adult who will be able to report any post-procedure complications.

g. Discharge instructions are given, including resources to contact if any problems arise.

h. Patient and/or responsible adult verbalize understanding of discharge instructions.

DOCUMENTATION:

1. The Procedural Sedation Flow Sheet and the electronic medical record will be utilized for documentation before, during and after the procedure.

2. Documentation will include, but will not be limited to:

   a. The patient's status before, during and after the procedure;

   b. Dosage and route of all drugs and agents used;

   c. Type and amount of intravenous fluids administered;

   d. All assessment data;

   e. Unusual events during the procedure.

COMPETENCY REQUIREMENTS

NURSING STAFF

1. All RNs administering medications to produce moderate procedural sedation are required to demonstrate competency in management of the patient. At the end of the initial training program, the nurse will be able to:

   a. State the pharmacological agents used for local analgesia and procedural sedation, their dosages, route, desired effects and adverse reactions.

   b. Identify the pharmacologic agents used as antagonists to opioids and benzodiazepines and their dosages.

   c. Describe the procedure for procedural sedation including benefits and potential complications.

   d. Demonstrate appropriate assessment parameters prior to, during and after the procedure.

   e. Identify basic dysrhythmias

   f. Demonstrate ability to recognize and treat an obstructed airway

   g. Describe reportable conditions and appropriate nursing interventions.

2. Both cognitive and psychomotor skills, including airway management, will be validated initially and annually through the E-Learning Module and annual nursing competency fair.

3. All RNs who do procedural sedation monitoring must have valid and current BLS and ACLS certifications. Emergency Department RNs must also have PALS certification.

PHYSICIAN TRAINING AND COMPETENCY

1. Minimum formal training requirements are delineated on Procedural Sedation Privilege Request form.

2. Current ACLS is required for non-anesthesiologists who are not Board Certified in Emergency Medicine, Pulmonology or Cardiology. Physicians who have completed a residence training in Emergency Medicine and are not Board Certified, will be exempt from the ACLS or ATLS requirements if they have had 10+ years current consecutive practice in an emergency department environment.

3. Completion of the tutorial on Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, Airway Management Tutorial, and is passing the exam by no less than 80%.

4. Competency re-exam is waived for the reappointment applicant that has documented satisfactory performance of 10 cases within the last twenty-four months.

5. The privilege to perform moderate procedural sedation will be granted upon recommendation by the Department of Anesthesiology and approved by the Credentials Committee, the Medical Executive Committee and the Governing Board.

6. Only those practitioners who have been granted appropriate clinical privileges by the Governing Board are permitted to order and/or supervise the administration of moderate procedural sedation.

QUALITY ASSURANCE and RISK MANAGEMENT

1. Outcomes for patients undergoing sedation are collected and analyzed in the aggregate to identify opportunities to improve care.

2. The following events are reported through the QM/RM module and are evaluated for Risk Management and Performance Improvement Services. A summary of the findings are reported to the Anesthesia Services quarterly, including cases appropriate for peer review.

    a. Cardiac or respiratory arrest

    b. Use of reversal agents

    c. Need for assisted ventilation (ambu)

    d. Sedatives or analgesic dosing outside of the dosing guidelines

    e. Transfer to a higher level of care after sedation

REFERENCES:

Practice Guidelines for Moderate Procedural Sedation and Analgesia 2018: **A Report by the American Society of Anesthesiologists Task Force on Moderate Procedural Sedation and Analgesia, the American Association of Oral and Maxillofacial Surgeons, American College of Radiology, American Dental Association, American Society of Dentist Anesthesiologists, and Society of Interventional Radiology.** *Anesthesiology* 2018; 128:437–479
doi: https://doi.org/10.1097/ALN.0000000000002043

- American Society of Post Anesthetic Nurses. 2021-2022. Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements. Pg 73.
- Association of perioperative Registered Nurses (AORN) Standards and Recommended Practices, 2021
- Association of PeriOperative Registered Nurses: Guidelines for Perioperative Practice. Guideline for managing the patient receiving moderate sedation/analgesia. Denver, CO: AORN; 2021. https://aornguidelines.org/guidelines/content?sectionid=245927163&view=book#245927269. Retrieved March 2023
- American Society of Anesthesiologists. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/ Analgesia, 2010
- The Joint Commission. (2022). Sedation and Anesthesia-Understanding the Assessment Requirements.

CROSS REFERENCES:

- Assessment of Patients for Surgical/Invasive Procedures Policy – SVMC
- Intrafacility Transfers Policy- SVMC

APPENDIX A: Procedural Sedation & Analgesia Guidelines (Adult & Pediatric)

	MEDICATION	PEDIATRICS < 12 years	ADULTS PEDS ≥12 years	GERIATRIC > 60 years	ONSET	DURATION	COMMENTS
Moderate (Conscious) Sedation	FENTANYL (Sublimaze®)	1 mcg/kg/dose IM or slow IV push, if needed, may repeat by 1 mcg/kg increments; not to exceed a cumulative dose of 4mcg/kg	1-2 mcg/kg slow IV push (over 1-2 min); may repeat dose after 30 min	Same as adult dosing unless renal impairment	1 – 2 min	30 – 60 min	• **Reversal with Naloxone if respiratory depression occurs** • IV push slowly • Risk of skeletal and thoracic muscle rigidity with rapid injection. Risk of respiratory depression • ***(If patient is pre-medicated with opiate or other CNS depressant, reduce dose by 50%.)*** • **Use lowest possible dose in patients with renal impairment. Modify dose based on clinical response and degree of renal impairment**
	HYDROMORPHONE (Dilaudid®)	**Not recommended**	Incremental doses of 0.5 mg – 1 mg; **not to exceed 6 mg maximum**	Incremental doses of 0.5 mg – 1 mg; **not to exceed 6 mg maximum**	3 – 5 min	1 – 4 hours	• **Reversal with Naloxone if respiratory depression occurs** • Risk of respiratory depression • Monitor for 45 minutes after last dose. Watch for

							delayed respiratory depression • **Use lowest possible dose in patients with renal impairment. Modify dose based on clinical response and degree of renal impairment**
	LORAZEPAM (Ativan®)	**For infants and children:** 0.05 mg/kg PO, IM, or IV (range: 0.02-.09 mg/kg) one hour prior to procedure. **Not to exceed 2 – 4 mg/dose.** Alternatively, for slow titration to effect, 0.01—0.03 mg/kg IV initially, may repeat every 20 minutes to titrate to desired effect within the hour before procedure.	0.044 mg/kg IV 15-20 min before procedure. **Max dose of 2 mg IV.** Alternative: 0.05 mg/kg IM 2 hours before procedure. **Max IM dose of 4 mg.**	Refer to adult dosing. Increased sensitivity to lorazepam in this age group.	5 – 20 min	6 – 8 hours	• **Reversal with Flumazenil if respiratory depression occurs** • Use of this in infants and children is an off-label indication and safety and efficacy has not been established • **Dosage should be modified depending on clinical response and degree of renal impairment, but no quantitative recommendations are available**

	DIAZEPAM (Valium®)	0.2 – 0.4 mg/kg PO. **Not to exceed a total dose of 0.4 mg/kg. (Max dose is 20 mg PO)** or Incremental dose of 0.05 – 0.1 mg/kg IV. **Not to exceed a total dose of 0.25 mg/kg**	5-15 mg IV 5-10 min before cardioversion or titrated up to 20 mg IV for endoscopy. Alternative: 10 mg PO 45-60 minutes before procedure.)	Refer to adult dosing. Increased sensitivity to diazepam in this age group.	IV: 1 – 5 min Oral: rapid	IV: 20 – 30 min Oral: variable	• **Reversal with Flumazenil if respiratory depression occurs** • **Dosage should be modified depending on clinical response and degree of renal impairment and/or hepatic impairment but no quantitative recommendations are available**
	MEPERIDINE (Demerol®)	Pre-op sedation induction: SC/IM: 1.0 - 2.2 mg/kg 30-90 min. before beginning of anesthesia. **Not to exceed max adult dose (100mg)**	Pre-op sedation induction: 50—100 mg SC/IM 30—90 minutes before the beginning of anesthesia. **Not to exceed 100mg**	Pre-op sedation induction: 50 mg SC/IM 30—90 minutes before the beginning of anesthesia. **Not to exceed 50mg.**	SC: 10 – 15 min IV: 5 min	2 – 4 hours	• **Reversal with Naloxone if respiratory depression occurs** • Note: Naloxone does not reverse, and may even worsen, neurotoxicity (anxiety, tremors, seizures) • Avoid use in the elderly if possible • **Avoid use in renal impairment** • **Use caution in hepatic impairment**

	MIDAZOLAM (Versed®)	**Infants under 6 mos:** DO NOT GIVE 6 mos. – 5 years: Initial dose of 0.05-0.1 mg/kg IV, up to 0.6 mg/kg may be necessary. **Max dose = 6 mg** **6 – 12 years:** Initial dose of 0.025 – 0.05 mg/kg IV, up to 0.4 mg/kg may be necessary. **Max dose = 10 mg.** **12 – 16 years:** Dose as adults **Max dose = 10 mg**	Initial: Incremental doses of 0.5 – 2 mg slow IV over at least 2 minutes. Slowly titrate to effect by repeating doses every 2 – 3 min if needed. Usual total dose needed is 2.5 – 5 mg. Maintenance: 25% of the dose needed to reach sedative effect	Initial: 0.5 mg slow IV; give no more than 1.5 mg in a 2 minute period. If additional titration is needed, give no more than 1 mg over 2 min, waiting another 2 min or more to evaluate sedative effect. A total dose of > 3.5 mg is rarely needed	3 – 5 min	< 2 hours	• **Reversal with Flumazenil if respiratory depression occurs** • IV push slowly • Wait ≥ 2 min to assess sedative effect prior to administering additional doses • NOTE: Children < 6 years old may require higher doses and closer monitoring than older children. • **If patient is pre-medicated with opiate or other CNS depressant, reduce dose by 50%**
	MORPHINE Dilute to 1 mg/mL	Infants, children & adolescents: 0.1 - 0.2 mg/kg IV with onset of action 2 - 5 mins. Neonates:	**Off label** dosing for sedation induction: 2 mg IV *Reduce dose if patient is pre-medicated with	Increased risk of respiratory depression in elderly. Use with caution.	5 – 10 min	2 – 4 hours	• **Reversal with Naloxone if respiratory depression occurs** • Use fluids and trendelenburg position if hypotension occurs • IV push slowly

		0.05 - 0.2 mg/kg IV. Onset of action 5 mins. Use lower end of range for opiod-naïve neonates. Use preservative free formulation.	benzodiazepine				over 4 to 5 minutes • Monitor for 45 minutes after last dose. Watch for delayed respiratory depression • **If patient is pre-medicated with benzodiazepine reduce dose by 50%.** • **Prolonged half-life and/or accumulation in hepatic and renal impairment & pre-term neonates. Use with caution.**
	KETAMINE	6 – 10 mg/kg PO for one dose. (mixed in Cola or another beverage). Given 30 min. before procedure. 0.5 – 1.0 mg/kg/dose IV (given slowly over 60 seconds). **Not to exceed 0.5 mg/kg/min.**	Off label use: IM: 2 – 4 mg/kg IV: 0.2 – 0.75 mg/kg Titrate dose to effect	Refer to adult dosing	IV: 30 sec IM: 3 – 4 min PO: 15 – 20 min	IV: 5 – 10 min IM: 12 – 25 min	• In children, drink oral dose immediately after mixing with cola or other beverage. • Can cause emergence psychosis. Pre-treatment with a benzodiazepine can decrease psychosis by > 50% • **No renal adjustment appears to be necessary.**
	NALOXONE (Narcan®)	**Post-operative opiate agonist**	0.1 – 0.2 mg IV push every 2-3 min. until desired	Refer to adult dosing.	2 min	20-60 min	• Reversal agent for opioids o Fentanyl o Hydromorph

		induced respiratory depression: Initially, 0.005 – 0.01 mg/kg IV at 2 – 3 min intervals until desired response obtained.	response obtained.				one o Meperidine o Morphine • Administer over 30 seconds • Use in caution in patients with CVD and liver impairment • Additional doses may be necessary at 1–2 hour intervals depending on patient response as well as dosage/duration of action of the opiate agonist. • **It appears that no renal adjustment is necessary.**
	FLUMAZENIL (Romazicon®)	<u>For Adolescents and Children:</u> Dosage has not been definitively established. Initial dose of 0.01 mg/kg (max = 0.2 mg), followed by 0.005 – 0.01 mg/kg (max = 0.2 mg) every minute. **Not to exceed a total cumulative dose of 1 mg.**	0.2 mg IV initial, then repeat dose after 45 seconds, then every 1 minute until desired level of consciousness achieved. **Max Total Cumulative Dose: 1 mg over 5 min** If resedation occurs, repeat the regimen at 20 minute	Refer to adult dosing, however, increased sensitivity may occur in some elderly patients	1 – 3 min	~ 1 hour	• Reversal agent for benzodiazepines o Midazolam o Lorazepam o Diazepam • Administer over 15 seconds • May induce seizure • CAUTION: the effects of flumazenil may subside prior to those of the Benzodiazepine and therefore, the patient may require additional ventilator support.

			intervals, up to a maximum of 3 mg/hour.				DO NOT USE in patients requiring benzodiazepine for control of a potentially life-threatening condition or in patients with serious concurrent cyclic antidepressant overdose. • Safety and efficacy has not been established in children less than 1 year old • **It appears that no renal adjustment is necessary.** • **In hepatic impairment, no adjustment to the initial dose but subsequent doses should be reduced in size or frequency**

SUBJECT:	SECTION:
PYXIS ACCESS	***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 describe the management of Pyxis access privileges, to define what personnel will have access to Pyxis, and the termination process.

POLICY:

1. Access privileges to Pyxis shall be managed to ensure adequate security for medications, including controlled substance, to provide for proper and appropriate documentation of medication use.

2. A Pyxis user is defined as anyone with access to Pyxis. User templates will be created based on job titles; each user will be assigned user templates with specific access rights based upon their job duties.

3. Access privileges will be terminated immediately whenever the employee no longer works for the hospital.

4. Staff to complete a Pyxis Tutorial prior to Pyxis access being granted.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, RESPIRATORY THERAPY, ANESTHESIA, EDUCATION*

PROCEDURES:

Access Definition

1. User access may be requested for the following hospital staff:

    a. Pharmacist

    b. Pharmacy Technician

    c. RN Clinical Director/ Manager/Chief Nurse Executive

    d. Charge Nurse

    e. Staff Nurse

    f. Nursing Instructor

    g. Respiratory Therapist

    h. Anesthesiologist

    i. CRNA (Certified registered nurse anesthetist)

j. Medical Assistants in Urology Clinic

k. Medical Assistants in Rural Health Clinic

l. Medical Assistants at Academic Health Center

m. Medical Assistants at Surgery Clinic

n. IR Technician

o. Medical Imaging Technologist

p. Ultrasonographers

2. The pharmacy department shall designate an individual as the system manager. The system manager or designee will be responsible for creating and maintaining user template. The template will be reviewed and approved by the pharmacist in charge prior to activation.

Request Access

1. Regular

a. Access to Pyxis will be requested by the department director and/or manager on the Access Request Form initiated by Human Resources upon hire or on the Access Update Form located in the Approval Database in the FormStack database for an existing employee.

b. Access Right will be assigned by Pharmacy System Manager based on employee's position.

c. Anesthesiologist, Midwife, and CRNA

- Access to Pyxis will be requested by Medical Staff on the Access Request Form initiated by Human Resources upon hire or on the Access Update Form located in the Approval Database in the Formstack database for an existing employee.

2. Travelers

a. Access by travelers will have access for only the length of their contract. Their access will automatically terminate on the date their contract expires.

b. Upon hire, human resources will initiate the Access Request form with the Traveler's name, user name, and date the contract will begin and expire.

c. Once the Access Request has been approved by Department Director, and sent to pharmacy via IT, access will be assigned by Pharmacy System Manager.

d. If a traveler's contract is extended beyond the original time specified, an Access Update form will be initiated by Human Resources at the time the contract is renewed. The form, which including the new contract dates (beginning and expiration dates), will be sent on for approval in the usual manner.

3. Temporary

a. A charge nurse may set up temporary users. These temporary users are given access to the particular Display Terminal (DT) for a limited timeframe (14 hours) with specified rights.

b. Temporary users include any nurse that has floated to a department where access has not been assigned.

c. Float Nurses and Registry Nurses will be given access for 14 hours to cover assign shift in the department only.

d. Traveling Nurse may be given Temporary Access for up to 14 hours if access for length of contract has not yet been approved.

Termination of Access

1. For routine voluntary termination, once the department director or manager receives the notice, a Termination Notice form located in the Approval Database in the Formstack database will be filled out by department director or manager and sent to Human Resources. Human Resources will forward this information to Pharmacy System Manager. Pharmacy System Manager will disable the user's login privileges at the end of the last scheduled day of work.

2. For immediate termination without advance notice, human resources will contact pharmacy immediately. Pharmacy System Manager or designee will disable the user's access privilege right away. The department director or manager will still need to fill out the Termination Notice form. If immediate access removal is needed after pharmacy operating hours, the house supervisor will contact the on-call pharmacist who will remove Pyxis access for that user.

3. Access may be revoked immediately at the discretion of the Pharmacist in Charge or their designee in their absence. Notification to Human Resources and the user's manager will be sent as soon as possible to initiate a full investigation of activity. Determination of reinstating the access will be dependent on the internal investigation.

REFERENCE:

- Hospital Accreditation Standards. (2024). Oak Brook, IL: Joint Commission Resources, Inc.
  a. MM.05.01.13, EP2

SUBJECT:	SECTION:
PYXIS MEDICATION OVERRIDES AND DISCREPANCY	***Medication Management (MM)*** **Page 1 of 14**

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

PURPOSE:

To define the use of the override function in the PYXIS automated dispensing cabinets and identify the best practices associated with its use.

POLICY:

Medications available via the override function shall be limited to those drugs which may result in patient harm due to a delay in administration. The override list shall be reviewed and approved annually by the Pharmacy and Therapeutics Committee.

AFFECTED AREAS/PERSONNEL: *PHARMACY; NURSING*

PROCEDURES:

A. The override groups will include the following categories:

1. **Basic**- Includes controlled substances, over the counter (OTC) medications, respiratory medications.
2. **Emergent-** Includes the Basic group, plus those medications that require special training beyond the scope of the floor nurse to administer.
3. **Nursing House Supervisors**- Access to all medications house wide.
4. **OB Group**- Obstetric and Gynecological-related medications.
5. **RT Group**- Only access to respiratory medications.

B. Pharmacist Review of Override Medications

1. All medications removed via the override function shall be reviewed by the pharmacist the following day. Such review shall include:
   a. Verifying that there was a physician order for the over-ridden medication.
   b. Verifying that the nurse did not remove the medication on override after the order had been entered by a pharmacist.
   c. Verifying that the nurse did not override a medication using one route of administration, while the order was actually for another route.
   d. Verifying that the medication was not withdrawn on override after it had been discontinued or had expired.

e. Verifying proper dose, allergy status, and that interactions with other medications have not occurred.

2. Problems or issues with inappropriate use of the override function shall be documented in the hospital's medication event database and sent to the Nurse Managers for investigation, review and action.

3. Unresolved discrepancies shall be investigated by the Nurse Manager and the Pharmacy Director, as appropriate, and reported via the hospital medication event database and notification of the Chief Nursing Officer, as warranted.

4. For unresolved discrepancies involving controlled substances, refer to the procedures outlined in the Controlled Substances Procurement, Administration and Documentation policy.

Generic Name	Trade Name	Med ID	Override Group Name
ACETAMINOPHEN	Ofirmev	ACET1000I	Basic
ACETAMINOPHEN	Tylenol	ACET120S	Basic
ACETAMINOPHEN SUSP	Tylenol	ACET160UD	Basic
ACETAMINOPHEN	Tylenol	ACET325	Basic
ACETAMINOPHEN	Tylenol	ACET325S	Basic
ACETAMINOPHEN	Tylenol	ACET325UD	Basic
ACETAMINOPHEN ES	Tylenol ES	ACET500ES	Basic
OBC-ACETAMINOPHEN TAB	Tylenol ES Tab	ACET500OBC	Basic
ACETAMINOPHEN	Tylenol	ACET650S	Basic
Atropine	Atropine	ATRO0.4I	Basic
Atropine	Atropine	ATRO1I	Basic
Atropine	Atropine	ATROSYR	Basic
SODIUM CHL 0.9% (Aviva) IVPB	NS	AVIV250NS	Basic
SODIUM CHL 0.9% (Aviva) IVPB	NS	AVIV500NS	Basic
AZITHROMYCIN	Zithromax	AZIT500I	Basic
BIVALIRUDIN	Angiomax	BIVA250I	Basic
Calcium Chloride 10% Abbojject	Calcium Chloride	CACLSYR	Basic
Calcium Gluconate 10%		CAGL10I	Basic
Crash Cart Tray	Crash Cart Tray	CCTRAY	Basic
CEFEPIME	Maxipime	CEFE1I	Basic

CEFEPIME	Maxipime	CEFE2I	Basic
cefTRIAXone/D5w	Rocephin/d5w	CEFT1FZ	Basic
cefTRIAXone	Rocephin	CEFT1I	Basic
cefTRIAXone	Rocephin	CEFT250I	Basic
cefTRIAXone/D5w	Rocephin/d5w	CEFT2FZ	Basic
cefTRIAXone	Rocephin	CEFT2I	Basic
cefTRIAXone	Rocephin	CEFT500I	Basic
activated charcoaL	Actidose-Aqua	CHAR25S	Basic
DEXTROSE 10%-WATER	D10W	D10W500	Basic
DEXTROSE 5%-0.25% NS	D5-1/4NS	D5.2NS500	Basic
DEXTROSE 5%-0.45% NS	D5-1/2NS	D5.5NS1000	Basic
DEXTROSE 5%-LACTATED RINGERS	D5-LR	D5LR1000	Basic
DEXTROSE 5%-NS	D5-NS	D5NS1000	Basic
DEXTROSE 5%-WATER	D5w	D5W100	Basic
DEXTROSE 5%-WATER	D5w	D5W1000	Basic
DEXAMETHASONE	Decadron	DEXA4I	Basic
Dextrose* 50%	D50w I	DEXT50I	Basic
DEXTROSE GEL	Glutose-15 Gel	DEXTG	Basic
DEXTROSE 50%-WATER	D50w Abboject	DEXTSYR	Basic
DEXTROSE 25%-WATER	D25w Abboject	DEXTSYR25	Basic
DIAZEPAM	Valium	DIAZ10I	Basic
DIGOXIN	Lanoxin	DIGO0.5I	Basic
DIGOXIN	Lanoxin	DIGOEL	Basic
DiphenhydrAMINE	Benadryl	DIPH50I	Basic
EPINEPHrine	Adrenalin	EPIN1I	Basic
OBC-EPINEPHrine Inj	Adrenalin Inj	EPIN1IOBC	Basic
EPINEPHrine Pf	EPINEPHrine Pf	EPIN1IPF	Basic
EPINEPHrine	Adrenalin	EPIN30I	Basic
EPINEPHrine Abboject		EPINSYR	Basic
ETOMIDATE	Amidate	ETOM20I	Basic
fentaNYL (ASD)	Sublimaze	FENT100ASD	Basic
fentaNYL	Sublimaze	FENT100I	Basic
fentaNYL CIT	Sublimaze	FENT2500I	Basic
fentaNYL CIT	Sublimaze	FENT250I	Basic
fentaNYL CIT PCA	Sublimaze	FENT550PCA	Basic
flumazeniL	Romazicon	FLUM1I	Basic
FOSPHENYTOIN SOD	Cerebyx	FOSP100I	Basic

FOSPHENYTOIN SOD	Cerebyx	FOSP500I	Basic
FUROSEMIDE	Lasix	FURO20I	Basic
FUROSEMIDE	Lasix	FURO40I	Basic
guaiFENesin SYRUP	Robitussin	GUAI200UD	Basic
guaiFENesin/COD 100-10 mg SYRUP	Robitussin Ac 100/10	GUAICUD5	Basic
HALOPERIDOL DECA	Haldol	HALO50I	Basic
HALOPERIDOL LACTATE	Haldol	HALO5I	Basic
Heparin		HEPA1000I	Basic
HEPARIN/NS	Heparin in Ns	HEPA1000PM	Basic
HEPARIN SOD LOCK	Hep-Lock	HEPA100I5S	Basic
Heparin		HEPA10KI	Basic
Heparin		HEPA1KI	Basic
Heparin/D5w	Heparin in D5w	HEPA25250P	Basic
Heparin/D5w	Heparin in D5w	HEPA25KPM	Basic
Heparin		HEPA40KI	Basic
Heparin		HEPA5K10	Basic
Heparin		HEPA5KI	Basic
HYDROmorphone-HP PCA	Dilaudid	HYDPCA	Basic
HYDROCORTISONE SOD SUCC	SoluCORTEF	HYDR100I	Basic
HYDROmorphone-Hp	Dilaudid-Hp	HYDR10I5	Basic
hydrALAZINE	Apresoline	HYDR20I	Basic
HYDROCORTISONE SOD SUCC	SoluCORTEF	HYDR250I	Basic
HYDROmorphone	Dilaudid	HYDR2I	Basic
HYDROmorphone (ASD)	Dilaudid	HYDR2IASD	Basic
HYDROmorphone (CTC)	Dilaudid	HYDR2I-CTC	Basic
INDOMETHACIN	Indocin	INDO50S	Basic
INSULIN GLULISINE	Apidra	INSGLUL1	Basic
INSULIN ASPART PROTAM / ASPART	NovoLOG MIX 70-30 VIAL	INSU7030M	Basic
INSULIN LISPRO (RHC)	Humalog (RHC)	INSUH	Basic
INSULIN LISPRO (HumaLOG)	HumaLOG	INSUH1	Basic
INSULIN NPL/LISP	HumaLOG 75/25	INSUH75251	Basic
INSULIN GLARGINE	Lantus	INSUL5	Basic
INSULIN ASPART (RHC)	NovoLOG	INSUNOV	Basic
INSULIN ASPART (NovoLOG)	NovoLOG	INSUNOV1	Basic

INSULIN HUM REG (RHC)	NovoLIN R	INSUREG	Basic
INSULIN REGULAR	NovoLIN-R	INSUREG1	Basic
LEVOFLOXACIN/D5W	Levaquin	LEVO250PM	Basic
LEVOFLOXACIN/D5W	Levaquin	LEVO500PM	Basic
LEVOFLOXACIN/D5W	Levaquin	LEVO750PM	Basic
LIDOCAINE 1% (10ML)	Xylocaine	LIDO1I10	Basic
LIDOCAINE HCL 1%	Xylocainej	LIDO1I20	Basic
LIDOCAINE HCL 1%	Xylocaine	LIDO1I50	Basic
LIDOCAINE PF INJ. 1%	Xylocaine Pf Inj. 1%	LIDOM1I2	Basic
LIDOCAINE 1% PF 30 ML	Xylocaine 1% Pf 30 ml	LIDOM1I30	Basic
LIDOCAINE 1% PF	Xylocaine 1% Mpf	LIDOM1I5	Basic
LIDOCAINE PF 2%	Xylocaine-Mpf	LIDOM2I10	Basic
LIDOCAINE PF 2%/EPI 1:200K	Xylocaine-Mpf 2% w/Epi	LIDOM2I10E	Basic
LIDOCAINE PF 2%	Xylocaine-Mpf 2%	LIDOM2I2	Basic
LIDOCAINE PF 2%	Xylocaine-Mpf 2%	LIDOM2I5	Basic
LIDOCAINE 2%	Xylocaine 2% Abbojject	LIDOSYR	Basic
LORazepam	Ativan	LORA2I	Basic
LORazepam (ASD)	Ativan	LORA2IASD	Basic
LORazepam (CTC)	Ativan	LORA2ICTC	Basic
LORazepam	Ativan Inj	LORA2S	Basic
HYDROcodone/APAP 10/300 mg	Lortab 10/300	LORT15UD	Basic
RINGERS SOLUTION,LACTATED	Lactated Ringers	LR1000	Basic
MG HYD/AL HYD/SIME SUSP	Maalox	MAAL30L	Basic
MG HYD/AL HYD/SIME SUSP	Maalox	MAALOUD	Basic
MG HYD/AL HYD/SIME SUSP	Maalox Es	MAALUD	Basic
MEPERIDINE	Demerol	MEPE100I	Basic
MEPERIDINE (ASD)	Demerol	MEPE25ASD	Basic
MEPERIDINE	Demerol	MEPE25I	Basic
MEPERIDINE (CTC)	Demerol	MEPE25ICTC	Basic
MEPERIDINE	Demerol	MEPE50I	Basic
MEROPENEM	Merrem	MERO500I	Basic
MEROPENEM	Merrem	MERR1I	Basic
Methadone	Methadone HCl	METH5UD	Basic
MethylPREDNISolone.*	SoluMEDROL	METHY125I	Basic

MethylPREDNISolone.	SoluMEDROL	METHY1I	Basic
MethylPREDNISolone.	SoluMEDROL	METHY40I	Basic
MethylPREDNISolone.	SoluMEDROL	METHY500I	Basic
METOCLOPRAMIDE	Reglan	METOC10I	Basic
MIDAZOLAM	Versed	MIDA2I	Basic
MIDAZOLAM (ASD)	Versed	MIDA2IASD	Basic
MIDAZOLAM	Versed	MIDA50I	Basic
Morphine Sulfate PCA	Morphine Sulfate PCA	MOPCA	Basic
Morphine Sulfate PF PCA	Morphine Sulfate PF PCA	MOPCACM	Basic
Morphine	Morphine Inj	MORP1000I	Basic
Morphine	Morphine	MORP10I	Basic
Morphine (ASD)	Morphine (ASD use only)	MORP10IASD	Basic
Morphine (CTC)	Morphine (CTC)	MORP10ICTC	Basic
Morphine	Morphine	MORP2I	Basic
Morphine Inj (CTC)	Morphine Inj (CTC)	MORP4CTC	Basic
Morphine	Morphine	MORP4I	Basic
Morphine (ASD)	Morphine (ASD)	MORP4IASD	Basic
Morphine Oral	Morphine	MORPUDC	Basic
NALOXONE	Narcan	NALO0.4I	Basic
NALOXONE	Narcan	NALOSYR	Basic
NIFEdipine	Procardia	NIFE10	Basic
NIFEdipine	Procardia XI	NIFE30XL	Basic
NITROGLYCERIN	Nitroglycerin	NITR50I	Basic
NITROGLYCERIN	Nitrostat 1/150	NITRSL	Basic
NITROGLYCERIN OINT 2%	Nitro-paste Oint 2%	NITRT	Basic
ELECTROLYTE-M SOLUTION/D5W	Normosol-M	NORM1000B	Basic
SODIUM CHLORIDE 0.45 %	NS 0.45%	NS.51000	Basic
SODIUM CHLORIDE 0.45 %	NS 0.45%	NS.5500	Basic
SODIUM CHLORIDE 0.9% FLUSH	NS Flush	NS10	Basic
SODIUM CHLORIDE 0.9%	NS	NS100	Basic
SODIUM CHLORIDE 0.9%	NS	NS1000	Basic
SODIUM CHLORIDE 0.9% (P)	NS	NS100M	Basic
SODIUM CHLORIDE 0.9%	NS	NS250	Basic

SODIUM CHLORIDE 0.9% FLUSH	NS Flush	NS3F	Basic
SODIUM CHLORIDE 0.9%	NS	NS50	Basic
SODIUM CHLORIDE 0.9%	NS	NS500	Basic
SODIUM CHLORIDE 0.9% (P)	NS	NS50M	Basic
SODIUM CL IRRIG SOLN	NS Irrig	NSIR3000	Basic
SODIUM CL IRRIG SOLN	NS Irrig	NSIR500	Basic
ONDANSETRON	Zofran	ONDA4I	Basic
PATIROMER CALCIUM	Veltassa	PATI8.4P	Basic
PHENobarbital	PHENobarbital	PHEN130I	Basic
ELECTROLYTE-56/D5W	Plasmalyte	PLAS1000	Basic
PROMETHAZINE	Phenergan	PROM25I	Basic
RETURN Topex	RETURN Topex	RETTOP	Basic
SODIUM CHLOR, BACTERIOSTATIC	NaCl Bacterostatic	SOCLBA10I	Basic
SODIUM CHLORIDE BACTERIOSTATI	NaCl Bacterostatic	SOCLBAI	Basic
MethylPREDNISolone.	SoluMEDROL	SOLUM2I	Basic
SOD POLYSTYRENE SULFON SUSP	Kayexalate Susp	SOPO15UD	Basic
SOD POLYSTYRENE SULFON SUSP	Kayexalate Susp	SOPOLPED	Basic
Sterile Water	Sterile Water	STWA10I	Basic
Sterile Water	Sterile Water	STWA50I	Basic
ACETAMINOPHEN w/COD 300-30 mg	Tylenol w/Cod 300-30	T3	Basic
ACETAMINOPHEN w/COD 120-12 mg ELIX	Tylenol w/Cod Elix	T3UD	Basic
THIAMINE	Vitamin B-1	THIA100I	Basic
TICAGRELOR	Brilinta	TICA90	Basic
Vancomycin Inj	Vancomycin Inj	VANC1.5I	Basic
VANCOMYCIN/D5W 1,250 MG IVPB	VANCOMYCIN/D5W 1,250 MG IVPB	VANC1250FZ	Basic
VANCOMYCIN/WATER 1250 MG IVPB	VANCOMYCIN/WATER 1250 MG IVPB	VANC1250PM	Basic
VANCOMYCIN/D5W	VANCOMYCIN/D5W	VANC1FZ	Basic
Vancomycin	Vancomycin	VANC1I	Basic
VANCOMYCIN/NS	VANCOMYCIN/NS	VANC1NSFZ	Basic
Vancomycin	Vancomycin	VANC500I	Basic
VANCOMYCIN/NS	VANCOMYCIN/NS	VANC500NFZ	Basic
Vancomycin	Vancomycin	VANC750I	Basic

VANCOMYCIN/NS	VANCOMYCIN/NS	VANC750NFZ	Basic
WATER FOR IRRIGATION,STERILE	Sterile Water Irrig	WATIR1000	Basic
WATER FOR IRRIGATION,STERILE	Sterile Water Irrig	WATIR1500	Basic
WATER FOR IRRIGATION,STERILE	Sterile Water Irrig	WATIR3000	Basic
WATER FOR IRRIGATION,STERILE	Sterile Water Irrig	WATIR500	Basic
PIPER/TAZO	Zosyn	ZOS2.25FZ	Basic
PIPER/TAZO	Zosyn	ZOS3.375FZ	Basic
PIPER/TAZ	Zosyn	ZOS4.5FZ	Basic
PIPERACILLIN/TAZO	Zosyn	ZOSY2.25I	Basic
PIPER/TAZO	Zosyn	ZOSY3.375I	Basic
PIPER/TAZO	Zosyn	ZOSY4.5I	Basic
KETOROLAC	TORADOL	KETO30I	Basic, Obstetric
OBC-KETOROLAC INJ	TORADOL INJ	KETO30IOBC	Basic, Obstetric
KETOROLAC	TORADOL	KETO60I	Basic, Obstetric
Magnesium Sulfate		MAGN1PM	Basic, Obstetric
MAGNESIUM SULF 20 GM		MAGN20PM	Basic, Obstetric
Magnesium Sulfate		MAGN2PM	Basic, Obstetric
Magnesium Sulfate		MAGNE4PM	Basic, Obstetric
ALBUTEROL RT	Proventil	ALBU0.5IN	Basic, Respiratory
ALBUTEROL RT	Proventil	ALBU3IN	Basic, Respiratory
ALBUTEROL INHALER	Proventil	ALBU90IN	Basic, Respiratory
DEXAMETHASONE	Decadron	DEXA10I	Basic, Respiratory
Magnesium Sulf 50%	Magnesium Sulf	MAGN1I	Basic, Urgent/Emergent
Magnesium Sulf 50% (mEq)		MAGN4IMEQ	Basic, Urgent/Emergent
OBC-ONDANSETRON ODT	Zofran Odt	ONDA4OBC	Basic, Urgent/Emergent
Sodium Bicarb 4.2%	Sodium Bicarb 4.2%	SOBI0.5I5	Basic, Urgent/Emergent
Sodium Bicarb 4.2%	Sodium Bicarb 4.2%	SOBI42S10	Basic, Urgent/Emergent
Sodium Bicarb 8.4%	Sodium Bicarb 8.4%	SOBI84I50	Basic, Urgent/Emergent
Sodium Bicarb 8.4%	Sodium Bicarb 8.4%	SOBI84S10	Basic, Urgent/Emergent
Sodium Bicarb 8.4%	Sodium Bicarb 8.4%	SOBI84S50	Basic, Urgent/Emergent
Ammonia Inhalant		AMMONA	Obstetric
Ampicillin	Ampicillin	AMPI500I	Obstetric
CITRIC ACID/SODIUM CITR	Bicitra	BICI15L	Obstetric

CEFOXITIN	Mefoxin	CEFOX1I	Obstetric
ePHEDrine SULF		EPHE50I	Obstetric
Gentamicin Ped	Gentamicin	GENT20I	Obstetric
Gentamicin/Ns* Ivpb (Ped)	Gentamicin/Ns	GENT-PED	Obstetric
MISOPROSTOL	Cytotec	MISO100	Obstetric
MISOPROSTOL	Cytotec	MISO200	Obstetric
MISOPROSTOL	Cytotec	MISO25	Obstetric
MISOPROSTOL	Cytotec	MISO50	Obstetric
Morphine Pf	Duramorph-Pf	MORPF10I	Obstetric
Morphine Pf	Duramorph-Pf	MORPF5I	Obstetric
LR with PITOCIN	Pitocin in LR	OXY20LRPM	Obstetric
OXYTOCIN 20 units in NS	Pitocin 20 units in Ns	OXY20NSPM	Obstetric
LR with PITOCIN	Pitocin in LR	OXY30LRPM	Obstetric
OXYTOCIN 30 units in NS	Pitocin 30 units in Ns	OXY30NSPM	Obstetric
PORACTANT ALFA INHALANT	Curosurf	PORA240IN	Obstetric
Ampicillin	Ampicillin	AMPI1I	Obstetric, Urgent/Emergent
Ampicillin	Ampicillin	AMPI250I	Obstetric, Urgent/Emergent
Ampicillin	Ampicillin	AMPI2I	Obstetric, Urgent/Emergent
CARBOPROST TROMETH	Hemabate	CARB250I	Obstetric, Urgent/Emergent
ceFAZolin/D5W 1 GM IVPB	Ancef	CEFA1FZ	Obstetric, Urgent/Emergent
ceFAZolin	Ancef	CEFA1I	Obstetric, Urgent/Emergent
ceFAZolin/D5W	Ancef	CEFA2FZ	Obstetric, Urgent/Emergent
ceFAZolin	Ancef	CEFA2I	Obstetric, Urgent/Emergent
CEFOXITIN	Mefoxin	CEFOX2I	Obstetric, Urgent/Emergent
BETAMET ACET/BETAMET NA PH	Celestone	CELE6I	Obstetric, Urgent/Emergent
CLINDAMYCIN/NS	Cleocin/Ns	CLIN300NS	Obstetric, Urgent/Emergent
CLINDAMYCIN/NS	Cleocin/Ns	CLIN600NS	Obstetric, Urgent/Emergent
CLINDAMYCIN/NS	Cleocin/Ns	CLIN900NS	Obstetric, Urgent/Emergent
CLINDAMYCIN/D5W	Cleocin/D5W	CLIN900PM	Obstetric, Urgent/Emergent

FAMOTIDINE	Pepcid	FAMO20I	Obstetric, Urgent/Emergent
METHYLERGONOVINE	Methergine	METH0.2I	Obstetric, Urgent/Emergent
OXYTOCIN	Pitocin	OXYT10I	Obstetric, Urgent/Emergent
PHYTONADIONE	Vitamin K	PHYTSYR	Obstetric, Urgent/Emergent
TERBUTALINE SULF	Brethine	TERB1I	Obstetric, Urgent/Emergent
ALBUTEROL	Proventil	ALBU17IN	Respiratory
ALBUTEROL	Proventil	ALBUIN	Respiratory
LEVALBUTEROL RT	Xopenex	LEVA0.31IN	Respiratory
SODIUM CHLORIDE RT SOL 3%	NS Rt Sol 3%	NS4IN	Respiratory
ACETYLCYSTEINE RT 10%	Mucomyst	ACETIN1010	Respiratory, Urgent/Emergent
ACETYLCYSTEINE RT 10%	Mucomyst	ACETIN1030	Respiratory, Urgent/Emergent
ACETYLCYSTEINE RT 10%	Mucomyst	ACETIN104	Respiratory, Urgent/Emergent
ACETYLCYSTEINE RT 20%	Mucomyst	ACETIN2010	Respiratory, Urgent/Emergent
ACETYLCYSTEINE 20%	Mucomyst	ACETIN204	Respiratory, Urgent/Emergent
ALBUTEROL/IPRATR 2.5-0.5 mg RT SOL	Duoneb	DUONEB	Respiratory, Urgent/Emergent
EPINEPHrine Rt Sol	Racemic Epi	EPIN0.5IN	Respiratory, Urgent/Emergent
IPRATROPIUM BROMIDE RT SOL	Atrovent	IPRA0.5IN	Respiratory, Urgent/Emergent
LEVALBUTEROL RT	Xopenex	LEVA0.63IN	Respiratory, Urgent/Emergent
LEVALBUTEROL RT	Xopenex	LEVA1.25IN	Respiratory, Urgent/Emergent
ACETYLCYSTEINE	Acetadote	ACET200I	Urgent/Emergent
ACETYLCYSTEINE 20%L	Mucomyst	ACETIN2030	Urgent/Emergent
Adenoscan	Adenoscan	ADEN60I	Urgent/Emergent
Adenosine	Adenocard	ADEN6I	Urgent/Emergent
ALBUMIN HUMAN 25% IVPB	Albuminar	ALBUM125PM	Urgent/Emergent
ALBUMIN HUMAN 25% IVPB	Albuminar	ALBUM25PM	Urgent/Emergent
ALBUMIN HUMAN 5% IVPB	Albuminar	ALBUM5PM2	Urgent/Emergent
ALPROSTADIL	Prostin Vr	ALPR500I	Urgent/Emergent

ALTEPLASE BOLUS	ACTIVASE	ALTBOLUS	Urgent/Emergent
ALTEPLASE(Activase)	Activase	ALTE100I	Urgent/Emergent
ALTEPLASE(Activase) INJ	Activase Inj	ALTE50I	Urgent/Emergent
AMIODARONE	Cordarone	AMIO150I	Urgent/Emergent
AMIODARONE	Nexterone	AMIO150PM	Urgent/Emergent
AMIODARONE	Nexterone	AMIO360PM	Urgent/Emergent
AMIODARONE INJ	Cordarone Inj	AMIO450I	Urgent/Emergent
AMIODARONE INJ	Cordarone Inj	AMIO900I	Urgent/Emergent
ANTIVENIN,CROTALIDAE (EQUINE)	Anavip	ANAVIP	Urgent/Emergent
Aspirin	Aspirin	ASPI325	Urgent/Emergent
ASPIRIN	Ecotrin	ASPI325EC	Urgent/Emergent
Aspirin Chew		ASPI81	Urgent/Emergent
Aspirin	Ecotrin	ASPI81EC	Urgent/Emergent
DEXTROSE 5%-WATER (Aviva)	D5w (Aviva)	AVIV250	Urgent/Emergent
BENZOCAINE 20% SPRAY	Hurricane One 20% Spray	BENZ20TS	Urgent/Emergent
BUMETANIDE	Bumex	BUME1I	Urgent/Emergent
BUMETANIDE	Bumex	BUME2.5I	Urgent/Emergent
CAFFEINE CITRATE INJ	CAFFEINE CITRATE INJ	CAFF60I	Urgent/Emergent
CISATRACURIUM INJ	Nimbex Inj	CISA200I	Urgent/Emergent
FAT EMUL/OLIVE/SOY/PHOS 20% IV	Clinopid 20% Iv	CLINO20PM	Urgent/Emergent
CLOPIDOGREL	Plavix	CLOP300	Urgent/Emergent
CLOPIDOGREL	Plavix	CLOP75	Urgent/Emergent
Cocaine Topical 4%		COCA4TS	Urgent/Emergent
ANTIVENIN, CROTALIDAE	Crofab	CROFAB	Urgent/Emergent
DESMOPRESSIN ACETATE	DDAVP	DDAVP4V	Urgent/Emergent
DESMOPRESSIN ACET	Ddavp	DESM40I	Urgent/Emergent
DEXMEDETOMIDINE	Precedex	DEXM200I	Urgent/Emergent
DEXMEDETOMIDINE 200 MCG IVPB	Precedex Ivpb	DEXM200PM	Urgent/Emergent
DEXMEDETOMIDINE	Precedex	DEXM400PM	Urgent/Emergent
DIGOXIN IMMUNE FAB	Digifab	DIGO40I	Urgent/Emergent
DILTIAZEM	Cardizem	DILT125I	Urgent/Emergent
DILTIAZEM in D5W	Cardizem in D5W	DILT125PM	Urgent/Emergent

DILTIAZEM	Cardizem	DILT25I	Urgent/Emergent
DILTIAZEM	Cardizem	DILT50I	Urgent/Emergent
DOBUTamine/D5w	Dobutrex/D5w	DOB500B	Urgent/Emergent
DOBUTamine	Dobutrex	DOBU250I	Urgent/Emergent
DOPamine	Intropin	DOPA200I5	Urgent/Emergent
DOPamine	Intropin	DOPA400I10	Urgent/Emergent
DOPamine/D5w	Intropin in D5w	DOPA400PM	Urgent/Emergent
CONTAINER,EMPTY 50 ML	Empty Container	EMPTY50	Urgent/Emergent
ENALAPRILAT	Vasotec	ENAL1.25I	Urgent/Emergent
ENOXAPARIN	Lovenox	ENOX100I	Urgent/Emergent
ENOXAPARIN	Lovenox	ENOX120I	Urgent/Emergent
ENOXAPARIN	Lovenox	ENOX150I	Urgent/Emergent
ENOXAPARIN	Lovenox	ENOX300I	Urgent/Emergent
ENOXAPARIN	Lovenox	ENOX30I	Urgent/Emergent
ENOXAPARIN	Lovenox	ENOX40I	Urgent/Emergent
ENOXAPARIN	Lovenox	ENOX60I	Urgent/Emergent
ENOXAPARIN	Lovenox	ENOX80I	Urgent/Emergent
EPINEPHrine/NS 4 MG IVPB	EPINEPHrine/NS 4 MG IVPB	EPIN4PM	Urgent/Emergent
EPTIFIBATIDE	Integrilin	EPTI20I	Urgent/Emergent
EPTIFIBATIDE IVPB	Integrilin	EPTI75PM	Urgent/Emergent
ESMOLOL HCL	Brevibloc	ESMO100I	Urgent/Emergent
ESMOLOL in NS		ESMO2000PM	Urgent/Emergent
ESOMEPRAZOLE	Nexium	ESOM40I	Urgent/Emergent
fentaNYL	Sublimaze	FENT2500PM	Urgent/Emergent
GLUCAGON	GLUCAGON	GLUC1I	Urgent/Emergent
GLYCOPYRROLATE	Robinul	GLYC0.2I	Urgent/Emergent
GLYCOPYRROLATE	Robinul	GLYC0.2I5	Urgent/Emergent
INSULIN REG 100 UNITS/100 ML	Myxredlin	INSUDRIP	Urgent/Emergent
ISOPROTERENOL	ISUPREL	ISOP1I	Urgent/Emergent
PROTHROMBIN COMPLEX CONCENT	Kcentra IV	KCENT1I	Urgent/Emergent
POTASSIUM CHL 10 mEq IVPB	Kcl	KCL10PM	Urgent/Emergent
POTASSIUM CHL 20 mEq IVPB		KCL20PM	Urgent/Emergent
Ketamine		KETA500I	Urgent/Emergent
Ketamine Inj	Ketamine Inj	KETA500I5	Urgent/Emergent

Ketamine		KETA50S	Urgent/Emergent
POT PHOS /NS		KPHOS15PM	Urgent/Emergent
LABETALOL IV	Trandate	LABE100I	Urgent/Emergent
LABETALOL SYR	Trandate	LABE20S	Urgent/Emergent
LACOSAMIDE	Vimpat	LACO200I	Urgent/Emergent
LACOSAMIDE	VIMPAT	LACO50	Urgent/Emergent
levETIRAcetam	Keppra	LEVE500I	Urgent/Emergent
LIDOCAINE in D5W	Xylocaine in D5W	LIDO1PM	Urgent/Emergent
LIDOCAINE/D5W	Xylocaine in D5w	LIDO2PM	Urgent/Emergent
FAT EMULSIONS 20%	Liposyn II 20%	LIPI20PM	Urgent/Emergent
Mannitol 25%		MANN12.5I	Urgent/Emergent
Mannitol 20%		MANN20PM	Urgent/Emergent
Mannitol Inj 20% IVPB	Osmitrol Inj 20% IVPB	MANNI250PM	Urgent/Emergent
METOPROLOL TARTRATE	Lopressor	METO5I	Urgent/Emergent
MIDAZOLAM/NS	Versed/Ns	MIDA100PM	Urgent/Emergent
MIDAZOLAM SYRUP	Versed	MIDAUDC	Urgent/Emergent
MIDODRINE	Proamatine	MIDO2.5	Urgent/Emergent
MIDODRINE	Proamatine	MIDO5	Urgent/Emergent
Morphine	Morphine Sulfate	MORP100PM	Urgent/Emergent
NALBUPHINE	Nubain	NALB200I	Urgent/Emergent
NICARDIPINE/NS 20MG IVPB	Cardene Ivpb	NICA20PM	Urgent/Emergent
Nitroglycerin/D5w	Nitroglycerin in D5w	NITR50PM	Urgent/Emergent
Norepinephrine/NS	Levophed in NS	NORE16NS	Urgent/Emergent
NOREPINEPHRINE	LEVOPHED	NORE4I	Urgent/Emergent
NOREPINEPHRINE/D5W	Levophed in D5w 8mg/250ml	NORE8PM	Urgent/Emergent
OCTREOTIDE ACET	SandoSTATIN	OCTR100I	Urgent/Emergent
OCTREOTIDE ACET INJ	SandoSTATIN Inj	OCTR200I	Urgent/Emergent
OCTREOTIDE ACET	SandoSTATIN	OCTR500I	Urgent/Emergent
OCTREOTIDE ACET	SandoSTATIN	OCTREO50I	Urgent/Emergent
OLANZAPINE	Zyprexa	OLAN10I	Urgent/Emergent
PANTOPRAZOLE	Protonix	PANT40I	Urgent/Emergent
PANTOPRAZOLE/NS 80MG IV PREMIX	Protonix/NS 80mg IV Premix	PANT80FZ	Urgent/Emergent
PHENYLEPHRINE in NS	Neo-synephrine /Ns	PHEN1000S	Urgent/Emergent
PHENYTOIN	Dilantin	PHEN100I	Urgent/Emergent
PHENYLEPHRINE	Neo-synephrine	PHEN10I	Urgent/Emergent

PHENobarbitaL	PHENobarbitaL	PHEN20UD	Urgent/Emergent
PHENYTOIN	Dilantin	PHEN250I	Urgent/Emergent
PHENYLEPHRINE HCL	Neo-Synephrine	PHEN50I	Urgent/Emergent
PHENTOLAMINE MESYLATE	Regitine	PHEN5I	Urgent/Emergent
PHYTONADIONE	Vitamin K	PHYT10I	Urgent/Emergent
PROCAINAMIDE HCL	Pronestyl	PROCSYR	Urgent/Emergent
PROPOFOL	Diprivan	PROP100PM	Urgent/Emergent
PROPRANOLOL	Inderal	PROP1I	Urgent/Emergent
PROPOFOL	Diprivan	PROP20I	Urgent/Emergent
PROTAMINE SULFATE	PROTAMINE	PROT10I	Urgent/Emergent
PYRIDOSTIGMINE	Regonol	PYRI10I	Urgent/Emergent
RABIES IMMUNE GLOBULIN/THIMER	Kedrab	RABI2I	Urgent/Emergent
RIVAROXABAN	Xarelto	RIVA10	Urgent/Emergent
RIVAROXABAN	Xarelto	RIVA2.5	Urgent/Emergent
ROCURONIUM	Zemuron	ROCU10I	Urgent/Emergent
NITROPRUSSIDE SOD	Nipride	SONI50I	Urgent/Emergent
SUCCINYLCHOLINE	Anectine	SUCC200I	Urgent/Emergent
TENECTEPLASE	TNKase	TENE50I	Urgent/Emergent
BENZOCAINE Spray 20% (Topex)	Topex Spray	TOPE20S	Urgent/Emergent
TRANEXAMIC ACID		TRAN1000I	Urgent/Emergent
TRANEXAMIC ACID		TRAN1000PM	Urgent/Emergent
VALPROIC ACID SYRUP	Depakene Syrup	VALP250UD	Urgent/Emergent
VALPROATE SOD	Depacon	VALP500I	Urgent/Emergent
VALPROIC ACID SYRUP	Depakene Syrup	VALPLPED	Urgent/Emergent
VASOPRESSIN	Pitressin	VASO20I	Urgent/Emergent
VASOPRESSIN/D5W	Vasostrict/D5w IVPB	VASO20PM	Urgent/Emergent
VASOPRESSIN IN NS IVPB	Vasostrict/Ns Ivpb	VASOP20PM	Urgent/Emergent
VECURONIUM	Norcuron	VECU10I	Urgent/Emergent
VERAPAMIL	Calan	VERA5I	Urgent/Emergent

REFERENCE:

Hospital Accreditation Standards. (2025). Oak Brook, IL: Joint Commission Resources, Inc. MM.08.01.01, EP 16

SUBJECT:	SECTION:
QUALITY IMPROVEMENT – RADIOLOGY AND LAB VARIANCES	**Page 1 of 2**

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

PURPOSE:

To ensure appropriate treatment has been rendered after patient discharge or release.

POLICY:

The Emergency Department (ED) will participate in quality improvement activities. All radiology and lab culture reports will be cross-checked with the ED physician's interpretation and treatment for variances to determine if patients receiving these services warrant further intervention or notification.

AFFECTED PERSONNEL/AREAS: *EMERGENCY DEPARTMENT DIRECTOR/EMERGENCY DEPARTMENT STAFF*

PROCEDURE:

A. Radiology Reports

1. Upon receipt of a radiology report for a patient that has been discharged from the Emergency Department, an ED nurse will review the patient's chart to compare the radiologist's interpretation with the ED physician's interpretation.

2. If a variance is perceived, the variance report will be completed by the ED nurse and placed with a copy of the patient's chart in the Emergency Department's Medical Staff's order slot for their review.

3. The Emergency Department Medical Staff will determine what action will be taken. If orders are written on the variance form, they will be completed by an ED nurse.

4. Documentation of all variances will be logged and sent to Performance Improvement on a quarterly basis.

5. The completed form will be sent to medical records, to be placed on the patient's permanent record.

B. Laboratory Reports

1. Upon receipt of the final culture and sensitivity report, the ED nurse will review the patient's chart to determine if the patient is on the proper medication.

2. If the sensitivity report indicates the infectious agent is not covered by the medication given to or prescribed for the patient, the variance form will be completed by the ED nurse and placed with a copy of the patient's chart in the Emergency Department's Medical Staff's order slot for their review.

3. If the sensitivity report indicates a communicable disease, the Confidential Morbidity Report will be filled out by the ED nurse in accordance with Tulare County Public Health regulations.

4. The Emergency Department Medical Staff will determine what action is to be taken. If orders are written on the variance form, they will be completed by the ED nurse.

5. The ED nurse will follow the Emergency Department's Medical Staff's orders for notifying the patient, and calling any prescription in to the patient's pharmacy of choice.

6. If the patient is unable to be contacted by phone, a **CERTIFIED LETTER** will be mailed to the patient's address on record. The letter will notify the patient that results of radiology or laboratory services utilized during their visit have been reviewed and as a result, SVMC has additional information/instructions regarding their treatment. The patient will be requested to contact the Emergency Department for further information.

7. The completed form will be sent to medical records, to be placed on the patient's permanent record.

REFERENCES:

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

- Title 17, California Code of Regulations (2020), §2500, §2593, §2641-2643, and §2800-2812; Reportable Diseases and Conditions. Retrieved from https://govt.westlaw.com/calregs/Document/I5849DB60A9CD11E0AE80D7A8DD0B623B?viewType=FullText&originationContext=documenttoc&transitionType=DocumentItem&contextData=(sc.Default).

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SUBJECT:	SECTION:
REGISTRATION PROCESS IN THE EMERGENCY DEPARTMENT	**Page 1 of 1**

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

PURPOSE:

To ensure all patients are registered into the Emergency Department (ED) in a consistent, orderly manner that maintains patient safety and privacy while retaining departmental flow patterns.

POLICY:

Patients will be registered as soon as possible upon request for treatment in the Emergency Department.

AFFECTED PERSONNEL/AREAS: *EMERGENCY DEPARTMENT DIRECTOR/EMERGENCY DEPARTMENT STAFF, PATIENT REGISTRATION DIRECTOR/PATIENT REGISTRATION STAFF IN THE EMERGENCY DEPARTMENT*

PROCEDURE

1. Patients are greeted either at the front reception desk or through the ambulance entrance.

    a. Patients arriving to the ED lobby will be pre-registered by the ED Greeter RN. Patients arriving through ambulance bay entrance will be pre-registered by ED Registration Clerk or ED RN.

    b. **Registration of the patient is secondary to immediate assessment and screening by medical staff. Registration will occur after the Medical Screening Examination (MSE).**

    c. If the patient or family is unable or unwilling to provide patient information immediately upon arrival, "**IMP A001**" will be used. Patient consent for treatment shall be obtained by the patient's ED Physician as outlined in the SVMC Consent Manual.

    d. An identification band will be put on the patient **immediately after arrival** by the ED Registration Clerk or ED RN.

2. The medical screening exam (MSE) is performed by the physician or Allied Health Professional (AHP) in the Emergency Department. After completion of the MSE, the Registration Clerk will complete the registration process by inputting the patient's demographic information.

REFERENCES:

- EMTALA Interpretive Guidelines (07/19/2019). CMS State Operations Manual. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf.

SUBJECT:	SECTION:
TARGETED TEMPERATURE MANAGEMENT (TTM)- THERAPEUTIC HYPOTHERMIA	**1 of 3**

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

PURPOSE:

- To provide a clear outline for patients receiving Targeted Temperature Management (TTM) post cardiac arrest.
- To develop a clinical guideline outlining specific steps in inducing, maintaining, and rewarming patients for optimal neurological recovery.
- To reduce mortality and improve neurological outcomes for patients who achieve Return of Spontaneous Circulation (ROSC) after sudden cardiac arrest.

DEFINITIONS:

- Targeted Temperature Management (TTM) refers to the strict control of a patient's core temperature following cardiac arrest. TTM is also referred to as "Therapeutic Hypothermia".

POLICY:

1. To prevent reperfusion injury, TTM should be started as soon as possible following cardiac arrest
2. Temperature should be strictly kept between 33°C and 36°C during the maintenance phase
3. All patients undergoing TTM will be intubated

INCLUSION CRITERIA:

- Post cardiac arrest patients with Return of Spontaneous Circulation (ROSC)
- GCS of <8 and unresponsive and intubated

EXCLUSION CRITERIA:

- Awake and responsive to verbal commands
- GCS > 9
- Active GI bleed, DIC, or Intracerebral hemorrhage
- Uncontrolled cardiac arrhythmias
- Hemodynamic instability
- Major traumatic injury

AFFECTED PERSONNEL/AREAS: *Intensive Care Unit, Emergency Department, and Cardiac Cath Lab.*

EQUIPMENT:

- Hypothermia Unit and blankets
- Esophageal Probe
- Cardiac Monitor

PROCEDURE:

- Obtain a physician's order
- Documentation will take place under the "Therapeutic Hypothermia" intervention
- Obtain baseline labs and EKG (CBC, CMP, ABG, PT/INR, PTT, Troponin, Magnesium, Lactate)
- Complete a set of PAN cultures as ordered by physician (Sputum, Urine, Blood, Nares, MRSA)

INDUCTION PHASE:

1. Provide education to patient/family
2. Administer analgesia/sedatives as ordered
3. Insert esophageal temperature probe
4. Keep head of bed (HOB) at 30 degrees if patient tolerates
5. Set temperature on the hypothermia unit for automatic control
6. Observe patient for complications (goal is to reach 33°C to 36°C within four hours)
7. Monitoring of temperature and vital signs will occur every 15 minutes until reaching maintenance phase

MAINTENANCE PHASE:

1. Temperature should maintain between 33°C and 36°C for 24 hours.
2. Monitor temperature at minimum of every hour to maintain strict body temperature

REWARMING PHASE:

1. Rewarming should occur slowly, and not exceed 0.25°C per hour.
2. Monitoring of temperature and vital signs will occur every 15 minutes until normothermic
3. Hypothermia unit should be set to auto control at 37°C
4. Once patient reaches 36.5°C, the automatic warming should be discontinued
5. Pt should remain normothermic for 48 hours after reaching goal temperature (37°C)
6. Avoid hyperthermia

RISKS:

- Cardiovascular abnormalities (bradycardia, ventricular tachycardia, ventricular fibrillation, other dysrhythmias)
- Hyperglycemia
- Electrolyte imbalances (monitor magnesium and potassium)
- Bleeding
- Hypotension
- Impaired skin integrity
- Gastrointestinal abnormalities (ileus, aspiration)

REFERENCES:

Omairi, A. M. (2021, January 1). *Targeted Hypothermia Temperature Management*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK556124/.

Taccone, F. S., Picetti, E., & Vincent, J.-L. (2020). High Quality Targeted Temperature Management (TTM) After Cardiac Arrest. *Critical Care*, 24(1). https://doi.org/10.1186/s13054-019-2721-1

Sierra View Medical Center
465 W. Putnam Ave. Porterville, CA 93257

Medicare Change of Status Notice

Important! You're getting this notice because your hospital changed your status from "hospital inpatient" to "hospital outpatient receiving observation services."

The box marked below shows what applies to you:

☐ **While you're still in the hospital**, your hospital stay will now be billed to Medicare Part B instead of Part A.

Your hospital bill may be lower or higher than the Part A inpatient deductible. Your hospital can give you more information about billing.

After you leave the hospital, Medicare will not pay if you go to a skilled nursing facility.

☐ **While you're still in the hospital**, the hospital may charge you the full cost of your outpatient hospital stay because you don't have Medicare Part B.

After you leave the hospital, Medicare will not pay if you go to a skilled nursing facility.

You Can Appeal

- You can appeal your status change to a Quality Improvement Organization right away. Quality Improvement Organizations are independent of Medicare.
- If you decide to appeal, your Quality Improvement Organization will look at your records and give you its decision about 2 days after you ask for an appeal.
- Call your Quality Improvement Organization to appeal at:

BFCC QIO PROGRAM Livanta
9090 Junction Drive Suite 10
Annapolis Junction, MD 20701
1-877-588-1123
TTY- 855-887-6668
FAX- 1-855-694-2929

- You should ask for an appeal as soon as possible and before you leave the hospital.
- **After you leave the hospital, you still have appeal rights.** Call your Quality Improvement Organization.

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
MEDICARE CHANGE OF STATUS NOTICE
Form # 026606 REV 01/25

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

PATIENT'S LABEL

What Happens After I Appeal?

- You'll get the appeal decision from the Quality Improvement Organization about 2 days after you appeal, even if you leave the hospital.
- If you decide to stay in the hospital beyond your planned discharge date you may be responsible for payment of services you get during the appeal process.
- If your appeal is favorable to you, Medicare may cover your skilled facility nursing stay after you leave the hospital.

Questions?

- If you think you may want to appeal and want more information about the appeals process, call your Quality Improvement Organization at:

BFCC QIO PROGRAM Livanta
9090 Junction Drive Suite 10
Annapolis Junction, MD 20701
1-877-588-1123
TTY- 855-887-6668
FAX- 1-855-694-2929

- For more information about your Medicare coverage, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Additional Information (Optional):

Sign below to show you received and understood this notice.

Signature of patient or representative	Date

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
MEDICARE CHANGE OF STATUS NOTICE
Form # 026606 REV 01/25

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

PATIENT'S LABEL

Sierra View Medical Center
465 W. Putnam Ave. Porterville, CA 93257

Aviso de Cambio de Condición de Medicare

¡Importante! Usted recibe este aviso porque su hospital ha cambiado su condición de "paciente hospitalizado" a "paciente ambulatorio que recibe servicios de observación".

La casilla marcada a continuación indica lo que se corresponde a usted:

☐ **Mientras usted continúa en el hospital**, su estadía en el hospital ahora se facturará a Medicare Parte B en lugar de Parte A.

Su factura del hospital podría ser menor o mayor del deducible de hospitalización de Parte A. Su hospital puede brindarle más información sobre la facturación.

Luego de que salga del hospital, Medicare no pagará si usted va a un centro de enfermería especializada.

☐ **Mientras usted continúa en el hospital**, el hospital podría cobrarle el costo total de su estadía en el hospital en calidad de paciente ambulatorio porque usted no tiene Medicare Parte B.

Luego de que salga del hospital, Medicare no pagará si usted va a un centro de enfermería especializada.

Usted Puede Apelar

- Puede apelar inmediatamente su cambio de condición a una Organización para el Mejoramiento de Calidad. Organizaciones para el Mejoramiento de Calidad son independientes de Medicare.
- Si usted decide apelar, su Organización para el Mejoramiento de Calidad examinará sus expedientes y le dará su decisión unos 2 días luego de que solicite la apelación.
- Para apelar, llame a su Organización para el Mejoramiento de Calidad al:

BFCC QIO PROGRAM Livanta
9090 Junction Drive Suite 10
Annapolis Junction, MD 20701
1-877-588-1123
TTY- 855-887-6668
FAX- 1-855-694-2929

- Usted debe solicitar una apelación lo antes posible y antes de salir del hospital.
- **Luego de que salga del hospital, aún tiene derechos de apelación.** Llame a su Organización para el Mejoramiento de Calidad.

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
MEDICARE CHANGE OF STATUS NOTICE
Form # 026607 REV 01/25

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

PATIENT'S LABEL

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¿Qué ocurre después de presentar una apelación?

- Usted recibirá la decisión sobre la apelación de la Organización para el Mejoramiento de Calidad unos 2 días después de presentar la apelación, incluso si salga del hospital.
- Si usted decide quedarse en el hospital más allá de la fecha prevista para el alta, podría ser responsable de pagar los servicios que recibe durante el proceso de apelación.
- Si la decisión sobre su apelación es favorable para usted, Medicare podría cubrir su estadía en un centro de enfermería especializada después de que salga del hospital.

¿Preguntas?

- Si usted cree que desea apelar y quiere más información sobre el proceso de apelación, llame a su Organización para el Mejoramiento de Calidad al:

BFCC QIO PROGRAM Livanta
9090 Junction Drive Suite 10
Annapolis Junction, MD 20701
1-877-588-1123
TTY- 855-887-6668
FAX- 1-855-694-2929

- Para obtener más información sobre la cobertura Medicare, llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY pueden llamar al 1-877-486-2048.

Información adicional (opcional):

Firme a continuación para mostrar que ha recibido y entendido este aviso.

Firma del paciente o representante	Fecha

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED AT MEC MEETING (JULY)

MEDICAL EXECUTIVE COMMITTEE	07/02/2025
BOARD OF DIRECTORS APPROVAL	
	07/22/2025
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
July 22, 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**
	• Abbreviations in the Medical Record	1-28	
	• Aid in Dying	29	
	• Aldrete PACU Scoring System	30-31	
	• Apnea Test	32-33	
	• Attire in the Operating Room, Endoscopy, Central Processing, Obstetrics, Interventional Radiology, Cardiac Cath Lab	34-37	
	• Blood & Blood Components, Transfusion Reaction	38-40	
	• Care Level Classifications – Emergency Department	41-50	
	• Care Management Plan	51-53	
	• Cesarean Deliveries	54-60	
	• Community Resources	61	
	• Documentation of Cardiac Rhythm	62	
	• Drug Withdrawal: Newborn	63-73	
	• Epidural/Intrathecal	74-80	
	• External Contaminated Instrument Transportation	81-82	
	• Floating Guidelines	83-85	
	• Fluid Restrictions	86-87	
	• Forceps Application for Assisted Vaginal Delivery	88-90	
	• Guidelines for Outpatient Documentation (Outpatient)	91-94	
	• Hepatitis B Vaccination	95-97	
	• Hyperbilirubinemia	98-101	
	• Hypertensive Disorders of Pregnancy	102-111	
	• Intra-Aortic Balloon Pump Therapy	112-115	
	• LPS Conservatorship Guidelines	116-117	
	• Maternal Child Health Patient Overflow	118-119	
	• Nutrition Assessment, Care Plans, Minimum Data Set and Documentation – DP/SNF	120-121	
	• Patient Food from Home – DPSNF	122-123	
	• Performance Improvement Plan	124-129	
	• Procedures – Reference Materials	130-133	
	• Pronouncing Cessation of Life Signs	134-136	
	• Scope of Practice Advance Practice Nurse	137-139	
	• Scope of Services – Academic Health Clinic	140-141	
	• Scope of Services – OB/Gyn Clinic	142-143	
	• Suicidal Patient Assessment & Management	144-148	
	• Surrogate Decision Maker, Selection of	149-154	

	• Time Frames of Documentation	155	**APPROVE**
	• Transfer of Patient to Higher Level of Care for Neurological Services	156-157	
	• Unrepresented Patients – Healthcare Decisions for	158-166	
II.	**Forms:**		
	• Respiratory Medical Need Form	167	

SUBJECT: **CARE LEVEL CLASSIFICATIONS – EMERGENCY DEPARTMENT**	SECTION: **Page 1 of 10**

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

PURPOSE:

To clarify the classification of emergency care level charges of the Sierra View Medical Center (SVMC) Emergency Department.

POLICY:

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

AFFECTED PERSONNEL/AREAS:

EMERGENCY DEPARTMENT DIRECTOR/EMERGENCY DEPARTMENT STAFF

PROCEDURE:

Charges for Emergency Services will be generated according to the following guidelines. The physician's Professional Fee is generated separately by the physician following their established guidelines. Charges for supplies, medications, and diagnostic tests are added to the professional and service fees. There is no distinction made between new and established patients in the emergency department.

See attachment for examples of clinical diagnoses that are gathered under the appropriate CPT codes. It is understood that the following diagnoses correlate with specific nursing interventions and can be used to assign a CPT code for Emergency Department services.

REFERENCE:

- American Medical Association (2019). CPT Professional Edition. Chicago, IL: American Medical Association.
- American Health Information Management Association (2019). Retrieved from https://www.ahima.org/.

Attachment A

Sierra View Medical Center /

Emergency Department Care Level Guidelines

	Definition	*Possible Interventions*	*Signs & Symptoms*	*Clinical Examples*
ER Left Before Triage				
CDM 16000038	Patient comes to the ED and leaves before they are triaged			
ER Triage Level				
CPT 99281-52		Triage		
CDM 16000006	Patient comes to the ED for the MD exam of a perceived or true emergency condition	Nursing Triage Assessment	Patient who leaves the ED after triage without being seen by a doctor	
		Vital Signs		
ER Level 1		Initial Assessment		
CPT 99281		No Medication or treatments	Read TB skin test	Medication Refill
CDM 16000001		Note for Work or School	Insect bite (uncomplicated)	Insect Bite
		Lab/X-ray result		
		Rx refill only - asymptomatic		
		Discussion of discharge instructions (straightforward)		

SUBJECT:	SECTION:
CARE LEVEL CLASSIFICATIONS – EMERGENCY DEPARTMENT	**Page 3 of 10**

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ED Level 2

CPT 99282

CDM 16000002

Illness or injury affecting one body area or organ system; Requires minimal nursing care or facility services

Could include interventions from previous levels, plus any of the following:

Visual Acuity

Accucheck

Simple wound care

Steri-strips

Suture Removal (uncomplicated)

PO medications - non narcotic

Ace Wrap or Sling

Wound Check

Booster or follow up immunization

Dressing Changes (uncomplicated)

Cough, runny nose, sore throat

Infection of one body area or organ system requiring only a prescription

Puncture wound/small laceration requiring no sutures

Sprain or strain not requiring x-ray

Acne

Cyst

Contact Dermatitis

Impetigo

Head Lice

Scabies

Poison Ivy

Conjunctivitis

Eye Discharge

Sun Burn

Insect Bite

Medication Refill

Chicken Pox

Earache - Otitis media or externa

Toothache

Re-check

Pharyngitis

SUBJECT: CARE LEVEL CLASSIFICATIONS – EMERGENCY DEPARTMENT	SECTION: Page 4 of 10

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ED Level 3

CPT 99283 **CDM 16000003**	Complaint is of moderate severity and often involving more than one body area or organ system	Could include interventions from previous levels, plus any of the following: Prep or assist w/ procedures such as: joint aspiration/injection, fracture care etc. Moderate wound care Single specimen collection Oral suctioning G-tube/trach care Fetal heart tones Saline/Hep lock Application of ace wrap, sling, immobilizer, splint etc. Breathing treatment (nebullzer x1) C-spine w/ Physician early clearance Eye/ Ear Irrigation	Head injury without loss of consciousness Moderate laceration care Extremity injury requiring x-ray Simple fractures - finger ext. Vaginal discharge or itch - no abdominal pain Dysuria Nausea and Vomiting not requiring IV medications or fluids Shortness of breath (asthma, bronchitis, COPD) that improves with 1 breathing treatment Controlled bleeding	Upper Respiratory Infection Rash: Pruritic or uticarial Corneal Abrasion Epistaxis Headache Lacerations Minor MVA Sprains/Strains Fracture Nursemaids Elbow Foreign Body Hemorrhoids Animal Bite/Human Bite Burn Constipation Diarrhea Allergic Reaction Fever

SUBJECT: CARE LEVEL CLASSIFICATIONS – EMERGENCY DEPARTMENT	SECTION: Page 5 of 10

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Sutures

IM Meds - non narcotic

Prescription medications administered PO

I&D

Foreign body removal - simple

Cardiac Monitor

Preparation for EKG

Receipt of EMS/Ambulance patient

Stool Hemoccult

Preparation for Lab Tests

Preparation for plain x-rays for only 1 area

Foley Catheters

In/Out Catheters

Emesis/Incontinence care

Mental Health - anxious w/o Mental Health Evaluation

Limited social worker intervention

Direct admit via ED

Discussion of Discharge Instruction (moderate complexity)

Urethral Discharge

Abscess

Cellulitis

Wound Infection

Back Pain

Contusion

Abrasion

Anxiety

UTI

Well Child Exam

sh

SUBJECT: CARE LEVEL CLASSIFICATIONS – EMERGENCY DEPARTMENT	SECTION:

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ED Level 4 **CPT 99284** **CDM 1600004**	Requires extended treatments and significant nursing care and monitoring.	Could include interventions from previous levels, plus any of the following: Major wound care Multiple specimen collection Mental Health Evaluation Enema/disimpaction Monitoring for: Seizures 1-2 IV fluid infusion IM or IV narcotic IV meds - non cardiac Pelvic Exam X-ray multiple body areas > 2 labs, EKG, X-ray 2-3 interventions from previous levels Accessing port-a-cath Prep for special imaging (MRI, CT, US etc.)	Short of breath -requiring 2 breathing treatments and/or IV medication or fluids Chest Pain - non cardiac requiring EKG/cardiac monitor or IV but no cardiac medications CT Scan Ultrasound MRI IV hydration 1-2 bags IV antibiotics Pain requiring IM or IV narcotics Trauma to 1-2 body areas, not requiring admission Overdose not requiring gastric lavage Seizures, uncomplicated Blunt penetrating trauma requiring	Pleuritic Chest Pain Chest Wall Pain Palpitations Abdominal Pain Anemia Syncope Vaginal Bleed (not menstrual) Edema COPD Exacerbation

		Breathing Treatment (nebulizer x2)	limited diagnostic testing	
		Tube placement/replacement	Headache with nausea and vomiting	
		Prep or assist w/ procedures such as: eye irrigation with Morgan lens, bladder irrigation with 3-way foley, pelvic exam, etc.		
		Sexual assault exam w/out specimen collection		
		Discussion of Discharge Instructions (complex)		
ER Level 5				
CPT 99285	Patients require extended treatment with significant nursing care.	Could include interventions from previous levels, plus any of the following:	Chest pain or cardiac receiving thrombolytics - TNKase	Chest Pain - cardiac
CDM 16000005		Multiple nursing assessment/vital signs	Septic	Tachycardia
		Transfer of pt. to a higher care	Hypertension requiring therapy	ALOC
		Major burn care	Paracentesis	Alcohol withdrawal
		Or prep	Central Line	TIA/CVA
		Post mortem care	Seizure - IV medications	GI Bleed
		Monitor for:	Respiratory Distress	DKA
		Leather/soft restraints	Blunt penetrating trauma requiring	Emergency Delivery
				Gunshot wound

Procedural Sedation	multiple diagnostic tests	Stab Wound
IV cardiac medications		Pedestrian vs. Auto
IV titratable drips		Traumatic Amputation
Lumbar Puncture	Systemic multi system medical emergency requiring multiple diagnostics	Major motor vehicle accident
4+ interventions of previous levels	Code 30 minutes or less	Admission to Hospital

Restraints

Cooling or heating blanket

Extended social worker intervention

Prep for special imaging (MRI, CT, US, etc.) with multiple or parenteral medications or IV/Oral contrast

Administration of blood transfusion/blood products

Breathing Treatments >3 ()If nebulizer is continuous, each 20 min is considered a treatment

Prep or assist with procedures such as: central line insertion, gastric lavage, LP, paracentesis, etc.

		Physical/Chemical restraints Coordination of hospital admission or transfer Critical Care less than 30 minutes		
ER Critical Care **CPT 99291** **CDM 16000007**	30-74 minutes of critical care provided by nursing staff Time spent with the individual patient must be documented in the medical record	Could include interventions from previous levels Multiple parenteral medications requiring constant monitoring Provision of any of the following: Major trauma care/multiple surgical consultants Chest tube insertion CPR Defibrillation/Cardioversion Pericardiocentesis Administration of ACLS drugs in cardiac arrest	Multiple trauma Cerebral hemorrhage Non-hemorrhagic strokes with vital function impairment Cardiac Arrhythmia requiring emergency treatment Major envenomation by a poisonous reptile Code 30 minutes or >	Status epilepticus Acute Myocardial Infarction Aortic Dissection Aneurysm; thoracic or abdominal Acute respiratory failure Acute renal failure DKA

Intubation

Arterial line placement

Delivery of baby

Ventilator Management

Major burn

Treatment of active chest pain

BiPAP/CPAP

Critical Care >30 minutes

ER Critical Care

CPT 99292 — As above in additional 30 minute increments.

75 minutes or more (see grid) of Critical Care

75-104 (99291 x1 and 99292 x1)

105-134 (99291 x1 and 99292 x2)

135-164 (99291 x1 and 99292 x3)

165-194 (99291 x1 and 99292 x4)

ALTHOUGH PROCEDURES ARE LISTED, THE LEVEL IS NOT BASED ON THE PROCEDURES

THIS ONLY REFLECTS THE SEVERITY OF THE PATIENT RECEIVING THOSE TYPES OF PROCEDURES

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SUBJECT: **CARE MANAGEMENT PLAN**	SECTION: **Page 1 of 3**

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

PURPOSE:

The Care Management Program at Sierra View Medical Center (SVMC) is a collaborative process which assesses plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health care needs through communication and available resources to promote quality cost-effective outcomes.

AFFECTED AREAS/PERSONNEL: *CARE MANAGEMENT AND NURSING*

OBJECTIVES:

- To maximize efficiency in utilization of available resources.
- To collaborate with the patient and their family, physician(s) and other hospital resource staff to implement a plan of care which meets the individual health care needs.
- To objectively provide educational information related to identified health care knowledge deficit.
- To promote the optimal expenditure of health care dollars through effective and efficient utilization of resources.

GOALS:

- To promote an optimal state of patient wellness, as appropriate to the individual, though assessment, monitoring and coordination of the patient's health care needs.
- To ensure that all services are necessary and beneficial to the patient, and are provided in a timely and cost-effective manner.
- To assist the patient to achieve an optimal level of wellness and functioning through facilitation of necessary health care services and needs.
- To encourage and assist patients to appropriately assume an active role in the health care, through acceptance and understanding of self-advocacy.
- To facilitate and maintain cost-effectiveness in all areas of health care delivery.

SCOPE:

- The scope of care management plan encompasses those important processes necessary to provide a system of health care delivery that leads to optimal wellness for each patient, at their highest level of achievable functioning. These processes are direct and indirect clinical assessment, problem identification, outcome identification, planning, monitoring and evaluating. Inclusive in the case management scope of services are the tenants of patient advocacy, quality of care and service, health team collaboration and optimum preparation to manage clinical, psychosocial and other social determinants of health.

- Care management will be conducted in accordance with all legal mandates while supporting the patient's ethical and moral directives. Care management services are available to all patients and families, regardless of age, sex, nation origin, race and sexual orientation and are admitted to Sierra View Medical Center for their health care needs.

METHODOLOGY:

Care Management Selection Procedure

- The Care Management selection process includes inpatients and outpatients.
- For the purposes of this plan, all individuals, whether inpatient or outpatient, will be referred to as patients.
- Patients selected for Care Management will be identified through referral patterns, direct provider referral, specific case review and referral from any source, dependent upon case manager approval.
- A criteria list specifying acute, severe diseases and long term, chronic disease entities which, by nature, are known to require an increased level of medical management, will serve as a review tool for patient identification in the case management program. The care integration team will review all inpatient admissions on a working day (Monday –Friday 0800-1630, excluding holidays) basis against the list to determine if any admitted patients meet the criteria for placement on case management.
- A criteria list including, but not limited to: those diseases entities which are known to be chronic, impact other bodily systems or organs, require a high degree of resources usage, impact quality of life and functioning, and/or can directly or indirectly affect the patient's psychosocial outlook, will serve as a review tool for patient identification in the case management program.

Implementation of Care Management

1. Care management is initiated upon identification and selection of a patient who meets criteria for care management.
2. The care integration team performs a thorough assessment of the patient, family and support system. The assessment includes:
    a. Collection, aggregation and analysis of all relevant clinical information, functional status, situation status and personal history;
    b. Identification of family members, friends or key individuals who are able to provide support or direct care for the patient;
    c. Review and analysis of the current plan of care to determine patterns or trends in care, alternative treatment programs, revisions necessary to reduce resource usage and increase patient satisfaction;

d. Communication with designated family members to identify specific needs versus perceived needs and to work with the patients' family in coordinating care and achieving an agreed goal.

REFERENCE:

- California Code of Regulations. (2025). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I6F56A7E1D4B611DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=%28sc.Default%29&bhcp=1.
- The Joint Commission (2025). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **CESAREAN DELIVERIES**	SECTION: **Page 1 of 7**

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

PURPOSE:

To set nursing guidelines for the care of women undergoing Cesarean delivery. And to assure the safety of all patients (mother and fetus) for high risk Cesarean deliveries, and to clarify when a Cesarean section (C-section) needs to be done in the Main Operating Room (OR) on the second floor.

POLICY:

1. Scheduled and emergency Cesarean deliveries may be done in the Labor & Delivery Surgical Suite.

2. Communication for unscheduled (called) Cesarean Sections will include:

   a. Category of electronic fetal monitor (EFM) Tracing

   b. Type of Cesarean Section:

      - Emergent:
      - Non-emergent (medically necessary):
      - Planned:
      - Elective (as circumstances permit)

   c. Notify the Pediatrician of need to attend the Cesarean delivery:

      - Per OB physician request
      - If the Labor RN/Charge RN anticipates need for neonatal resuscitation

   d. Any pertinent orders for anesthesiology or communication between OB physician and anesthesiology provider.

3. Patients for scheduled Cesarean delivery will **not** be taken to the Labor & Delivery Surgical Suite:

   a. Until physician arrives

   b. Without valid History & Physical

4. Universal Protocol ("Time Out") for ensuring correct patient, correct site and correct procedure will be followed.

High Risk Cesarean: Patients who are at significant high risk for Cesarean delivery will not be scheduled as elective procedures at Sierra View Medical Center without consultation with the surgeon and an anesthesiologist. If the patient cannot be transferred to a tertiary care facility for advanced level of care, the procedure will be schedule is OB unless the physician request to use the main OR or if the OB OR is in use.

The following list describes what constitutes a high risk Cesarean delivery:

- Placenta previa
- Partial placenta previa
- Known or history of placenta accreta
- History of significant hemorrhage with any previous deliveries
- Upon physician request

TO SCHEDULER IN THE MAIN OR:

1. A scheduling request for a cesarean section will be submitted to the labor and delivery department. Upon receipt, the patients prenatal records will be reviewed for any high risk factors and/or specific physicians instructions. The procedure will then be scheduled in the operating room as indicated per policy.
   a. The OB Charge Nurse will call the Surgery department and speak to the Charge Nurse and notify him/her of an active high risk delivery that needs to be done in the Main OR.
   b. The OB Charge Nurse will call the surgeon and notify him/her of the need to do the procedure in the Main OR.
   c. If the patient arrives on the weekend or the night shift, the Charge Nurse will call the Nursing House Supervisor so that the Main OR team can be called in.

AFFECTED AREAS/ PERSONNEL: *MCH DEPARTMENT PERSONNEL*

PROCEDURE:

1. The Labor and Delivery nurses will prepare the patient for surgery:
   a. Prep/Foley catheter
   b. Obtain consents
2. Pending C-section patients in Labor and Delivery will be transferred into the Labor & Delivery Surgical Suite via bed.

3. C-Section Team:
   a. Obstetrician
   b. Assistant obstetrician or Certified Registered Nurse First Assist (CRNFA)
   c. Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist
   d. Circulating RN
   e. Surgical Technician
   f. Nursery RN
   g. Respiratory Therapist
   h. Pediatrician, if indicated or requested (Please cross reference these policies: PEDIATRICIANS: CRITERIA FOR ATTENDANCE AT DELIVERIES and NURSES ATTENDANCE AT CESAREAN SECTION DELIVERIES FOR CARE OF THE NEWBORN.)

4. The C-section team is responsible for bagging all linen and disposable paper items, including disposal of suction canisters. All instruments will be put in the case cart and returned to Central Processing.

5. Environmental Services personnel, with appropriate training, will clean the Labor & Delivery Surgical Suite upon notification that the surgery is completed.

SAFETY:

1. Anyone entering the Labor & Delivery Surgical Suite will be appropriately dressed including:
   a. Shoe covers/boots
   b. Surgical Scrubs (Circulating Nurse)
   c. "Bunny suit" (Registered Nurse, Respiratory Therapist, Pediatrician)
   d. All hair contained under appropriate PPE
   e. Surgical mask

2. Doors to the Labor & Delivery Surgical Suite will be closed except when in use.

3. During the entire surgical procedure, this door will remain closed.

CANCELLATION OF SCHEDULED C-SECTION:

1. Unit Clerk/ OB Tech will enter C-section deliveries done after hours.
2. If the patient was previously scheduled for another day, the Unit Clerk/ OB Tech will notify department director or manager to follow through for all cancellations.
3. Notify Pediatrician, CRNA, RNFA when C-section is canceled.

PATIENT PREPARATION FOR CESAREAN DELIVERY:

1. Patient will have nothing by mouth per physician and/or anesthesia orders.
2. Verify known allergies, if any.
3. Confirm that history and physical is in the electronic medical record (EMR):
   a. Dictation number does not qualify
   b. Short form verifying that History and Physical has been dictated qualifies
4. Dentures/partials and contact lenses to be removed .
5. Consent for Cesarean delivery; consent for sterilization if appropriate:
   a. Obtain CBC, Type and Screen/Cross (per MD or Anesthesia orders) .
   b. Start IV 1000 mL Ringers Lactate, if not already infusing, Bolus with 1000-1500 ml per anesthesia.
   c. Give Bicitra 30 mL PO, as ordered, 30 minutes prior to start time.
   d. Insert Foley catheter unless otherwise ordered.
   e. Remove body jewelry – i.e. earrings, necklaces, watches etc. (may tape rings).
   f. No bra – only hospital gown.
   g. No clips, hairpins or bands in hair – dress patient with hat.
   h. Check for ID bracelet.
   i. Transfer patient to Labor & Delivery Surgical Suite.

j. Position the patient on the OR table to support optimal placental perfusion as anesthesia procedures permit.

k. Attach cardiac, B/P and oxygen monitors; record a set of vital signs.

l. Cover patient with warmed blankets as needed.

m. Position patient's support person in designated place, per CRNA/Anesthesiologist.

PREPARATION OF C-SECTION SUITE:

1. Warmer:
   a. Plugged in and turned on
   b. Warm blankets
2. Check for:
   a. Pediatric stethoscope hanging on warmer
   b. Resuscitation supplies/crash cart
   c. Suction tubing attached
   d. Infant oxygen mask available
   e. Oxygen tubing connected to oxygen outlet
   f. Ensure that oxygen and suction are functioning
3. Other room preparations

CHART PREPARATION:

1. Surgery consent
2. Complete infant's chart:
   a. Name (include mother's first, also)
   b. Pediatrician and obstetrician

c. Mother's blood type

d. Mother's due date

e. Method of feeding (breast or bottle)

f. Mother's gravida and para

g. Attach two name bands

h. Note any pertinent information for pediatrician's edification, if applicable

i. Mother's assigned room number

3. Make appropriate charges:

a. IVs, supplies and tubing

b. Foley catheter tray

c. Pre-op medication (chart on MAR)

d. Extra charges, if applicable, including pre-op antibiotics and/or other medications not routinely given during labor

DOCUMENTATION:

Ensure all documentation in electronic tracking system and the "Labor and Delivery Summary" is complete. Ensure all medications are documented in the electronic medication administration record.

REFERENCE:

- PC §70547 (b)(17)
- AWHONN Standards and Guidelines for Professional Nursing Practice in the Care of Women and Newborns (2019). (8th Ed). Washington, D.C.; AWHONN.
- Mattson, S. & Smith, J. E. (2016). Core curriculum for maternal-newborn nursing (5th ed.). St. Louis, MO: Elsevier Saunders.
- Lee, Richard MD (2015). Placenta Accreta and Percreta: Incidence, Risks, Diagnosis, Counseling and Preparation for Delivery. CMQCC,March 2015.

CROSS-REFERENCES:

- PEDIATRICIANS: CRITERIA FOR ATTENDANCE AT DELIVERIES
- NURSES ATTENDANCE AT CESAREAN SECTION DELIVERIES FOR CARE OF THE NEWBORN.

SUBJECT: **COMMUNITY RESOURCES**	SECTION: **Page 1 of 1**

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

PURPOSE:

To define the facility's responsibility for providing community resource information to patients, to assist with safe discharging, meeting basic needs, and safety.

POLICY:

The Social Service staff will compile and maintain a directory of community resources for the benefit of all patients and families.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES*

PROCEDURE:

1. The Social Service staff will compile and maintain a listing of community resources for health care, housing, social services, and other information that may be useful for residents, families, and staff. This will be maintained electronically and can be produced upon request in part or in full.

2. Resource information will include:

   a. Agency name

   b. Services provided

   c. Address and telephone number

   d. Contact person(s)

   e. Financial information

3. This information will be maintained in a manner and location that is easily accessible as reference material for residents, families, and facility staff.

4. The Social Service staff will update this list of resources regularly, but at least every year.

SUBJECT: **DOCUMENTATION OF CARDIAC RHYTHM**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish a standard of practice related to documentation of cardiac rhythm of patients having Electrocardiogram (ECG) monitoring in the Emergency Department.

POLICY:

All patients determined to need cardiac monitoring will have rhythm documentation at appropriate intervals for diagnostic and documentation purposes.

AFFECTED PERSONNEL/AREAS: *EMERGENCY DEPARTMENT DIRECTOR/EMERGENCY DEPARTMENT STAFF*

PROCEDURE:

1. Patients placed on cardiac monitors in the Emergency Department must have documentation of cardiac rhythm on the Emergency Department chart.

2. A monitor rhythm strip will be printed from the main monitoring system and placed on the chart with a patient label attached.

3. Documentation will be completed every 2 hours and prior to discharge from the Emergency Department.

4. Once the patient has been admitted to the hospital and cardiac monitoring is required:

    a. Monitor rhythm strips will be printed from the main monitoring system on each monitored patient every 4 hours and placed on the patient chart with a patient label attached.

    b. Monitor Rhythm strip printing will take place at 0400, 0800, 1200, 1600, 2000, and 0000 hrs.

REFERENCE:

- The Joint Commission (2020). Hospital accreditation standards. NPSC.02.03.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT:	SECTION:
DRUG WITHDRAWAL: NEWBORN	***MCH Patient Care (Other) Policy*** **Page 1 of 11**

PURPOSE:

To set nursing guidelines in the management of a newborn experiencing withdrawal symptoms after exposure to drugs or alcohol.

POLICY:

1. Physician provider and/or registered nurse will assess all newborns for signs of withdrawal and will manage symptoms of withdrawal according to policy.

2. Infants with positive urine drug screen or signs of abstinence will have Neonatal Abstinence scoring every 2 hours for 48 hours. Score per guidelines as attached appendix.

3. Physician will be notified if any 3 successive scores are greater than 8 for possible medication intervention.

4. Infants experiencing withdrawal will receive appropriate interventions.

5. Neonatal urine will be screened for drugs if any of the following criteria are met by the mother:

    a. Maternal or paternal history, signs or symptoms of illicit drug use or alcohol abuse, oral history of intrauterine drug exposure in a sibling

    b. Maternal or paternal HIV, recent gonococcal or chlamydial infections, hepatitis B or syphilitic infection. Previous positive toxicology screen(s) in prenatal period

    c. Skin lesions, such as abscesses or track marks consistent with IV drug abuse

    d. Withdrawal symptoms

    e. Current enrollment in drug/alcohol treatment program

    f. Presence of drug paraphernalia in the mother's belongings or hospital room

    g. Altered mental status consistent with drug/alcohol intoxication

    h. Inconsistent or inadequate prenatal care (less than 3 visits) or no prenatal care

    i. Precipitous labor and delivery

    j. Poor maternal weight gain

    k. Premature onset of labor

    l. Unexplained changes in mental status

    m. Intrauterine growth retardation or oligohydramnios in the absence of other identifiable causes

    n. Intrauterine fetal demise or stillbirth in absence of other identifiable causes

    o. Placental abruption in the absence of other identifiable causes

    p. Unexplainable severe hypertension

q. Violence and substance abuse in the home

r. History of incarceration, probation and parole

AFFECTED PERSONNEL/AREAS: *MCH STAFF-RNs and physicians.*

EQUIPMENT:

Neonatal Abstinence Scoring Form

PROCEDURE:

1. Assess infant for risk factors.

2. Assess infant for signs/symptoms of drug/alcohol use (true onset of abstinence can vary from shortly after birth to two weeks of age. Symptoms usually appear within 72 hours):

   a. Central Nervous System

   - Irritability
   - High pitched crying
   - Tremors
   - Increased musle tone
   - Frequent yawning and sneezing
   - Occasional seizures
   - Hyperactive deep tendon reflex
   - Exaggerated Moro reflex

   b. Gastrointestinal dysfunction

   - Vomiting
   - Diarrhea
   - Uncoordinated and constant sucking
   - Poor feeding
   - Dehydration

- Poor weight gain

c. Respiratory distress

- Tachypnea
- Stuffy nose
- Flaring
- Retractions
- Apnea

d. Other

- Yawning
- Sneezing
- Mottled color
- Fever
- Cyanosis

3. Notify physician if the average of any three (3) successive scores is greater than eight (8) for possible medication intervention.

4. Most common medicines:

   a. Methadone -0.05 mg/kg q 12 hours for Heroin and other opiate use.
   b. Morphine-0.05 mg/kg q 4hrs PRN for score of 8 and above.

5. Once medication has been started, scoring may be done according to attached scoring guidelines.

6. Be certain there has been a maternal referral to Social Services.

7. Upon confirmation of newborn positive drug screen, notify CPS and Social Services following policy.

8. Encourage parental interaction with the newborn under nursing supervision.

   Note: Maternal use of methadone does not eliminate the need for scoring, as methadone withdrawal is more severe than any other narcotic alone or cocaine alone.

9. Interventions to support the newborn experiencing withdrawal:

   a. Swaddling

   b. Rocking

c. Decrease tactile stimulation

d. Dark room

e. Decrease environmental noise and stimulation

f. Small frequent feedings

g. Use of a pacifier

DOCUMENTATION:

1. Document reason for Neonatal Abstinence Scoring (i.e., maternal history of drug use).

2. Use Neonatal Abstinence Scoring Form (see attached):

   a. Record time of scoring.

   b. Give points for all behaviors seen during the scoring interval even if they are not present at the time of scoring.

   c. Wake the newborn to test reflexes. Calm before assessing muscle tone, respirations, or Moro reflex.

   d. A startle reflex should not be mistaken for the Moro reflex.

   e. Many of the signs of hunger can appear the same as withdrawal. The appearance after feeding gives a good idea of muscle activity.

   f. Count respirations for a full minute.

   g. Always take the temperature at the same site. Temperatures listed on the scoring sheet are rectal, an axillary temperature that is 2 degrees lower may indicate withdrawal.

   h. Do not give points for perspiration if it is due to swaddling.

   i. Record daily weight.

3. Social Services and CPS referrals.

4. Document interventions (i.e., swaddling, rocking) that are effective.

5. Document parental interaction.

REFERENCES:

- Verklan, M. T., & Walden, M. (2015). Core curriculum for neonatal intensive care nursing (5th ed.). St. Louis, MO: Elsevier Saunders.

- Gardner, S. L., Carter, B. S., Hines, M. E., & Hernandez, J. A. (2016). Merenstein & Gardners handbook of neonatal intensive care (8th ed.). St Louis, MO: Elsevier.

NEONATAL ABSTINENCE SCORING FORM

CENTRAL NERVOUS SYSTEM DISTURBANCES														
SIGNS AND SYMPTOMS	SCORE	AM							PM					
Excessive High-pitched Cry	2													
Continuous High-Pitched Cry	3													
Sleeps <1 Hour After Feeding Sleeps <2 Hours After Feeding Sleeps <3 Hours After Feeding	3 2 1													
Hyperactive Moro Reflex Markedly Hyperactive Moro Reflex	2 3													
Mild Tremors Disturbed Moderate-Severe Tremors Disturbed	1 2													
Mild Tremors Undisturbed Moderate-Severe Tremors Undisturbed	1 4													
Increased Muscle Tone	2													
Excoriation (Specify Area):	1													
Myoclonic Jerks	3													
Generalized Convulsions	5													
METABOLIC/VASOMOTOR /RESPIRATORY DISTURBANCES														
Sweating														
Fever <101(99-100.8°F/37.2-38.2°	1													
Fever >101(38.2°C and Higher) Frequent Yawning (>3-4 times/ interval)	2 1													
Mottling	1													
Nasal Stuffiness	1													
Sneezing (>3-4 times/interval)	1													
Nasal Flaring	2													
Respiratory Rate >60/Min. Respiratory Rate >50/Min. with Retractions	1 2													
GASTROINTESTINAL DISTURBANCES														

Excessive Sucking	1												
Poor Feeding	2												
Regurgitation Projectile Vomiting	2 3												
Loose Stools Watery Stools	2 3												
TOTAL SCORE													
Initials													

Modified Finnegan Neonatal Abstinence Score Sheet1

System	Signs and Symptoms	Score	AM	PM	Comments
Central Nervous System Disturbances	Excessive high-pitched (or other) cry < 5 mins	2			
		3			
	Sleeps < 1 hour after feeding	3			
	Sleeps < 2 hours after feeding	2			
	Sleeps < 3 hours after feeding	1			
	Hyperactive Moro reflex	2			
	Markedly hyperactive Moro reflex	3			
	Mild tremors when disturbed	1			
	Moderate-severe tremors when disturbed Mild tremors when undisturbed	2			
		3			
		4			
	Increased muscle tone	1			
	Excoriation (chin, knees, elbow,	1			
	Myoclonic jerks (twitching/jerking	3			
	Generalized convulsions	5			
Metabolic/ Vasomotor/ Respiratory Disturbances	Sweating	1			
	Hyperthermia 37.2-38.3C	1			
	Hyperthermia > 38.4C	2			
	Frequent yawning (> 3-4 times/	1			
	Mottling	1			
	Nasal stuffiness	1			
	Sneezing (> 3-4 times/scoring	1			
	Nasal flaring	2			
	Respiratory rate > 60/min	1			
	Respiratory rate > 60/min with	2			
Gastrointestinal	Excessive sucking	1			
	Poor feeding	2			
	Regurgitation (≥ 2 times	2			
	during/post feeding)	3			

	Loose stools (curds/seedy	2														
	Watery stools (water ring on nappy around stool)	3														
	Total Score															
	Date/Time															
	Initials of Scorer															

1. Finnegan LP. Neonatal abstinence syndrome: assessment and pharmacotherapy. In: Nelson N, editor. Current therapy in neonatal-perinatal medicine. 2 ed. Ontario: BC Decker; 1990.

The NAS score sheet lists 21 symptoms that are most frequently observed in opiate-exposed infants. Each symptom and its associated degree of severity are assigned a score and the total abstinence score is determined by totalling the score assigned to each symptom over the scoring period.

Key points

- The first abstinence score should be recorded approximately two hours after birth or admission to the nursery (baseline score). This score reflects all infant behaviour up to the first scoring interval time point.
- Following the baseline score all infants should be scored at 4-hourly intervals, except when high scores indicate more frequent scoring.
- The score sheet allows for 2-hourly scoring over the 24-hour period.
- A new sheet should be started at the beginning of each day.
- Scoring is dynamic. All signs and symptoms observed during the scoring interval are included in the point-total for that period.
- If the infant's score at any scoring interval is ≥ 8, scoring is increased to 2-hourly and continued for 24 hours from the last total score of 8 or higher.
- If the 2-hourly score is ≤ 7 for 24 hours then 4-hourly scoring intervals may be resumed.
- If pharmacotherapy is not needed the infant is scored for the first 4 days of life at 4-hourly intervals.
- If pharmacotherapy is required the infant is scored at 2- or 4-hourly intervals, depending on whether the abstinence score is less than or greater than 8 throughout the duration of therapeutic period.
- If after cessation of pharmacotherapy the score is less than 8 for the following 3 days, then scoring may be discontinued.
- If after cessation of pharmacotherapy the score is consistently 8 or more, then scoring should be continued for the following 4 days (minimum) to ensure that the infant is not likely to develop late onset of withdrawal symptoms at home following discharge.

Guide to assessment and scoring2, 3

1. The neonatal abstinence syndrome scoring system was designed for term babies on four-hourly feeds and may therefore need modification for preterm infants. In a term infant scoring should be performed 30 minutes to one hour after a feed, before the baby falls asleep.
2. If necessary the infant should be awakened to elicit reflexes and behaviour, but if the infant is woken to be scored then diminished sleep after scoring should not be recorded. A crying infant should be soothed and quietened before assessing muscle tone, Moro reflex and respiratory rate.

High-pitched cry	Score 2 if high-pitched at its peak, 3 if high-pitched throughout. Infant is scored if crying is prolonged, even if it is not high-pitched.2
Sleep	This is a scale of increasing severity and a term infant should receive only one score from the three levels of severity. A premature infant on 3 hourly feeds can sleep for 2½ hours at most. Scoring should thus be 1 if the baby sleeps less than 2 hours, 2 if less than 1 hour and 3 if the baby does not sleep between feeds.2
Moro reflex	The Moro or startle reflex is a normal reflex of young infants and occurs when a sudden loud noise causes the child to stretch out the arms and flex the legs. Score if the infant exhibits pronounced jitteriness (rhythmic tremors that are symmetrical and involuntary) of the hands during or at the end of a Moro reflex. Score 3 if jitteriness and clonus (repetitive involuntary jerks) of the hands and/or arms are present during or after the initiation of the reflex.

Tremors	This is a scale of increasing severity and an infant should only receive one score from the four levels of severity. Undisturbed refers to the baby being asleep or at rest in the cot.2
Increased muscle tone	Score if excessive or above-normal muscle tone or tension is observed - muscles become "stiff" or rigid and the infant shows marked resistance to passive movements, e.g. if the infant does not experience any head lag when being pulled to the sitting position; or if there is tight flexion of the infant's arms and legs (unable to slightly extend these when an attempt is made to
Excoriation	Excoriations (skin abrasions resulting from constant rubbing against a surface that is covered with fabric such as bed linen). Score only when excoriations first appear, increase or appear in a new area.2
Myoclonic jerks	Score if involuntary muscular contractions which are irregular and exceedingly abrupt (usually involving a single group of muscles) are observed.4
Generalized convulsions	In the newborn infant generalized seizures or convulsions are often referred to as tonic seizures. They are most commonly seen as generalized activity involving tonic extensions of all limbs, but are sometimes limited to one or both limbs on one side. Unusual limb movements may accompany a seizure. In the upper limbs these often resemble "swimming" or "rowing". In the lower limbs, they resemble "pedalling" or "bicycling." Other subtle signs may include eye staring, rapid involuntary movements of the eyes, chewing, back arching,
Sweating	Score if sweating is spontaneous and is not due to excessive clothing or high room temperature4
Hyperthermia	Temperature should be taken per axilla. Mild pyrexia (37.2-38.3ºC) is an early indication of heat produced by increased muscle tone and tremors.
Yawning	Score if more than 3 yawns observed within the scoring interval.2, 4
Mottling	Score if mottling (marbled appearance of pink and pale or white areas) is present on the infant's chest, trunk, arms, or legs.4
Nasal stuffiness	Score if the infant sounds congested; mucous may be visible.4
Sneezing	Score if more than 3 sneezes observed within the scoring interval.2, 4
Nasal flaring	Score only if repeated dilation of the nostrils is observed without other evidence of lung or airways disease.4
Respiratory rate	Respirations are counted for one full minute. Score only if >60 per minute without other evidence of lung or airways disease.2 Score 2 if respiration involves drawing in of the intercostal muscles (retractions).
Excessive sucking	Score if hyperactive/disorganized sucking, increased rooting reflex, or attempts to suck fists or thumbs (more than that of an average hungry infant) are observed.3, 4
Poor feeding	Score if the infant demonstrates excessive sucking prior to feeding, yet sucks infrequently during a feeding taking a small amount of breast milk or formula, and / or demonstrates an uncoordinated sucking reflex (difficulty sucking and swallowing).3 Premature infants may require tube feeding and should not be scored for poor feeding if tube feeding is expected at their gestation.2
Regurgitation	Score if at least one episode of regurgitation is observed even if vomit is contained in the mouth.4

Loose/watery stools	Score if loose (curds/seedy appearance) or watery stools (water ring on nappy around stool) are observed. Check the nappy after the examination is completed if not apparent during the examination.[4]

References

1. Finnegan LP. Neonatal abstinence syndrome: assessment and pharmacotherapy. In: Nelson N, editor. Current therapy in neonatal-perinatal medicine. 2 ed. Ontario: BC Decker; 1990.
2. Royal Women's Hospital Drug Information Centre. Newborn Emergency Transport Service (Victoria). Neonatal handbook. Carlton, Vic: Royal Women's Hospital; 2004.
3. Finnegan LP, Kaltenbach K. Neonatal abstinence syndrome. In: Hoekelman RA, Friedman SB, Nelson N, Seidel HM, editors. Primary pediatric care. 2 ed. St Louis: C V Mosby; 1992. p. 1367-78.
4. Lester BM, Tronick EZ, Brazelton TB. The Neonatal Intensive Care Unit Network Neurobehavioral Scale Procedures. Pediatrics. 2004;113(3 Pt 2):641-67.

SUBJECT: **EPIDURAL/ INTRATHECAL**	SECTION: **Page 1 of 7**

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

PURPOSE:

To set guidelines in the nursing care of patients receiving epidural/intrathecal anesthesia (regional anesthesia) and to facilitate the provision of epidural/intrathecal anesthesia (regional anesthesia) to relieve pain during the labor and delivery process.

POLICY:

1. The nurse must obtain an order from Obstetrician/Certified Nurse Midwife (CNM) for "intrathecal/epidural.

2. The nurse must examine the patient prior to administration of epidural/intrathecal (regional) anesthesia to evaluate progress of labor and fetal status.

3. The Anesthesiologist/CRNA must do a history and physical on the patient and document it on the Anesthesia Record prior to administration of the epidural/intrathecal (regional) anesthesia.

4. The responsible physician (Obstetrician/CNM) should be consulted and should be readily available to deal with any obstetric complications that may arise.

5. Continuous electronic fetal monitoring is required. Exceptions to this policy will be discussed with the Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist.

6. BOLUS: Anesthesia provider is to be present for 30 minutes after the initial and each medication bolus thereafter.

7. CONTINUOUS INFUSION: The Anesthesiologist/CRNA must remain at the hospital during the continuous infusion (the definition of immediately available from BETA Risk management).

8. Anesthesia can do a continuous infusion with patient controlled anesthesia.

9. Universal Protocol ("Time Out") for ensuring correct patient, correct site and correct procedure will be followed before the procedure begins.

10. Anesthesiologist/CRNA must obtain an informed consent from the patient and document this on the anesthesia informed consent sheet. The nurse will assist to have the patient sign the consent.

AFFECTED PERSONNEL: *MATERNAL CHILD HEALTH (MCH) REGISTERED NURSES (RN)s, ANESTHESIA PROVIDERS*

EQUIPMENT:

- Electronic Fetal Monitoring equipment
- Anesthesia cart stocked per anesthesia provider request

- Noninvasive blood pressure machine
- Cardiac monitor
- Pulse oximeter
- Epidural tray
- Epidural chair
- Epidural pump
- Epidural/Intrathecal Tubing
- Medication mixed by anesthesia, or premixed solution from the pharmacy (all drugs must be preservative free)
- Suction set up (and is functional)
- Oxygen set up, including mask

PROCEDURE:

1. RN will apply electronic fetal monitor if not already in place and document on Labor Flow sheet in the EMR (electronic medical record).
2. The nurse will obtain an epidural packet to include consent, anesthesia work sheets, anesthesia consent, care plan for epidural, etc.
3. The nurse will obtain patient consent (the anesthesia provider will obtain a separate informed consent).
4. The nurse will provide patient education and emotional support.
5. The nurse will assemble epidural cart and equipment needed.
6. The Anesthesiologist/CRNA will assemble the medication needed for the procedure.
7. Ensure current lab work is in the chart if ordered.
8. Nurse/patient ratio is 1:1 during procedure and for 30 minutes after procedure.
9. Have patient empty her bladder.
10. Start an IV if one is not infusing.

11. IV bolus of 500 to 1000 ml per CRNA or physician's order (can be greater than 1000 ml of ordered max. of 1500 ml) to decrease possible hypotension, obtain specific orders for bolus if patient is PIH or has a cardiac history.

12. Obtain and document baseline vital signs, rhythm strip and pulse oximeter reading, and document on the Labor flow sheet in EMR.

13. Universal Protocol – "Time out" immediately before starting the procedure. Final verification of correct patient, procedure and site.

    a. This will be conducted where the procedure will be performed (Conducted at the bedside or in the OR if having a Cesarean Section).

14. The CRNA/Anesthesiologist and RN caring for the patient will actively communicate with the patient during the procedure as necessary.

15. The nurse will document the time out and any discussion that took place between the patient and Anesthesiologist/CRNA on the patient record in EMR.

16. The nurse will assist the patient into the position requested by the anesthesia provider, most commonly in a sitting position using epidural chair. The nurse may need to assist the patient in maintaining this position throughout the procedure.

17. Continue fetal monitoring during the procedure if possible. The anesthesia provider may require that the monitoring be discontinued during the procedure. Document FHR immediately after procedure.

18. Assist CRNA/Anesthesiologist as appropriate.

DURING AND AFTER PROCEDURE:

1. Notify anesthesia provider or OB MD/CNM for events (see list of conditions at end of policy).

2. The patient's oxygen saturation is to remain above 95% on room air.

3. Monitor and record BP every 5 minutes during the procedure and up to 30 minutes after the procedure is completed, then every 30 minutes thereafter until the continuous infusion is stopped.

4. After the Anesthesiologist or CRNA gives any epidural bolus, the nurse must again monitor and record BP every 5 minutes up to 30 minutes. Recorded blood pressure on monitor strips and the EMR.

5. If patient is receiving oxytocin infusion, consider stopping oxytocin only after asking the Obstetrician or any fetal strip indication (then follow the uterine resuscitation policy) if the procedure takes over 30 minutes and uterine contractions and fetal heart rate cannot be accurately

assessed. Re-start the oxytocin after the procedure is completed per the policy, "Oxytocin Infusion".

6. Position the patient as instructed after the epidural is in place, usually supine with head of bed at 30 degrees with lateral tilt. Avoid flat supine position and raise both side rails by the head of the bed for patient safety.

7. Assess and document dizziness, ringing in the ears, a metallic taste, inability to move the legs and/or numbness in the legs and document in the medical record.

8. **The anesthesiologist or CRNA will program the pump and give the patient the patient controlled bolus button and explain to the patient what the purpose of the patient controlled bolus. Per BETA and AWHONN the nurse can only monitor the patient and the rate of infusion.**

9. Ensure that continuous epidural tubing is:

   a. Without ports to prevent accidental injection into an epidural catheter.

   b. Specific epidural tubing is to be used with the yellow striping.

   c. Filled with the solution to be infused.

10. Protect the catheter and site during changes in position.

11. If patient has breakthrough pain, assess for a displaced or kinked catheter or tubing before requesting additional medication or bolus.

12. Assess and document side effects and interventions.

13. Do not give opioids, antiemetics, or sedatives unless cleared by the anesthesia provider.

14. Assess for nausea/vomiting, be prepared to administer antiemetics per Anesthesia/CNRA or OB/CNM order, protect the patient from aspiration, and document in the EMAR (Electronic Medication Administration Record).

15. Monitor intake and output, assess for dehydration or urine retention, and document in the medical record.

16. Assess bladder for distention every 1 hour. If bladder becomes distended and patient is unable to void, insert indwelling catheter to avoid repeated catheterizations.

SECOND STAGE/PUSHING:

1. Obtain order from anesthesia provider to stop the infusion once anesthesia is no longer needed or if patient is unable to push.

2. Consult with Anesthesiologist/CRNA to avoid stopping too early.

3. Anesthesiologist/CRNA must remain immediately available while a continuous epidural is running (remains in the hospital) per BETA risk management.

AFTER DELIVERY:

1. Consult the anesthesia provider for catheter removal after delivery.

2. An RN may remove the catheter as instructed by the anesthesia provider when insertion and management has been uncomplicated after the consultation with the Anesthesiologist/ CRNA.

    a. The registered nurse must demonstrate completion of appropriate in-service training.

3. Remove the dressing.

4. Have the patient sit up and flex the neck with the chin toward the chest.

5. Remove the catheter by pulling straight down with gentle traction.

6. If resistance is felt, stop and call the anesthesia provider.

7. Place a small dressing/band-aid at the puncture site.

8. Document removal and "tip intact" after examining the catheter for the black/blue marking at the distal end, in the recovery record.

9. Continue to assess patient for motor and sensory return. Evaluate and document in the medical record any abnormal findings of:

    a. Gait

    b. Stability

    c. Urinary output

10. Assist patient to the bathroom as needed.

11. Assess patient for Fall Risk until pre-procedure function has returned.

REPORTABLE CONDITIONS:

1. Notify the anesthesia provider for any of the following conditions:

    a. Respiratory rate less than 10, difficulty breathing, or oxygen saturation less than 95%

b. Systolic blood pressure less than 90 (or a decrease of 20-30 mm Hg)

- Start oxygen by facemask at 8 to 10 L/minute

c. If the analgesia is inadequate or unilateral (pain score > 3)

d. Loss or change in sensation above T-6 (xiphoid)

e. Disorientation or changes in sensorium

f. Any problems related to the catheter or the site

g. Patient complains of severe itching or nausea

2. Notify the anesthesia provider when patient has delivered.

3. **Notify the Obstetrician or Midwife for any of the following conditions**:

a. FHR tracing Category II trending to Category III tracing

- For fetal bradycardia, correct maternal position and start oxygen. If bradycardic for more than 10 minutes, closely monitor FHR and maternal BP. Be aware, a deceleration within 7 to 8 minutes of an epidural test dose may be a direct anesthetic response.

b. Sustained decrease in uterine activity

c. Patient becomes hypotensive

4. Continue to follow Labor and Delivery Policies

DOCUMENTATION:

1. Document start and end of procedure in EMR

2. Document in EMR:

a. Test dose

b. Initial pump rate

c. Boluses

d. Pump rate changes

e. Patient response to treatment including relief and any need for increased medication

3. Document pain scale:

a. Every 5 to 10 minutes upon initiation of block until patient is comfortable

b. Every 30 minutes thereafter

REFERENCES:

- The Joint Commission (2018). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- American Academy of Pediatrics American College of Obstetricians and Gynecologists, (2017) *Guidelines for Perinatal Care*, (8th Ed), Washington, DC.
- AANA (2011) Guidelines for the Management of the Obstetrical Patient for the Certified Registered Nurse Anesthetist in *Professional Practice Manual for the Certified Registered Nurse Anesthetist.* Park Ridge, Illinois: American Association of Nurse Anesthetist.
- AWHONN (2015). Issue: Role of the Registered Nurse (RN) in the Management of the Patient Receiving Analgesia by Catheter Techniques (Epidural, Intrathecal, Intrapleural or Peripheral Nerve Catheters) AWONN Position Statement.
- AWHONN Standards and Guidelines for Professional Nursing Practice in the Care of Women and Newborns, (7th Ed). Washington, D.C.; AWHONN.
- Simpson, K. R., & Creehan, P. A. (2014). AWHONNs perinatal nursing (4th ed.). Philadelphia: Lippincott Williams & Wilkins Health.

CROSS REFERENCES:

- Labor & Delivery Nursing Standards of Care – SVMC Policy and Procedure
- Pain Management During Labor – SVMC Policy and Procedure

SUBJECT: **EXTERNALCONTAMINATED INSTRUMENT TRANSPORTATION**	SECTION: **Page 1 of 2**

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

PURPOSE:

Define the processes of decontamination and transport of surgical instruments between the point of use and Central Processing Department, to minimize the spread of potentially infectious microorganisms.

POLICY:

1. All instruments, sterile or decontaminated, must be in solid closed containers for transport between buildings.

2. All decontaminated instruments will be transported at the end of the day from the point of use to the Central Processing Department.

3. Hospital vehicles are to be used for transport.

AFFECTED AREAS/ PERSONNEL: *CPD, , ASD, WOUND CLINIC, UROLOGY CLINIC, SURGERY CLINIC, OB/GYN Clinic, Rural Health Clinic*

PROCEDURE:

1. Instruments with lumens should be irrigated with sterile water to remove obstructive organic material.

2. Immediately after use and prior to transport, instruments are pre-treated to ensure excess bio-burden is removed. This will occur in the decontamination or workroom area of each point-of-use location.

3. Instruments will be placed in a rigid, puncture resistant, covered transport container and kept moist by the use of an enzymatic foam product.

4. Never allow free fluid to remain in the tray/biohazard container as it may spill during transport.

5. If the external surfaces of the transport container are contaminated, the container will be placed in a red biohazard plastic bag for transport. Items will be labeled "biohazard" before being transported to the CPD.

6. Carts, reusable covers, bins and other transport containers should be decontaminated after every use with an EPA-registered intermediate level disinfectant.

SUBJECT: **EXTERNALCONTAMINATED INSTRUMENT TRANSPORTATION**	SECTION: **Page 2 of 2**

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

7. Staff carrying containers with soiled instruments will enter the hospital through the loading dock and go immediately to the Decontamination area of CPD. Instruments will be logged in upon receipt. Containers should be maintained in a horizontal position during transport to prevent dislodging or potential damage during transport.

8. A log is maintained at the remote facilities and the CPD documenting instruments transported and received between the two locations. The log is to show the name of the person sending the instruments, the receipt of the instruments and that the (for sterile packages) sealing tape is intact.

9. Sterile items will also be placed in rigid, closed containers for transport.
10. All medical devices being transported will be labeled to identify clean, sterile versus contaminated content to assure they remain separate during transport.Transport carts used as transport carriers should be decontaminated and dried before they are reused and at the end of the shift.
11. Routine decontamination of the transport vehicle will be completed and logged daily.
12. A vehicle used to transport soiled items should contain a hazard spill kit and PPE in case a breach of containment occurs.

13.

REFERENCES:

AAMI TIR109: 2025 External transport of reusable medical devices for processing

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

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

PURPOSE:

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

POLICY:

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

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

PROCEDURE:

1. Generally, the float assignment will be determined according to the Float Log in each unit keeping in mind the premises of "Novice to Expert" (Benner) principles.
2. Once floated to a specific unit, the skills needed and the familiarity with the assigned unit will determine the placement of the assigned patients to the nurse floating.
3. Utilization of Float Pool (FP) Staff:
   a. These staff can only float to the units to which they have been oriented. (See updated Staffing Grid in each unit or house supervisor's office.)
   b. New FP Staff, once oriented to a specific unit, should be assigned to lesser acuity patients if possible. More experienced FP staff may be assigned higher acuity patients based on their ability.

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

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

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

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

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

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

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

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

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

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

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

    a. No float personnel will be assigned to more than two (2) areas within the 12-hour shift (unless part of the Nursing float Pool department).

    b. The same nurse will not be floated two (2) or more days in a row (unless they agree or there is no alternative).

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

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

11. New graduate RNs (Nurse Residents) will not be eligible to float for 12 months after their hire to the hospital, unless patient care requires and they have been trained and competent in the area of need.

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

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

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

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

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

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

REFERENCES:

California Board of Registered Nursing. (n.d). *RN responsibility when floating to new patient care unit or assigned to new population.* https://www.rn.ca.gov/pdfs/regulations/npr-b-21.pdf

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

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

PURPOSE:

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

POLICY:

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

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

PROCEDURE:

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

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

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

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

5. The following items will be considered as fluids:

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

6. The following items will NOT be considered as fluids

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

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

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

8. Fluid amounts for standard containers and foods:

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

9. Standard Calculation for ounces to cc.

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

REFERENCES:

- The Joint Commission (2025). Hospital accreditation standards. PC.02.02.03, EP 7
- CMS Title 42 Regulations: Chapter 4 § 482.28(b)(1)

SUBJECT: **FORCEPS APPLICATION FOR ASSISTED VAGINAL DELIVERY**	SECTION: **Page 1 of 3**

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

PURPOSE:

To set guidelines for the use of forceps in a vaginal delivery.

POLICY:

1. Continuous electronic fetal monitoring during procedure.
2. The Physician performing this procedure should be experienced in the use of forceps application.
3. Pediatric assistance should be available if needed.
4. Assessment of maternal pelvis-fetal size relationship.
5. The patient (mother) will receive adequate anesthesia.
6. Emergency equipment/instruments are available if problems occur.

AFFECTED AREAS/ PERSONNEL: *MCH DEPARTMENT, RNs*

GUIDELINES:

1. Forceps are tools used in an operative vaginal delivery to achieve or expedite safe vaginal delivery for maternal or fetal indications.
2. Forceps are used to assist vaginal delivery to shorten the second stage of labor due to maternal exhaustion, ineffective pushing (descent) or fetal intolerance to labor in second stage with possibility of rapid delivery.
3. Avoidance of cesarean delivery.
4. In some maternal conditions where prolonged pushing should be avoided (i.e., cardiac or cerebrovascular disease).

EQUIPMENT:

1. Electronic fetal monitor
2. Appropriate type of forceps:
    a. Simpson (similar to DeLee) – used for outlet vaginal deliveries and are designed for application to the molded fetal head
    b. Tucker-McLane (solid) – Used for rotational deliveries and are appropriate for application to the fetal head with little or no molding.

c. Piper – have a reverse pelvic curve to be used for breech deliveries.

3. Lubricant such as Betadine scrub or -lubricant gel.

PROCEDURE:

1. Forceps are classified by the level of the fetal head to the maternal ischial spines; mid, low or outlet forceps.

2. Outlet forceps:

   a. Scalp is visible at the introitus without separating the labia

   b. Fetal skull has reached the pelvic floor

   c. Sagittal suture is in the antero-posterior diameter or right or left occiput anterior or posterior position

   d. Fetal head is at or on the perineum

   e. Rotation does not exceed 45 degrees

3. Low forceps:

   a. Leading point of the fetal skull is at station $\geq +2$ cm and not on the pelvic floor

   b. Without Rotation ≤ 45 degrees (left or right occiput anterior to occiput anterior, or left or right occiput posterior to occiput posterior)

   c. Rotation > 45 degrees

4. Mid-forceps: station above + 2 cm but head is engaged.

5. Simultaneously prepare for a cesarean delivery in the event that the forceps maneuver is unsuccessful.

INDICATIONS:

1. Prolonged second stage of labor

2. Suspicion of immediate or potential fetal compromise

3. Shortening of the second stage of labor for maternal benefit.

4. Maternal health conditions(i.e., cardiac, cerebrovascular, or neurologic conditions)

5. Face presentation
6. Assisted delivery of the head in a breech delivery
7. Instrumented birth with the woman under general anesthetic
8. Cord prolapse in the second stage of labor

DOCUMENTATION:

1. Fetal heart rate pattern throughout procedure
2. Type of forceps used and time of application
3. Length of use
4. Maternal condition after delivery
5. Infant's response and condition

REFERENCE:

- American College of Obstetricians and Gynecologist. (2018). Practice Bulletin No. 154: Operative vaginal delivery. Obstetrics & Gynecol 2015; 126:e56-65
- Kennedy, B. B., & Baird, S. M. (2017). Intrapartum management modules: A perinatal education program (5th ed.). Philadelphia: Wolters Kluwer.

SUBJECT: **GUIDELINES FOR OUTPATIENT DOCUMENTATION (OUTPATIENT)**	SECTION: **Page 1 of 4**

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

POLICY:

To establish documentation guidelines for all therapies for outpatients.

AFFECTED AREAS/PERSONNEL: *ALL REHABILITATION PERSONNEL*

PROCEDURE:

1. All patient visits will be documented in writing in the patient's record.
   a. Proper documentation of communications with the referring physician should be maintained in the patient's permanent medical record.
2. Each outpatient will have a medical record of care and treatment which includes pre-authorization, subsequent referrals, copies of progress notes and treatment plans
3. The initial evaluation will document
   a. Personal and functional goals.
   b. Prognosis and, if possible, timeframes to achieve goals.
   c. Factors that may influence outcomes.
   d. Plan of treatment.
4. Documentation requirements:
   a. Any cancellations or missed appointments will be documented and will include the reason for the missed treatment, if provided.
5. Progress Report:
   a. This report is designed to exhibit the patient's progress and overall response to the initial treatment plan and justifies the continuance of the established treatment plan or the necessity for a change in the initial treatment plan.
   b. After every 10th treatment, a progress report will be prepared that reflects changes in patient status since the start of treatment and changes since the previous progress report.
      - Reassessment will be done sooner if there is a significant change in patient's condition or diagnosis.
      - The progress report will be completed by the treating/licensed therapist. Progress or changes documented will be stated in behavioral, objective, functional and

measurable terms (i.e., range of motion, strength, endurance, gait) where indicated.

c. Any changes in the treatment plan will be made by the treating therapist based on objective findings and in consideration of any necessary medical direction.

d. Each progress summary may include as needed;

- Comparison of all objective data (range of motion, strength, special testing, etc.) to initial findings;
- Comparison of all subjective data;
- Objectives and current patient progress;
- Necessity to modify initial objectives;
- Necessity to modify the treatment plan;
- Signature of therapist.

6. Daily Treatment Note:

a. Each treatment will be documented appropriately.

b. All treatment given, subjective comments or complaints, response to treatment and patient progress must be stated.

c. Only individuals authorized to document in the patient's medical record, according to state law, document in the record. For each treatment session, there will be documentation which includes, but is not limited to, the following information:

- Date of treatment;
- Area of treatment;
- Treatment given, including length of time for each procedure and intensities or total treatment time, if applicable;
- Any formal or informal education;
- Review of or instruction in home exercise/care programs, including any instruction provided to the patient's family or primary caregiver. Include a statement of the patient's demonstration of the covered aspects of the program(s) and understanding of the covered aspects;

- Subjective comments or complaints made by the patient;
- Objective findings;
- Positioning of patient during treatment(if different from the usual and dictated by the patient's medical condition);
- Patient's response to treatment;
- Plan for continuation or discontinuation of treatment;

7. Discharge summary

a. Will be included as part of the final patient visit.

b. All information concerning the patient's clinical condition will be compared to information contained in the initial evaluation.

c. Subjective comments by the patient relevant to his or her overall recovery should be included.

d. The Discharge Summary lists the patient's final outcome and whether the long-term objectives were achieved.

- A discharge plan will be part of this report and will include any specific instructions given to the patient, including follow-up care, instructions for the prevention of physical dysfunction and instructions on progressing in a home care environment.
- Total number of treatments as an outpatient
- Comparison of all objective data (range of motion, strength, special testing) to initial findings;
- Comparison of all subjective data and/or patient complaints;
- Goals and achievement of those goals, or lack thereof;
- Discharge plans and instructions provided;
- Reason(s) for discharge;
- Progress toward goal achievement;
- Final outcome status;

- Any special discharge care needs (discussions with other members of the health care team);
- Date of discharge;

REFERENCES:

Centers for Medicare and Medicaid Services. (2022, May). *Complying with Outpatient Rehabilitation Therapy Documentation Requirements.* Medicare Learning Network. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/outptrehabtherapy-booklet-mln905365.pdf

SUBJECT: **ABBREVIATIONS IN THE MEDICAL RECORD**	SECTION:

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

PURPOSE:

To define the standardized abbreviations and symbols acceptable for use in the medical record at Sierra View Medical Center.

POLICY:

There shall be an approved abbreviation list available for use throughout the Hospital. Only abbreviations from this list shall be used in the medical record.

Only those abbreviations from the medical staff list of approved abbreviations will be utilized for documentation.

Pre-printed forms shall not include any abbreviations identified on the "Do Not Use" list. All pre-printed forms include, but not limited to, physician orders forms, protocols, clinical practice guidelines and pathways.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL DEPARTMENTS*

PROCEDURE:

1. The HIM Director, Vice President of Patient Care Services and the Vice President of Quality and Regulatory Affairs shall have the authority to add, delete, and otherwise update the abbreviation list as the needs of the hospital shall dictate.

2. The abbreviation list shall be submitted to the Medical Executive Committee for review and approval.

3. The abbreviation list shall be an addendum to this policy and shall be available in all copies of the manual.

REFERENCE:

- The Joint Commission. (2025). Hospital accreditation standards. IM.02.02.01. Joint Commission Resources, Oakbrook Terrace, Illinois

CROSS REFERENCE:

- Health Information Management Policy: Subject: Medical Record – Unacceptable Abbreviations and Symbols.

SIERRA VIEW MEDICAL CENTER
APPROVED ABBREVIATION LIST
ATTACHMENT A

A

@	at
a	before
A1	aortic first sound
A2	aortic second sound
aa	of each
A	assistance
AAA	abdominal aortic aneurysm
AaDO2	alveolar-arterial oxygen difference
AAROM	active assisted range of motion
A&O	alert and oriented
A&P	auscultation and percussion
AB	abortion
ABD	abduction
abd	abdomen
abd pol	abductor pollicis
ABG	arterial blood gas
abn	abnormal
ABX	antibiotics
a.c.	before meals
AC	acromioclavicular
ACL	anterior cruciate ligament
ACLS	Advanced Cardiac Life Support
ACT	activated clotting time
ACTH	adrenocorticotrophic (hormone)
ACVD	arteriosclerotic cardiovascular disease
A.D.	right ear (auris dextra)
ADA	American Diabetic Association
Adapt.	Adaptive
ADC	average daily census
ADD	attention deficit disorder
ADH	antidiuretic hormone
ADL	activities of daily living
ad lib	as desired
add pol	adductor pollicis
ADM	administrative
adm	admission
adq	abductor digiti quinti (muscle)
AE	above elbow
AFB	acid fast bacilli
A-fib	atrial fibrillation

ag	antigravity
AgNO3	silver nitrate
A/G Ratio	albumin-globulin
AGA	appropriate for gestational age
AGE	acute gastroenteritis
AHD	acute hemodialysis
AI	aortic insufficiency
AIDS	autoimmune deficiency syndrome
AIN	allergic interstitial nephritis
AK	above knee
AKA	above knee amputation
alb	albumin
alk.p'tase	alkaline phosphatase
alk.	alkaline
ALOC	altered level of consciousness
ALS	amyotrophic lateralizing sclerosis
a.m.	morning
AMA	Against Medical Advice
amb	ambulatory
AMI	acute myocardial infarction
amp	ampule
amt	amount
anes	anesthesia
angio	angiogram
ANS	autonomic nervous system
ant	anterior
A/O	alert and oriented
AOCD	Anemia of chronic dsease
AODM	adult onset diabetes mellitus
AP	anterior-posterior
APAP	acetaminophen (not abbrev. brand name)
APB	abductor pollicis brevis
APL	abductor pollicis longus
A/P	auscultation and percussion
ap	apical pulse
approx	approximately
appt	appointment
appy	appendectomy
APS	Adult Protective Services
ARDS	adult respiratory distress syndrome
ARF	acute renal failure
AROM	artificial rupture of membranes
ART	Accredited Record Technician
art.	arterial
art.line	arterial line
artic	articulation

A.S.	left ear (auris sinistra)
AS	arteriosclerosis
ASA	acetylsalicylic acid (aspirin)
ASAP	as soon as possible
ASCVD	atherosclerotic cardiovascular disease
ASD	atrial septal defect
ASHD	arteriosclerotic heart disease
ASIS	anterosuperior iliac spine
ASO	antistreptolysin titre O
Assoc.	association
asst	assistance
as tol	as tolerated
ASVD	arteriosclerotic vascular disease
asym	asymmetrical
A.T.C.	around the clock
A.U.	both ears
auth	authorize(d)
A-V	arteriovenous
AV	arterioventricular
AVB	atrioventricular block
AWMI	anterior wall myocardial infarction
ax	axilla

B

B+C	board and care
Bab.	Babinski
Bact	bacterium(a)
bal	balance
Baso	basophils
BBB	bundle branch block
BBS	bilateral breath sounds
BC	blood culture
BG	blood glucose
BIB	brought in by
b.i.d.	twice daily
bilat; bil	bilateral
BILI	bilirubin
bio	biological
BE	barium enema
BF	breast feeding
BK	below the knee
BKA	below knee amputation
bld	blood
BLE	bilateral lower extremities
BLS	basic life support

BM	bowel movement
BMEVT	bilateral middle ear ventilation tubes
BMR	basal metabolism rate
BMT	bilateral myringotomy/tube placement
BOA	born out of asepsis
BOM	bilateral otitis media
BOME	bilateral otitis media with effusion
BOOP	bilateral organizing obstructive pnemonia
BOW	bag of waters
BP	blood pressure
BPH	benign prostatic hypertrophy
BPPN	benign paroxysmal postural nystagmus
BPPV	benign paroxysmal positional vertigo
BR	bedrest
BRB	bright red blood
B.R.P.	bathroom privileges
Bs; B/S	blood sugar
bs	breath sounds
BS	bowel sounds
BSA	body surface area
BSC	bedside commode
BSGT	bedside glucose tolerance
BSO	bilateral salpingo-oohorectomy
BST	breast stimulation test
BSW	Bachelor of Social Work
BTL	bilateral tubal ligation
BUE	bilateral upper extremities
BUN	blood urea nitrogen
BUR	back up rate
BUS	Bartholin, urethral and Skenes glands
BTL	bilateral tubal ligation
btl.	bottle
bx	biopsy

C

C/O	complaints of
c	with
C	centigrade (celsius)
C&S	culture and sensitivity
Ca	cancer/carcinoma
Ca++	calcium
CABG	coronary artery bypass graft
CAD	coronary artery disease
cal	calorie
Cap.	Capsule

CAPD	continuous ambulatory peritoneal dialysis
CAT	CAT Scan
Cat	cataract
cath	catheter/catheterization
Cauc	caucasian
CAVH	continuous arteriovenous hemoperfusion
CAVHD	continuous ateriovenous hemodialysis
CBC	complete blood count
CBOME	chronic bilateral otitis media with effusion
CBS	chronic brain syndrome
cc	cubic centimeter
CC	chief complaint
CCPD	Continuous Cycling Peritoneal Dialysis
CCS	California Children's Services
C.C.S.	Certified Coding Specialitst
CCU	coronary care unit
CDB	cough & deep breathe
CDC	Centers for Disease Control and prevention
CEA	carcinoembryonic antigen
CEO	Chief Exective Officer
ceph.floc.	cephalin flocculation test
cert.	Certification
cerv.	Cervical
CFO	Chief Financial Officer
CGA	Contact Guard Assist
CHAL	central hyperalimentation dialysis
CHD	coronary heart disease
CHF	congestive heart failure
chg	charge
CHO	carbohydrate
chol	cholesterol
Chole	cholecystectomy
CHT	Certified Hand Therapist
CI	cardiac index
CIE	counter immunoelectrophoresis
CIN	cervical intraepithelial neoplasia
circ	circumcision
CIS	carcinoma in situ
Cl	chloride
Cllig	clear liquid
cm	centimeter
CMCJ	carpometacarpal joint
CMV	cytomegalovirus
CNA	Certified Nurse Assistant
CNM	Certified Nurse Midwife
CNS	central nervous system

CO	cardiac output
c/o	complaint(s) of
CO2	carbon dioxide
Cocci	coccidioicomycosis
Cog	cognitive
COG	center of gravity
comp	compliance
conc.	Concentration
cong.	Congestion/congested
conj.	Conjunctiva(l)
cont.	continuous
contr.	Contractions
COO	Chief Operating Officer
COPD	chronic obstructive pulmonary disease
COS	Chief of Staff
COTA	Certified Occupational Therapy Assistant
C/P	cardiopulmonary
CP	cerebral palsy
cp	cold pack
CPAP	continuous positive airway pressure
CPD	cephalopelvic disproportion
CPK	creatinine phosphokinase
CPM	continuous passive motion
CPR	cardiopulmonary resuscitation
CPS	Child Protective Services
C/R	cardiorespiratory
CRC	Cypress Rehabilitation Center
CRF	chronic renal failure
CRNA	Certified Registered Nurse Anesthetist
Cr nn 2-12	cranial nerves two through 12
CRS	community re-entry skills
CRT	Certified Radiology Technician
C/S	cesarean section
CSF	cerebrospinal fluid
CSM	circulation, sensation, motion
CSOM	chronic suppurative otitis media
C-spine	cervical spine
CST	Certified Scrub Technician
CT	computerized axial tomography
CTR	carpal tunnel release
CTS	carpal tunnel syndrome
ctx	contraction
cu	cubic
cu.in.	cubic inch
C/V	cardiovascular
CVA	cerebrovascular accident

CVD	cardiovascular disease
CVP	central venous pressure
cx	cervix
CXR	chest x-ray

D

D&C	dilation and curettage
D&I	dry and intact
DAT	diet as tolerated
DB	diaphragmatic breathing
DBW	desired body weight
dc	discontinue
dep	dependent
DC	discontinue
dc'd	discontinued
D5W	IV Dextrose, 5% in water
DDS	Doctor of Dental Surgery
DDSc	Doctor of Dental Science
decub	decubitus
demo	demonstrate
Dept	department
diam	diameter
diff	differential
dig.	Digoxin,Lanoxin
dil	dilute(d)
DIPJ	distal interphalangeal joint
disch	discharge
dist	distilled
DJD	degenerative joint disease
DM	diabetes mellitus
DMV	Department of Motor Vehicles
DNR	Do Not Resuscitate
DOA	dead on arrival
DOB	date of birth
DON	Director of Nursing
DPM	Doctor of Podiatric Medicine
DPT	diphtheria, pertussis, tetanus
Dr.	doctor
dr.	dram
drng	drainage
dsg	dressing
DT	diphtheria/tetanus
D.T.'s	delirium tremens
DTRs	deep tendon reflexes
dtr.	daughter

dur.	duration
DVT	deep vein thrombosis
Dx	diagnosis

E

E coli	escherichia coli
e.g.	for example
ea	each
EBL	estimated blood loss
EBV	Epstien-Barr virus
ECF	extended care facility
ECG;EKG	electrocardiogram
ECHO	echocardiogram
Ed	education
ED	emergency department
EDC	estimated date of confinement
EDD	estimated date of delivery
EDW	estimated dry weight
EEG	electroencephalogram
EENT	eye, ear, nose and throat
EFM	external fetal monitor
EGD	esophagogastroduodenostomy
EJ	external jugular
ELF	elective low forceps
elix	elixir
emerg	emergency
EMG	electromyo(myelo)gram
EMS	Electric muscle stimulation
EMT	Emergency Medical Technician
ENG	electroneptagmogram
ENT	ear, nose and throat
EOA	esophagogastric oral airway
EOB	edge of bed
EOM	extraocular movements
eos	eosinophils
EPB	extensor pollicis brevis
EPC	electronic pain control
Epi	epinephrine
epi	epidural
EPL	extensor pollicis longus
Equip	equipment
equiv	equivalent
er	external rotation
ERD	emergency room
ERCP	endoscopic retrograde cholangiopancreatography

ERS	extension rotation sidebend
ES	electrical stimulation
ESR	erythrocyte sedimentation rate
ESRD	end stage renal disease
est	estimated
ESWL	extracorporeal shockwave lithotripsy
et	and
etal	and others
ET	endotracheal
ETA	estimated time of arrival
Etc.	et cetera (and so forth)
ETCO2	end tidal carbon dioxide
ETIOL	etiology
ETOH	ethyl alcohol
ev	eversion
eval	evaluate(ion)
ex	exercise
exam	examination
exp	expiratory
exs	exercises
ext	external
exte	extension
extr	extraction

F

F	fundus
F/B	followed up
FB	foreign body
FBS	fasting blood sugar
F.C.	FlexCare
FCE	functional capacity evaluation
FCH	Fresno Community Hospital
FCU	flexor carpi ulnaris
FDP	flexor digitorum profundus
FDS	flexor digitorum superficialis
fe	female
Fe	iron (ferrum)
FESS	functional endoscopic sinus surgery

Fetal positions and presentations:

LFA(RFA)	left frontoanterior (right)
FP(RFP)	left frontoposterior (right)
LFT(RFT)	left frontotransverse)right)
LMA(RMA)	left mentoanterior (right)

LMP(RMP)	left mentoposterior (right)
LMT(RMT)	left mentotransverse (right)
LOA	left occiput anterior
LOP	left occiput posterior
LOT	left occiput transverse
LSA(RSA)	left sacrum anterior (right)
LSP(RSP)	left sacrum posterior (right)
LST(RST)	left sacrum transverse
ROA	right occiput anterior
ROP	right occiput posterior
ROT	right occiput transverse
FEV	timed forced expiratory volume
FFC	fixed flexion contracture
FFP	fresh frozen plasma
FH	family history
FHM	fetal heart monitor
FHR	fetal heart rate
FHT	fetal heart tones
FI	fiscal intermediary
fib	fibrillation
FIL	fetal intolerance tolabor
Flliq	full liquid
FIM	Functional Independent Measure
Fi02	fraction of inspired oxygen
fl	fluid
fl oz	fluid ounces
flex	flexion
FLM	fetal lung maturity
FMS	fine motor skills
FNP	Family Nurse Practitioner
FOP	foot of bed
FPB	flexor pollicis brevis
FPL	flexor pollicis longus
FR	fluid restriction
Fr.	French
FRC	Functional Residual Capacity
freq	frequency
Fri	Friday
FROM	full range of motion
FRS	flexion rotation sidebend
FS	frozen section
FSH	follicle stimulating hormone
FT	fullterm
ft.	foot(feet)
FTA	fluorescent treponema antibody

F/U	followup
FUO	fever unknown origin
FVC	forced vital capacity
FVD	fluid volume deficit
FVE	fluid volume excess
FWB	full weight bearing
FWW	front wheeled walker
fx	fracture

G

G	gravid
GA	gestational age
GB	gallbladder
GBS	Guillian-Barre' Syndrome
GC	gonorrhea
GCS	Glasgow Coma Scale
gd	good
gen	general (appearance, anesthetic, etc)
GERD	gastroesophageal reflux disease
GH	glenohumeral
GI	gastrointestinal
gm	gram
GMC	gross motor control
gr	grain
GSW	gunshot wound
GT	gastrostomy tube
GTT	glucose tolerance test
gtt	drop
gtts	drops
GU	genitourinary
Gyn	gynecology(ist)

H

(H)	hypodermic into subcutaneous tissue
h	hour
H/H	hemoglobin/hematocrit
H&H	hemoglobin and hematocrit
HA	headache
hams	hamstrings
HB	heart block
HBP	high blood pressure
HCL	hydrochloric acid
HCO3	bicarbonate
Hct	hematocrit

HCVD	hypertensive cardiovascular disease
Hct	hematocrit
HD	hemodialysis
HEENT	head,eyes,ears,nose and throat
HEP	Home Exercise Program
Hep	hepatitis
Hg	mercury
Hgb	hemoglobin
hgm	hemogram
HHA	Home Health Agency
CHHA	Certified Home Health Aide
HHN	Hand Held Nebulizer
HHRN	Home Health Registered Nurse
HHVN	Home Health Vocational Nurse
hi cal	high caloric
hi chd	high carbohydrate
hi pro	high protein
hi vit	high vitamin
HIE	hypoxic encephalopathy
HIV	human immunosuppressive virus
HL	heparin lock
HLP	hyperlipoproteinemia
HM	Human milk
HNP	herniated nucleus pulposus
H/O	history of
HOB	head of bed
HOH	hard of hearing
HONK	Hyperosmolar nonketosis
hosp	hospital
H&P	history and physical examination
HP	hot packs
HPF	high power field (microscopic field)
HPI	history of present illness
HPPE	hyperpermeability pulmonary edema
HR	heartrate
hr	hour
h.s.	at bedtime
ht	height
HTL VIII	lab test for AIDS virus
HTN	hypertension
H2O	water
H2O2	hydrogen peroxide
HVD	hypertensive vascular disease
Hx	history
H20	water

I

I	independent
I131	radioactive iodine
IABP	intra-aortic balloon pump
IAC	ineffective airway clearance
IBCLC	International Board Certified Lactation Consultant
ibid	in the same place (ibidem)
IBW	ideal body weight
IC	iliac crest
ICN	Infection Control Nurse
ICP	intracranial pressure
ICS	intraclavicular space
ICT	intermittent cervical traction
ICU	Intensive Care Unit
ID	identification
I&D	incision and drainage
IDDM	insulin dependent diabetes mellitus
i.e.	that is (id est)
IGE	impaired gas exchange
IHSS	idiopathic hypertrophic subaortic stenosis
ILS	independent living skills
IM	intramuscular
IMI	brand name abbreviation for a radiant
Imp.	impression
IMV	intermittnet mandatory ventilation
in.	inch
inc.	increase
inf	inferior
inf mono	infectious mononucleosis
init	initial
inj	injection
insp	inspiration(ory)
int	internal
INTF	interferential
I&O	intake and output
IOL	intraocular lens
IPD	Intermittant Peritoneal Dialysis
IPJ	interphalangeal joint
IPPB	intermittent positive pressure breathing
I.Q.	intelligence quotient
IR	internal rotation
irrig	irrigate
I/S	incentive spirometry
ISE	internal scalp electrode

IUD	intrauterine contraceptive device
IUP	intra uterine pregnancy
IUPC	intrauterine pressure catheter
IV	intravenous
IVAB	intravenous antibiotics
IVC	inspiratory vital capacity
IVF	IV fluids
IVP	intravenous pyelogram(phy)
IV push	intravenous push
IVPB	intravenous piggyback
IVSS	intravenous soluset

J

J.P.	Jackson Pratt (hemovac/bulb)
JRA	juvenile rheumatoid arthritis
JV	jugular venous
JVD	jugular venous distention
JVP	jugular venous pressure or pulse
jt.	joint

K

K	potassium
KCI	potassium chloride
KDDH	Kaweah Delta District Hospital
kg	kilogram
K&K	Kline and Kohlmer (test for syphilis)
KUB	kidneys, ureters, bladder (x-ray)
KVO	keep vein open

L

L	liter
LAB	laboratory
LAD	lactic acid dehydrogenase
Lap	laporoatomy
LAO	left anterior oblique
LAQ	long arc quads
lat	lateral
LBBB	left bundle branch block
LBQC	large base quad cane
lb	pound
LC	Lactation consultant
LCL	lateral collateral ligament
LCSW	Licensed Clinical Social Worker

LD	left deltoid
LDH	Lindsay District Hospital
LE	lupus erythematosus
LF	left forearm
LFT	lower function test
Lg	large
LGA	large for gestational age
Litho	lithotripsy
LLE	left lower extremity
LLH	left lateral heelstick
LLL	left lower lobe
LLQ	left lower quadrant
LMH	left medial heelstick
LMP	last menstrual period
LOB	loss of balance
LOC	loss of consciousness
LOS	length of stay
LP	lumbar puncture
LR	lactated ringers
LS	lumbosacral
L-spine	lumbar spine
LSC	left subclavian
LSD	lysergic acid diethylamide
Lt	left
LTV	long term variability
LUE	left upper extremity
LUL	left upper lobe
LUQ	left upper quadrant
LVF	left ventricular failure
LVH	left ventricular hypertrophy
LVN	Licensed Vocational Nurse
L&W	living and well
LWBS	left without being seen
lymph	lymphocyte
lytes	electrolytes

M

M	male
m	minim
M1	mitral first sound
M2	mitral second sound
MA	milliamperes
MAC	monitored anesthesia care
macro	macrocytic(scopic)
MAE	moves all extremities

man.	manual(ly)
MAR	medication administration record
MAT	multifocal atrial tachycardia
max.	maximum
MAX A	maximum assistance
MCA	motorcycle accident
mcg	microgram
MCH	mean corpuscular hemoglobin
MCL	mid clavicular line
MCV	mean corpuscular volume
MD	Doctor of Medicine
mec	meconium
MED/SURG	medical/surgical unit
meds.	medications
MEF	maximal expiratory flow
mEq	milliequivalent
mg	milligram
Mg.	Magnesium
mgmt.	Management
mgr.	Manager
MI	myocardial infarction
micro	microscopic(cytic)
mid.	middle
MIN A	minimal assistance
min.	minute
ml	milliliter
Mlat	mediolateral
mm	millimeter
MMT	manual muscle test
mn	midnight
mo.	month
mob.	mobility
mod.	moderate(ly)
MOD A	moderate assistance
MOM	milk of magnesia
Mon.	Monday
monos	monocytes
MR	mitral regurgitation
MRI	Magnetic Resonance imaging
MRSA	methicillin resistant staphylococcus aureus
MS	morphine sulfate
M/S	multiple sclerosis
MSG	massage
MSS	medical social services
MSW	Medical Social Worker
MT	Medical Technologist

MTT	manual therapy
M+T	myringotomy and tubes
multip	multiparous
MVA	motor vehicle accident
MVP	mitral valve prolapse
MVV	maximum voluntary ventilation

N

N	nitrogen
N/A	not applicable
Na	sodium
N.A.	nursing assistant
NaCl	sodium chloride
NAD	no acute distress
NaHCO3	sodium bicarb
NB	newborn
NBN	newborn nursery
N/C	no charge
neg	negative
neuro	neurology(ist)(ical)
NG	nasogastric
NGT	nasogastric tube
NH3	ammonia
NICU	Neonatal Intensive Care Unit
NIDDM	noninsulin dependent diabetes
NKA	no known allergies
NKDA	no known drug allergies
NKDC	nonketotic diabetic coma
NKHHC	nonketotic hyperglycemic-hyperosmolar coma
nl	normal
NMES	Neuromuscular Electrical Stimulation
NN	nerves
No.	number
noc	at night (nocturia)
norm.	normal
NP	non-productive
NPO	nothing by mouth
NS	normal saline
N/S	no show
NSA	no significant abnormality
NSAID	nonsteroidal anti-inflammatory drugs
nsg.	nursing
NSR	normal sinus rhythm
NST	non-stress test
NSY	nursery

NT	non-tender
N/T	not tested
N&T	nose and throat
NTG	nitroglycerine
nullip	nulliparous
N&V	nausea and vomiting
NWB	nonweight bearing

O

O2	oxygen
OA	occiput anterior
OB	obstetrics
obl	oblique
OBS	organic brain syndrome
occ	occasional
OCG	oral cholecystogram
OCT	oxytocin challenge test
O.D.	right eye
od	overdose
OK	okay
OM	otitis media
OME	otitis media with effusion
OOB	out of bed
OPD	outpatient department
ophth	opthalmology
OPS	outpatient surgery
OR	operating room
ORIF	open reduction internal fixation
ortho	orthopedics
O.S.	left eye
os	mouth
O.T.	occupational therapy
O.U.	both eyes
oz	ounce

P

p	after
P	pulse
pa	pulmonary artery
PA	Physician Assistant
P&A	percussion and auscultation
PA-C	Physician Assistant-Certified
PAC	premature atrial contractions
PACO2	partial pressure carbon dioxide (arterial)

PACU	post anesthesia care unit
PAEDP	pulmonary artery end diastolic pressure
PAF	paroxysmal atrial fibrillation
PAFIB	paroxysmal atrial fibrillation
PA&L	poseterior, anterior and lateral chest x-ray
palp	palpate(ion)
PAP	Papanicolaou smear(test)
PAR	post anesthesia room
Para	parous(number of viable children)
PAT	paroxysmal atrial tachycardia
pap	papanicolaou, smear test
para	parity
path	pathology
PAWP	pulmonary artery wedge pressure
PBI	protein bound iodine
p.c.	after meals
PCA	patient controlled analgesia
PCE	physical capacity evaluation
PCL	posterior cruciate ligament
PCN	penicillin
pCO2	partial pressure CO2
PCV	packed cell volume
PCWP	pulmonary capillary wedge pressure
PDA	posterior descending artery
PDR	Physician's Desk Reference
PE	physical examination
PE tubes	pressure equalizaer tubes
ped.	pediatric
PEG	percutaneous endoscopic gastrostomy
PEEP	positive end expiratory pressure
per	by or through
peri	perineal
PERRLA	pupils equal, regular, react to light and accommodation
pf	plantar flexion
PF	peak flow
PFT	pulmonary function test
pg.	page
pH	hydrogen iron concentration
PH	past history
phal	phalanx
PI	present illness
PID	pelvic inflammatory disease
PIP	proximal interphalangeal joint
Pit	pitocin
PJC	premature junctional contractions
PKU	phenylketonuria

P.M.	afternoon
PMD	private medical doctor
PMH	past medical history
PMI	point of maximum impulse
PMR	polymyalgia rheumatura
PMS	premenstrual syndrome
PN	parenteral nutrition
PNC	premature nodal contraction
PND	paroxysmal nocturnal dyspnea
pneumo	pneumoencelphalogram
PNG	peripheral nerve glides
P.O.	phone order
p.o.	per mouth
pO2	partial pressure of oxygen
pO4	phosphate
POC	position of comfort
POD	postoperative day
Polys	polymorphonuclear leukocytes
POS	positive
post	posterior
postop	postoperative
POT	plan of treatment
POV	private vehicle
PP	postpartum
P&PD	percussion and postural drainage
PPD	purified protein derivative (tuberculin)
PRBC	packed red blood cells
PRBOW	prolonged ruptured bag of waters
pre	before
preg.	pregnancy
preop	preoperative
prep	preparation
prev.	previous
primip	primiparous (first birth)
prn	as necessary; when indicated
PROM	premature rupture of membranes
iPROM	prolonged ruptre of membranes
prog	progress
pro time	pro-thrombin time
prox.	Proximal
PSIS	posterior superior iliac spine
P.T.	physical therapy(ist)
PT/PTT	pro-thrombin/partial thromboplastin (time)
pt	patient
PTA	Physical Therapy Assistant
P.T.A.	prior to admission

PTC	prior to consult
PUD	peptic ulcer disease
PUW	pick-up walker
PVC	premature ventricular contractions
PWB	partial weight bearing
PXR	portable chest xray

Q

q	every
qam	every morning
qh	every hour
qhs	every bedtime
qid	four times a day
qns	quantity not sufficient
qs	to make sufficient quantity
qt	quart
QUAD	quadrant
quads	quadriceps

R

R	right
(R)	rectal thermometer
RA	rheumatoid arthritis
Rad	radiology
RB	read back
RBBB	right bundle branch block
RBC	red blood cell
RBOW	ruptured bag of water
RBS	random blood sugar
RCNA	restorative certified nursing assistant
R.D.	Registered Dietitian
RDS	respiratory distress syndrome
recert.	recertification
reg.	regular
rehab	rehabilitation
reps	repetitions
resp.	respiration(ory)
resist.	resistance
Rh	Rhesus factor
RHD	rheumatic heart disease
RHIT	Registered Health Information Technician
RL	ringers lactate
RLE	right lower extremity
RLH	right lateral heel

RLL	right lower lobe
RLQ	right lower quadrant
RMH	right medial heel
RML	right middle lobe
RN	Registered Nurse
RNA	ribonucleic acid
RNFA	Registered Nurse First Assistant
RNIP	Registered Nurse Interim Permittee
R/O	rule out
RO	routine orders
ROA	right occiput anterior
ROM	range of motion
ROP	right occiput posterior
ROS	review of systems
ROT	right occiput transverse
rot	rotation
RP	renal panel
RPR	rapid plasma regain test (for syphilis)
RR	respiratory rate
rrot	right rotator cuff
RSV	respiratory syncytial virus
R/T	released to
RTW	return to work
RTC	return to clinic
RUE	right upper extremity
RUL	right upper lobe
RUQ	right upper quadrant
RV	right ventricle
Rx	prescription

S

s	without
SAB	spontaneous abortion
sang.	Sanguineous
SAQ	short arc quads
Sat	Saturday
sat	saturated
SBA	stand by assist
SBO	small bowel obstruction
SCH	supra condylar humerus
Schiz	shizophrenia
SCI	spinal cord injury
SCM	sternocleidomastoid (joint)
sec	second(s)(ary)
sed.rate	erythrocyte sedimentation rate (blood)

segs	segmented neutrophils
serol.	serology
serosang.	Serosanguineous
SF	side flexion
SFB	superficial femoral artery
S/G	Swan-Ganz
SGA	small for gestational age
SGOT	serum glutamic oxaloacetic transaminase
SGPT	serum glutamic pyruvic transaminase
SH	social history
Shldr	Shoulder
SI	sacroiliac joint
SIADH	syndrome of inappropriate antidiuretic hormone secretion
SL	sublingual
SLE	systemic lupus erythematosus
SLR	straight leg raising
SNF	skilled nursing facility
SOAP	subjective/objective/assessment/plan
SOB	shortness of breath
sol	solution
SOM	serous otitis media
S/P	status post
spec	specimen
SPgr	specific gravity
SR	sinus rhythm
SROM	spontaneous rupture of membranes
ss	one half
SS	soapsuds
SSE	soapsuds enema
SS#	social security number
S/S	signs and symptoms
stab	band cell
staph	staphylococcus
stat	at once
strep	streptococcus
STSG	split thickness skin graft
STV	short term variability
St WP	sterile whirlpool
Sub-L	sublingual
Sub-Q	subcutaneous
Sun.	Sunday
sup	superior
surg	surg(ical)ery
SVD	spontaneous vaginal delivery
SVDH	Sierra View District Hospital
SVT	supraventricular tachycardia

Sx	symptom
sym	symmetrical

T

T	thermoscan (thermometer)
T&A	tonsillectomy and adenoidectomy
tab	tablet
TAB	therapeutic abortion
T&C	type and crossmatch
TAH	total abdominal hysterectomy
TAR	treatment authorization request (MediCal)
TAT	tetanus antitoxin
T.B.	tuberculosis
TBA	to be admitted
T.C.	traffic collision
Tbsp	tablespoon
TCDB	turn, cough, deep breathe
TCDHS	Tulare County Department of Health Services
TCU	Transitional Care Unit
TEA	thromboendarterectomy
tech	technician(ologist)
TED	antithromboembolic stockings
temp	temperature
TENS	transcutaneous electrical nerve stimulator
TFT	Thyroid Function Test
THEX	therapeutic exercise
THR	total hip replacement
thru	through
Thur.	Thursday
TIA	transient ischemic attack
TIC	transitional inpatient care
tid	three times a day
tinct	tincture
TJR	total joint replacement
TKO	to keep open
TKR	total knee replacement
TLC	triple lumen catheter
TM	tympanic membrane
TMJ	temporomandibular joint
TMJD	temporomandibular joint dysfunction
TMs	tympanic membranes
TNS	transcutaneous nerve stimulation
TO	telephone order
tol.	tolerate(d)
TOLAC	trial of labor after cesarean

tomo	tomogram
TORB	telephone order read back
TORCH	toxoplasmosis, syphilis, rubella, cytomegaloviras, herpes
TPA	tissue plasminogen activator
TPN	total parenteral nutrition
TPR	temperature, pulse, respiration
TR	transfer
trach	tracheostomy
tsp	teaspoon
T-spine	thoracic spine
Tues.	Tuesday
T.U.R.	transurethral resection
TURBT	transurethral resection of bladder tumor
TURP	transurethral resection of prostate
TVH	total vaginal hysterectomy
TV	tidal volume
Tx	treatment

U

U	uranium
Ua	urinalysis
UAC	umbilical artery catheter
U/C, UC	uterine contraction
UBW	usual body weight
U.C.	unit clerk
UCG	urine chorionic gonadotropin
UGI	upper gastrointestinal
UE	upper extremity
UF	ultrafiltration
UKE	unknown etiology
UMC	University Medical Center
UO	undetermined origin
Upper GI	upper gastrointestinal
URI	upper respiratory infection
Uro	urology(ist)
U.S.	both eyes
US	ultrasound
USP	United States Pharmacopoeia
UTI	urinary tract infection
UV	ultraviolet

V

VA	visual acuity
Vag	vaginal

VBAC	vaginal birth after cesarean section
VC	vital capacity
VCH	Valley Children's Hospital
VD	venereal disease
VDRL	Venereal Disease Research Laboratory
VE	vaginal exam
Vent	mechanical ventilator
VFD	visual field deficit
V-fib	ventricular fibrillation
via	by way of
Vit	vitamin
VO	verbal order
vol	volume
VORB	verbal order read back
VPB	ventricular premature beat
Vre	Vancomycin Resistant Enterococci
VS	vital signs
v, vs	versus
VSD	ventriculoseptal defect

W

w/a	while awake
WB	weight bearing
WBAT	weight bearing is tolerated
WBC	white blood count(cells)
W/C	wheelchair
WDWN	well developed, well nourished
W &	white female
W %	white male
Wed.	Wednesday
WFL	within functional limits
WIC	Women, Infants & Children (assistance program)
wk	week
wlkr	walker
wnd	wound
WNL	within normal limits
w/o	without
WP	whirlpool
wt	weight

X

x	times
XRT	radiation therapy

Y

yd.	yard
yrs	years

SUBJECT: **AID IN DYING**	SECTION: **Page 1 of 1**

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

PURPOSE:

To describe the position of Sierra View Medical Center (SVMC) regarding physician-assisted death under the California End of Life Option Act and to provide guidance in caring for patients who express interest in ending their life under the Act.

POLICY:

A. Patients, families, nurses, physicians and other providers are encouraged to explore fully and discuss care and treatment options for terminally ill patients. As part of that discussion, requests for physician-assisted death or self-administered life-ending medication may occur. We respect the rights of patients and their care team to discuss and explore all treatment options; however, SVMC programs and caregivers do not participate in any way in assisted death. Any member of a patient care team may respond to questions from a patient and family, but any request for planning of physician-assisted death must be referred to an "attending physician," as defined in the Act.

B. SVMC physicians, employees, contractors, and volunteers may not knowingly participate in or facilitate physician-assisted death and may not provide, deliver, administer, or assist with the administration of any medication intended for physician-assisted death, or be present when a patient ingests medications with the intent of completing physician-assisted death.

C. When a patient expresses intent to pursue physician-assisted death, the patient will be informed that SVMC will not participate or assist in that act and its physicians, employees, contractors, and volunteers will not provide, deliver, administer or assist the patient with the lethal prescription. SVMC caregivers will still provide all other requested end-of-life and palliative care and other services to patients and families.

D. Consistent with this policy, SVMC will continue to provide care to patients who qualify for and request services, regardless of their stated interest in seeking physician-assisted death.

AFFECTED PERSONNEL/AREAS: *ALL AREAS*

REFERENCES:

- End of Life Option Act. Health and Safety Code 443 (2016). Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=1.&title=&part=1.85.&chapter=&article=.

SUBJECT: **ALDRETE PACU SCORING SYSTEM**	SECTION:

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

PURPOSE:

To establish cohesiveness and uniformity in the interpretation of discharge criteria for post-operative patients.

POLICY:

- The patient is evaluated using the Aldrete scoring system on admission to the Post Anesthesia Care Unit (PACU) and at least every 30 minutes while in Phase I.
- An evaluation is always done prior to discharge from the PACU or unit where patient is being recovered. A score within 2 points of pre-op is required for discharge, except on written orders from the anesthesiologist. There may be gray areas; these can include not fully oriented for a variety of pre-existing conditions, such as senility, aphasia, organic brain syndrome or developmental disability.

AFFECTED AREAS/PERSONNEL: *PACU REGISTERED NURSES, ENDOSCOPY REGISTERED NURSES, MATERNAL & CHILD HEALTH REGISTERED NURSES, AND ANESTHESIA PROVIDERS*

PROCEDURE:

The Aldrete scoring assessment is found in the Phase I and Phase II assessments.

1. Each parameter is rated on a scale of 0-2, the latter being the highest score.

   a. Motor Activity: An evaluation of the muscular activity of the body.

      2 = Moves 4 extremities vol/command
      1 = Moves 2 extremities vol/command
      0 = Moves 0 extremities vol/command

   b. Respiration: to evaluate respiratory efficiency.

      2 = Deep breathe & cough freely
      1 = Dyspnea or limited breathing
      0 = Apneic

   c. Circulation:

      2 = B/P + or - 20mmHg of pre proc level
      1 = B/P + or – 20 to 50mmHg of pre proc level
      0 = B/P + 50mmHg of pre proc level

d. Neurologic Status:

2 = Fully awake and oriented
1 = Arousable on calling – drifts to sleep
0 = Not responding or responds to pain

e. Oxygen Saturation:

2 = O2 sat > or = to 92% on room air
1 = Needs O2 for O2 sat > or = 90%
0 = O2 sat < 90% even with O2

The Aldrete score must be documented in the electronic chart in the SUR application.

REFERENCES:

- American Society of PeriAnesthesia Nurses. (2022). *Perianesthesia Nursing Standards Practice Recommendations and Interpretive Statements.* Cherry Hill, NJ: American Society of PeriAnesthesia Nurses.

- Association of Women's Health, Obstetric and Neonatal Nurses. (2019) *Perioperative Care of the Pregnant Woman, Evidence Based Clinical Practice Guidelines, 2nd Ed.* Washington, DC: Association Of Women's Health, Obstetric and Neonatal Nurses.

SUBJECT: **APNEA TEST**	SECTION: **Page 1 of 2**

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

PURPOSE:

To determine brain death.

POLICY:

To provide a secondary method to assess ventilator dependent patient for brain death. This can be used to determine if an EEG should be performed.

AFFECTED PERSONNEL/AREAS: *RESPIRATORY CARE PRACTITIONER*

PROCEDURE:

1. Physician order
2. Pre-oxygenate with 100% FI02 for at least 10 minutes.
3. Draw a baseline ABG.
4. Disconnect ventilator and provide passive O_2 via tubing @ 4-6 L/min.
5. Observe for spontaneous breathing.
    - Test should be discontinued if SpO2 falls below 80% for >30seconds.
6. Draw ABG at 8 to 10 minute intervals; conclude test when PaCO2 is 20mmHg greater than the baseline PaCO2 or if patient becomes hemodynamically unstable.*
7. Reconnect the ventilator.
8. Test is consistent with brain death if $PaCO_2$ is 20mmHg greater than the baseline PaCO2 and there is no breathing.

***If patient becomes hemodynamically unstable, immediately draw ABG and reconnect the ventilator. Consider other confirmatory tests.**

REFERENCES:

- Goldemund, D. (2023). Apnea test for brain death diagnosis. *Stroke Manual treatment and prevention*. Updated January 2025. https://www.stroke-manual.com/apnea-test-brain-death/

- Pediatric and Adult Brain Death/Death by Neurologic Criteria Consensus Guideline. Report of the AAN Guidelines Subcommittee, AAP, CNS, and SCCM. (2023). *Neurology*, 101 (24), 1112-1132. https://www.neurology.org/doi/10.1212/WNL.0000000000207740#sec-4

SUBJECT:	SECTION:
ATTIRE IN THE OPERATING ROOM, ENDOSCOPY, CENTRAL PROCESSING, OBSTETRICS, INTERVENTIONAL RADIOLOGY, CARDIAC CATH LAB	**Page 1 of 4**

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

PURPOSE:

To provide guidance to perioperative personnel about surgical attire, including scrub apparel, shoes, and head coverings, worn in the semi-restricted and restricted areas. The expected outcome is that the patient will be free from signs and symptoms of infection.

POLICY:

- Clean surgical attire will be worn in semi-restricted and restricted areas.
- Individuals who enter semi-restricted and restricted areas will wear scrub apparel that has been at the health care–accredited laundry facility or at the health care organization.
- The health care worker's arms may be covered during performance of preoperative patient skin antisepsis.
- The health care worker's scalp and hair will be covered in the semi-restricted and restricted areas.
- The health care worker's beard will be covered in the restricted areas and during preparation and packaging of items in the clean assembly section of the sterile processing department.
- Shoes worn within the perioperative environment will be clean and meet the health care organization's safety requirements.
- Stethoscopes will be cleaned and disinfected before each patient use.
- Personal items brought into the semi-restricted and restricted areas will be cleaned and disinfected or contained.
- Personal electronic devices will be cleaned and disinfected before they are brought into the OR.
- Visitors entering the semi-restricted or restricted areas of the surgical suite will don either clean surgical attire or a single-use jumpsuit that completely covers personal attire.

AFFECTED AREAS/ PERSONNEL: *MAIN OR, ASD, MCH-OR, ENDOSCOPY, CPD, IR, CARDIAC CATH LAB*

PROCEDURE:

1. After each daily use, leave scrub apparel at the health care facility to be laundered per facility policy.
2. Remove attire that has been penetrated by blood, body fluids, or other potentially infectious materials immediately or as soon as possible and replace with clean attire.
3. Bag or containerize the contaminated, soiled, or wet attire and leave it at the location where it was used. Do not rinse or sort the attire.
4. After each daily use, leave scrub apparel at the health care facility to be laundered per facility policy.
5. Remove surgical attire before leaving the health care facility.

Long Sleeves

1. Arms may be covered with long sleeves during performance of preoperative patient skin antisepsis.

Head Coverings

1. Cover your scalp and hair when entering the semi-restricted and restricted areas.
2. Cover your beard when entering the restricted areas and while preparing and packaging items in the clean assembly section of the sterile processing department.
3. Remove head coverings at the end of the shift or when contaminated.
4. Leave reusable head coverings contaminated with blood, body fluids, or other potentially infectious material at the health care facility for laundering.

Shoes

1. Wear shoes that are clean.
2. Wear fluid-resistant shoe covers or boots when gross contamination can be reasonably anticipated.
3. Remove single-use shoe covers worn as personal protective equipment immediately after use, discard them, and perform hand hygiene.

Identification Badges, Access Cards, and Lanyards

1. Clean and disinfect identification badges, access cards, and lanyards and when they become soiled.

Stethoscopes

1. Clean and disinfect stethoscopes before each patient use.

Personal Items

1. Clean and disinfect briefcases, backpacks, and other personal items taken into the semi-restricted or restricted areas or place them in a disposable bag.
2. Clean and disinfect cell phones, tablets, and other personal communication or handheld electronic equipment according to the manufacturer's instructions for use before taking these items into the OR, and perform frequent hand hygiene after using the devices.

Visitor Attire

1. Provide visitors entering the semi-restricted or restricted areas of the surgical suite (eg, law enforcement officers, parents, biomedical engineers) with clean surgical attire or a single-use jumpsuit (eg, coveralls, bunny suit) designed to completely cover personal apparel.
2. Ensure vendors who are required in the OR follow the health care organization surgical attire policy and procedures.

Jewelry

1. Jewelry that cannot be confined within the scrub apparel should not be worn within the semi-restricted or restricted areas.

Masks

1. All persons entering the restricted areas of the surgical suite or Core area shall wear a mask when there are opened sterile items present, or a case is in progress. Surgical masks in combination with eye protection devices such as goggles, glasses with solid side shields, or face shields, must be worn whenever splashes, spray, splatter or droplets of blood, bodily fluids or other potentially infectious materials may be generated and eye, nose or mouth contamination can be reasonably anticipated.
    a. Reusable eye protection, such as goggles, should be cleaned according to the manufacturer's instructions before and after each use.
    b. Single use surgical masks must be worn in the surgical environment where open sterile supplies or scrubbed persons are located. The mask must cover both mouth and nose, and be flush with the sides of the face in such a manner that prevents venting at any point around the mask.
    c. Masks are to be carefully removed and discarded after use by handling only the ties or loops. Masks are not to be tucked in a pocket or saved by hanging around the neck.
    d. Wet masks do not provide a protective barrier and are capable of transmitting blood borne pathogens. A mask contaminated by blood or bodily fluids must be changed as soon as possible.
    e. In the event that a mask tie becomes loose and dangles below the shoulder level of a gown, the surgical gown must be considered contaminated.

DECONTAMINATION AREA: *SURGERY MAIN, ASD, MCH-OR, ENDOSCOPY, CENTRAL PROCESSING DEPARTMENT*

Additional personal protective attire is required in the Decontamination area as delineated below:

- The Occupational Safety and Health Administration (OSHA) exposure control plan outlines potential hazards personnel might encounter on the job. To maintain the Health and Safety of personnel working in a decontamination area, they are required to wear Personal Protective Equipment (PPE). Protective attire must be appropriate for the task being performed. In situations that require the highest level of protection, a Level 4 gown (as defined by ANSI/AAMI) should be used.

- In addition to attire recommendations for semi-restricted and restricted areas, personnel working in the decontamination areas should wear general purpose utility gloves and a liquid resistant covering with sleeves (for example a backless gown, jumpsuit or surgical gown).

Liquid resistant shoe covers should be worn if there is a potential for shoes becoming contaminated and/or soaked with blood or other bodily fluids.

- If there is any risk of splash or splatter, PPE should include a fluid-resistant face mask and eye protection which protects from exposure to splash from all angles.
- Hand washing with soap and water is to be performed after removal of protective attire.

REFERENCES:

- AORN Guideline for Surgical Attire, AORN Standards and Recommended Practices, 2025.

SUBJECT: **BLOOD & BLOOD COMPONENTS, TRANSFUSION REACTION**	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:

To establish guidelines for the handling, determining and reporting of adverse transfusion reactions.

POLICY:

All transfusion reactions shall be handled as an emergency and documented accordingly on the specified transfusion reaction form and submitted to the laboratory.

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

EQUIPMENT:

- 0.9% Normal Saline Solution IV bag
- Primary IV tubing set

PROCEDURE:

1. If a transfusion reaction is suspected, immediately clamp off the blood unit.

2. Keep blood unit and tubing set intact, but disconnect from the IV port, protecting the tubing port connection.

3. Connect an IV bag of 0.9% Normal Saline with new primary tubing set to the injection port closest to the patient.

4. Regulate the IV to keep a vein open rate (25mL/hr).

5. Report symptoms to the physician and notify the blood bank.

   a. If the physician elects to stop the transfusion, notify the blood bank.

      - Enter and administer orders as given by the physician.
      - Complete the blood transfusion reaction form.
      - Call the lab to draw a blood sample.
      - Prepare the blood component bag and blood tubing and return to the blood bank.
      - Collect a urine sample, label it properly, and send to the lab.

   b. If the physician elects to continue the transfusion with symptomatic treatment:

- Notify the Blood Bank of the physician's decision.
- Obtain an order that physician elects to continue transfusion.
- Administer medications (if ordered).
- Observe the patient and continue to take and record the patient's vital signs.
- Update the physician with the patient's condition as needed.

DOCUMENTATION:

1. On the "Transfusion Administration Record"

   a. Note the reactions in the portion entitled "Patient Response to Transfusion"

   b. The most common symptoms are:

   - Fever (2 degree increase from baseline) with or without chills
   - Chest pain
   - Hypotension (30mmHg below baseline)
   - Nausea
   - Flushing
   - Dyspnea
   - Bleeding
   - Hemoglobinuria
   - Rapid onset of rales

   ***The above common symptoms often occur within the first 15 minutes.**

2. Documentation in medical record should include *(Please use "transfusion reaction" intervention):*

   a. Date and time of the reaction

   b. Description of objective and subjective symptoms of the patient

   c. Condition of the patient/ assessment

   d. Physician notified

   e. Vital signs every 15 minutes until stable or as ordered by the physician

   f. Persons contacted and time contacted

g. Samples drawn, e.g. urine/lab draws with times taken

h. Patient's response to the reaction and to interventions, if taken

REFERENCES:

- Nettina, S. (2019). Manual of Nursing Practice, (11th ed., pp. 781). Ambler, PA. Lippincott Williams and Wilkins.
- Kelly, William (2022). Health and Willness. Blood transfusion reactions: a comprehensive nursing guide. obtained from https://healthandwillness.org/blood-transfusion-reactions/

CROSS REFERENCES:

- *BLOOD & BLOOD COMPONENTS, ADMINISTRATION OF* - SVMC policies and procedures

SUBJECT: **HEPATITIS B VACCINATION**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide guidelines for administering Hepatitis B vaccine for newborns to protect them from Perinatal Hepatitis B infection. To protect newborns from Hepatitis B infection if he /she is exposed to the virus later in life.

POLICY:

1. Newborns will be vaccinated for prophylaxis of Hepatitis B infection as ordered by physician and in compliance with Center for Disease Control and Prevention (CDC) and American Academy of Pediatrics (AAP) recommendations.

2. Parental consent must be obtained prior to administration of Hepatitis B vaccination.

3. This is the first of a series of three vaccinations for Hepatitis B.

4. It will be administered to all consented infants, weighing more than 2000 grams prior to discharge.

5. In addition, if mother is Hepatitis B surface antigen (HBsAg) positive and unknown, the infant will receive one dose of Hepatitis B immunoglobulin and the first dose of Hepatitis B vaccine IM at different anatomic sites within 12 hours of birth (after initial bath) *Refer to the policy for administration of HBIG (Hepatitis B immunoglobulin).

AFFECTED AREAS/PERSONNEL: *MCH RN*

EQUIPMENT:

1. Hepatitis B vaccination information paperwork

2. Signed consent for administration of Hepatitis B vaccination to infant

3. Syringe with 25 gauge needle

4. Vial of hepatitis B vaccine:

   a. Recombivax (5 mcg/0.5 mL) **OR**

   b. Engerix – B (10 mcg/0.5 mL)

5. Alcohol swab

6. Vaccine Information Sheet (most recent revision)

SUBJECT: **HEPATITIS B VACCINATION**	SECTION: **Page 2 of 3**

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

PROCEDURE:

1. Give Hepatitis B – Give parents the most recent VIS (Vaccine Information Sheet).
2. Obtain parental consent for vaccine to be administered
3. Wash hands and wear gloves.
4. Prepare medication as ordered and draw into syringe using a one inch 25 gauge needle.
   a. Dosage: Recombivax (5mcg/0.5 ml) **OR**
      Engerix – B (10 mcg/0.5 ml)
5. Cleanse the middle 1/3 of the vastus lateralis muscle with alcohol. The gluteal muscles should NEVER be used as the muscle is underdeveloped and danger of injury to the sciatic nerve is great.
6. Aspirate prior to injecting medication to check for blood return. If blood return, withdraw needle and discard. If no blood return, inject the medication slowly into the muscle.
7. Withdraw the needle quickly and apply pressure to the site. Watch for bleeding.
8.
   a. Second dose in one month
   b. Third dose in six months

DOCUMENTATION:

1. Complete the following documentation on the Electronic Medication Administration Record (EMAR):
   a. Date of administration
   b. Site of administration
   c. Vaccine manufacturer lot number and expiration date
   d. VIS given and date of revision
2. Document infant's response in the EMR.

REFERENCES:

- American Academy of Pediatrics & American College of Obstetrics and Gynecologist . (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors.
- The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Vaccine Information Statement | Hepatitis B Vaccine | VIS | CDC. (2018, October 12). Retrieved May 7, 2019, from https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf.

SUBJECT: **HYPERBILIRUBINEMIA**	SECTION: **Page 1 of 4**

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

PURPOSE:

To outline the risk assessment guidelines and nursing management of the infant/neonatal patient with documented hyperbilirubinemia.

POLICY:

Because most newborn infants develop some degree of jaundice, all newborn infants will be screened for hyperbilirubinemia upon admission, during their hospital stay, and prior to discharge. Visual inspection/assessment for evidence of jaundice will be completed immediately upon birth and will occur with all vital signs up to and including discharge from the hospital.

Bilirubin is formed from the breakdown of erythrocytes. Hyperbilirubinemia may be physiologic or due to multiple factors including hemolytic disease, sepsis or liver dysfunction. Most jaundice is benign, but because of the potential toxicity of bilirubin, newborn infants must be monitored to identify those who might develop severe hyperbilirubinemia and in rare cases, acute bilirubin encephalopathy and kernicterus.

AFFECTED PERSONNEL/AREAS: *CDU REGISTERED NURSES (RNs)* Med/Surg, NICU, Post Partum – RN's.

DEFINITIONS:

Hyperbilirubinemia or jaundice is a yellowing of the skin due to the presence of unconjugated (indirect) bilirubin in the blood from the breakdown of red blood cells.

Bilirubin is a byproduct formed from the breakdown of the red blood cells, which may accumulate to levels that cause the infant's skin and/or sclera to become yellowed.

Kernicterus is free or unconjugated bilirubin that circulates freely in plasma and can easily cross the blood- brain barrier, causing damage to brain cells.

Phototherapy is a treatment used to convert bilirubin in the infant's skin to a more water soluble form which can be secreted into the intestines and excreted through the infant's stool and urine.

PROCEDURE:

Assessment: Risk for Hyperbilirubinemia in Infants:

1. Visual inspection/assessment for evidence of jaundice is to be completed upon admission and every shift.

2. If the infant appears to be jaundiced, the nurse will report to the pediatrician.

EQUIPMENT

- Phototherapy light (Neo-blue) or Bili Blanket
- Bassinet (Infants greater than 2.5 kg)
- Isolette (Infants less than 2.5 kg or demonstrated temperature instability of 36.4 C or 97.5 F).
- Eye protection (Bili-mask)
- Dosimeter (bilimeter)

STEPS FOR INITIATING PHOTOTHERAPY

1. Remove all of the infant's clothing (photo-oxidation is dependent on skin exposure).
2. Fold diaper down where possible to expose skin and yet protect scrotum/ovaries.
3. To prevent injury to the retina by excessive exposure to phototherapy lights, cover the infant's eyes with the Bili mask. Secure in place, making sure the eyes are closed when the mask is applied and the nares are not occluded.
4. Turn on phototherapy light(s) to appropriate setting: single, double or greater.
5. Obtain dosimeter reading with Bili Meter upon initializing phototherapy and each shift
6. Dosimeter intensity

   Low/Single light therapy: 12-14 µW/cm2/nm
   High/double or greater therapy: 30-35 µW/cm2/nm
7. Appropriate distance from infant to bili lights is approximately:

   Bassinet: 4 inches or 10 cm
   Isolette: 15-18 inches or 38-46 cm
8. If the infant is in an open crib or isolette, check infant's temperature every 30 minutes until temperature stabilization has been assured (greater than 98° F).

SUBJECT: **HYPERBILIRUBINEMIA**	SECTION: **Page 3 of 4**

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

FOR BILI BLANKET:

• Fully insert the fiber optic light pad connector into the light box.

• Verify that the air circulation vents on the sides and back of the light box are unobstructed.

• Obtain photometer reading with Bili Meter upon initializing phototherapy and every shift.

• Place the fiber optic light pad on a flat surface. Insert the Bili blanket fiber optic light pad into a Bili blanket pad cover. Replace the disposable cover when it becomes soiled and between patients.

• Place the pad on the mattress with the light emitting side up.

• Remove all clothing from the infant except their diaper. Place the infant with their back directly on the light emitting section of the pad. There should be nothing between the infant's skin and the fiber optic light pad. The infant may be covered or wrapped in a blanket along with the fiber optic light pad, and will receive effective phototherapy treatment as long as the light emitting section of the pad remains in contact with skin.

- When measuring light intensity, use appropriate dosimeter for bili blanket (bili blanket meter). Measurements should be conducted per manual guidelines.
- Small pad measure points (C +D)/2 > or equal to 60.0
- Large pad measure points (D +E+F)/3 > or equal to 40.0

• Discard disposable cover when treatment is completed

DIAGNOSTIC LAB DRAWS:

1. On-going lab draws will be per physician's orders. Physician will be notified promptly of all results.

2. Unmask infant and turn off phototherapy lights during blood draws to prevent false results.

3. Turn off phototherapy lights when drawing blood or bilirubin levels since lights may degrade the bilirubin in the blood.

FEEDINGS:

1. Bili masks are to be removed during feeding and for sensory stimulation at least every 3 to 4 hours for at least 10 minutes, unless order is for continuous therapy per physician. Try to cluster with feeding to reduce the infant's time away from the bili lights.

2. Lights must be off if the mask is removed. Observe the eyes and document any signs of conjunctivitis, erythema, yellow drainage or discharge.

3. Infant should not be out from overhead lights for more than one-half hour at a time.

4. Encourage feedings every 2 or 3 hours or more unless otherwise ordered by the pediatrician. Breast feeding will continue to be promoted and supported during treatment of hyperbilirubinemia. Consult with the physician regarding use of formula with breast feeding if additional fluid is needed.

5. Weigh infant daily and notify physician of any weight loss greater than 10% from the birth weight.

6. Assess and document infant's fluid intake and stool output (I and O) each shift. Notify physician of decreased PO intake and/or decreased urine output.

7. When weighing diapers, output should be greater than 2ml/kg/hr for the previous 12 hours.

TEACHING:

1. Teach parents about the disease process and principals of treatments.

2. Explain procedures, equipment, and transient side effects (loose stools, lethargy, transient rash).

3. Inform parents that their infant will not be discharged until results of any bilirubin levels are obtained.

4. Allow parents time to discuss concerns and ask questions.

5. Inform parents that their infant should be appropriately followed up in their pediatrician's office once discharged, for an assessment of jaundice.

DOCUMENTATION: Document all interventions in the patient's medical record such as: education, time of initiation of phototherapy, dosimeter reading, measurement from light, and eye protection.

REFERENCES:

- Bowden, V. and Smith-Greenburg, C. (2016). Pediatric nursing procedures 4th edition. Lippincott Williams& Wilkins. Fullerton, CA.

- Bilisoft 2.0 Phototherapy System Operation Manual. (2018). Retrieved August 21, 2023 from https://customer-doc.cloud.gehealthcare.com/#/cdp/dashboard/2108689-001/A.

SUBJECT: **HYPERTENSIVE DISORDERS OF PREGNANCY**	SECTION: 10 **Page 1 of 9**

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

PURPOSE:

To outline the clinical management of inpatients who have preeclampsia or other hypertensive disorders of pregnancy, including special considerations for management of patients on magnesium sulfate, patients on antihypertensive medications and management of eclampsia, using the Quality Improvement Framework of Readiness, Recognition, Response, and Reporting to prevent short and long-term severe maternal and perinatal morbidity and mortality.

DEFINITIONS:

Hypertensive disorders of pregnancy constitute one of the leading causes of maternal and perinatal mortality worldwide. It has been estimated that preeclampsia complicates 8-10% of pregnancies globally. Preeclampsia is a hypertensive disorder of pregnancy characterized by vasospasm and endothelial damage, which may impact the cardiovascular, renal, hematological, neurologic, and hepatic systems as well as the uteroplacental unit. It is of unknown etiology.

Hypertensive Disorders of Pregnancy:

1. **Preeclampsia:** SBP of 140 mmHg or greater OR DBP of 90 mmHg or greater on two occasions at least 4 hours apart after 20 weeks of gestation in a woman whose blood pressure had previously been normal AND presence of proteinuria with excretion of 300mg or more protein in a 24 hour urine specimen. Protein/ creatinine ratio of 0.3 or more, or dipstick reading of 2+ (used only if other quantitative methods not available). Preeclampsia may be diagnosed in the absence of proteinuria with new-onset hypertension and any of the following:

    a. Thrombocytopenia: platelet count less than 100 x 10^9/L
    b. Renal insufficiency: serum creatinine concentrations greater than > 1.1mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease.
    c. Impaired liver function: elevated blood concentrations of liver transaminases to twice normal concentration
    d. Pulmonary edema
    e. A new onset headache unresponsive to medications and not accounted for by alternative diagnoses or visual symptoms.

    Preeclampsia may first present in the postpartum woman.

2. **Preeclampsia with severe features:** if one or more of the following occur:

    a. A SBP of 160 mmHg or higher OR a DBP of 110 mmHg or higher on two occasions at least four (4) hours apart while the patient is on bed rest (unless antihypertensive therapy is initiated before this time).
    b. New development of renal insufficiency, increased creatinine of 1.1mg/dl, or doubling of the creatinine in the absence of other renal disease.
    c. Pulmonary edema
    d. Impaired liver function that is not accounted for by the alternative diagnoses and as indicated by abnormally elevated blood concentrations of liver enzymes (to more than twice the upper limit normal concentrations), or by severe persistent right upper quadrant or epigastric pain unresponsive to medications.
    e. Visual disturbances
    f. Thrombocytopenia (platelet count less than 100 x 10^9/L)
    g. New onset headache unresponsive to medication and not accounted for by alternative

3. **Gestational Hypertension**: occurs when hypertension without proteinuria or severe features develops after 20 weeks of gestation and blood pressure levels return to normal in the postpartum period. Management of Gestational Hypertension and Preeclampsia without severe features is similar and both require enhanced surveillance.

   a. **HELLP (Hemolysis, Elevated Liver enzymes, Low Platelets) Syndrome:** System failure in organs throughout the woman. Most often develops from preeclampsia with severe features but in up to 15% of cases it can present with atypical onset lacking either hypertension or proteinuria and in 30% of cases it can first express or progress in the postpartum period.Lactate Dehydrogenase (LDH) elevated >600 IU/L
   b. AST and ALT elevated more than twice the upper limits of normal
   c. Thrombocytoepenia < 100 x 10^9 L

4. **Eclampsia: Convulsive manifestation of Hypertensive Disorders of Pregnancy.** Development of new onset tonic –clonic seizures without a neurological cause, drug use, or fever in patient with a Hypertensive Disorder of Pregnancy.

5. **Chronic Hypertension (CHTN):** Systolic BP (SBP) 140 mmHg or greater OR diastolic BP (DBP) 90 mmHg or greater, or both, diagnosed or present before pregnancy or before 20 weeks of gestation. Hypertension that persists after the 6 weeks postpartum period.

6. **CHTN with Superimposed Preeclampsia**: Sudden onset increased hypertension or increased proteinuria from baseline after 20 weeks in a patient known to have chronic hypertension. New onset thrombocytopenia or elevation of liver enzymes in a patient with chronic hypertension raises suspicion of superimposed preeclampsia and deserves further evaluation. Up to 20-50% of patients with chronic hypertension might develop superimposed preeclampsia.

POLICY:

Prompt and timely recognition of patients with Hypertensive Disorders of Pregnancy and to delineate an evidence based rapid response approach and management guidelines to prevent short and long term severe maternal and neonatal morbidity and mortality..

AFFECTED PERSONNEL/AREAS: *MATERNAL CHILD HEALTH RNs, ICU/TELEMETRY AND EMERGENCY DEPARTMENT (ED) RNs*

PROCEDURE:

1. Accurate Blood Pressure Measurements

Step 1: Prepare Equipment	a. Aneroid sphygmomanometer is the gold standard for measuring BP; Automated equipment are an accepted alternative. b. When using automated BP equipment ensure that it has been calibrated per hospital protocol d. Check cuff for any defaults. e. Obtain correct size cuff; appropriate for patient

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Step 2: Prepare the patient	a. Ensure the patient is sitting or in a semi-recumbent position with the back supported and arm at heart level. If BP must be taken in a recumbent position, place the patient in a left lateral decubitus position with cuff at the level of the right atrium. b. Patient needs to sit quietly for 5 minutes prior to measurement. c. Free the bare upper arm of any restrictive clothing. d. Patient's feet should be flat, not dangling from examination table or bed, and legs uncrossed. e. Assess recent (within previous 30 minutes) consumption of caffeine or nicotine. If BP is at the level that requires treatment, the patient should be treated. Recent use of nicotine or caffeine should not lead to delays in initiating appropriate antihypertensive therapies.
Step 3: Take measurement	a. At time of admission, BP should be taken in both arms; continue BP measurements in arm with higher pressure. b. Support patient's arm at heart level. c. For auscultatory measurement: use first audible sound (Korotkoff I) as systolic pressure and use disappearance of sound (Korotkoff V) as diastolic pressure. D. Read BP level to the nearest 2 mm Hg. e. Instruct the patient not to talk. f. Use the highest reading obtained to determine next steps. g. If BP is ≥ 140/90 mm Hg, repeat within 15 minutes and if still elevated, further evaluation for preeclampsia is warranted. Notify provider. h. Do not reposition patient to either side to obtain a lower BP. Repositioning will give you a false reading.
Step 4: Record Measurement	Document: a. Blood pressure measurement.

2. **Proteinuria Assessment:**
   1) Urine dipstick is an acceptable initial screen. If 1+ or more, obtain sample for protein/creatinine ratio.
   2) Obtain 24-hour urine protein from patients noted with proteinuria pre-pregnancy or during early pregnancy; per physician order.
   3) Obtain urine sample from a urinary catheter in presence of ruptured membranes when confirmation of proteinuria is needed for diagnosis; as a clean catch sample may result in higher protein values

Dipstick	24-hour urine	Protein/Creatinine ratio
2+ for diagnosis 1+ for further screening	≥ 300 mg/24 hours	≥ 0.3

3. Maternal Early Warning Criteria:

1) Notify Physician and charge nurse if any of the following criteria is met:

Parameters	Two or more Triggers	One or more Triggers
Systolic BP mmHg (repeat in 15 minutes)	**<90 or >155-159 mmHg**	**≥160**
Diastolic BP mmHg (repeat in 15 minutes)	**105-109 mmHg**	**≥110**
Mean arterial Pressure	**<65 or >110 mmHg**	**<55**
Heart Rate- beats/minute	**<50 or 110-20**	**>120**
Respiratory rate- breaths per minute	**<12 or 25-30**	**<10 or >30**
Oxygen Saturation- % room air	**<95%**	**<93%**
Oliguria- ml/hr for ≥2 hrs	**35-49 ml/hr**	**<35**
Altered mental status		**Maternal agitation, confusion, unresponsiveness**
Neurologic		**Unrelenting, severe headache unresponsive to medication**
Visual Disturbances		**Blurred or impaired vision**
Physical		**Shortness of breath or epigastric pain**

2) Order appropriate labs and tests
   - CBC, AST, ALT, LDH, BNP, CMP, Serum Creatinine, urine protein, & urine analysis
3) Sustained BP ≥160 systolic or ≥110 diastolic, initiate **Hypertension in Pregnancy Protocol within 30-60 minutes and magnesium sulfate 4 gm bolus (use 6 gm bolus if BMI >35),** followed by maintenance dose 1-2 gm/hour based upon renal status.
4) If O_2 Saturation <93% or RR >24/min, consider pulmonary edema. Supplemental oxygen at 10L per non-rebreather mask.
5) Consider anesthesia consult if indicated
6) If unrelenting neurologic or visual disturbances, consider neurology consult and CT scan to rule out SAH/ Intracranial hemorrhage
7) If Chest Pain, consider CT angiogram

4. Nursing Assessment for Preeclampsia without severe features

Assessment type	Frequency Antepartum	Frequency Intrapartum	Frequency Recovery	Frequency Postpartum
BP, Pulse, Respiration, SpO_2	Q 4 hrs (awake) to 8 hrs (sleeping)	Every 1 hour	Q 15 mins x 4, then Q 30 mins x 2	Q 4-8 hours
Lung auscultation	Q 4-8 hours	Q 4-8 hours	N/A	Q 4-8 hours
DTRs, clonus, level of consciousness, Edema Assessment of headaches, visual disturbances, epigastric pain	Q 4-8 hours depending on patient condition	Q 4-8 hours depending on patient condition	N/A	Q 4-8 hours depending on patient condition
Fetal status and uterine activity	Every shift	Continuous	N/A	N/A
Temperature	As per policy	As per policy	As per policy	As per policy
Intake and output	Q 12 hrs; total q24hsr	Q 4 hrs; total q12hrs	Q 4 hrs	Q 12 hrs; total q24hrs

5. Nursing Assessment for Preeclampsia with severe features on magnesium sulfate

Assessment type	Assessment frequency and action plan
BP, Pulse, Respiration, SpO_2	• Q 5-15 min during magnesium sulfate loading dose • Q 30 min during magnesium sulfate maintenance infusion for 1 hour, then hourly
Lung auscultation	• Q 2 hours
DTRs, edema, level of consciousness	• Q 4 hours or more frequently as per patient condition
Assessment for headaches, visual disturbances, epigastric pain	• Q shift or more frequently as per patient condition
Temperature	• As per protocol
Intake and output	Intake • Use infusion pumps for al IV solutions and medication drips • Ensure total hourly intake should be <125 ml/hr • NPO with ice chips or as permitted by provider Output • Insert urinary catheter • Calculate hourly, with totals q12hr • Notify provider of urine output <30

Fetal status and uterine activity	Continuous fetal monitoring

6. Nursing Assessment for Post Eclamptic seizure and magnesium sulfate toxicity

Assessment type	Assessment frequency
BP, Pulse, Respiration	Q 5 minutes until stable, then use assessment recommendations for patients on magnesium sulfate
SpO_2	Continuous
Level of consciousness	Q 15 minutes for a minimum of 1 hour
Fetal status and uterine activity	Continuous

7. Nursing Assessment for acute BP Treatment with IV Medication

Assessment type	Assessment frequency
BP, Pulse, Respiration	Q 10-20 min until stable, then BP q 10 min x 1 hour, q 15 min x 1 hour, q 30 min x 1 hour and q 1 hour x 4 hours
SpO_2	Continuous
Level of consciousness	Q 5-15 min for a minimum of 1 hour
Fetal status and uterine activity	Continuous until delivery

8. Therapy for severe Hypertension in preeclampsia

1) Hypertensive emergency: acute-onset severe hypertension (≥160 mmHg systolic or ≥110 mmHg diastolic) that is persistent for >15 minutes.
2) BP should be controlled to a level between 130-150 mmHg systolic and 80-100 mmHg diastolic.
3) Consider antihypertensive therapy at 155 mmHg systolic and 105 mmHg diastolic in the presence of other clinically significant co-morbidities.
4) Consider placement of an arterial line in patients when BP is difficult to control or difficult to get cuff measure.
5) Consider alternative medications to Beta Blockers in patients with history of drug use or heart failure

9. First line agents for acute-onset severe hypertension in pregnancy and postpartum

Medication agents	**Labetalol IV**	**Hydralazine IV**	**Nifedipine (immediate release)**
Route	Intravenous	Intravenous	PO
Initial dose	20 mg	5-10 mg	10 mg
Onset	2-5 minutes	10 to 80 minutes	20 minutes
Usual maximum cumulative dose	300 mg	20 to 30mg	50 mg/treatment episode
Typical Dosage	20 mg IV followed by 40 mg IV if not effective within 10 minutes; followed by 80 mg IV if not effective within 10 minutes	5-10 mg IV followed by 5 to 10 mg IV if not effective within 20 minutes	10 mg PO, followed by 10 to 20 mg PO if not effective within 20 minutes; followed by another 10 or 20 mg PO if not effective within 20 minutes

a. In the presence of sinus bradycardia, history of asthma or concern for heart failure hydralazine or nifedipine should be used as first line agents.

b. If maternal HR >110 min, labetalol should be the preferred first line agent.

c. For patients whose BP cannot be controlled using the sequence of two first line agents, consider transferring patient to a higher level of care unit and consult with an anesthesiologist or intensivist to use second line agents within the provider's scope and ensuring to have emergency airway equipment at bedside. These agents are not limited to but may include.

1) Esmolol
2) Propofol
3) Nicardipine

10. Magnesium Sulfate

Loading dose	4-6 gm IV over 20 minutes (BMI >35 requires 6 gm dose
Maintenance dose	1-2 g/hr continuous IV infusion (BMI >35 requires 2 g/hr)

a. Magnesium sulfate should be started upon diagnosis, continued during labor and intraoperatively until 24 hours after delivery.

b. If suspected magnesium sulfate toxicity: hypotension, new-onset loss of DTRs, respiratory depression, respiratory arrest, oliguria, shortness of breath, chest pains
   1) Discontinue magnesium sulfate
   2) Obtain STAT serum magnesium levels
   3) Calcium gluconate: 1000 mg/10 mL IV over 2-5 minutes, repeat doses as needed

c. Magnesium should be used with caution in patients with renal insufficiency (creatinine > 1.1 mg/dl)
   1) Maintenance dose @ 1 gm/hour

d. Magnesium sulfate is contraindicated in patients with Myasthenia Gravis

11. Management of Eclamptic Seizures

Seizure status	Nursing actions at provider discretion on order.
Seizure occurs; No magnesium sulfate infusing	Magnesium sulfate 4-6 gm IV loading dose over 20-30 minutes followed by 1-2 gm/hour maintenance dose if renal function is normal *BMI >35, 6 gm loading, 2 gm/hr maintenance Continue for at least 24 hours after last seizure
Recurrent seizures; magnesium sulfate infusing	Administer additional loading dose of magnesium sulfate 2-4 gm IV over 5 minutes
Recurrent seizure after 2nd loading dose of magnesium sulfate or more than two recurrences	Midazolam 1-2 mg IV, may repeat in 5-10 min Diazepam 5-10 mg IV slowly, may repeat q 15 minutes, usual max dose: 30 mg Phenytoin

a. For recurrent seizures, consult anesthesia for potential airway management, consult neurology and consider head imaging

12. Delivery Consideration

a. The decision to deliver must balance the maternal and fetal risks.
b. For Gestational Hypertension or Preeclampsia without severe features, continued observation is appropriate until 37w 0d of gestation in the absence of abnormal antepartum testing, vaginal bleeding, Preterm Labor or PPROM. At 37w 0d or beyond, delivery is indicated.
c. For Gestational Hypertension or Preeclampsia with severe features, delivery is indicated if diagnosed at or beyond 34w 0d of gestation. Delivery should not be delayed for the administration of steroids at 34w 0d or beyond.
d. For Gestational Hypertension or Preeclampsia with severe features diagnosed at less than 34w0d with maternal and fetal stable conditions, expectant management may be considered. Consider transfer to another institution for a higher level of care and NICU if appropriate. Delivery is recommended at any time in the case of maternal or fetal condition deterioration.
e. Indications for expedited delivery irrespective of gestational age after maternal stabilization:

1) Maternal

- Uncontrolled severe-range hypertension (>160/110) not responsive to antihypertensive medications

- Epigastric or RUQ pain, unresponsive to repeat analgesics

- Visual disturbance, motor deficit or altered sensorium
- Stroke
- Myocardial infarction
- HEELP syndrome
- New or worsening renal dysfunction (serum creatinine >1.1mg/dl or twice baseline)
- Pulmonary edema
- Eclampsia
- Suspected Placental abruption

2) Fetal

- Abnormal fetal testing
- Fetal death
- Fetus without expectation for survival (fetal lethal anomaly, extreme prematurity)

13. Patient and Family Education

Discuss the following using teach back methodology:

a. Nature of disorder
b. Treatment and reasons for treatment
c. Potential side effects of medication
d. Importance of quiet environment with limited visitors
e. Notification of nurse regarding presence of headache, visual changes, epigastric pain, chest pain, dyspnea, etc.

14. Criteria for Hospital Discharge

a. Adequate BP control: no severe-range BP values for > 24 hours.
b. No treatment with IV antihypertensives or immediate release nifedipine for > 24 hours.
c. Patient is asymptomatic and controlled with or without oral antihypertensive medications
d. Provide patient education and postpartum support. Nursing staff should review detailed signs and symptoms of preeclampsia with the patient and family, and provide written instructions indicating what to do should symptoms arise.
e. Patients should be encouraged to get a BP cuff to do home BP monitoring. BP parameters to withhold antihypertensive medications should be provided in writing: < 115 systolic, < 65 diastolic.
f. A follow-up appointment scheduled within 3-7 days of discharge.

15. Postpartum Management

a. Delayed Postpartum Preeclampsia: hypertension that begins 2 or more days after childbirth in women who did not previously have a Hypertensive

delivery, which for many patients, is after postpartum discharge.

b. Patients whom have been discharged and return requiring inpatient care for management of hypertensive disorders during the postpartum period, will be managed in the postpartum unit up to 12 weeks post delivery.
c. The following evaluation is recommended for newly elevated BP ≥140/90 mm Hg or symptoms considered to be severe.
    1) BP values of 160/110 mm Hg or higher should be treated in accordance with the Acute Hypertension treatment protocol
    2) Order CBC, CMP, BNP, Uric acid, Protein/ creatinine ratio
    3) Consider Abdominal US for persistent epigastric or RUQ pain.
    4) Consider Brain CT or MRI for persistent headaches or other neurologic symptoms.
    5) Consider Magnesium sulfate therapy in patients who develop de-novo postpartum severe features and did not receive magnesium sulfate previously.
    6) Retreatment with magnesium sulfate should be considered for patients who represent with severe features after a period of time without severe features (>48 hours).
    7) BP goal should be a BP range of 130-150 mm Hg systolic and 80-100 mm Hg diastolic.
    8) Women who wish to breastfeed their infants should be encouraged to do so as soon as they are able. Use of antihypertensive medications do not preclude breastfeeding.
    9) Appreciating the risk of long-term opioid dependence and abuse, NSAIDS are a critical part of postpartum pain management, and should not be withheld in patients with preeclampsia in the absence of other contraindications.

References

- California Maternal Quality Care Collaborative. Improving Health Care Response to Hypertensive Disorders of Pregnancy. 2021.
- ACOG. Practice Bulletin, Gestational Hypertension and Preeclampsia. Number 222. June 2020.

Cross Reference

- Magnesium Sulfate in the Management of Hypertensive Disorders or Pregnancy

SUBJECT:	SECTION:
INTRA-AORTIC BALLOON PUMP THERAPY	***Patient Care Services***

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

PURPOSE:

To provide safety guidelines for staff caring for patient with a requiring counter pulsation by Intra-Aortic Balloon Pump (IABP).

DEFINITIONS:

Intra-Aortic Balloon Therapy (IABP): A cardiac assist device consisting of an invasively placed balloon catheter (IABP) attached to a bedside pump console that controls balloon inflation and deflation. Inflation/deflation is timed to the cardiac cycle. The therapy is designed to increase coronary perfusion and decrease myocardial oxygen consumption.

Critical Care Registered Nurse define in this policy: A registered nurse competent in intensive care management with specific competency in IABP management. These RN's include the ICU and Cardiovascular Cath Lab.

POLICY:

A. Only IABP patients with catheter placed for augmentation will be consider for admission to ICU patients. Patients with high potential for cardiac surgery need should not be admitted but transferred to a higher level of care.

Indications but not limited to the following:

1. Refractory unstable angina.
2. Impending myocardial infarction (MI).
3. Acute MI with mechanical impairment as a result of mitral regurgitation, ventricular septal defect, papillary muscle dysfunction
4. Intractable ventricular tachycardia as a result of myocardial ischemia.
5. Refractory ventricular arrhythmias.
6. Cardiogenic shock.
7. Support for diagnostic percutaneous revascularization and interventional procedures.
9. Emergency support following PTCA or high-risk percutaneous coronary interventions.

Contraindications but not limited to the following:

1. Severe Aortic Insufficiency.
2. Thoracic and abdominal aortic aneurysms.
3. Severe calcific aorta-iliac disease or peripheral vascular disease.
4. Prosthetic graft in thoracic aorta.

B. The patient with an IABP will be cared for by a critical nurse as defined by this policy. The patient will be considered high acuity and receive 1:1 nurse to patient ratio as needed by a nurse who has IABP competency.

C. Revalidation of IABP knowledge and skills will be done annually.

D. IABP will be inserted in the cardiac cath-lab and stabilized for transport before transferring to the ICU.

E. Cardiovascular Cath Lab will serve as a resource to the ICU until the catheter is removed. *(Cath Lab leadership will make every attempt to have someone on call after hours to assist if needed)*

AFFECTED PERSONNEL/AREAS: *CARDIAC CATHETERIZATION LABORATORY (CCL) AND INTENSIVE CARE UNIT (ICU)*

EQUIPMENT:

- IABP, helium gas supply.
- ECG and arterial pressure monitoring supplies.
- Single-Pressure transducer system.
- Emergency equipment available for immediate use.

PROCEDURE:

A. Before transfer to ICU: Counter pulsation should began immediately after insertion and verification by X- ray in the procedure room

B. Review manufacture manual for IABP equipment use which is kept attached to the IABP machine.

C. Keep limb straight to not kink tubing, use log roll technique to maintain straight limb

D. Head of bed should be kept 30-45 degrees to avoid aspiration and prevent upward migration of catheter

E. Perform a baseline physical assessment this should include all items that are included in the maintenance monitoring section of this policy:

F. **Maintenance Monitoring**

a. Assessment of circulation, including capillary refill on pedal and left radial pulses. This should be done every 15 minutes for the first hour then hourly. *(The IABP or thrombus can obstruct flow to distal extremities; if the catheter migrates to high, it can obstruct flow to the left subclavian artery.)*

b. Monitor blood pressure and MAP during counter pulsation every hour and every 15 minutes during vasoactive drip titration

c. Presence of dorsalis pedialis posterior tibial pulses (these can be marked with indelible ink to facilitate checks) Distal pulses should be checked every 15-30 minutes for the first 6 hours then hourly with VS to monitor for limb ischemia.

d. Monitor Vital Signs (VS) every 15-30 minutes for the first 6 hours then hourly until catheter is removed.

e. Arterial balloon pressure and cardiac output index every hour (can use NICOM for continuous value recording)

f. Neurological checks every hour

g. Urine output every hour

h. Insertion site and dressing evaluation, every hour for 8 hours then every 4 hours monitoring for oozing and hematoma. *(if abnormal finding contact provider immediately)*

i. Palpate extremity with regular physical assessment to monitor for swelling and tension every 4 hours

j. Auscultate bowel sounds every 4 hours with regular physical assessment to detect evidence ischemia Ankle brachial index (ABI) every 4 hours

k. ECG and IABP waveform every 4 hours and prn, print and place strip in the patient chart

l. Observe skin temperature color, sensation, and movement of extremity *(notify provider if dusky, cool, mottled, painful, numb or tingling)*

m. Strict and accurate intake and output daily

n. Monitor weight daily

G. **Ankle Brachial Index (ABI):**

a. Obtain a brachial systolic pressure
b. Record the highest pressure as the "B" brachial pressure
c. Place the blood pressure cuff on the ankle same side at the IABP catheter
d. Using a Doppler find the posterior tibial artery or dorsalis pedis, inflate cuff and listen for the first sound record this as "A" systolic ankle pressure
e. Then divide the "A" ankle by "B" brachial
Example: ankle systolic pressure= 110
Brachial systolic pressure =140
110 divided by 140= .78= 78% flow

(Normal ABI is 097-100%) nursing should contact physician if ABI is below 60% or if patient has signs of vascular compromise

f. **Interpreting Result:** greater than 1.3 results may not be reliable because of calcified vessels such as someone with diabetes, this will show falsely elevated pressures.
1.01 to 1.3: correlate with history
0.97 to 1 normal
0.8 to 0.96 mild ischemia
0.4 to .079 moderate to severe ischemia
0.39 or less severe ischemia in danger of limb loss

H. **Trouble Shooting:**

a. **Suspected Balloon Pump leak:**
*Observe for loss of augmentation or lack of normal pressure waveform (gas could be gradually leaking from the balloon)
*Check for blood in the catheter or connecting tubing.
* Notify physician, you may need to stop counter pulsation. Prepare for removal of IABP

b. **Actual Balloon perforation (blood in catheter)**
*place IABP on standby
*Clamp catheter
*Disconnect the catheter from the IABP console
*Notify physician and prepare for removal/replacement

c. **ALARMS:**

* Refer to Operators Manuel

REFERENCES:

- Johnson, K. L. (2024). AACN Procedure Manual for High Acuity, Progressive, and Critical Care. 8th edition. St. Louis: Elsevier.
- Maquet Getinge Group. (2018, December). Mechanisms of Counterpulsation Clinical Support Manual. Wayne, New Jersey, United States of America: Datascop Corp.
- Nettina, S. M. (2019). Lippincott Manual of Nursing Practice 11th edition. Philadelphia: Wolters Kluwer.

CROSS REFERENCES:

Intra-Aortic Balloon Pump (IABP) Management

SUBJECT: **LPS CONSERVATORSHIP GUIDELINES**	SECTION: ***Ethics, Rights & Responsibilities (RI)*** **Page 1 of 2**

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

PURPOSE:

To define Lanterman Petris Short (LPS) Conservatorship and how it may be obtained when the physician has requested conservatorship be considered.

DEFINITIONS:

LPS Conservatorship: A mental health (LPS) conservatorship makes one adult (called the conservator) responsible for a mentally ill adult (called the conservatee). These conservatorships are only for adults with mental illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Conservatorships are only granted by the court for adults with mental disorder as listed in the Diagnostic and Statistical Manual of Mental Disorders and who also meet gravely disabled criteria.

AFFECTED AREAS/ PERSONNEL: *SOCIAL SERVICES STAFF*

PROCEDURE/GUIDELINES:

1. When consideration for a conservatorship has been requested, nursing services is to contact Social Services for assistance.

2. Social Services will evaluate the request for appropriateness. Evaluation will be completed and staffed with the on call LCSW.

3. If the patient has met 5150 criteria, the LPS conservatorship process then continues at an LPS facility if accepted.

   LPS conservatorship process at an LPS facility if deemed appropriate by the psychiatrist:

   - After the 72-hour hold, a 14-day hold, (5250 hold) may be initiated. During this time a probable cause hearing is held. After the probable cause hearing is held, the psychiatrist may request an LPS conservatorship investigation from the public guardian's office. Request is reviewed and a petition for a Temporary Conservatorship (T-Con). A court date will be scheduled for LPS conservatorship court hearing. The patient is held at the psychiatric hospital under Temporary Conservatorship for up to 30 days.

4. The establishment of a temporary conservatorship does not guarantee the establishment of a permanent conservatorship. The court annually reviews an LPS Conservatorship to assess if it is still needed.

5. LPS conservatorship status establishes a conservatorship for both the person and estate of an individual diagnosed with an acute mental disorder who is gravely disabled (defined as the inability to provide for food, clothing, or shelter due to the mental disorder).

   - LPS Conservatorship of a person- A conservator is responsible for approving or disapproving a place for the conservatee to live and approving or disapproving the treatment and medication program.

- LPS Conservatorship of the estate-A conservator is responsible for all financial matters pertaining to the estate.

6. If a patient presents that is already established as an LPS conserved, then all medical decisions must be discussed and decided upon by the person named as the conservator of that patient.

7. Any question regarding the rights of a conserved patient can be sent to the VP of Quality/Regulatory Affairs, or designee, at 559-788-6047.

RESOURCES:

- National Alliance on Mental Illness. (2019). Los Angeles County Chapter.
- California Welfare Institute Act – Code 5300, 5358.5.
- Suicidal Patient Assessment & Management

SUBJECT: **MATERNAL CHILD HEALTH PATIENT OVERFLOW**	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 procedure to be followed to adequately handle the assigned patients when all Maternal Child Health (MCH) beds are filled.

POLICY:

1. The MCH Unit will ensure that all patients admitted to the facility will have an assigned bed for the provision of their care.
2. Mothers with infants will be transferred to medical / surgical (M/S) overflow.
3. All patients being transferred to another unit will require a physician order.

AFFECTED AREAS/ PERSONNEL: *NURSING ADMIN, MCH DEPARTMENT /RNs & LVNs*

GUIDELINES:

1. Patients will only be moved following recovery and stability.
   a. All patients delivering vaginally will be recovered in the MCH Unit for a minimum of two hours.
   b. Cesarean sections may be recovered in the MCH Unit or post-anesthesia care unit (PACU) (two hours or as needed).
2. Only stable patients (no excessive bleeding) will be transferred to the Medical/Surgical Unit.
   a. If at all possible, nursing mothers will be kept in the MCH Unit.
   b. Cesarean section will be the last patients to be transferred.
   c. Mothers with infants will be transferred to the M/S overflow.

PROCEDURE:

1. Assess the needs of the Unit.
2. Notify the Nursing Supervisor of the status of the census on MCH.
3. Determine the volume of patients that may be moved using the above criteria.
4. Notify providers of the needs of the Unit, and the possibility of patient transfers to another unit.
5. Inform the patient and family/significant others of the transfer.

6. Transfer the patient in the appropriate manner with the appropriate staff.

7. Report patient status to the accepting nurse.

8. Transfer of mother/baby couplet.

9. Security will be assigned to monitor entrance/exit door(s) to prevent infant abduction. Additionally, eMonitoring may be accomplished by remote video, but does not replace at least 1 security officer minding the unit where these patients are being accommodated.

DOCUMENTATION IN THE ELECTRONIC MEDICAL RECORD (EMR):

- Notification of the physician
- Completion of transfer

REFERENCES:

- Silveira, A. (2024). *Staffing Standards - AWHONN.* AWHONN. https://www.awhonn.org/resources-and-information/published-resources/staffing-standards/
-
- Practice, A. C. O. F. a. N. a. C. O. O. (2017). Guidelines for perinatal care. In *American Academy of Pediatrics eBooks*. https://doi.org/10.1542/9781610020886

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

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

PURPOSE:

To establish the procedure for providing comprehensive nutritional care.

POLICY:

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

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

PROCEDURE:

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

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

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

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

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

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

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

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

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

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

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

6. The facility will utilize an assessment form recommended by the Registered Dietitian.

7. The Registered Dietitian will complete the MDS nutrition section after admission within the appropriate timeframe. Information from the MDS observation period shall be used to complete the assessment.

REFERENCES:

- Centers for Medicare and Medicaid Services, Conditions of Participation (2025). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html.

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

SUBJECT: **PATIENT FOOD FROM HOME - DPSNF**	SECTION:

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

PURPOSE:

To establish a policy regarding use and storage of foods brought to Sierra View Medical Center Distinct Part Skilled Nursing Facility (DP/SNF) for residents by family and other visitors to ensure safe and sanitary storage, handling and consumption.

POLICY:

It is the policy of the Food & Nutrition Services (FNS) Department to prepare and deliver food safely to our residents, families and staff. This policy will ensure proper handling, serving and storage of any food items brought in for our residents from all outside sources.

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

PROCEDURE:

1. It is a resident's right to obtain foods from outside sources such as ordering takeout and to receive foods brought in by the resident's family and friends. The FNS Department and the unit's nursing staff will make every effort to advise the residents of foods that are permitted within their diet restriction. However, the resident has the right to make food choices that may not follow their diet restriction.

2. All food or beverages brought into the unit for resident consumption will be checked by a staff member before being accepted for storage. Any suspicious or obviously contaminated food or beverage will be discarded immediately.

3. Foods and beverages brought in from the outside will be labeled with the resident's name, room number and dated by the receiving staff with the current date that the item(s) are brought into the facility for storage.

4. Residents with dietary restrictions, texture modifications and adaptive equipment needs will be advised and assisted as necessary to ensure the resident's diet/devices are being followed/provided.

5. Food or beverage items may be stored in the designated patient refrigerator, freezer or pantry. Items may be stored in the resident's room or their personal room refrigerator.

    a. Food or beverage in the original container that is past the manufacturer's expiration date will be discarded by staff.

    b. All cooked or prepared food brought in from outside will be dated by the receiving staff member, when accepted for storage, and discarded after three (3) days. No home-prepared foods that are home canned or preserved will be permitted.

REFERENCES:

- CMS, Conditions of Participation. Title 42 Chapter IV, Subchapter G, Regulation **483.60(i)(3)** Food Safety Requirements
- Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2025). Hospital accreditation standards. PC.02.02.03. Joint Commission Resources. Oak Brook, IL.
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of regulations 72343, 72335 (6), San Francisco, California. Title 22.
- Food From Home handout, Tips for Family Members 2022. https://www.cahf.org/Portals/29/Clinical-Quality/Food%20From%20Home%20Handout.pdf?ver=2022-03-29-180723-740

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

PURPOSE:

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

POLICY:

A. Authority and Responsibility

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

B. Specific Performance Improvement Components

1. **Hospital Support Service**

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

2. **Medical Staff Peer Review Program**

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

3. **Medical Staff Committees**

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

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

4. **Patient Safety Program**

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

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

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

6. **Process Improvement Teams**

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

AFFECTED PERSONNEL/AREAS: *ALL HOSPITAL STAFF*

PROCEDURE:

A. Reporting and Coordination

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

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

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

   a. *Critical Care*
   b. *Emergency Services*
   c. *Operative/Invasive Services*
   d. *Renal Services*
   e. *Cancer Treatment Center (CTC)*
   f. *Distinct Part Skilled Nursing Facility (DP/SNF)*
   g. *Wound Care*
   h. *Cardiac Cath Lab*
   i. *Urology Clinic*
   j. *OBGYN – Women's services clinic*
   k. *Pediatrics*
   l. *Maternal Child Health*
   m. *Academic Health Center*
   n. *Sierra View Multi Specialty Center*

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

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

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

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

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

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

B. Individual Practitioner Competence Issues

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

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

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

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

C. Communication and Coordination of Results

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

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

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

D. Annual Appraisal

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

REFERENCES:

- Centers for Medicaid Services. (2025). The CMS Compliance Crosswalk. § 482.21 Quality Assessment and Performance Improvement Program. Brentwood, TN.

- The Joint Commission. (2025). Hospital Comprehensive Accreditation Manual. Standards: (PI 01.01.01, LD 03.07.01, MS05.01.01, PI 02.01.01 Oakbrook Terrace, IL.

- The Joint Commission (2025) Laboratory and Point-of-Care Testing Standards Manual. Standards – PI 01.01.01, PI 02.01.01, LD 03.07.01, LD 03.05.01, LD 04.03.09 Oakbrook Terrace, IL.

SUBJECT: **PROCEDURES - REFERENCE MATERIALS**	SECTION: **Page 1 of 4**

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

PURPOSE:

To establish uniform guidelines for basic and unit-specific nursing procedures.

POLICY:

Sierra View Medical Center (SVMC) will utilize nursing reference books for basic and intensive care nursing procedure guidelines.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE SERVICE AREAS*

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SUBJECT: **PROCEDURES - REFERENCE MATERIALS**	SECTION: **Page 4 of 4**

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

PROCEDURE:

"The Lippincott Manual of Nursing Practice" will be used as a reference for basic procedure guidelines.

"AACN Procedure Manual for Critical Care" will be used as a reference for all procedure guidelines that are not found in the Intensive Care Unit specific manual.

REFERENCE:

Johnson, K. L. (2024). *AACN Procedure Manual for progressive and critical care*. Elsevier.

SUBJECT: **PRONOUNCING CESSATION OF LIFE SIGNS**	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:

To define the steps for determining and assessing cessation of life signs for the ***No Code*** or ***No Code with Comfort Measures*** patient.

POLICY:

Those Registered Nurses (RNs) who have satisfactorily completed a Life Sign Cessation competency may pronounce patients deceased who meet specific criteria.

AFFECTED AREAS/PERSONNEL: *RNs with SPECIFIC COMPETENCY*

EQUIPMENT:

- Stethoscope
- Doppler
- Flashlight

PROCEDURE:

1. The RN may pronounce the patient as long as the patient status is within the acceptable criteria as listed below:

   a. The physician has documented in the patient electronic medical record a Do Not Resuscitate (No Code) order.

   b. The patient ***does not*** meet the criteria for Organ Donation.

   c. The patient has a Do Not Resuscitate (No Code) order on the chart or in the electronic medical record ***and*** is being sustained by external mechanical life support.

   NOTE: RNs may not pronounce death on the basis of irreversible cessation of brain function.

2. If patient status does NOT meet acceptable criteria:

   a. Notify the attending physician (may be delegated).

   b. Emergency physician may pronounce, if available.

   c. If the Emergency physician is NOT available, the attending physician will be responsible to pronounce the patient.

3. Assess the patient continuously for ten (10) minutes. (All criteria X 3.)

   a. Pulseless (apical).

   b. Breathless (absence of lung sounds).

   c. No measurable blood pressure (doppler).

   d. Skin cool and mottled.

   e. Pupils not responsive to light.

   f. No response to painful stimuli (sternal rub).

4. Notify the attending physician (may be delegated).

5. Notify the family (may be delegated).

6. Document findings in the medical record under the intervention "Pronouncing Cessation of Life Signs." If in downtime, document findings in the Physician's Progress Notes with the following:

   a. _____ (Date & Time) "Initial Assessment".

   b. "Patient assessed for absence of life signs".

      - pulseless (apical)
      - breathless (absence of lung sounds)
      - no measurable blood pressure (doppler)
      - skin cool and mottled
      - pupils not responsive to light
      - no response to painful stimuli (sternal rub)

   c. _____ (Time) "Patient pronounced deceased/expired."

   d. _____ (Time) "Dr. _____ notified by _____."

   e. Signature with title.

7. Notify mortuary. May be delegated.

REFERENCE:

- Cornell Law School. (n.d.) *Cal. Code Regs. Tit. 15, § 3999.327 - Registered nurse pronouncement of death.* Legal Information Institute. https://www.law.cornell.edu/regulations/california/15-CCR-3999.327#:~:text=(a)%20The%20California%20Department%20of,Assessment%20and%20determination%20of%20death%20.
- Jennings, Jeannie (2011). Your Final Assessment: Determination of Death. *Issues in Nursing*, 41(6), 8-8.

SUBJECT: **Scope of Practice for Advance Practice Nurse**	SECTION: **Page 1 of 3**

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

PURPOSE:

This policy outlines the scope of practice for certified nurse midwives (CNM) as known as advances practices nurse (APN)- within the Sierra View Medical Center, healthcare setting, encompassing prenatal, intrapartum, and postpartum care, as well as gynecological and family planning services.

Advanced Practice Registered Nurse (APRN) are independently licensed healthcare providers who provide care and treatment while working under the supervision of a Physician. They have been certified to perform many of the same tasks as a Physician and are referred to as Advanced Practice Providers.

POLICY:

SS 2746.5 (a) The Certified Nurse-Midwife is an advanced practice nurse who has met the educational standards and certification requirements established by the Board of Registered Nursing and possesses additional advanced practice educational preparation and skills consistent with the Core Competencies for Basic Midwifery Practice adopted by the American College of Nurse-Midwives. After receiving a certificate from the BRN, a CNW is authorized to attend cases of low-risk pregnancy and childbirth to provide prenatal, intrapartum, and postpartum care, including interconception care, family planning care, and immediate care for the newborn. For the purposes of this subdivision, "low risk pregnancy: means a pregnancy in which all of the following conditions are met:

1. There is a single fetus.
2. There is a cephalic presentation at onset of labor
3. The gestational age of fetus is greater than or equal to 37 weeks and zero days and less than or equal to 42 weeks and zero days at the time of delivery.
4. Labor is spontaneous or induced.
5. The patient has no preexisting disease or condition, whether arising out of the pregnancy or otherwise, that adversely affects the pregnancy and that the certified nurse-midwife is not qualified to independently address consistent with this section.

(b)(1) The certificate to practice nurse-midwifery authorizes the holder to pursuant to policies and protocols that are mutually agreed upon by a physician and surgeon, that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care, and that are signed by both the certified nurse-midwife and a physician and surgeon, to do any of the following:

A. Provide a patient with care that falls outside the scope of services specified in subdivision (a).

B. Provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium.

C. Furnish or order Schedule II or III controlled substances, including for patients that fall within the scope of services specified in subdivision (a).

(2) If a physician and surgeon assumes care of the patient, the certified nurse-midwife may contrinue to attend the birth of the newborn and participate in physical care, counseling, guidance, teaching, and support, as indicated by the mutually agreed-upon policies and protocols signed by both the certified nurse-midwife and a physician and surgeon.

(3) After a certified nurse-midwife refers a patient to a physician and surgeon, the certified nurse-midwife may continue care of the patient during a reasonable interval between the referral and the initial appointment with the physician and surgeon.

(c)(1) If a nurse-midwife does not have in place mutually agreed-upon policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care, signed by both the certified nurse-midwife and a physician and surgeon pursuant to paragraph (1) of subdivision (b), the patient shall be transferred to the care of a physician and surgeon to do either or both of the following:

(A) Provide a patient with care that falls outside the scope of services specified in subdivision (a).

(B) Provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium.

(2) After the certified nurse-midwife initiates the process of transfer pursuant to paragraph (1), for a patient who otherwise meets the definition of a low-risk pregnancy but no longer meets the criteria specified in paragraph (3) of subdivision (a) because the gestational age of the fetus is greater than 42 weeks and zero days, if there is inadequate time to effect safe transfer to a hospital prior to delivery or transfer may pose a threat to the health and safety of the patient or the fetus, the certified nurse-midwife may continue care of the patient consistent with the transfer plan described in subdivision (a) of Section 2746.54 (Obtaining Informed Consent).

(3) A patient who has been transferred from the care of a certified nurse-midwife to that o fa a physician and surgeon may return to the care of the certified nurse-midwife after the physician and surgeon has determined that the condition or circumstance that required, or would require, the transfer from the care of the nurse-midwife pursuant to paragraph (1) is resolved.

(f) The certificate to practice nurse-midwifery does not authorize the holder of the certificate to assist childbirth by vacuum or forceps extraction, or to perform any external cephalic version.

(h)(1) A certified nurse-midwife shall refer all emergencies to a physician and surgeon immediately.

(2) A certified nurse-midwife may provide emergency care until the assistance of a physician and surgeon is obtained.

AFFECTED PERSONNEL/AREAS: *Multi-Specialty Clinic staff and MCH nursing staff*

PROCEDURE:

Advances practices/nurse-midwives will provide comprehensive family planning, gynecological, prenatal, intrapartum, postpartum care under the supervision of a physician specializing in obstetrician/gynecologist. The APN/ CNM will practice within their outline scope of practice and be overseen by a physician with privileges to practice at Sierra View Medical Center.

Every Advanced Practice Provider is required to have the following documents:

- Current California License.
- Delegation of Services Agreement: Defines specific procedures identified in practice protocols or specifically authorized by the Supervising Physician, and must be dated and signed by the Physician and Advanced Practice Provider.

a. Approved Supervising Physician's Responsibility for Supervision of Advanced Practice Provider Agreement; The following procedures must be identified:

   i. Procedures for when the Supervising Physician is not on the premises.

   ii. One or more methods for performing medical record review by the Supervising Physician.

b. Each Advanced Practice Provider that prescribes controlled substances must have a valid DEA Registration Number.
c. The designated Supervising or back-up Physician is available in person or by electronic communication at all times when an Advanced Practice Provider is caring for patients.

REFERENCES:

- California Code, HSC 128297. (n.d.). https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=128297.&article=4.&highlight=true&keyword=advanced%20practice%20nursesCalifornia Legislative Information

- California Code HSC 15822. (n.d.). https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=15822.&highlight=true&keyword=advanced%20practice%20nurses

- Business and Professions Code, Division 2, Chapter 9, Article 4 Requirements for Prescriptions (2022), Retrieved from http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4076.&lawCode=BPC

- Nursing, C. B. O. R. (n.d.). *Nurse-Midwife*. https://www.rn.ca.gov/practice/nmw.shtml

- California Nurse Practice Act. (2024). Authority conferred by certificate; Required supervision. Pages 21-23. State Statute 2746.5.

CROSS REFERENCES:

Medical Staff Services Policy and Procedure Manual, Medical Staff Peer Review Link

SUBJECT: **SCOPE OF SERVICES**	SECTION: ***Academic Health Clinic*** **Page 1 of 2**

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

PURPOSE:

To define the scope of services provided in the Outpatient Academic Health Clinic

POLICY:

The Academic Health Clinic (AHC) is an outpatient department of Sierra View Medical Center (SVMC) and, as such, is found on the hospital's license issued by California Department of Public Health.

AFFECTED PERSONNEL/AREAS: ALL OUTPATIENT CLINIC PERSONNEL, MEDICAL STAFF, GME AND AHC PERSONNEL

PROCEDURE:

The Academic Health Clinic will provide general medical service and treatment to include but not limited to:

1. Primary care and health maintenance
2. Disease diagnosis
3. Diagnostic screening
4. Prevention and management of disease
5. Referrals as needed

Emergency Medical Services:

- During business hours, emergency services will be provided as a first response until local 911 Emergency Medical Services arrive.

Equipment and Supplies:

- There shall be sufficient and appropriate equipment and supplies related to the scope and nature of the anticipated needs and services provided.

REFERENCES:

- California Code of Regulations (2022). Title 22. Outpatient Service Equipment and Supplies § 70531 Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- California Code of Regulations (2022). Title 22. Outpatient Service Definition § 70525. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- California Code of Regulations (2022). Title 22. Outpatient Service General Requirements § 70527. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT:	SECTION:
SCOPE OF SERVICES	***Obstetrics Gynecology Clinic*** **Page 1 of 2**

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

PURPOSE:

To define the scope of services provided in the Outpatient Obstetrics Gynecology Clinic

POLICY:

The Obstetrics Gynecology (OB-GYN) Clinic is an outpatient department of Sierra View Medical Center (SVMC) and, as such, is found on the hospital's license issued by California Department of Public Health.
AFFECTED PERSONNEL/AREAS: ALL OUTPATIENT CLINIC PERSONNEL, MEDICAL STAFF, AND OB-GYN CLINIC PERSONNEL

PROCEDURE:

The Obstetrics Gynecology Clinic will provide general and specialty women's services care and treatment to include but not limited to:

1. Care for pregnant women
2. Family Planning/ contraceptive
3. Diagnostic screening
4. Gynecological concerns/needs

B. Emergency Medical Services:

- During business hours, emergency services will be provided as a first response until local 911 Emergency Medical Services arrive.

C. Equipment and Supplies:

- There shall be sufficient and appropriate equipment and supplies related to the scope and nature of the anticipated needs and services provided.

REFERENCES:

- California Code of Regulations (2022). Title 22. Outpatient Service Equipment and Supplies § 70531 Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- California Code of Regulations (2022). Title 22. Outpatient Service Definition § 70525. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- California Code of Regulations (2022). Title 22. Outpatient Service General Requirements § 70527. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I

D7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **SUICIDAL PATIENT ASSESSMENT & MANAGEMENT**	SECTION: **Page 1 of 5**

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

PURPOSE:

To create a timely process whereby suicidal ideation is identified in patients hospitalized with acute medical needs in order to provide a safe environment across the continuum of care.

POLICY:

All patients with expressed or reliably reported suicidal ideation or behavior; thoughts or attempts at self-harm; suspicious high-risk or self-injurious behaviors; or established diagnosis of a psychiatric disorder will be screened for suicide risk utilizing the "Columbia Suicide Severity Rating" scale for appropriate referral and management. Patients who are admitted as a result of an attempted suicide or found to be a danger to another person will be placed on suicide precautions immediately upon presentation to the facility, regardless of their "Columbia Suicide Severity Rating" scale score. They are to remain on suicide precautions until such time they are cleared by SVMC ED Care Coordinator in consult with their leadership. In cases of individuals 21 years of age or under, ED Care Coordinator may utilize TCOE as a resource to assess the patient.

AFFECTED AREAS/PERSONEL: *ALL PATIENT CARE AREAS; REGISTERED NURSES; LICENSED CLINICAL SOCIAL WORKERS*

PROCEDURE:

- **Registered Nursing staff:** Any patient who demonstrates suicidal ideation or behavior will be screened for suicide risk using the "Columbia Suicide Severity Rating" scale for appropriate management.

  Any patient with a score of moderate or high on the Columbia Suicide Severity Rating scale, is considered to be at risk for suicide and intervention is required. Refer to the Columbia Suicide Severity Rating scale for specific actions required.

The High Risk Emergency Department Patient

When the Emergency Department (ED) patient becomes medically cleared and <u>will not</u> be admitted, contact the ED Care Coordinator for a 5150 evaluation.

- All high risk patients will be placed on general suicide precautions and have 1:1 observation at all times, until they have been cleared by ED Care Coordinator, or transferred from Sierra View Medical Center (SVMC) for further psychiatric intervention.

The High Risk Admitted Patient

All high risk patients will be admitted with 1:1 observation and general suicide precautions.

- Patients will be placed in appropriate units based on their medical needs.

- When medically ready for discharge, nursing staff will contact ED Care Coordinator for reassessment of suicide risk.

SUICIDE PRECAUTIONS:

Suicide precautions are initiated and terminated on a physician's order. In an emergency, suicide precautions may be implemented as contact is being made with the physician.

The risk of self-harm is greatly increased if the patient has developed a plan and has the means to execute the plan. Creating a safe environment for the patient during his/her hospital stay helps to reduce this risk. The following actions will be implemented to help ensure a safe environment for the patient:

1. The physician will order a 1:1 sitter, hospital assigned personnel, who will monitor the patient at all times for signs of self-harm, harm to others, or flight risk. Refer to "Patient Observation" policy.

    a. Sitters are trained non-clinical personnel who are assigned to high risk patients to provide continuous observation of the patient while on suicide precautions. This includes bathing and toileting. In the event that the sitter is the opposite sex of the patient, a same sex employee will be engaged to observe bathing and toileting.

    b. Observation sheets are to be maintained throughout the time assigned to the patient. Patient status is to be documented every 15 minutes.

    c. Observation sheets are turned into the assigned Registered Nurse (RN) at the end of each shift, and maintained in the patient's chart.

2. At the time suicide precautions are ordered, conduct a patient/room search and remove all potentially harmful objects from the patient/room (see below "Suicide Precautions Room Search"). See "Ligature Risk Assessment," located on the intranet, for additional specific items per each unit.

    a. Glass objects, mirrors, vases, picture frames, glass bottles (perfume, after-shave, mouthwash)

    b. Eyeglasses may be allowed to remain at the discretion of the RN.

    c. Sharp or plastic objects that may be broken: pens, pencils, pins, clips, scissors, razors, compacts, other cosmetics

    d. Objects with any length: belts, shoelaces, bras, electrical cords, telephone pantyhose, suitcase straps

    e. Electrical/electronic appliances are to be inspected for ligature risk and removed if deemed a threat.

f. Objects that may be used over or in the mouth - No extra pillowcases and bed linens

g. No plastic bags left in room

h. Matches, lighter, cigarettes

i. Any alcohol based product, which may include deodorant, mouthwash, after-shave, perfume, hair spray, nail polish remover, and other essential activities of daily living (ADL) products.

3. After admission, any additional searches of the patient room will be done when there is reasonable suspicion of contraband items and documented by the nurse.

4. All visitors are to check in with security in the main lobby. Personal items are to be inspected for potential threat of self-harm prior to admittance to visit the patient's room. This will be accomplished as follows:

   a. Upon visitor presenting to the room, the assigned sitter will advise the visitor that a security check will need to be conducted of their personal items prior to entering the room.
   b. The sitter will provide some examples of items that will not be allowed (weapons, medication, alcohol based items, sharp items), allowing the visitor the option of securing these items prior to requesting security to come and check their belongings.
   c. Once the visitor has had the chance to secure any items, the sitter will call and request security to come and check their belongings prior to entering the room.
   d. In the event that the patient is located in the Emergency Room, the visitor security check will be done prior to the visitor entering the department, by security.

5. At the end of each meal, Nursing will account for all silverware/plastic ware.

6. No medications are to be left at the bedside.

7. An assigned staff member must accompany the patient when they leave the floor.

8. If hard leather restraints are required to prevent self-harm, the patient will be placed in ICU for care, and the RN assuming care will initiate the Behavioral Restraint Policy and patient monitoring. (Refer to Behavioral Restraint Policy).

INTRAFACILITY TRANSPORTATION:

In addition to following the "Intrafacility Patient Transport" policy, the patient's sitter will accompany the patient if intrafacility transport is required in the course of the patient's treatment. It is the responsibility of the bedside RN to communicate to the receiving personnel that the patient is on suicide precautions at the time of Situation, Background, Assessment, Recommendation (SBAR), prior to transport.

DOCUMENTATION:

The RN will ensure completion of the "Columbia Suicide Severity Rating" scale on presentation, given the patient is alert/oriented and able to participate in the process. The RN will complete the Columbia Suicide Severity Rating scale, by answering all the "yes/no" questions. Findings are to be discussed with the patient's provider and all indicated actions completed. Prior to discharge, ED Care Coordinator is to be called, who will complete an assessment for the need of on-going psychiatric stabilization or indicate if the patient is able to discharge home with outpatient resources. Patients evaluated by ED Care Coordinator will receive mental health resources and referrals from the clinician sent to evaluate the patient.

LEAVING PRIOR TO CRISIS CLEARANCE:

If a patient who is on a 5150, 1799 hold, or on suicide precautions, wants to leave prior to having a psychiatric evaluation completed, SVMC staff is to employ the following steps:

1. Communicate: What is worrying them? Why do they want to leave? Can we assist in anything that would make them reconsider staying? Can we call someone to sit with them?

2. Ask if they are willing to wait for the social worker to come talk with them?

3. If the above interventions are not effective and the patient continues to want to leave, do not physically stop them. Allow them to leave, and call Porterville Police Department immediately. Report to them what the patient was wearing and that they were on a mental health hold.

4. Initiate a Code Green.

5. Notify the Risk / Patient Safety Department.

6. Document all of the above clearly in a note in the medical record.

PATIENT RIGHTS:

Psychiatric patients have the same rights as all other patients. They have the right to the following basic privileges unless clearly documented as to why that right is being denied:

- Phone calls
- Visitors
- Knowledge of the plan of care

- Right to refuse treatment
- Right to ask questions and have them answered in a professional and courteous manner
- The right to a safe environment

REFERENCES:

- The Joint Commission. (2025) Comprehensive Accreditation Manual. National Patient Safety Goal 15. Oakbrook Terrace, IL.
- Columbia Suicide Severity Rating Scale (n.d.). Retrieved from www.C-SSRS.org.

CROSS REFERENCES:

- Columbia Suicide Severity Rating Scale
- Restraint Use – Medical/Surgical and Behavioral Restraint Policy
- Intrafacility Patient Transport Policy
- 1799 Holds in the Emergency Department Policy
- Patient Observations
- SVMC Intranet-Ligature Risk Assessment
- Code Green—Missing Patient or Resident

SUBJECT: **SURROGATE DECISION MAKER, SELECTION OF**	SECTION: ***Provision of , Treatment and Services (PC)*** **Page 1 of 6**

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

PURPOSE:

To provide a guide for selecting a surrogate decision maker when a patient lacks decision making capacity and lacks a written advance directive for health care or a court appointed conservator.

PREAMBLE

When a patient without an Advance Directive does not have the capacity for making decisions, health care professionals turn to the patient's relatives for guidance. This common process usually works to the satisfaction of all concerned. Often, a family member steps forward with the support of others to take on the responsibility of becoming the surrogate health care decision maker. The interaction with health care staff and this individual is amicable, patient-centered decision making is emphasized, and family integrity is maintained.

Occasionally, the process of surrogate selection breaks down. Family members may disagree over who among them would be best able to make medical decisions on the patient's behalf. Sometimes the person closest to the patient is unable or unwilling to take on this responsibility. In such circumstances, health care professionals try to identify someone else who knows the patient's values, can speak for the patient, and can assist in making health care decisions.

POLICY:

The following procedures will be followed for selecting a surrogate decision maker when a patient lacks decision-making capacity and lacks a written advance directive for health care or a court appointed conservator.

DEFINITIONS

Capacity: a patient's ability to understand the nature and consequences of a decision, and to make and communicate a decision, and includes in the case of proposed health care, that ability to understand its significant benefits, risks and alternatives. (Probate Code section 4609, 812 & 813).

Health care: any care, treatment, service, or procedure to maintain, diagnose or otherwise affect a patient's physical or mental condition.

Health care decision: a decision made by a patient or the patient's agent, conservator or surrogate, regarding the patient's health care, including the following:

- Selection and discharge of health care professionals and institutions
- Approval or disapproval of diagnostic tests, surgical procedures and programs of medication
- Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation

Health care professional: an individual licensed, certified or otherwise authorized or permitted by the law of this state to provide health care in the ordinary course of business or practice of a profession.

Primary physician: a physician designated by a patient or the patient's agent, conservator or surrogate, to have primary responsibility for the patient's health care or, in the absence of a designation or if the designated physician is not reasonably available or declines to act as primary physician, a physician who undertakes the responsibility.

Supervising health care professional: the primary physician or, if there is no primary physician or the primary physician is not reasonably available, the health care professional who has undertaken primary responsibility for a patient's health care.

Surrogate: the person who makes health care decisions on behalf of the patient

PROCEDURE:

SELECTION OF A SURROGATE BY PATIENTS WITH DECISION-MAKING CAPACITY

1. A patient with a written Advance Health Care Directive (AHCD):

   a. The agent named by the patient within this document will be the decision maker for the patient when the patient lacks decision making ability. (See NOTE below for exceptions).

2. A patient who has not or chooses not to complete an AHCD:

   a. A patient may orally designate who should assist in making health care decisions if the patient becomes unable to make such decisions.

   b. If a patient expresses a clear and consistent choice, the physician must document the identity of this individual in the medical record.

      NOTE: If the patient has appointed an agent in a written AHCD prior to the oral designation, the more recent orally appointed surrogate's authority supersedes that of the agent during the period of hospitalization during which the oral designation is made.

   c. When an oral designation of a surrogate decision maker is made by a patient, this designation is effective only:

      - During the course of the patient's treatment or illness,
      - During the patient's hospitalization, or
      - For 60 days, whichever period is shorter. If desired, the patient may choose to make the designation for an even shorter period of time. If the patient is still hospitalized at the end of 60 days, the patient should be re-engaged in steps 1 and 2 above.

SELECTION OF A SURROGATE FOR PATIENTS WITHOUT DECISION-MAKING CAPACITY WHO LACK AN APPOINTED SURROGATE

If the patient has not appointed a surrogate or agent through a valid written or oral directive and if there is no court appointed conservator for health care decision making; or if the designated surrogate, agent or conservator is not reasonably available, it may be necessary to rely upon the consent given by a relative to make health care decisions on behalf of the patient [1,2].

Identifying an Appropriate Family Member to Consent

There is no hierarchy/order as to which member of the family has the right to consent on behalf of the patient. The surrogate decision maker is generally appointed by the patient's family unit and should be the individual who appears, after a good faith inquiry, to be best able to function in this capacity.

If any of the following circumstances are present, the facility should re-engage the family with a multi-disciplinary team and discuss the circumstance, communicate the issues and determine whether a new surrogate should be appointed.

- The relative's capacity to make health care decisions or motives are questionable
- There is a substantial question as to whether the patient, if he or she had the capacity to make health care decisions, would consent to the procedure
- Another close relative objects to the medical procedure

If the patient's relatives cannot agree as to who shall be the surrogate decision maker for the patient, then a multi-disciplinary team to include an attending physician, nurse familiar with the patient, social worker familiar with the patient, and a representative from Risk Management will appoint a surrogate.

In identifying a surrogate, input from any or all of the following may be used as appropriate:

- Family and friends of the patient
- Other health care professionals
- Institutional committees
- Social workers
- Chaplains

In determining the individual best able to serve as the surrogate, all relevant factors may be considered, among them:

- Familiarity with the patient's personal values
- Demonstrated care and concern for the patient
- Degree of regular contact with the patient before and during the patient's illness
- Availability to visit the patient
- Availability to engage in meaningful contact with health care professionals for the purpose of fully participating in the health care decision making process
- Ability to understand the medical condition and treatment options as explained by physicians or other health care professionals
- Ability to assume the duties of a surrogate detailed below
- Previous designation as a surrogate, whose authority has expired

NOTE: Agreement by a potential surrogate with the treatment recommendations of the physician or other health care professionals should not be a criterion used in the selection of a surrogate.

AUTHORITY OF THE SURROGATE

A surrogate may make health care decisions on behalf of a patient if the patient has no available, previously appointed conservator or designated agent with authority to make such decisions, and the primary physician determines and documents that the patient lacks capacity for making health care decisions. The surrogate may not make decisions that are limited by statute.

DUTIES OF THE PHYSICIAN AND OTHER HEALTH CARE PROFESSIONALS

1. The primary physician, in conjunction with other health care professionals shall make reasonable efforts to contact potential surrogates before selecting the surrogate.[3]
2. The primary physician shall document in the patient's health care record the determination that the patient lacks decision-making capacity.
3. The primary physician or designated member of the multidisciplinary team shall document the name of the surrogate who best meets the above criteria in an easily seen location in the patient's health care record.
4. The physician will communicate with and educate the surrogate about matters relevant to the patient's medical condition.
5. The supervising health care professional shall inform the patient, if possible, of the identity of the recognized surrogate and the decisions the surrogate authorizes.

DUTIES OF THE SURROGATE

1. The surrogate shall make health care decisions and advocate on behalf of the patient as necessary, in accordance with the patient's values, individual health care instructions, if any, and other wishes to the extent known to the surrogate so that the patient's values, health care instructions, and known wishes remain the basis for the decisions with regard to restorative, palliative and other interventions. Otherwise, the surrogate shall make decisions in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

2. The surrogate shall provide information about the patient's known values and beliefs to health care professionals to assist in providing health care and in making health care decisions. The surrogate may be asked to assist in obtaining information about the patient's known values and beliefs from the patient's friends and family. The surrogate may be asked to assist in communications with relatives and associates of the patient as they are necessary for good medical care as judged by the physicians, and as the patient would have allowed.

REFERENCE:

- California Supreme Court Cobbs v. Grant, 8 Cal.3d 229,244 (1972) "If the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or *closest available relative* (emphasis added).

- Barber v. Superior Court, 147 Cal App.3d 1006 (1983) California law does not specify that only court appointed guardians or conservators have the authority to act on behalf of another person and that in the absence of such prohibition an incompetent patient's immediate family could make health care decisions for the patient. Court cautioned that such persons must first be guided by the patient's own desires and feelings to the extent they were expressed before the patient became incompetent.

- California Probate Code Section 4717 states that:

  (a) Notwithstanding any other provision of law, within 24 hours of the arrival in the emergency department of a general acute care hospital of a patient who is unconscious or otherwise incapable of communication, the hospital shall make reasonable efforts to contact the patient's agent, surrogate, or a relative or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient. A hospital shall be deemed to have made reasonable efforts, and to have discharged its duty under this section, if it does all of the following:

  (1) Examines the personal effects, if any, accompanying the patient and any medical records regarding the patient in its possession, and reviews any verbal or written report made by emergency medical technicians or the police, to identify the name of any agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient.

(2) Contacts or attempts to contact any agent, surrogate, or relative or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient, as identified in paragraph (1).
(3) Contacts the Secretary of State directly or indirectly, including by voice mail or facsimile, to inquire whether the patient has registered an advance health care directive with the Advance Health Care Directive Registry, if the hospital finds evidence of the patient's Advance Health Care Directive Registry identification card either from the patient or from the patient's family or authorized agent.

(b) The hospital shall document in the patient's medical record all efforts made to contact any agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient.

(c) Application of this section shall be suspended during any period in which the hospital implements its disaster and mass casualty program, or its fire and internal disaster program.

SUBJECT: **TIME FRAMES OF DOCUMENTATION**	SECTION:

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

PURPOSE:

To establish time frames for the completion of documentation.

POLICY:

1. Certain time-specific documentation is required from the Rehabilitation Department, when providing care within all scopes of inpatient and skilled nursing care, as well as outpatient care.

2. Rehabilitation services are provided under a written plan of patient care, initiated by the attending physician and developed in consultation with appropriate Rehabilitation Department staff, based on initial and continuing assessment of the patient.

AFFECTED AREAS/PERSONNEL: *ALL REHABILITATION PERSONNEL*

PROCEDURE:

Please refer to the following:

Documentation	**Time Frame**
Initial In Patient Assessment and Evaluation	Completed within 24 hours of receipt of physician's order in acute, including frequency and duration. In the DPSNF, it is to be completed within 5 days.
Daily Treatment Notes	Completed on the day of each treatment.
Progress Notes	*For Sub Acute Inpatients:* completed at least every 7 days, beginning the seventh day after the initial assessment. *For Acute patients*: Incorporated in the Treatment Notes.
Discharge Orders	Required if services are discontinued prior to discharge from the facility.

REFERENCES:

- Centers for Medicaid and Medicare Services (2025, March 13), *Billing and Coding: Therapy, Evaluation, Re-evaluation and Formal Testing.* Retrieved April 11, 2025, from https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=53309

SUBJECT: **TRANSFER OF PATIENT TO HIGHER LEVEL OF CARE FOR NEUROLOGICAL SERVICES**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide guidelines for a safe and timely transfer of the neurological patient from the Emergency Department (ED) to a higher level of care in the event of an emergency situation or when needed medical services are not offered at Sierra View Medical Center (SVMC).

POLICY:

Patients treated at SVMC who require a higher level of care due to their neurological diagnosis or when needed medical services are not offered at SVMC will be transferred to the accepting hospital for further medical treatment.

Examples – Intracranial bleed or mechanical thrombectomy

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS, RESPIRATORY THERAPY, HOUSE SUPERVISORS, SOCIAL SERVICES, CASE MANAGEMENT.*

EQUIPMENT:

- Portable ventilator
- Infusion pumps

PROCEDURE:

A. Emergency Transfer

a. Immediately notify the charge nurse of need for transfer; also notify the Transfer Center Registered Nurse. Transfer happens as soon as possible, preferably within two (2) hours

1. Obtain order from attending provider to transfer patient to desired hospital.

2. Charge nurse or Transfer Center will contact facilities that offer the needed level of care and obtain acceptance from the facility and receiving physician.

3. Contact Emergency Medical Services (EMS) or air transfer dispatch of need for emergency transfers from patient's unit (ED, ICU, Med Surg, CDU, Telemetry, or other patient care area) to accepting facility.

4. Stabilize and prepare patient for transfer.

5. Obtain the following documentation:

a. Physician Transfer Certification Form (pink) completed by RN and MD (copy goes with patient)

b. Physician certification statement (copy goes in packet) CD of all relevant images
c. Copy of lab results
d. Copy of patient's face sheet
e. List of medications – both home and medications received at SVMC
f. Copy of patient's history and physical, if inpatient. If in the ED, copy of the ED physician note
g. Copies of radiology reports (along with CD of images)

6. Notify patient's family if physician has not already done so

Patients with infusing titratable medications will be accompanied by an SVMC Registered Nurse, unless transferred with Critical Care RN and flight team..

7. Patients requiring a portable ventilator will be accompanied by a Respiratory Care Practitioner (RCP), unless transferred with Critical Care RN and flight team.

REFERENCES:

- The Joint Commission (2024). Comprehensive Certification Manual for Disease-Specific Care. Oakbrook Terrace, IL

CROSS REFERENCES:

- EMTALA- Interfacility Transfers, MSE, Emergency Care and Stabilization

SUBJECT: **UNREPRESENTED PATIENTS-HEALTHCARE DECISIONS FOR**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 9**

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

PURPOSE:

To provide a process for making ethically and medically appropriate treatment decisions on behalf of persons who lack health care decision-making capacity and for whom there is **no** surrogate decision maker.

PREAMBLE

Despite their incapacity, such "unrepresented" patients are entitled to have ethically and medically appropriate medical decisions made on their behalf and to have these decisions made in their best interest. The process set forth in this policy is intended to meet these goals. This policy is considered necessary since no clear-cut legal guidelines exist that cover these circumstances. This policy is designed to provide uniformity and consistency within the acute care hospital[1] on the process to make medical treatment decisions for unrepresented patients.

Decisions made without clear knowledge of an unrepresented patient's specific treatment preferences must be in the patient's best interest, taking into consideration the patient's personal history, values and beliefs to the extent that these are known. Decisions about treatment should be based on sound medical advice and should be made without the influence of material conflicts of interest. These decisions must be made with a focus on the patient's interests, and not the interests of healthcare providers, the Hospital, or other affected parties. In this regard, appropriate health care decisions include both the provision of needed medical treatment and the avoidance of non-beneficial or excessively burdensome treatment, or treatment that is medically ineffective or contrary to generally-accepted health care standards.[2]

This policy is procedural in nature and applies to most medical decisions for which informed consent is usually required. This policy is meant to support Sierra View Medical Center's underlying consent policy.

Adoption of this policy does not preclude any party from seeking judicial intervention. Appropriate judicial remedies may include a timely court order authorizing the provision, withdrawing, or withholding of treatment or appointment of a conservator; however, courts are not necessarily the proper forum in which to make health care decisions.[3]

POLICY:

The following procedures will be followed for making ethically and medically appropriate treatment decisions on behalf of persons who lack health care decision-making capacity and for whom there is no surrogate decision maker.

PROCEDURE:

WHEN USE OF THIS POLICY IS APPROPRIATE

This policy may be used when all of the following conditions are met:

1. The patient has been determined by the primary physician (with assistance from appropriate consulting physicians if necessary) to *lack capacity to make health care decisions*. Capacity means a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate a health care decision. *Conditions for which psychiatric or psychological treatment may be required do not, in and of themselves, constitute a lack of capacity to make health care decisions.*

2. No agent, conservator, or guardian has been designated to act on behalf of the patient.

3. There is no individual health care directive or instruction in the patient's medical record or other available sources that would eliminate the need for a surrogate decision maker.

4. No surrogate decision maker or family member can be located who is reasonably available[4] and who is willing and able to serve. Efforts to locate a surrogate should be diligent and may include contacting the facility from which the patient was referred, and contacting public health or social service agencies known to have provided treatment for the patient.

NOTE: ***This policy does not address the criteria for determining and appointing an appropriate decision maker when one or more are available and willing to serve (refer to Policy Surrogate Decision Maker-Selection of). And finally, this policy is not meant to be applied in emergency medical situations.***

When use of this policy is appropriate (as outlined above), medical decisions will be made by a multi-disciplinary team whose members shall include, but not be limited to, individuals directly involved with the care of the patient. It is recommended that the multi-disciplinary team include an attending physician, nurse familiar with the patient, social worker familiar with the patient, representation from Risk Management, chair or vice-chair of the ethics committee, non-medical (community) member of the ethics committee or other appropriate committee and, if available and appropriate, consulting clinicians and pastoral care staff.[5]

In order to determine the appropriate medical treatment for the patient, the multi-disciplinary team should:

1. Review the diagnosis and prognosis of the patient and assure itself of the accuracy thereof.

2. Determine appropriate goals of care by weighing the following considerations:

   a. Patient's previously-expressed wishes, if any and to the extent known

   b. Relief of suffering and pain

   c. Preservation or improvement of function

   d. Recovery of cognitive functions

   e. Quality and extent of life sustained

   f. Degree of intrusiveness, risk or discomfort of treatment

   g. Cultural or religious beliefs, to the extent known

3. Establish a care plan based upon the patient's diagnosis and prognosis and the determination of appropriate goals of care. The care plan should determine the appropriate level of care, including categories or types of procedures and treatments.

   Except to the extent that such a factor is medically relevant, any medical treatment decision made pursuant to this policy shall not be biased based on the patient's age, sex, race, color, religion, ancestry, national origin, disability, marital status, sexual orientation (or any other category prohibited by law), the ability to pay for health care services, or avoidance of burden to family/others or to society.

   Under the terms of this policy, the multi-disciplinary team may make the same treatment decisions, and will have the same limitations, as does an agent appointed pursuant to a power of attorney for health care specified under current law.[6,7] However, this policy shall not apply to decisions pertaining to autopsies, anatomical gifts, or disposition of remains. Specific laws apply to these procedures [8]

The multi-disciplinary team must assure itself that the medical decision made is based on sound medical advice and is in the patient's best interest taking into account the patient's values, to the extent known. In determining the best interest of the patient, it is not required that life support be continued in all circumstances, where treatment is otherwise non-beneficial or is medically ineffective or contrary to generally-accepted health care standards, when the patient is terminally ill and suffering, or where there is no reasonable expectation of the recovery of cognitive functions.

Agreement on Treatment

1. If all members of the multi-disciplinary team agree to the appropriateness of providing treatment, it shall be provided.

2. If all members of the multi-disciplinary team agree to the appropriateness of withholding or withdrawing treatment, it shall be withdrawn or withheld. Any implementation of a decision to withhold or withdraw life-sustaining medical treatment will be the responsibility of the primary treating physician.[9]

Disagreement on Treatment

If the members of the multi-disciplinary team disagree about the care plan, the ethics committee, ethics resource expert(s) or other resource experts will meet with the team to explore their disagreement and facilitate resolution.

1. If agreement is reached either to provide or to forgo treatment, the decision of the multi-disciplinary team then becomes final.

2. If agreement still is not reached, current treatments will be continued and any other medically necessary treatments provided, until such time that the issue is resolved through court intervention or the disagreement is otherwise resolved.[10] Court-imposed legal remedies should be sought only in extreme circumstances and as a last resort.[3]

In all cases, appropriate pain relief and other palliative care shall be continued.

EXCEPTIONAL CIRCUMSTANCES

Legal counsel should be consulted if a decision to withdraw or withhold treatment is likely to result in the death of the patient or the situation arises in any of the following circumstances:

- The patient's condition is the result of an injury that appears to have been inflicted by a criminal act
- The patient's condition was created or aggravated by a medical accident
- The patient is pregnant
- The patient is a parent with sole custody or responsibility for support of a minor child

DOCUMENTATION

Signed, dated and timed medical record notes will be made by those involved in the below activities:

- The findings used to conclude that the patient lacks medical decision-making capacity
- The finding that there is no advance health care directive, no conservator, guardian or other available decision maker, and no health care instructions in the patient's medical record or other available sources.
- The attempts made to locate surrogate decision makers and/or family members and the results of those attempts
- The bases for the decision to treat the patient and/or the decision to withhold or withdraw treatment
- Any information from the ethics committee or other consult, should it be convened

REFERENCES:

[1] This policy is intended for use in the general acute care hospital. California Health and Safety Code Section 1418.8 set forth a statutory decision-making process for patients in a skilled nursing facility or intermediate care facility.

[2] California Probate Code Section 4735 states that: "A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution."

[3] California Probate Code Section 4650(c) states that: "In the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment."

[4] California Probate Code Section 4717 states that:

a. Notwithstanding any other provision of law, within 24 hours of the arrival in the Emergency department of a general acute care hospital of a patient who is unconscious or otherwise incapable of communication, the hospital shall make reasonable efforts to contact the patient's agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient. A hospital shall be deemed to have made reasonable efforts and to have discharged its duty under this section, if it does all of the following:

- Examines the personal effects, if any, accompanying the patient and any medical records regarding the patient in its possession, and reviews any verbal or written report made by emergency medical technicians or the police, to identify the name of any agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient.

- Contacts or attempts to contact any agent surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient, as identified in paragraph (1).

- Contacts the Secretary of State directly or indirectly, including by voice mail or facsimile, to inquire whether the patient has registered an advance health care directive with the Advance Health Care Directive Registry, if the hospital finds evidence of the patient's Advance Health Care Directive Registry identification card either from the patient or from the patient's family or authorized agent.

b. The hospital shall document in the patient's medical record all efforts made to contact any Agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient.

c. Application of this section shall be suspended during any period in which the hospital implements its disaster and mass casualty program, or its fire and internal disaster program. California Probate Code Section 4736 states that:

- A health care provider or health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following:
  - Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient.
  - Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.
  - Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care shall be continued.

[5] Institutions should designate by policy the particular types and numbers of providers who may constitute the multi-disciplinary team, and should ensure that non-medical/community representatives are properly prepared to serve on the multi-disciplinary team.

[6] California Probate Code Section 4617 states that:

a. **"Health care decision"** means a decision made by a patient or the patient's agent, conservator, or surrogate, regarding the patient's health care, including the following: (a) Selection and discharge of health care providers and institutions. (b) Approval or disapproval of diagnostic tests, surgical procedures, and programs of medication. (c) Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

California Probate Code Section 4683 states that: "Subject to any limitations in the power of attorney for health care: (a) An agent designated in the power of attorney may make health care decisions for the principal to the same extent the

principal could make health care decisions if the principal had the capacity to do so."

[7] California Probate Code Section 4652 states that: "This division does not authorize consent to any of the following on behalf of a patient: (a) Commitment to or placement in a mental health treatment facility. (b) Convulsive treatment (as defined in Section 5325 of the Welfare and Institutions Code). (c) Psychosurgery (as defined in Section 5325 of the Welfare and Institutions Code). (d) Sterilization. (e) Abortion."

[8] Health & Safety Code Sections 7100 (disposition of remains), 7113 (autopsy), and 7150 et seq. (anatomical gift).

[9] California Probate Code Section 4734 states that:

a. A health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience.

b. A health care institution may decline to comply with an individual health care instruction or health care decision if the instruction or decision is contrary to a policy of the institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.

[10] California Probate Code Section 4736 states that:

a. A health care provider or health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following:

- Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient.
- Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.

- Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care shall be continued.

CROSS REFERENCES:

ADVANCE DIRECTIVE
CONSENT/ INFORMED CONSENT
PATIENT RIGHTS
WITHOLDING OR WITHDRAWING LIFE-SUSTAINING TREATMENT

SIERRA VIEW MEDICAL CENTER **RESPIRATORY MEDICAL NEED FORM (CALIFONIA ONLY)**

Patient Full Name_____ D.O.B _____ Phone # _____

Address, City, State, Zip _____

Diagnosis _____

*** Please fax patient demographics and insurance information***

❑ **Oxygen** @ _____ 1pm via Nasal Cannula ❑ Continuous ❑ Nocturnal ❑ w/exertion

Facility testing performed at _____ Date of Test_____

O_2 Sats or PaO_2 results on room air: PaO_2_____ mmHg or O_2 Sat _____% resting _____% exercising and _____ % exercising on O_2 ❑ Gas Portability _____

❑ **Conserving Device** -RT to assess patient's need for a conserving device. Titrate liter flow to keep SaO_2 greater or equal to 90%

❑ **Comprehensive Pulse Oximetry** (Resting, Exertion, Nocturnal) Room air _____ Current O_2 settings

❑ **Overnight Pulse Oximetry**_____ Room air _____ Current O_2 settings

❑ **CPAP**_____ cmH_2O ❑ **Bilevel**_____ IPAP _____ EPAP _____ Rate ❑ Heated Humidifier

❑ With O_2 Bleed-in @ _____ 1pm ❑ 2 wk CPAP titration study _____ cmH_2O to _____ cmH_2O

❑ **Aerosol Nebulizer** and Supplies _____ Length of Need

- ❑ DuoNeb Unit Dose Solutions _____ Frequency
- ❑ Albuterol Sulfate Unit Dose Solution 0.083% _____ Frequency
- ❑ Ipratropium Bromide Unit Dose Solution 0.02% _____ Frequency
- ❑ Budesonide .25mg Unit Dose Solution _____ Frequency
- ❑ Budesonide .5mg Unit Dose Solution _____ Frequency
- ❑ Perforomist Unit Dose Solution _____ Frequency
- ❑ Brovana Unit Dose Solution _____ Frequency

Quantity of vials prescribed _____ **Refills** _____

Special Instructions _____

Durable Medical Equipment _____ Length of Need _____ HT _____ WT

❑ Bed ❑ Walker ❑ Wheelchair ❑ Crutches ❑ Commode ❑ Other _____

Physician Name_____ Physician's DEA # _____ Phone # _____

Address, City, State, Zip _____

Calif. License # _____ NPI _____

Physician's Signature _____ Date _____

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

RESPIRATORY MEDICAL NEED FORM (CALIFONIA ONLY)

Form # 024259 REV. 4/21

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

PATIENT'S LABEL

167

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 **June 24, 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 5:03 p.m.

Board Attendance:

- Liberty Lomeli, Chair - Present
- Bindusagar Reddy, Vice Chair - Absent
- Areli Martinez, Secretary - Present
- Hans Kashyap, Director – Present
- Gaurang Pandya, Director - Present

Others Present: Donna Hefner, President/Chief Executive Officer, Craig McDonald, Chief Financial Officer, Melissa Crippen, VP of Regulatory Affairs, Jeff Hudson, VP of Patient Care Services and CNO, Terry Villareal, Executive Assistant and Clerk to the Board, Kim Pryor-DeShazo, Director of Marketing and Communications, Jessica Gruendler, Director of Surgical Services, Jennifer Regalado, Compliance Privacy Manager, Silvia Roberts, Director of Care Integration, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff.

I. Approval of Agenda:

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

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Yes
REDDY	Absent
LOMELI	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:05 p.m. to discuss the following items:

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

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

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

2. Quality Division Update – Quality Report

Closed Session Item C discussion commenced but could not be completed. As a result, Closed Item C, along with Closed Session Items D,E,F and G were deferred to the conclusion of Open Session , as there was not sufficient time to address these items prior to the scheduled start of Open Session.

III. Open Session: Chair LOMELI adjourned Closed Session at 5:49 p.m., reconvening in Open Session at 5:49 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.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

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

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Yes
REDDY	Absent
LOMELI	Yes

2. Quality Division Report

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

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Yes
REDDY	Absent
LOMELI	Yes

C. Conference with Legal Counsel Regarding Existing Litigation

This discussion will continue after Open Session as there was not enough time to address completely.

IV. Public Comments
None

V. Consent Agenda

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

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Yes
REDDY	Absent
LOMELI	Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director KASHYAP and seconded by Director MARTINEZ to approve the May 27, 2025 Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Yes
REDDY	Absent
LOMELI	Yes

VII. Business Items

A. May 2025 Financials

Craig McDonald, CFO presented the Financials for May 2025.

Following review and discussion, it was moved by Director PANDYA, seconded by Director KASHYAP and carried to approve the May 2025 Financials as presented. The vote of the Board is as follows:

KASHYAP	Yes
MARTINEZ	Yes

PANDYA	Yes
REDDY	Absent
LOMELI	Yes

Business Items B and C were deferred to the end of the meeting to allow time for review of the remaining Closed Session items.

VIII. SVLHCD Board Chair Report

Donna Hefner, President/CEO presented an Emergency Department Report on initiatives that are in the works for process improvement.

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

IX. Announcements:

A. Regular Board of Directors Meeting – July 22, 2025 at 5:00 p.m.

X. Closed Session: Chairman LOMELI adjourned Open Session at 6:23 p.m., reconvening in Closed Session at 6:36 p.m.

C. Pursuant to Gov. Code Section 54954.5(c) and 54956.9(d): Conference with Legal Counsel Regarding Existing Litigation: SVLHCD vs. Dr. Snyder; Tulare County Superior Court Case # VCU308242

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated Date of Disclosure: November 2025

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated Date of Disclosure: December 2025

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2027

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

XI. Open Session: Chairman LOMELI adjourned Closed Session at 7:45 p.m., reconvening in Open Session at 7:45 p.m.

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

C. Conference with Legal Counsel Regarding Existing Litigation

Motion 1: After serious considerations and performing our due diligence, I Director PANDYA, make a motion that Sierra View Local Health Care District make the following findings:

1. Orrenzo Snyder, MD and Sequoia Urology did not fulfill their contractual obligation of repayment of time, and failed to provide urology services to the Porterville community for the remaining 36 months of the contract.

2. As a result of their breach, the District has a right to recover $2,064,174.32 from Orrenzo Snyder, MD and Sequoia Urology.

3. After substantial investigation into the Defendants' assets it is very unlikely that Sierra View Local Health Care District could recover any judgment it obtains against Defendants as they appear to have very limited financial assets.

4. Additionally, the District has considered the substantial cost to proceed to trial, which would also not be recoverable from Defendants.

Motion seconded by Director MARTINEZ

The vote of the board is as follows:

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Yes
REDDY	Absent
LOMELI	Yes

Motion 2: Based on the Board's adoption of the aforementioned findings, I Chairman LOMELI, make a motion, that the $2,064,174.32 debt owed by Defendants Orrenzo Snyder, MD and Sequoia Urology to Sierra View Local Health Care District be forgiven and the District report the loan forgiveness in compliance with Federal and California law by issuing Defendants a 1099 - C in the amount of $2,064,174.32, seconded by Director PANDYA.

The vote of the board is as follows;

KASHYAP	Yes
MARTINEZ	Yes

PANDYA	Yes
REDDY	Absent
LOMELI	Yes

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Recommended Action: Information Only; No Action Taken

E. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Recommended Action: Information Only; No Action Taken

F. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Recommended Action: Information Only; No Action Taken

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

The board resumed discussion on Business Items B and C.

B. SVLHCD Fiscal Year 2026 Operating Budget

Following review and discussion, it was moved by Director PANDYA and seconded by Director MARTINEZ to approve the SVLHCD Fiscal Year 2026 Operating Budget as presented. The vote of the Board is as follows:

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Yes
REDDY	Absent
LOMELI	Yes

C. SVLHCD Fiscal year 2026 Capital Budget

Following review and discussion, it was moved by Director PANDYA and seconded by Director MARTINEZ to approve the SVLHCD Fiscal Year 2026 Capital Budget as presented. The vote of the Board is as follows:

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Yes
REDDY	Absent
LOMELI	Yes

XII. Adjournment

The meeting was adjourned at 7:49 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
Jun-25

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
June 2025

Statistic	Jun-25 Actual	Budget	Over/ (Under)	% Var.	YTD Actual	Budget	Over/ (Under)	% Var.	Fiscal 24 YTD	Increase/ (Decrease) Jun-24	% Change
Utilization											
SNF Patient Days											
Total	4	56	(52)	-92.9%	143	675	(532)	-78.8%	477	(334)	-70.0%
Medi-Cal	4	60	(56)	-93.3%	143	676	(533)	-78.8%	477	(334)	-70.0%
Sub-Acute Patient Days											
Total	1,026	970	56	5.8%	11,881	11,636	245	2.1%	11,723	158	1.3%
Medi-Cal	523	883	(360)	-40.8%	5,925	10,175	(4,250)	-41.8%	10,260	(4,335)	-42.3%
Acute Patient Days	1,662	1,648	14	0.9%	19,833	19,771	62	0.3%	19,849	(16)	-0.1%
Acute Discharges	447	427	20	4.7%	5,306	5,122	184	3.6%	5,213	93	1.8%
Medicare	175	169	6	3.7%	2,149	2,005	144	7.2%	2,041	108	5.3%
Medi-Cal	215	185	30	16.2%	2,476	2,460	16	0.6%	2,504	(28)	-1.1%
Contract	56	65	(9)	-14.2%	648	616	32	5.2%	627	21	3.3%
Other	1	7	(6)	-85%	33	40	(7)	-17.3%	41	(8)	-19.5%
Average Length of Stay	3.72	3.86	(0.14)	-3.7%	3.74	3.86	(0.12)	-3.2%	3.81	(0.07)	-1.8%
Newborn Patient Days											
Medi-Cal	151	161	(10)	-6.3%	1,808	1,924	(116)	-6.0%	1,923	(115)	-6.0%
Other	40	31	9	28.5%	397	382	15	4.0%	373	24	6.4%
Total	191	192	(1)	-0.7%	2,205	2,306	(101)	-4.4%	2,296	(91)	-4.0%
Total Deliveries	96	101	(5)	-5.0%	1,155	1,190	(35)	-2.9%	1,186	(31)	-2.6%
Medi-Cal %	80.21%	83.43%	-3.22%	-3.9%	82.54%	83.43%	-0.89%	-1.1%	83.43%	-0.89%	-1.1%
Case Mix Index											
Medicare	1.3310	1.6368	(0.3058)	-18.7%	1.5924	1.6368	(0.0444)	-2.7%	1.6368	(0.0444)	-2.7%
Medi-Cal	1.0803	1.1975	(0.1172)	-9.8%	1.1882	1.1975	(0.0093)	-0.8%	1.1975	(0.0093)	-0.8%
Overall	1.1814	1.3724	(0.1910)	-13.9%	1.3599	1.3724	(0.0125)	-0.9%	1.3724	(0.0125)	-0.9%
Ancillary Services											
Inpatient											
Surgery Minutes	6,217	8,224	(2,007)	-24.4%	88,168	98,687	(10,519)	-10.7%	98,031	(9,863)	-10.1%
Surgery Cases	82	94	(12)	-12.5%	1,053	1,125	(72)	-6.4%	1,106	(53)	-4.8%
Imaging Procedures	1,485	1,404	81	5.8%	18,197	16,851	1,346	8.0%	17,060	1,137	6.7%
Outpatient											
Surgery Minutes	15,086	12,775	2,311	18.1%	169,199	153,301	15,898	10.4%	153,438	15,761	10.3%
Surgery Cases	196	204	(8)	-3.8%	2,280	2,445	(165)	-6.7%	2,415	(135)	-5.6%
Endoscopy Procedures	218	192	27	13.8%	2,224	2,298	(74)	-3.2%	2,206	18	0.8%
Imaging Procedures	4,070	3,886	184	4.7%	49,601	46,629	2,972	6.4%	48,297	1,304	2.7%
MRI Procedures	281	302	(21)	-6.9%	3,585	3,620	(35)	-1.0%	3,605	(20)	-0.6%
CT Procedures	1,401	1,237	164	13.3%	15,070	14,843	227	1.5%	15,030	40	0.3%
Ultrasound Procedures	1,271	1,244	27	2.2%	15,747	14,924	823	5.5%	15,681	66	0.4%
Lab Tests	35,221	32,140	3,081	9.6%	390,419	385,682	4,737	1.2%	385,089	5,330	1.4%
Dialysis	2	6	(4)	-68.4%	47	76	(29)	-38.2%	43	4	9.3%
Cancer Treatment Center											
Chemo Treatments	2,127	1,924	203	10.6%	23,666	23,085	581	2.5%	21,573	2,093	9.7%
Radiation Treatments	1,602	1,836	(234)	-12.7%	21,901	22,029	(128)	-0.6%	22,490	(589)	-2.6%

Sierra View Medical Center
Financial Statistics Summary Report
June 2025

Statistic	Jun-25 Actual	Budget	Over/ (Under)	% Var.	YTD Actual	Budget	Over/ (Under)	% Var.	Fiscal 24 YTD	Increase/ (Decrease) Jun-24	% Change
Cardiac Cath Lab											
Cath Lab IP Procedures	17	11	6	51.1%	152	135	17	12.6%	164	(12)	-7.3%
Cath Lab OP Procedures	27	30	(3)	-9.7%	413	359	54	15.0%	364	49	13.5%
Total Cardiac Cath Lab	44	41	3	6.9%	565	494	71	14.4%	528	37	7.0%
Outpatient Visits											
Emergency	3,387	3,415	(28)	-0.8%	41,655	40,975	680	1.7%	41,525	130	0.3%
Total Outpatient	14,587	13,994	593	4.2%	171,162	167,931	3,231	1.9%	164,960	6,202	3.8%
Staffing											
Paid FTE's	898.02	855.00	43.02	5.0%	878.01	855.00	23.01	2.7%	862.92	15.09	1.7%
Productive FTE's	758.21	734.21	24.00	3.3%	752.09	734.21	17.88	2.4%	741	11.49	1.6%
Paid FTE's/AOB	5.06	4.82	0.24	5.0%	5.12	4.89	0.23	4.7%	5.01	0.11	2.2%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,194	10,552	642	6.1%	11,239	10,552	687	6.5%	10,760	479	4.5%
Cost/Adj.Patient Day	3,107	2,566	541	21.1%	2,860	2,611	249	9.5%	2,694	166	6.1%
Revenue/Adj. Discharge	54,341	53,065	1,275	2.4%	54,478	53,065	1,413	2.7%	53,223	1,255	2.4%
Cost/Adj. Discharge	15,081	12,904	2,177	16.9%	13,862	13,128	733	5.6%	13,327	535	4.0%
Adj. Discharge	1,096	1,057	39	3.7%	12,916	12,689	226	1.8%	12,715	200	1.6%
Net Op. Gain/(Loss) %	6.74%	-2.21%	8.96%	-404.9%	-0.45%	-2.21%	1.76%	-79.7%	-3.60%	3.15%	-87.5%
Net Op. Gain/(Loss) $	1,195,497	(295,300)	1,490,797	-504.8%	(801,850)	(6,388,936)	5,587,086	-87.4%	(5,885,428)	5,083,578	-86.4%
Gross Days in Accts Rec.	86.70	95.03	(8.32)	-8.8%	86.70	95.03	(8.32)	-8.8%	94.00	(7.30)	-7.8%
Net Days in Accts. Rec.	37.21	57.75	(20.54)	-35.6%	37.21	57.75	(20.54)	-35.6%	49.85	(12.64)	-25.4%

Sierra View Local Health Care District
Balance Sheet

	Jun-25	May-25
Assets		
Current Assets:		
Cash & Cash Equivalents	22,428,191	24,887,087
Short-Term Investments	-	-
Assets Limited As To Use	5,499,933	5,010,028
Patient Accounts Receivable	173,258,474	163,909,642
Less Uncollectables	(14,220,797)	(14,409,380)
Contractual Allowances	(139,641,335)	(132,168,964)
Other Receivables	20,225,718	19,858,355
Inventories	4,492,911	4,586,799
Prepaid Expenses and Deposits	2,619,918	2,834,714
Less Receivable - Current	279,983	279,983
Total Current Assets	**74,942,995**	**74,788,264**
Assets Limited as to use, Less		
Current Requirements	32,278,190	32,191,300
Long-Term Investments	139,055,728	138,186,555
Property, Plant and Equipment, Net	71,364,020	71,987,671
Intangible Right of use Assets	279,156	291,196
SBITA Right of use Assets	3,498,677	3,648,105
Lease Receivable - LT	727,672	752,185
Other Investments	250,000	250,000
Prepaid Loss on Bonds	1,258,777	1,279,756
Total Assets	**323,655,215**	**323,375,033**
Liabilities and Funds Balances		
Current Liabilities		
Bond Interest Payable	693,525	577,938
Current Maturities of Bonds Payable	4,235,000	4,235,000
Current Maturities of Long Term Debt	939,806	1,024,719
Account Payable and Accrued Expenses	4,397,358	5,046,443
Accrued Payroll and Related Costs	6,463,558	7,574,915
Estimated Third-Party Payor Settlements	4,408,713	4,591,671
Lease Liability - Current	130,007	131,735
SBITA Liability - Current	1,696,245	1,698,269
Total Current Liabilities	**22,964,211**	**24,880,689**
Self-Insurance Reserves	2,129,089	2,081,632
Capital Lease Liab LT	0	0
Bonds Payable, Less Curr Reqt	33,275,000	33,275,000
Bonds Premium Liability - LT	2,078,576	2,130,533
Lease Liability - LT	172,542	182,943
SBITA Liability - LT	2,157,786	2,274,411
Other Non Current Liabilities	-	-
Deferred Inflow - Leases	946,027	970,524
Total Liabilities	**63,723,231**	**65,795,732**
Unresticted Fund	248,385,511	248,385,511
Profit or (Loss)	11,546,474	9,193,791
Total Liabilities and Fund Balance	**323,655,215**	**323,375,033**
	-	-

Sierra View Local Health Care District
Income Statement

For Period **Jun-25**

	ACTUAL	BUDGET	VARIANCE	% VARIANCE	ACTUAL YTD	BUDGET YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	5,410,671	5,253,782	(156,889)	(3%)	64,314,468	63,045,404	(1,269,064)	(2%)
Inpatient - Ancillary	18,947,537	17,396,294	(1,551,243)	(9%)	225,768,384	208,755,479	(17,012,905)	(8%)
Total Inpatient Revenue	**24,358,208**	**22,650,076**	**(1,708,132)**	(8%)	**290,082,852**	**271,800,883**	**(18,281,969)**	(7%)
Outpatient - Ancillary	35,202,184	33,463,072	(1,739,112)	(5%)	413,532,221	401,556,860	(11,975,361)	(3%)
Total Patient Revenue	**59,560,392**	**56,113,148**	**(3,447,244)**	(6%)	**703,615,072**	**673,357,743**	**(30,257,329)**	(4%)
Medicare	(18,769,240)	(18,243,309)	525,931	(3%)	(212,726,623)	(218,919,708)	(6,193,085)	3%
Medi-Cal	(16,547,339)	(18,032,202)	(1,484,863)	8%	(212,946,656)	(216,386,424)	(3,439,768)	2%
Other/Charity	(7,384,071)	(6,660,852)	723,219	(11%)	(90,605,209)	(79,930,224)	10,674,985	(13%)
Discounts & Allowances	(304,582)	(9,556)	295,026	(3,087%)	(14,453,549)	(114,672)	14,338,877	(12,504%)
Bad Debts	(230,187)	(499,610)	(269,423)	54%	(3,288,068)	(5,995,320)	(2,707,252)	45%
Total Deductions	**(43,235,419)**	**(43,445,529)**	**(210,110)**	0%	**(534,020,105)**	**(521,346,348)**	**12,673,757**	(2%)
Net Service Revenue	**16,324,974**	**12,667,619**	**(3,657,355)**	(29%)	**169,594,968**	**152,011,395**	**(17,583,573)**	(12%)
Other Operating Revenue	1,400,084	682,479	(717,605)	(105%)	8,635,708	8,189,777	(445,931)	(5%)
Total Operating Revenue	**17,725,057**	**13,350,098**	**(4,374,959)**	(33%)	**178,230,676**	**160,201,172**	**(18,029,504)**	(11%)
Salaries	5,939,772	5,487,939	(451,833)	(8%)	68,433,861	66,254,896	(2,178,965)	(3%)
S&W PTO	915,241	666,139	(249,102)	(37%)	7,703,595	8,066,233	362,638	4%
Employee Benefits	1,799,119	1,464,528	(334,591)	(23%)	17,427,514	17,562,186	134,672	1%
Professional Fees	2,069,838	1,399,838	(670,000)	(48%)	22,673,354	16,919,549	(5,753,805)	(34%)
Purchased Services	1,153,363	817,716	(335,647)	(41%)	10,721,524	10,007,066	(714,458)	(7%)
Supplies & Expenses	2,427,882	2,030,436	(397,446)	(20%)	26,063,730	24,359,256	(1,704,474)	(7%)
Maintenance & Repairs	383,111	265,792	(117,319)	(44%)	3,240,421	3,262,626	22,205	1%
Utilities	280,915	277,064	(3,851)	(1%)	3,158,935	3,324,768	165,833	5%
Rent/Lease	25,178	19,595	(5,583)	(28%)	467,704	235,240	(232,464)	(99%)
Insurance	127,475	121,228	(6,247)	(5%)	1,462,650	1,454,736	(7,914)	(1%)
Depreciation/Amortization	900,389	791,523	(108,866)	(14%)	11,055,871	11,312,820	256,949	2%
Other Expense	507,278	303,600	(203,678)	(67%)	6,412,086	3,830,732	(2,581,354)	(67%)
Impaired Costs	-	-	-	0%	211,281	-	(211,281)	0%
Total Operating Expense	**16,529,560**	**13,645,398**	**(2,884,162)**	(21%)	**179,032,525**	**166,590,108**	**(12,442,417)**	(7%)
Net Gain/(Loss) From Operations	**1,195,497**	**(295,300)**	**(1,490,797)**	**505%**	**(801,849)**	**(6,388,936)**	**(5,587,087)**	**87%**
District Taxes	190,379	138,251	(52,128)	(38%)	1,763,288	1,659,034	(104,254)	(6%)
Investment Income	452,022	343,456	(108,566)	(32%)	4,624,836	4,121,455	(503,381)	(12%)
Other Non - Operating Income	54,691	54,011	(680)	(1%)	2,812,203	648,126	(2,164,077)	(334%)
Interest Expense	(81,498)	(80,570)	928	(1%)	(961,397)	(966,876)	(5,479)	1%
Non-Operating Expense	(21,044)	(36,958)	(15,914)	43%	(444,661)	(443,442)	1,219	(0%)
Total Non-Operating Income	**594,550**	**418,190**	**(176,360)**	(42%)	**7,794,270**	**5,018,297**	**(2,775,973)**	(55%)
			-				-	
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	**1,790,047**	**122,890**	**(1,667,157)**	**(1,357%)**	**6,992,420**	**(1,370,639)**	**(8,363,059)**	**610%**
Net Incr/(Decr) in the Fair Value Invstmt	562,636	100,000	(462,636)	(463%)	4,554,053	1,200,000	(3,354,053)	(280%)
Net Gain/(Loss)	**2,352,683**	**222,890**	**(2,129,793)**	(956%)	**11,546,474**	**(170,639)**	**(11,717,113)**	6,867%

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SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
June-25

	Current Month	YTD
Cash flows from operating activities:		
Operating Income/(Loss)	1,195,497	(801,849)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation/Amortization	900,389	11,055,871
Provision for bad debts	(188,583)	(9,325,478)
		-
Change in assets and liabilities:		-
Patient accounts receivable, net	(1,876,460)	13,744,130
Other receivables	(367,363)	(1,975,535)
Inventories	93,888	(202,258)
Prepaid expenses and deposits	214,796	(298,514)
Advance refunding of bonds payable, net	20,980	251,755
Accounts payable and accrued expenses	(649,086)	(1,926,234)
Deferred inflows - leases	(24,497)	(277,889)
Accrued payroll and related costs	(1,111,357)	(2,096,261)
Estimated third-party payor settlements	(182,958)	751,768
Self-insurance reserves	47,457	(59,911)
Total adjustments	(3,122,794)	9,641,443
Net cash provided by (used in) operating activities	(1,927,297)	8,839,594
Cash flows from noncapital financing activities:		
District tax revenues	190,379	1,763,288
Noncapital grants and contributions, net of other expenses	16,829	(98,267)
Net cash provided by (used in) noncapital financing activities	207,209	1,665,021
Cash flows from capital and related financing activities:		
Purchase of capital assets	(264,698)	(5,430,482)
Proceeds from sale of assets	-	3,255,420
Proceeds from debt borrowings	-	-
Proceeds from lease receivable, net	24,513	285,236
Principal payments on debt borrowings	-	(4,055,000)
Interest payments	(1,050)	(1,495,365)
Issuance of bonds payable and bond premium liability	-	-
Net change in notes payable and lease liability	(66,263)	(1,197,414)
Net changes in assets limited as to use	(576,795)	(1,343,980)
Net cash provided by (used in) capital and related financing activities	(884,292)	(9,981,584)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(306,537)	(5,766,314)
Investment income	452,022	4,624,836
Net cash provided by (used in) investing activities	145,485	(1,141,478)
Net increase (decrease) in cash and cash equivalents:	(2,458,895)	(618,447)
Cash and cash equivalents at beginning of month/year	24,887,087	23,046,638
Cash and cash equivalents at end of month	22,428,191	22,428,191
	22,428,191	22,428,191
	0.00	0.00

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
June 2025

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Jul-24	13,499,837	278,849	13,778,686
Aug-24	10,684,807	298,095	10,982,902
Sep-24	12,800,001	1,611,606	14,411,607
Oct-24	14,933,404	1,420,062	16,353,466
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**

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

June 2025 Summary of Other Activity:

574,112	M-Cal IP DSH 04/25 - 05/25 1069.0030
2,371,675	M-Cal AB113 IGT FY25 1069.0030
52,628	M-Cal AB113 IGT FY24 Admin 1069.0030
149,694	M-Cal AB113 IGT FY24 Final 1069.0030
907,726	M-Cal HQAF8 Direct Grant CY24 1069.0030
253,428	M-Care interim payments 5814.6600 5815.6600 5814.6700
444,293	Miscellaneous
4,753,556	06/25 Total Other Activity