



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

**AMENDED AGENDA
February 24, 2026**

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.**

Bindusagar Reddy
Zone 1

Martha A. Flores
Zone 2

Hans Kashyap
Zone 3

Liberty Lomeli
Zone 4

Areli Martinez
Zone 5



**SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MONTHLY MEETING AMENDED AGENDA
February 24, 2026**

1. **General Update;**
 2. **Report on Peer Review/Credentials**
- B.** Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b):
1. **Quality Division Update**
 2. **Compliance Quarterly Report**
- C.** Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): **Discussion Regarding Trade Secrets Pertaining to Financial Services and Strategic Planning** and Gov. Code Section 54956.9 (B)(3)(F):: **Conference with Legal Counsel, Significant Exposure to Litigation.** Estimated date of disclosure December 1, 2026.
- D.** Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): **Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning.** Estimated date of disclosure December 1, 2026.
- 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 Items).

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

A. Chief of Staff Report:

1. General Report

Recommended Action: Information only; no action taken

Page 2

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**SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MONTHLY MEETING AMENDED AGENDA
February 24, 2026**

2. Report on Peer Review/Credentials

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

B. Quality Division Update:

1. General Report

Recommended Action: Approve/Disapprove Quality Division Report as Given

2. Compliance Report

Recommended Action: Approve/Disapprove Compliance Report as Given

C. Discussion Regarding Trade Secrets Pertaining to Financial Services and General Strategic Planning

Recommended Action: Information Only; No Action Taken

D. Discussion Regarding Trade Secrets Pertaining to Services and General 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 be 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/Disapprove Consent Agenda as presented



**SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MONTHLY MEETING AMENDED AGENDA
February 24, 2026**

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

VIII. Approval of Minutes

- A. January 27, 2026, Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove January 27, 2026, Minutes of the Annual Meeting of the Board of Directors

IX. Business Items

- A. January 2026 Financials**
Recommended Action: Approve/Disapprove January Report as Presented
- B. Board Self Evaluation and Goals**
Recommended Action: Information only; No Action Taken

X. SVLHCD Board Chair Report

XI. SVMC CEO Report

XII. Announcements:

- Regular Board of Directors Meeting – March 24, 2026, 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.

Page 4

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**SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MONTHLY MEETING AMENDED AGENDA
February 24, 2026**

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.

CONSENT AGENDA

**HOSPITAL POLICIES AND REPORTS FOR REVIEW
APPROVED BY SENIOR LEADERSHIP TEAM**

Senior Leadership Team	2/24/2026
Board of Director's Approval	
Liberty Lomeli, Chairman	<u>2/24/2026</u>

**SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
February 24, 2026
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
<p>Policies:</p> <ul style="list-style-type: none"> • Administrator on Call – Authority in the Absence of the CEO • Appointment of the Chief Executive Officer • Authority in the Absence of the V.P. of Patient Care Services • Board of Directors, Orientation, Continuing Education and Self-Assessment • Board of Directors, Authority and Responsibilities • Contingency Plan for Water Damaged Medical Records • Hospital Services – Closure, Elimination or relocation • Leadership Participation in Planning & Decision-Making • Mission and Vision Statements • Notice of Privacy Practices • Nurse Executive Qualifications and Appointment Process • Policy and Procedure System • Role Responsibilities of the CEO • Strategic Plan • Subpoenas, Summons & Complaints 	<p style="text-align: center;">1 2-3 4 5-6 7-10 11 12-16 17 18 19-22 23-25 26-29 30-31 32 33-38</p>	<p>Approve</p> <p>↓</p>

<p>SUBJECT: ADMINISTRATOR ON CALL/AUTHORITY IN THE ABSENCE OF THE CEO</p>	<p>SECTION: <i>Leadership (LD)</i></p> <p style="text-align: right;">Page 1 of 1</p>
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PURPOSE:

To maintain and define the continuity of care for our patients and sustain leadership within the Hospital while conveying the professional nature of our position in the community during the absence of the Chief Executive Officer.

POLICY:

1. In the absence of the Chief Executive Officer (CEO), the Administrator on Call (AOC) will act on the President/CEO's behalf.
2. The President/ CEO will designate the Senior Leadership and Administrative Directors Team membership as eligible to be AOC.
3. An Administrator On Call Schedule is prepared and will be distributed to all members of Sr. Management Leadership and Administrative Directors as well as the Nursing Supervisor's Office, Staffing Coordinator, Director of Patient Registration-Patient Access leadership and the Switchboard Operators.
 - A schedule will be created by the Executive Assistant to the President/CEO on a quarterly basis. Once approved by the membershipCEO, it will be distributed House-wide.
 - Each member of the team will be on Administrative Call beginning on Friday morning 7 a.m. and ending on the following Friday morning 6:59 a.m. on a rotating basis to include holidays. Hand-off communication to new on call leader will be provided by outgoing leader.
 - Special requests for specific dates can be traded amongst the Senior Leadership Team leaders to ensure coverage at all times.
4. In the absence of the Administrator On Call, a memorandum will be circulated stating the individual designated to act on the CEO's behalf. Should the occasion arise during non-working hours when the designated Administrator oOn Call cannot be reached, the Nursing Supervisor for the shift will act on the CEO's behalf.
5. The California Department of Public Health, Licensing and Certification shall be notified in writing, whenever a permanent change of CEO (administrator) occurs.

REFERENCES:

- Sierra View Local Health Care District Board Bylaws, Article VII, Section 7.5.10

SUBJECT: APPOINTMENT OF THE CHIEF EXECUTIVE OFFICER	SECTION: <i>Leadership (LD)</i>
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Page 1 of 2

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

PURPOSE:

To define the Sierra View Local Health Care District Board of Directors process and criteria for selection/appointment of the Sierra View Medical Center Chief Executive Officer (CEO).

POLICY:

1. Established in the Sierra View Local Health Care District Board of Directors Bylaws, the Board of Directors shall have the authority to select, employ, control and discharge the CEO, who shall report to the Board and who shall be its direct executive representative and responsible for the overall management of the hospital. The criteria for selection of the CEO is as follows:
 - a. Must have a Master's Degree in Hospital Administration or related field.
 - b. Must have previous experience at Senior Management Level in an Acute Care Hospital.
 - c. CEO must demonstrate excellent employee relation skills.
 - d. CEO must be visionary and provide strategic leadership.
 - e. Must demonstrate that previous employment demonstrated a very positive bottom line during their leadership as the CEO.
 - f. Must be flexible and be able to work under the following working conditions: Subject to varying and unpredictable situations, emergency or crisis situations, many long and irregular hours.
 - g. CEO to demonstrate ability to work effectively with a wide-range of stakeholders.
2. The duties and the responsibilities of the CEO include, but are not limited to, the provision of leadership, direction, and administration of all aspects for Sierra View Local Health Care District activities to ensure compliance with established objectives and the realization of quality, economical healthcare services and other related lines of business and are further delineated in writing in the Bylaws and formal Job Description of the Sierra View Medical Center Chief Executive Officer.
3. The Sierra View Local Health Care District Board of Directors may enter into a contract of employment with a CEO, the duration of which shall not exceed four years, but which may periodically be renewed upon expiration for not more than four years per contract period.
4. The Board of Directors shall perform an annual evaluation of the CEO, assessing the effectiveness of the CEO based upon the goals and criteria established by the Board of Directors.

SUBJECT: APPOINTMENT OF THE CHIEF EXECUTIVE OFFICER	SECTION: <i>Leadership (LD)</i> Page 2 of 2
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REFERENCES:

- Health & Safety Code Section 32121.5
- Title 22, Division 5, Article 7, Section 70701(2)
- Sierra View ~~District Hospital~~Local Health Care District Board Bylaws, Article 7, Section 7.5
- The Joint Commission (20~~19~~25). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: AUTHORITY IN THE ABSENCE OF THE V.P. OF PATIENT CARE SERVICES	SECTION: <i>Leadership (LD)</i> Page 1 of 1
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PURPOSE:

To provide for continuity of ultimate decision authority and accountability within the Division of Nursing.

POLICY:

1. The Vice President of Patient Care Services (VPPCS) / -Chief Nurse ~~Officer-Executive~~ has overall responsibility, accountability, and authority for directing all matters pertaining to Patient Care Services, including staffing patterns and patient care.
2. In the absence of the VPPCS/~~CNOE~~, a designee will be appointed by the VPPCS/~~CNOE~~ as “Acting Chief Nurse ~~Officer-Executive~~” and will be consulted on all nursing administrative matters.
3. The House Supervisor on duty during the hours when members of the senior nursing leaders (~~CNOE~~ and nursing directors) are not present is considered to be in charge of the hospital.
4. In the absence of nursing department directors, each director will appoint a designee to assume responsibility for their respective area(s).

AFFECTED AREAS/ PERSONNEL: *DIVISION OF NURSING*

REFERENCES:

- The Joint Commission (~~2019-2025~~~~2022~~). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- State of California. (20~~25~~~~14~~). California Administrative Code Title XXII, 70211(c).

Manual

SUBJECT: BOARD OF DIRECTORS, ORIENTATION, CONTINUING EDUCATION AND SELF- ASSESSMENT	SECTION: <i>Leadership (LD)</i> Page 1 of 2
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PURPOSE:

To define the Sierra View Local Health Care District Board of Directors orientation, continuing education and self-assessment.

POLICY:

1. Each newly elected or appointed Director shall be provided ~~with~~ a Director Orientation ~~Book~~ from the President/CEO/Current/Elected Chairman of the Board of Directors. Each newly elected, or appointed Director shall be duly oriented to the management of the hospital. At that time, the new Director shall be supplied with and oriented to the following material:
 - a. Sierra View Medical Center (SVMC) Mission and Vision Statements;
 - b. SVMC Organization Chart;
 - c. Sierra View Local Health Care District Board of Directors Bylaws;
 - d. SVMC Medical Staff Bylaws and Rules & Regulations;
 - e. SVMC ~~Management Leadership~~ Phone Directory;
 - f. SVMC Performance Improvement Plan to include but not be limited to safety, quality, and compliance goals;
 - g. Background on accrediting and licensing agencies and their requirements;
 - h. Applicable summary of titles and regulations;
 - i. Individual and interdependent responsibilities and accountabilities of the governing body, senior ~~management leadership~~ and leaders of the organized medical staff as they relate to supporting the mission of the hospital and to providing quality and safe care.
 - j. SVMC financial processes to include budget development as well ~~a~~-interpretation of the hospital's financial statements;
 - k. Copy of the Brown Act;
 - l. Copy of the previous three (3) months' Board minutes, financial statements, and agenda packet; and,

Manual

SUBJECT: BOARD OF DIRECTORS, ORIENTATION, CONTINUING EDUCATION AND SELF- ASSESSMENT	SECTION: <i>Leadership (LD)</i> Page 2 of 2
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- m. The new Director shall be offered the opportunity to schedule individual meetings with the Chief Financial Officer, Vice President of Physician Recruitment and Professional Services, Vice President of Patient Care Services and the opportunity to meet with the President/CEO again, if deemed necessary.
2. Continuing education may be provided by the President/CEO as requested by individual Board members. Board conferences, workshops and retreats as well as outside educational programs may be included as part of the continuing education program.
3. There shall be an annual self-assessment of the effectiveness of the Board of Directors, based upon the goals and criteria established by the Board of Directors, completed by each member of the Board.

REFERENCES:

- The Joint Commission (2025+9). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.



House Wide Policy & Procedure Manual

SUBJECT: BOARD OF DIRECTORS, AUTHORITY AND RESPONSIBILITIES	SECTION: <i>Leadership (LD)</i> Page 1 of 4
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PURPOSE:

To define the Sierra View Local Health Care District Board of Directors powers and responsibilities for provision of the general oversight and governance of Sierra View Medical Center (Hospital) in accordance to the California Code of Regulations, Title 22, and the Health and Safety Code Division 23, Chapter 2, Article 2, Section 32121 *et seq.*

The Sierra View Local Health Care District (District) is organized for the purposes described in the Local Health Care District Law, and shall have and may exercise such powers in the furtherance of its purposes as are now or may hereafter be set forth in the Local Health Care District law and any other applicable statutes, rules or regulations of the State of California. The Board of Directors (Board) is the governing body of the District and has the legal and fiduciary responsibilities to govern the district and its hospital services. All district powers and responsibilities shall be exercised by or under the direction of the Board.

POLICY:

1. The Board is ultimately accountable for the safety and quality of care, treatment and services, compliance and electronic security provided at the Hospital. To that end, they shall adopt written bylaws in accordance with legal requirements and its community responsibility which shall include, but not be limited to provision for:
 - a. Identification of the purpose, ~~s and~~ mission, vision and values of the hospital and the means of fulfilling them.
 - b. The Board is authorized to make appropriate delegations of its powers and authority to officers and employees to include identifying those responsible for planning, management and operational activities as well as those responsible for the provision of care, treatment and services, compliance and electronic security.
 - c. The Board shall select and appoint a President/Chief Executive Officer (CEO) (Administrator or Interim) whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body.
 - d. The Board works with CEO, Senior ~~Management Leadership~~ and leaders of the organized medical staff to annually evaluate the Hospital's performance in relation to its mission, vision, goals and compliance.
 - e. The Board provides strategic direction to meet the community health needs and represents the interests of the community served by incorporating input into decision-making.

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<p>SUBJECT: BOARD OF DIRECTORS, AUTHORITY AND RESPONSIBILITIES</p>	<p>SECTION: <i>Leadership (LD)</i></p> <p style="text-align: right;">Page 2 of 4</p>
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~~f. The Board adopts and approves policies and procedures and annual budgets and monitors financial performance, including audits.~~

~~e.~~

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~~d. The Board ensures effective operations of the Patient Grievance Process. Provides a system for resolving patients' grievances, employee concerns and grievances and patient safety event reporting.~~

~~g.~~

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~~f.h. The Board works with Medical Staff Leaders who are ultimately responsible for credentialing and re-credentialing of the Medical Staff.~~

~~The Medical Staff shall be self-governing with respect to the professional work performed in the hospital, governed in their professional conduct by the highest Ethical standards of the medical profession, as outlined in the Code of Ethics applicable to the Practitioner. Membership in the Medical Staff organization shall be a prerequisite to the exercise of clinical privileges in the hospital, except as otherwise specifically provided in the Medical Staff Bylaws.~~

~~Formal organization of the Medical Staff which shall be comprised of all independent licensed Practitioners-providers who are members of the medical staff and privileged to attend-admit or provide medical or health related services to patients in the hospital. Board will approve medical staff re-appointments on a biannual basis in accordance with medical staff bylaws, with appropriate officers and bylaws and with staff re-appointments on a biannual basis.~~

~~The Medical Staff shall be self-governing with respect to the professional work performed in the hospital, governed in their professional conduct by the highest ethical standards of the medical profession, as outlined in the Code of Ethics applicable to the Practitioner. Membership in the Medical Staff organization shall be a prerequisite to the exercise of clinical privileges in the hospital, except as otherwise specifically provided in the Medical Staff Bylaws.~~

~~Preparation and maintenance of a complete and accurate medical record for each patient.~~

~~Provides a system for resolving conflicts among individuals and employed physicians working in the hospital.~~

~~h.i. Require that the medical staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices, including provision that all members of the Medical Staff be required to demonstrate their ability to perform surgical and/or other procedures competently and to the~~

House Wide Policy & Procedure Manual

<p>SUBJECT: BOARD OF DIRECTORS, AUTHORITY AND RESPONSIBILITIES</p>	<p>SECTION: <i>Leadership (LD)</i> Page 3 of 4</p>
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satisfaction of an appropriate committee or committees of the Medical Staff, at the time of original application for appointment to the staff and at least every two years thereafter.

NOTE: Organized medical staff members are eligible for full membership in the hospital's governing body, unless legally prohibited (by election or appointment).

~~h.~~ i. Assure that the Medical Staff Bylaws, Rules and Regulations are subject to governing body approval, which approval shall not be withheld unreasonably. The Medical Staff Bylaws shall include an effective formal means for the Medical Staff, as a liaison, to participate in the development of all hospital policy.

~~7. The Board shall select and appoint a President/CEO (administrator or interim) whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body.~~

2. The Department of Health Services shall be notified in writing whenever a change of President/CEO (administrator) occurs.
3. Provide appropriate resources required to maintain safe, quality care, treatment and services, compliance and electronic security.
4. Take all reasonable steps to conform to all applicable federal, state and local laws and regulations, including those relating to licensure, fire inspection and other safety measures.
5. The Board shall be responsible for the operation of the facilities owned, leased, or operated by the District, according to the best interests of the public health, and shall make and enforce all rules, regulations and bylaws necessary for the administration, governance, protection and maintenance of the facilities under the Board's management and all property belonging thereto, (and may prescribe the terms upon which patients may be admitted thereto if necessary). ~~Biannual~~ Rreview and ~~or~~ revision of the existing Governing Board Bylaws ~~every 3-4 years~~ to assure compliance with such Federal, State and Governmental regulations effected by ongoing legislative changes.
6. Provide for the control and use of the physical and financial resources of the hospital.
7. The Board shall provide the organized Medical Staff representation (through attendance and voice), by allowing Chief of Staff as elected by Medical Staff, to attend Board Meetings and provide reports to the Board of Directors.

REFERENCES:

- Health & Safety Code Division 23, Chapter 2, Article 2, Section 32121 *et seq.*
- Sierra View Local Health Care District Bylaws



House Wide Policy & Procedure Manual

SUBJECT: BOARD OF DIRECTORS, AUTHORITY AND RESPONSIBILITIES	SECTION: <i>Leadership (LD)</i> Page 4 of 4
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- Title 22, Division 5, Article 7, Section 70701

SUBJECT: CONTINGENCY PLAN FOR WATER DAMAGED MEDICAL RECORDS	SECTION: Page 1 of 1
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POLICY:

It is the policy of Sierra View Medical Center (SVMC) to provide a contingency plan in the event that records are damaged due to water damage. Any type of damage is destructive. Water damage from flood or fire can be most devastating.

PROCEDURE

1. The following procedures should be implemented as soon as the water is removed and the amount of damage is assessed.
 - a. Determine what documents should be rescued using the retention requirements.
 - b. Prioritize which records should be removed first in order to keep the hospital functioning.
 - c. Records are to be removed within 48 hours of damage to prevent mold, mildew and bacteria growth.
 - d. Depending on the degree of damage, the records can be restored by:
 - Air drying the records by placing absorbent material between each document and then using fans for increased air circulation.
 - Freezing the records and keeping them in cold storage. This process stops the deterioration of handwritten data on paper records.
 - Freeze-drying is the quickest and most expensive method. It is only for optimal preservation of original records that are totally irreplaceable.
 - Remember that time is a critical factor. Move as quickly as possible to recover damaged information.

REFERENCE:

- California Code of Regulations, Title 22, § 70751



House Wide Policy & Procedure Manual

SUBJECT: HOSPITAL SERVICES – CLOSURE , ELIMINATION OR RELOCATION	SECTION: <i>Leadership (LD)</i> Page 1 of 5
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PURPOSE:

To establish a process wherein public notice is given ~~in advance 30 days prior~~ to closing a Sierra View Local Health Care District health facility, or eliminating a supplemental service; appropriate notices are posted; and, a notice forwarded to the California Department of Public Health Services (CDPH) and to the Tulare County Board of Supervisors. Local emergency medical services authority will be notified if emergency services are affected.

To establish a process where public notice is given ~~30 days prior~~ in advance to relocation of the provision of supplemental services to a different campus or a health facility and to provide posting of notices in appropriate locations at all affected facilities; and a notice forwarded to the California Department of Public Health Services (CDPH) and to the Tulare County Board of Supervisors.

Rationale

It is the intention of the Hospital Board of Directors and Leadership that this policy is enforced in a consistent and appropriate manner. The policy delineates the applicable Title 22, Division and Section of the California Code of Regulations that cites the process for posting a public notice for closure, elimination or relocation of any Hospital/District Services; and, to forward notices to CDPH and to the Tulare County Board of Supervisors.

This policy will be interpreted and enforced by the Board of Directors or Board-appointed designees.

The Board of Directors will assure that:

- A. Any Hospital/District Service(s) that are to be closed, eliminated or relocated shall be noticed in accordance with applicable laws and regulations and shall include all of the following:
 - 1. A description of the proposed closure, elimination, or relocation. The description shall be limited to publicly available data, including the number of beds eliminated, if any, the probable decrease in the number of personnel, and a summary of any service that is being eliminated, if applicable.
 - 2. A description of the three nearest available comparable services in the community. If the health facility closing these services serves Medi-Cal or Medicare patients; this health facility shall specify if the providers of the nearest available comparable services serve these patients.
 - 3. Written public notice will be posted at the facility entrances, website, local newspaper and with permission, at community health clinics.
 - 3.4. A telephone number and address for each of the following, where interested parties may offer comments:
 - a. The health facility;

SUBJECT: HOSPITAL SERVICES – CLOSURE , ELIMINATION OR RELOCATION	SECTION: <i>Leadership (LD)</i>
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- b. The parent entity, if any, or contracted company, if any, that acts as the administrator of the health facility; and,
- c. The Chief Executive Officer.
- d. The Board of Directors furthermore delegates the Senior ~~Management Team~~ **Leadership** staff to assure appropriate quasi-legislative processes and public notices are accomplished in compliance with the California Code of Regulations; Title 22.

B. Advance Public Notice will be posted for minimum notice periods as follows:

- a. At least 120 days for Hospital closure of entire facility
- b. At least 180 days notice for reduction or elimination of emergency medical services
- c. At least 120 days notice for elimination of perinatal services
- d. At least 30 days notice for closure or relocation of all other services

C. Public Hearings requirement (for closure of perinatal unit)

- a. Hold at least one public hearing 60 days after providing notice
- b. Make the hearing accessible including remote participation
- c. Notify the Tulare County Board of Supervisors and invite testimony about community impacts

D. Regulatory filings and notifications:

- a. CDPH will receive written notice of the closure within 30 days of the closure
- b. Notice will include the following:
 1. Last date of patient care
 2. Final licensure date
 3. Facility address and forwarding contact information

AFFECTED AREAS/PERSONNEL:

BOARD MEMBERS, ADMINISTRATION; AND, MEDICAL STAFF MEMBERS

REFERENCES:

- California Code of Regulations, Title 22 §97007, Division 5, Chapter 1, Section 70067, and Health and Safety Code Section §1255.250, Subdivision (a) or (b);
- AB 2037
- SB1300

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House Wide Policy & Procedure Manual

SUBJECT: HOSPITAL SERVICES – CLOSURE , ELIMINATION OR RELOCATION	SECTION: <i>Leadership (LD)</i> Page 3 of 5
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ATTACHMENT A

ESTABLISH AD HOC INVESTIGATORY COMMITTEE (AHIC) MEMBERSHIP

The AHIC shall consist of two Board Directors, Chief of Staff, Department Chair of Service being closed/relocated, President/CEO, a member of the community; the Department Director and Vice President over the Service to be closed/relocated and the District Secretary.

The role of the AHIC will be to review the evidence, findings, statements and other information submitted regarding the ____ Service. Based upon their findings, the AHIC will submit a report and recommendation to the Board of Directors at their regular meeting on ____ (date).

The evidentiary support of the benefits of closing/relocating the ____ Service should include some, or all of the following:



House Wide Policy & Procedure Manual

SUBJECT: HOSPITAL SERVICES – CLOSURE , ELIMINATION OR RELOCATION	SECTION: <i>Leadership (LD)</i> Page 4 of 5
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1. Preservation of the hospital’s management ability to make managerial and policy determinations in order to fulfill its responsibility to ensure the competence of the medical staff in the quality of the patient care provided;
2. ...continue with the applicable information related to closure/relocation of the particular Service being closed/relocated...

Any questions regarding the quasi-legislative review process and the AHIC’s responsibilities should be directed to the President/CEO or the District Secretary, at (559) 788-6101.

ATTACHMENT B

NOTICE
PUBLIC NOTICE

YOU WILL PLEASE TAKE NOTICE that the Sierra View Local Health Care District, dba, Sierra View Medical Center, Board of Directors has established a quasi-legislative review process and appointed an Ad Hoc Investigatory Committee (“AHIC”) to take evidence regarding the Hospital’s _____ Service operations and policies including consideration of closure/relocation of the _____ Service. The AHIC will make a report to the Board regarding its findings and recommendations.

The Board strongly encourages any interested members of the Medical Staff, particularly providers of the _____ Service, to submit written evidence, statements or other information with respect to the issues to the Sierra View Medical Center Administration office by _____ (date). No submissions



House Wide Policy & Procedure Manual

SUBJECT: HOSPITAL SERVICES – CLOSURE , ELIMINATION OR RELOCATION	SECTION: <i>Leadership (LD)</i> Page 5 of 5
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received after the deadline will be considered. At its regularly scheduled meeting in _____
(date), the Board of Directors will meet to consider AHIC's report and recommendations.

<p>SUBJECT: LEADERSHIP PARTICIPATION IN PLANNING & DECISION-MAKING</p>	<p>SECTION: <i>Leadership (LD)</i></p> <p style="text-align: right;">Page 1 of 1</p>
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PURPOSE:

To outline and define those processes of planning and decision-making where collaboration is required among leaders and other representatives from the organization.

POLICY:

1. The Sierra View Medical Center’s Senior ~~Management Team~~Leaders, Department Managers and Directors of the appropriate services collaborate to:
 - a. Develop organization-wide patient care programs, policies, and procedures that describe how patients’ care needs are assessed and met.
 - b. Develop and implement plan for provision of patient care.
 - c. Participate in decision-making processes and structures.
 - d. Implement an effective, continuous improvement program to measure, assess and improve outcome performance (~~Performance Improvement Program [long term] and Performance Improvement Teams [short term]~~).
 - e. Participate in the planning process for long and short-term facility needs including those related to patient care services.
 - f. Collaborate in budget planning and development.

2. The Senior ~~Management Team~~Leadership meets weekly, or more often as deemed necessary.

AFFECTED AREAS/PERSONNEL: *ALL IDENTIFIED LEADERSHIP*

REFERENCES:

- The Joint Commission (202519). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: MISSION AND VISION STATEMENTS	SECTION: <i>Leadership (LD)</i> Page 1 of 1
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PURPOSE:

To define the mission and vision of Sierra View Medical Center

PURPOSE:

The mission and vision of the Hospital will support the safety and quality of care, treatment and services of the population served.

It is the responsibility of the Hospital's leadership to provide for the safety and quality of care, treatment and services. The Board of Directors, hospital leaders and leaders of the organized medical staff will work together to create the Hospital's mission and vision statements which guide the actions of the leaders and the development and updating of the Hospital's Strategic Plan.

Ultimately, these will be communicated to staff and the population the hospital serves.

Sierra View Medical Center Mission Statement

SVMC promotes health and ensures access to high quality healthcare services. This will be achieved:

- Through partnerships and collaborations
- By being a good steward of resources to ensure it can continue to meet the health needs of the community

Sierra View Medical Center Vision Statement

Be the preferred choice for health care by providing excellent, patient-centered care through engaged/caring physicians and employees, academic training and timely access to care. Strengthen the quality of life through the delivery of integrated health care programs and services that promote access, care coordination and patient care experience.

REFERENCE:

- The Joint Commission (2025~~19~~). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCE:

- Strategic Plan

SUBJECT: NOTICE OF PRIVACY PRACTICES	SECTION: <i>Ethics, Rights, & Responsibilities (RI)</i> Page 1 of 4
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PURPOSE:

To define the manner by which Sierra View Medical Center (SVMC) will fulfill the requirement to provide a Notice of Privacy Practices to all patients as required by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, the Health Information Technology for Economic and Clinical Health Act (HITECH) component of the American Recovery and Reinvestment Act (ARRA), and any and all other Federal regulations and interpretive guidelines.

POLICY:

SVMC must provide adequate Notice of Privacy Practices to all patients, including newborns but excluding inmates. A written acknowledgement receipt of the Notice must be obtained from the patient or patient’s designated caregiver or legal representative.

DEFINITIONS:

Affiliated Covered Entity - Entities under common ownership or control may designate themselves as an Affiliated Covered Entity. Hospitals which are in a shared Clinical Patient Care System market and share patient information for purposes of payment and healthcare operations will automatically be designated as an affiliated covered entity under the rule.

Direct treatment relationship – A relationship between a healthcare provider and patient where the healthcare provider delivers healthcare directly to the individual.

Organized Health Care Arrangement - A clinically integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The facility and its medical staff are an Organized Health Care Arrangement under the rule.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

1. SVMC must provide a Notice that is written in plain language and that includes, at a minimum, the standard notice language attached to this policy. There may be individual facility situations that warrant additions to the standard form such as residency programs or research programs. These additions may be made at the discretion of the Chief Privacy Officer (CPO) in consultation with the SVMC Compliance committee responsible for the Privacy Program and, in appropriate circumstances SVMC’s Legal Counsel.

SUBJECT: NOTICE OF PRIVACY PRACTICES	SECTION: <i>Ethics, Rights, & Responsibilities (RI)</i> Page 2 of 4
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

2. The patient must acknowledge in writing (i.e., initials) receipt of each version of the Notice of Privacy Practices. This acknowledgement can be in either the Conditions of Admission/Consent for Treatment form or in another format that is included within the facility’s designated record set as deemed appropriate by the SVMC Compliance committee. Only the patient or the patient’s designated caregiver or legal representative may acknowledge receipt of the Notice. It is not appropriate for a spouse or other relative to acknowledge the Notice on the patient’s behalf unless they are the patient’s personal representative as defined by state law.

For emergency treatment situations, acknowledgement of the Notice is encouraged but not required.

3. Required Elements:
 - a. The header statement must state: “This notice describes how medical information about you may be used and disclosed and how you can get access to this information.”
 - b. A description, including at least one example, of the types of disclosures for the purposes of treatment, payment and healthcare operations.
 - c. A description of each of the other purposes for which SVMC is permitted or required to use or disclose the information without an individual’s consent or authorization (e.g., State Reporting).
 - d. A statement that if a use or disclosure is prohibited or materially limited by other applicable law, the description of such use or disclosure must reflect the more stringent law.
 - e. A statement that the facility may contact the individual to: a) provide appointment reminders; b) provide information about treatment alternatives; or c) provide information about other health-related benefits and services, as applicable and one or more of these communications may be left on the patient’s answering machine/voice mail.
 - f. A statement that other uses and disclosures will be made only with the individual’s written authorization and that the individual may revoke this authorization.
 - g. A statement of the patient’s rights with respect to protected health information
 - The right to access protected health information (PHI) ;
 - The right to amend PHI ;
 - The right to receive confidential communications;
 - The right to an accounting of disclosures;

SUBJECT: NOTICE OF PRIVACY PRACTICES	SECTION: <i>Ethics, Rights, & Responsibilities (RI)</i> Page 3 of 4
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- The right to request restrictions on certain uses and disclosures;
 - The right to obtain a copy of the Notice.
- h. A statement of the facility’s duties with respect to PHI.
- SVMC is required by law to maintain the privacy of PHI and to provide this Notice with respect to PHI;
 - SVMC must abide by the terms of the Notice;
 - SVMC may apply a change to the Notice and make the new Notice effective for all PHI it maintains. The statement will also include how it will provide the revised Notice to individuals.
- i. A statement that patients may complain to the CPO or the Secretary of the U.S. Department of Health and Human Services if they believe their privacy rights have been violated, a brief description of how the individual may file a complaint, and a statement that the individual will not be retaliated against for filing a complaint.
- j. A statement that includes the name or title and telephone number of the CPO.
- k. The effective date of the notice.
- l. A statement that the notice may change.
4. Facilities that have a direct treatment relationship with patients must:
- a. Provide the Notice no later than the date of the first service delivery; except in an emergency situation, in which case the facility must deliver the Notice as soon as practicable after the emergency situation. It is encouraged to distribute the Notice on subsequent service deliveries; however, are only required to do so if the Notice has had a material changed since last providing a copy to the patient;
 - b. Have the Notice posted in a clear and prominent location (i.e., each patient access/registration location) where it is reasonable to expect individuals seeking service from SVMC to read the Notice; and
 - c. Have the Notice available for individuals to take with them.
5. SVMC must prominently post its Notice on the website and make the Notice available electronically through the website.
6. Facilities may provide the Notice by e-mail. A paper copy must be provided at the request of the patient or if the mail transmission fails.

SUBJECT: NOTICE OF PRIVACY PRACTICES	SECTION: <i>Ethics, Rights, & Responsibilities (RI)</i> Page 4 of 4
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7. If the first treatment service delivery to a patient is delivered electronically, SVMC must provide the Notice automatically and immediately. The individual may obtain a paper copy at his or her request.
8. Facilities in an Organized Health Care Arrangement or in an Affiliated Covered Entity may use a joint Notice, meaning the same form; however, SVMC must provide the Notice upon interaction with the patient. These entities must be prepared to describe the facilities and physicians to which the joint Notice applies and must explain that information will be shared as necessary to carry out treatment, payment and healthcare operations.
9. For recurring patients the Notice may be provided at the initial interaction and does not need to be provided again unless a change has been made.
10. SVMC must document compliance by retaining copies of the Notices issued for at least six (6) years.
11. SVMC may review and update the Notice but must distribute its Notice whenever there is a material change to the uses or disclosures, individual's rights, legal duties or other privacy practices stated in the Notice. A material change to any term of the Notice may not be implemented prior to the effective date of Notice in which a material change is reflected.

REFERENCES:

- Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164
- American Reinvestment and Recovery Act of 2009, Title XIII, Subtitle D

CROSS REFERENCES:

- Privacy Official Policy
- Patient Privacy – [Right to Access Policy](#)
- Patient Privacy – [Right to Amend Policy](#)
- Patient Privacy – [Right to Request Privacy Restrictions Policy](#)
- [Records Management Policy](#)

SUBJECT: NURSE EXECUTIVE: QUALIFICATIONS AND APPOINTMENT PROCESS, RESPONSIBILITIES AND ACCOUNTABILITIES	SECTION: <p style="text-align: right;">Page 1 of 3</p>
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PURPOSE:

The ~~Chief Nurse Officer (CNO) Executive~~ directs the delivery of nursing care, treatment, and services (TJC-NR, 2025)

The ~~CNO nurse executive~~ functions at the senior leadership level to provide effective leadership and to coordinate leaders to deliver nursing care, treatment, and services (TJC, NR.2025).

The ~~CNO Chief Nurse Executive~~ assumes an active leadership role with the hospital’s governing body, senior leadership, medical staff, management, and other clinical leaders in the hospital’s decision-making structure and process (TJC, NR, ~~2025-01-01-01, 2019~~)

RATIONALE:

Nurses make up the front line of patient care; they are directly and intimately involved in the care, treatment, and services patients receive and are likely to be the most visible face of health care for patients who enter the hospital. As a leader in the health care delivery system, the ~~CNO nurse executive~~ is vital to the establishment of a cohesive and collaborative nurse-care team, and ultimately, to the hospital that wishes to maintain safe, quality patient care. The ~~CNO nurse executive~~ is also vital to the continuity of care each patient receives. ~~In order to~~To improve organization wide quality in nursing care, treatment, and services, the ~~CNO nurse executive~~ must assume an active leadership role in the hospital.

POLICY:

1. The ~~CNO nurse executive~~ will hold a current and active license as a registered nurse in the State of California. The ~~CNO nurse executive~~ is qualified by advanced education and management experience.
2. The ~~CNO nurse executive~~ has a job description that specifies the lines of authority and accountability. *(See Job Description)*
 - Consideration when selecting a ~~CNO nurse executive~~:
 - The ~~CNO nurse executive~~ possesses a Bachelor’s Degree in Nursing and a postgraduate degree in nursing or a related field; or the knowledge and skills associated with an advanced degree; or a written plan to obtain these qualifications.
 - The education and experience required for peer leadership positions.
 - The hospital’s scope of services and complexity and the position’s authority and responsibility.
 - The scope and complexity of the nursing care needs of the major patient population(s) served by the hospital.

SUBJECT: NURSE EXECUTIVE: QUALIFICATIONS AND APPOINTMENT PROCESS, RESPONSIBILITIES AND ACCOUNTABILITIES	SECTION: <div style="text-align: right;">Page 2 of 3</div>
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- The availability of nursing and administrative staff and services to assist the CNO nurse executive in the execution of responsibilities.

- 3. The CNO nurse executive coordinates and directs the hospital's nursing services
 - The development of hospital wide plans to provide nursing care, treatment, and services
 - The development of hospital wide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met and evaluated.
 - The development of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services.

- 4. The CNO nurse executive establishes guidelines for the delivery of nursing care, treatment, and services.
 - The CNO nurse executive, registered nurses, and other designated nursing staff write:
 - Standards of nursing practice for the hospital
 - Nursing standards of patient care, treatment, and services
 - Nursing policies and procedures
 - Nurse staffing plan(s)
 - Standards to measure, assess, and improve patient outcomes

- 5. The CNO nurse executive directs the implementation of nursing policies and procedures, nursing standards, and a nurse staffing plan(s).
 - The CNO nurse executive or designee approves policies; nursing standards of patient care, treatment, and services; and standards of nursing practice for the hospital before implementation.
 - The CNO nurse executive implements nursing policies, procedures, and standards that describe and guide how the staff provide nursing care, treatment, and services.
 - The CNO nurse executive provides access to all nursing policies, procedures, and standards to the nursing staff.
 - The CNO nurse executive is responsible for the provision of nursing services 24-hours a day, 7-days a week.
 - The CNO nurse executive or designee exercises final authority over the staff who provide nursing care, treatment, and services
 - A registered nurse provides or supervises the nursing services 24-hours a day, 7-days a week.

AFFECTED PERSONNEL/AREAS: *ADMINISTRATION; NURSING*

REFERENCE:

- The Joint Commission. (2025~~19~~). Nursing (NR) Chapter. Accreditation Participation Requirements (APR) Manual.

SUBJECT: NURSE EXECUTIVE: QUALIFICATIONS AND APPOINTMENT PROCESS, RESPONSIBILITIES AND ACCOUNTABILITIES	SECTION: Page 3 of 3
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SUBJECT: POLICY AND PROCEDURE SYSTEM	SECTION: Leadership (LD) Page 1 of 4
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PURPOSE:

~~To define a single, digital, comprehensive system for the development, communication and maintenance of policies and procedures.~~ To define the Document Management System – PowerDMS used at Sierra View Medical Center (SVMC) and the various applications and documents that will be maintained in the electronic document system.

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PowerDMS provides a streamlined collaboration and audit process through their digital document platform. The system has the ability to store, organize, distribute and track facility documents. PowerDMS integrates policies, training and accreditation content to archive and ensure Federal and State compliance.

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POLICY:

A. PowerDMS will allow the digital storage of the following:

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1. Policy Management
2. Forms Management
3. License Management
4. TJC Assessments/Mock Assessments
5. TJC Standards Manual – Hospital and Laboratory
6. Mobile access for iPhone and Android
7. Standard Operating Procedures (SOP's)
8. Manufacturer's Instructions For Use (MIFU) Logs

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~~A.B.~~ In order to establish organization-wide consistency, ensure compliance with the requirements for licensing and accreditation, and allow ~~affected personnel employees~~ to work effectively and efficiently, all levels of ~~affected personnel employees~~ will have access to policies and procedures. To accomplish these goals, the following guidelines are established:

1. All organizational policies and procedures shall be stored in PowerDMS (Document Management System). ~~the PolicyTech Policy and Procedure Management system~~. All ~~affected personnel employees~~ will have access to read all policies and procedures ~~in~~ the system.
2. All policies shall follow a standard format and editorial style as outlined in each policy template.
3. Policy Owners (~~–i.e.,~~ Department Directors, Managers and Senior Management) are responsible for creating new policies, revising policies when needed, reviewing policies as required and identifying the need to archiving obsolete policies.
4. ~~Department Directors and Senior Management are~~ Leadership is responsible for communicating the existence of new policies or policy revisions to employees affected by the changes, and for ensuring employees read new policies and revisions as required.

SUBJECT: POLICY AND PROCEDURE SYSTEM	SECTION: Leadership (LD) Page 2 of 4
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5. Policies may not be reproduced or distributed to parties outside of Sierra View Medical Center without authorization from the CEO.
6. All policies will remain in effect until archived or until superseded by a policy revision of a later date.

AFFECTED PERSONNEL/AREAS: ALL HOSPITAL PERSONNEL, STUDENTS, RESIDENTS, AND MEDICAL STAFF

PROCEDURE:

A. Create a New Policy & Archive a Policy

1. Policy Owners are required to generate a Message within PowerDMS to the System Administrator requesting a New Policy or to Archive a Policy. The following elements are to be provided to the System Administrator.

a. New Policy:

- i. Policy Name
- ii. Policy Owner
- iii. Review Cycle
- iv. Workflow Reviewers
- v. Department Name

Upon receipt of this Message, System Administrator will create the new policy, attach the Policy Word Template, and set up the Review Cycle and Workflow Template. Communication will be sent to the Policy Owner informing them that setup is complete and to proceed with policy development. When the workflow steps are complete, final step - Board Approval, the policy will be published through the automated process.

b. Archive Policy:

- i. Policy Name
- ii. Policy Owner
- iii. Document Folder Name
- iv. Detailed explanation for reason to Archive policy

Upon receipt of this Message, System Administrator will generate an Archive Workflow and request approval by Policy & Procedure Committee. Upon approval by Committee Members, System Administrator will Archive the policy. Although an archived policy will no longer be in the library of published policies, it will be stored in the system and can easily be accessed if needed.

B. Policy Review & Approve Process

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<p>SUBJECT: POLICY AND PROCEDURE SYSTEM</p>	<p>SECTION: Leadership (LD)</p> <p style="text-align: right;">Page 3 of 4</p>
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~~1. All policies stored in PowerDMS are automatically flagged for Review & Approval based on the policy's review requirements (i.e., annually, every two years, etc.). Each policy has a set review period, but it is the responsibility of the policy Owner to ensure this information is correct and that policies are reviewed when required.~~

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~~1. _____~~

~~1. The Department Director or member of Senior Management responsible for creating the policy (the Owner) must develop a first draft of the policy. Policy Owners also have the ability to designate someone else as the Writer of the policy, but the Owner must first create the document in Policy Tech (i.e. choose a template, type in the title, etc.) and then submit it to the Writer or submit it for review.~~

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~~2. When the draft policy is completed, it will be submitted for review and approval through the automated process.~~

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~~3. Reviewers will have the opportunity to approve the policy or offer revisions. If revisions are suggested, the policy will automatically be returned to the Owner. If no changes are needed, the policy will move on to the next person or group in the review process.~~

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~~4. Once the policy has made it through all steps of the review/approval process, it will be published in the policy library. (The system also offers the ability to publish the policy at a later date and can create quizzes to ensure reader comprehension of the policy.)~~

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~~B. Revise an Existing Policy~~

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~~1. The Owner of the policy must open the current version of the policy in PolicyTech.~~

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~~2. The Owner will click on the orange button at the top of the page that says "Create New Version." Once the revisions have been made, the Owner will send the revised version of the policy through the review/approval process. The new version will remain in draft form while edits are made and the changes are sent through the review/approval process. The original version will still be accessible in the system while the new version goes through the review/approval process.~~

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~~3. Once the revised policy has made it through every step of the review/approval process, the new version will be published. The old version of the policy will automatically be archived in PolicyTech.~~

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~~C. Policy Review Process~~

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~~1. All policies stored in PolicyTech are automatically flagged for review based on that policy's review requirements (i.e. annually, every two years, etc.). Each template has a set review period, but it is the responsibility of the policy Owner to ensure this information is correct and policies are reviewed when required.~~

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~~2. The Owner responsible for the policy will receive a notification when a policy is up for review.~~

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~~3. The Owner must review the policy and determine if revisions are required.~~

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SUBJECT: POLICY AND PROCEDURE SYSTEM	SECTION: <i>Leadership (LD)</i> Page 4 of 4
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~~2. If revisions are required, the Owner must make the necessary revisions and send the policy through the automated review/approval process.~~

2. All policies require a generation of New Draft from the published version. Policy Owner will assign the Workflow template to the Draft and proceed with the Review & Approval process. Upon completion of the Final Step, the New Policy will be published and the previous version will be archived.

~~3. If no revisions are required, the Owner must "Submit for Review" and place "No Revision Necessary" in the notes section.~~

~~D. Archive a Policy~~

~~1. Policy Owners are also responsible for requesting archive of any policies that are no longer relevant. Although an archived policy will no longer be in the library of published policies, it will be stored in the system and can easily be accessed if needed. The policy owner may make a request for archive by submitting the policy for review with a note that archive of the policy is being requested. Policy & Procedure Committee will approve or deny the policy owner's requests for archive.~~

References:

PowerDMS Lesson 2 Training Document

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<p>SUBJECT: ROLE & RESPONSIBILITIES OF THE PRESIDENT/CEO</p>	<p>SECTION: <i>Leadership (LD)</i> Page 1 of 2</p>
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PURPOSE:

To define the responsibilities and role of the Sierra View Medical Center President/CEO.

POLICY:

1. The duties and the responsibilities of the President/CEO are defined in the Bylaws and the formal President/CEO Job Description. The Sierra View Local Health Care District Board of Directors shall have the authority to select, employ, control and discharge the President/CEO, who shall be its direct executive representative in the overall management of the hospital.

The President/CEO shall be given the necessary authority, and be held responsible for the administration of the Hospital, in all its activities and departments, subject only to such policies as may be adopted and such orders as may be issued by the Board, or any of its committees to which it has delegated power for such action.

The President/CEO shall be responsible for the implementation of policies adopted by the Board of Directors. By working with standing and special committees of the Board and committees of the Medical Staff of the Hospital, the President/CEO is to participate in the development of policies which provide the framework for high quality patient care.

The President/CEO shall act as the “duly authorized representative” of the Board in all matters in which the Board has not formally designated some other person for that specific purpose. Individual members of the Board shall direct concerns they have regarding operations or personnel matters to the President/CEO. The authorities and duties of the President/CEO shall be:

- a. To provide for the recruitment, retention and when applicable, the discharge of all employees authorized by the Board, and pursuant to any regulation that may be adopted by the Board.
- b. Maintain District records and minutes of Board and Committee meetings. To submit regularly to the Board periodic reports showing the services performed and the financial activities of the Hospital.
- c. To attend all meetings of the Board and its committees when required.
- d. To identify a nurse leader at the executive level who will actively participate in decision-making.
- e. To perform any other duty that may be necessary in the best interests of the Hospital.
- f. To serve as the liaison officer and channel of communications for all official communications between the Board or any of its committees, the Medical Staff and the

<p>SUBJECT: ROLE & RESPONSIBILITIES OF THE PRESIDENT/CEO</p>	<p>SECTION: <i>Leadership (LD)</i> Page 2 of 2</p>
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personnel of the District. Providing periodic reports to the Board and to the Medical Staff(s) on the overall activities of the District and the Hospital(s) or other facilities, as appropriate, as well as pertinent federal, state and local developments that effect the operation of District Facilities.

- g. To provide information and support systems for the organization.
- h. To provide for and supervise all business affairs such as records of financial transactions, collections and accounts, and purchase and issuance of supplies and to ensure that all funds are collected and expended to the best possible advantage.
- i. To see that all physical properties of the district are kept in a good state of repair and operating condition.
- j. Provide the Board and its committees with adequate staff support.
- k. Maintenance of adequate insurance or self-insurance covering the physical properties and activities of the District.
- l. Designate other individuals by name and position who are, in the order of succession, authorized to act for the Sierra View Local Health Care District during any period of absence.
- m. Summarily to suspend, in accordance with Article VIII of the Bylaws, the Medical Staff Bylaws and applicable law, all or any portion of the clinical privileges of any Practitioner whenever, in his/her opinion, such suspension is necessary in the best interest of patient care and immediate suspension pursuant to Medical Staff Bylaws, is not a feasible solution to the problem presented.
- n. Act as a prosecuting authority for the District under the California False Claims Act as the local government official charged with investigating, filing and conducting civil legal proceedings on behalf of or in the name of the District, using private or government counsel as may be appropriate.
- o. Such other duties as the Board may from time to time direct.

REFERENCES:

- Sierra View Local Health Care District Bylaws, Article VII, Section 7.5-7.5.12
- Health & Safety Code Section 32121.5 (n.d.). Retrieved from <https://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-32121-5.html>.
- Title 22, Division 5, Article 7

SUBJECT: STRATEGIC PLAN	SECTION: <i>Leadership (LD)</i> Page 1 of 1
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PURPOSE:

To delineate responsibility for the Strategic Plan at Sierra View Medical Center (SVMC).

POLICY:

1. In conjunction with the Board of Directors, the President and Chief Executive Officer (CEO) will accept the leadership role in the preparation, development, and implementation of the Strategic Plan for Sierra View Medical Center.
2. Strategic planning will include definition of mission, vision, and values for the hospital and creating strategic, operational, programmatic and other plans and policies to achieve the mission and vision.
3. A copy of the strategic plan will be kept in the Administration offices.
4. Any and all data required for planning will be made available, as appropriate, to those involved in the strategic planning process.
5. The strategic plan is reviewed by the President/CEO and Senior Leadership, in conjunction with the Board of Directors, at least annually.
6. The Structure of the Strategic Planning Group may include the Board of Directors, Senior Leadership, Physicians, members of the community, and selected employees.

REFERENCES:

- The Joint Commission (2025⁴). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

<p>SUBJECT: SUBPOENAS, SUMMONS & COMPLAINTS, HANDLING OFRequests to Interview Patients by Law Enforcement and</p>	<p>SECTION: <i>Management of Information (IM)</i></p> <p style="text-align: right;">Page 1 of 2</p>
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PURPOSE:

- To outline steps to be taken when in receipt of a subpoena, summons or complaint.
- To provide guidelines for appropriate handling of patient citations or interviews with law enforcement personnel.
- To reduce the risk regarding the patient’s condition.
- To ensure appropriate orientation of forensic law enforcement personnel to the hospital.
- To ensure compliance with SB81, 2025, which restricts the sharing of medical information and limits access to non-public areas of healthcare facilities by immigration enforcement agencies without judicial authorization.

DEFINITIONS:

Complaint: A formal statement initiating a lawsuit by specifying the facts and legal grounds for the relief sought.

Subpoena: A writ or court order directed to a person requiring their attendance at a particular time and place to testify.

Subpoena duces tecum: An order issued by a court at the request of one of the parties to a suit that compels a person to appear in court or to a deposition and to bring any relevant or specifically requested documents that are under their control.

Medical Information: As defined under California Civil Code statute 56.05, now includes immigration status and place of birth when maintained by a healthcare provider

Non-Public Area: Any location within a facility (including all SVMC buildings) not accessible to the general public (E.G., OR, IR, ED, inpatient units, clinic rooms, registration booths, clinical workrooms, areas where physical therapy and occupational therapy may occur).

Public Areas: Any area where the general public can access such as lobby, waiting areas, café, public bathrooms.

Immigration Enforcement: Any official action undertaken by local, state, or federal agents for civil or criminal immigration law enforcement (E.G. ICE, DHS, Border Patrol).

Judicial Warrant: A warrant signed by a judge or magistrate. Administrative warrants (e.g. ICE Warrant (Form I200/I205) are not sufficient. ICE warrants, for example, do not authorize entry into non-public healthcare facility areas.

POLICY:

Sierra View Medical Center (SVMC) will comply with the California Code of Civil Procedure, whereby ensuring the appropriate receipt and response to all appropriately served court orders and requests.

1. Orders naming Sierra View (Medical Center), (District Hospital), (Local Health Care District):

<p>SUBJECT: <u>SUBPOENAS, SUMMONS & COMPLAINTS,</u> <u>HANDLING OF Requests to Interview</u> <u>Patients by Law Enforcement and</u></p>	<p>SECTION: <i>Management of Information (IM)</i> Page 2 of 2</p>
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Only designated employees may accept, from a process server, a subpoena, summons or complaint. The following are considered to be designated to receive subpoenas, summons or complaints between the hours of 0800 and 1630, Monday through Friday:

- a. Human Resources may receive court orders for production of documents related to the personnel file of a former or current employee. Refer to Human Resource Policy & Procedure Manual, *Employee's Right to Privacy*.
 - b. The Payroll Department may receive court orders for payroll deductions (support payments, garnishments, etc.).
 - c. Health Information Management (HIM) may receive court orders for production of medical records or Subpoena duces tecum. Refer to House-wide Policy & Procedures Manual, *Confidentiality*.
 - d. Risk Management will be called to review and possibly receive all other subpoenas, summons or complaints. When applicable, Risk Management will subsequently contact the department or individual involved.
2. Physician approval will be obtained prior to law enforcement officers issuing citations or conducting patient interviews. The hospital does not routinely care for in-custody patients. If this occurs, law enforcement personnel will be oriented to the hospital's protocols and procedures.
- All Immigration enforcement officers will immediately be referred to the RISK or Compliance department and not allowed into non-public areas.
3. Orders naming individual employees:
- a. Process servers attempting to serve an employee of the District, shall be directed to Human Resources. Human Resources will determine if the employee is working and request the employee present to Human Resources to receive the document.
 - b. If the employee is not available, the process server may choose to leave the document (California Code of Civil Proceedings 415.20). At this time the process server should be informed that there is no guarantee of the employee being on schedule and as such they may choose to serve the employee at their place of residence.
 - c. If the court order is left with Human Resources, documented attempts will be made to inform the employee.
 - d. If the employee does not respond within five (5) days of receipt, Risk Management should be contacted.
4. Orders naming non-employees (contractors/physicians):
- a. Sierra View Medical Center will not take receipt of any orders naming non-employees/contractors. If such are left by a process server, Risk Management should be contacted.
5. When a designated representative is not available, Risk Management should be contacted.

<p>SUBJECT: <u>SUBPOENAS, SUMMONS & COMPLAINTS,</u> <u>HANDLING OF Requests to Interview</u> <u>Patients by Law Enforcement and</u></p>	<p>SECTION: <i>Management of Information (IM)</i> Page 3 of 2</p>
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AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

Immigration Enforcement Officers

- Initial encounter – Staff must ask for official identification and notify manager/Risk/Compliance Leadership immediately.
- Warrant Verification – Contact Security to verify the warrant; the officer must wait in a public area
- Authorized Access – Only a valid judicial warrant (signed by a judge) or court order grants access. Administrative ICE warrants are insufficient.
- If no valid warrant – Deny access and direct agents as to the determination. Contact the AOC to advise of the situation. Call in local law enforcement if the immigration agents are not complying.

Other Law Enforcement Officers

1. All Law enforcement officers requesting permission to interview or serve papers to a patient in the hospital will be referred to Risk Management.
2. All Law enforcement officers must provide proper identification.
3. Law enforcement officers will request permission to interview any patient.
 - a. Applicable to all patients regardless of the patient’s relationship with the police (i.e., arrested, under investigation, victim, witness).
 - b. Not applicable to patients who are receiving treatment for psychiatric disorders, alcohol or drug abuse, since such patients are accorded special statutory protection.
4. If the patient is listed in the Hospital Directory, law enforcement will be provided with the patient’s room number and will be permitted to visit the patient.
5. Any patient who has “Opted Out” of the Hospital Directory will have that choice honored. Hospital personnel will use the standard script of “I have no patient listed in the Hospital Directory with that name. Federal Medical Privacy Laws permit us to disclose only the information in the Hospital Directory.”
6. Law enforcement officers will be oriented to policy regarding citations or interviews with patients by a member of the hospital’s Risk Management staff.
7. The hospital will contact the physician and inform them of the request by law enforcement and seek physician’s input as to medical conditions of such interaction. The physician must act consistently with their separate duties to protect the patient’s therapeutic condition and hospital privacy.

<p>SUBJECT: <u>SUBPOENAS, SUMMONS & COMPLAINTS,</u> <u>HANDLING OF Requests to Interview</u> <u>Patients by Law Enforcement and</u></p>	<p>SECTION: <i>Management of Information (IM)</i> Page 4 of 2</p>
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8. Law enforcement officers presenting with a Warrant or Subpoena shall be referred to Risk Management, Administration and/or the House Supervisor.

Minimum Instructions Include:

- Patient’s physician, in collaboration with law enforcement officers, will write specific instructions to hospital staff for each individual under legal or correctional restrictions.
- Risk Management will notified and will review the instructions for compliance with the California Penal Code.
- Use of restraints for non-clinical purposes.
- Impositions of disciplinary restrictions
- Anticipated length of stay
- Restrictions of rights
- Plan for discharge and continuing care

Patient’s Consents to Law Officer Interview:

- If a competent patient consents to cooperate with law enforcement officers, the patient’s desire should be respected.
- Patient will be informed of any possible adverse medical consequences at the direction of the physician
- The physician or nursing staff will document the patient’s understanding of medical consequences in the patient’s medical record.
- If it is medically inappropriate to conduct an interview, but patient wants to cooperate with law enforcement officers, hospital personnel will coordinate the transmission of information from patient to the officers.

Patient Objects to Interview:

- The hospital may object to non-consensual interrogations, but may not obstruct justice, which may include interview / interrogation.
- Hospital personnel should never attempt to physically prevent law enforcement officers from interrogating a patient.
- When a law enforcement officer insists on interrogating a patient, despite a warning that it may adversely affect the patient’s medical condition, the hospital will contact the law enforcement agency for assistance.
- If interview / interrogation is conducted, hospital personnel may monitor as appropriate to protect therapeutic interest of the patient. Law enforcement shall honor patient’s request to have hospital personnel present.
- If law enforcement officers do not permit the presence of hospital personnel, despite the patient’s desire to have them present, an objection should be clearly stated and recorded in the patient’s medical

<p>SUBJECT: <u>SUBPOENAS, SUMMONS & COMPLAINTS, HANDLING OF Requests to Interview Patients by Law Enforcement and</u></p>	<p>SECTION: <i>Management of Information (IM)</i> Page 5 of 2</p>
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record and the Commanding Officer of the law enforcement shall be notified by nursing personnel, Risk Management, Administration and/or House Supervisor.

- If the patient wants to exclude hospital personnel from interview / interrogation, it should be respected.

Release of Medical Information:

The California Medical Information Act (CMIA) establishes more stringent limits on disclosures to law enforcement than does HIPAA. CMIA prohibits the hospital from disclosing medical information without patient authorization unless the disclosure is compelled by:

- A subpoena or summons for release of medical information must be accompanied by, or be issued as a result of a court order.
- A search warrant lawfully issued to a governmental law enforcement agency.
- Senate Bill 497 prohibits the disclosure of medical information related to gender-affirming health care or mental health care in response to subpoenas, civil actions, or criminal actions initiated by laws from other states that interfere with an individual’s right to seek or receive such care. It also prohibits healthcare providers from cooperating with out-of-state authorities or law enforcement agencies seeking information related to gender-affirming care, unless required by federal law or a valid court order. Additionally, the DOJ is restricted from sharing data related to prescription drug monitoring across state lines for investigations based on laws that interfere with access to gender-affirming health care.

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REFERENCE:

- California Code of Civil Procedure (1985.3(B) (2))
- *Policy – Prisoners / Wards of Legal System Care of*
- *Policy – Subpoenas – handling of*
- *SVMC Updated Privacy Notice (English & Spanish versions)*
- *Brochure – Security Services Forensic Handout / Emergency Terms*
- 45 C.F.R. § 160.203
- 45 C.F.R. § 164.510(a)
- Civil Code § 56.16
- Penal Code §§ 69, 148
- Penal Code, Part Two, Title 12 Chapter 3.5, Section 1453
- California Senate Bill 81 (Arrequin, 2025).
https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB81
- California Civil Code, statute 56.05 (CMIA).
https://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV§ionNum=56.05

SUBJECT:

~~SUBPOENAS, SUMMONS & COMPLAINTS,
HANDLING OF Requests to Interview
Patients by Law Enforcement and~~

SECTION:

Management of Information (IM)

Page 6 of 2

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- HIPAA Privacy Rule, 45 CFR 164. <https://www.ecfr.gov/current/title-45/subtitle-A/suchapter-C/part-164?toc=1>
- National Immigration Law Center, 2025. <https://www.nilc.org/resources/warrants-and-subpoenas-facts/>

CROSS REFERENCES:

- Human Resource Policy & Procedure Manual, [Employee's Right to Privacy](#)
- House-wide Policy & Procedures Manual, [Protection of Patient Privacy](#)
- House-wide Policy & Procedures Manual, [Release of Patient Information](#)

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	02/04/2026
BOARD OF DIRECTORS APPROVAL	
	02/24/2026
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

**SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
February 24, 2026 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. <u>Policies:</u>		APPROVE
• 1799 Holds in the Emergency Department	1-3	
• Blood Specimen – Collection of	4-8	
• Care of the Dying Patient	9-10	
• Citations/Interviews of Patients by Law Enforcement	11-13	
• Closing/Opening of Patient Care Units	14-15	
• Criteria for Collection of Stool for Ova and Parasites	16-17	
• Dialysate Mixing	18-19	
• Discharge Policies and Procedures of a Minor	20-24	
• DNR Physician Order – Guidelines for Use	25-26	
• Electronic Fetal Monitoring Terminology	27-31	
• Identification of Patient’s Requests and Samples (Blood Bank)	32-34	
• Malignant Hyperthermia (MH), Patient Treatment Guidelines	35-45	
• Patient Death	46-53	
• Physician Medical Record Documentation & Dictation Requirements	54-59	
• Professional Practice Council Nursing Peer Review	60-64	
• Restriction of Communication	65	
• RN Staffing Policy	66-73	
• Standardized Procedures	74-77	
• Standards of Nursing Practice and Professional Performance	78-90	
• Treatment of Patient with Chest Pain – NSTEMI/STEMI	91-94	
• Transfer of Patient to Higher Level of Care from Cardiac Cath Lab	95-96	
• Vascular Access Device – Blood Draw	97-99	
• Vascular Access Device – Bolus Injections	100-101	
• Waived & Point of Care Testing: Abbott ID NOW COVID-19, Influenza A & B, RSV, and Strep A	102-108	
II. <u>Forms</u>		
• Heart/Chest Pain Alert	109	
• Post-Op Note	110	
• Provider’s Review of History and Physical	111	
• Short Form History and Physical	112	

SUBJECT: 1799 HOLDS IN THE EMERGENCY DEPARTMENT	SECTION: <i>[Enter manual section here]</i> Page 1 of 3
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define what a CA Health & Safety Code Section 1799.111(1799) hold is how to apply one in the emergency room, and how to determine if a patient meets criteria.

DEFINITIONS:

A 1799 can be used in a licensed general acute care hospital (within the Emergency Department only), as defined in a *subdivision of 1250*. *A physician of this facility shall not be held civilly or criminally liable for detaining a person if all of the following conditions exist during the detention:*

1. The person cannot be safely discharged from the hospital because, in the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Section 1316.5, the person, as a result of a mental disorder, presents a danger to himself or herself, or others, or is gravely disabled. For purposes of this paragraph, “gravely disabled” means an inability to provide for his or her basic personal needs for food, clothing, or shelter due to a mental disorder.
2. The hospital staff, treating physician and surgeon, or appropriate licensed mental health professional, have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person.
 - a. Telephone calls or other contacts required pursuant to this paragraph shall commence as the earliest possible time when the treating physician and surgeon has determined the time at which the person will be medically stable for transfer.
3. The person is not detained beyond 24 hours.
4. There is probable cause for the detention.
 - a. If the person is detained pursuant to subdivision beyond eight hours, but less than 24 hours, both of the following conditions shall be met:
 - A discharge or transfer for appropriate evaluation or treatment for the person has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.
 - In the opinion of the treating physician and surgeon, or a clinical psychologist with medical staff privileges or professional responsibilities provided for in Section 1316.5, the person, as a result of a mental disorder, is still a danger to himself or herself, or others, or is gravely disabled, as defined in paragraph 1.

SUBJECT: 1799 HOLDS IN THE EMERGENCY DEPARTMENT	SECTION: <i>[Enter manual section here]</i> Page 2 of 3
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- In addition to the immunities set forth in subdivision (a), a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or any physician and surgeon, providing emergency medical services in any department of those hospitals to a person at the hospital shall not be civilly or criminally liable for the actions of a person detained up to 24 hours in those hospitals who is subject to detention pursuant to subdivision (a) after that person's release from the detention at the hospital, if all of the following conditions exist during the detention:
 - The person has not been admitted to a licensed general acute care hospital or a licensed acute psychiatric hospital for evaluation and treatment pursuant to Section 5150 of the Welfare and Institutions Code.
 - The release from the licensed general acute care hospital or the licensed acute psychiatric hospital is authorized by a physician and surgeon or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, who determines, based on a face to face examination of the person detained, that the person does not present a danger to himself /herself or others and is not gravely disabled, as defined in paragraph (1) of subdivision (a). In order for this paragraph to apply to a clinical psychologist, the clinical psychologist shall have a collaborative treatment relationship with the physician and surgeon. The clinical psychologist may authorize the release of the person from the detention, but only after he or she has consulted with the physician and surgeon. In the event of a clinical or professional disagreement regarding the release of a person subject to the detention, the detention shall be maintained unless the hospital's medical director overrules the decision of the physician and surgeon opposing the release. Both the physician and surgeon and clinical psychologist shall enter their findings, concerns, or objections in the person's medical record.
- b. Nothing in this section shall affect the responsibility of a general acute care hospital or an acute psychiatric hospital to comply with all state laws and regulations pertaining to the use of seclusion and restraint and psychiatric medication for psychiatric patients. Persons detained under this section shall retain their legal rights regarding consent for medical treatment.
- c. A person detained under this section shall be credited for the time detained, up to 24 hours, in the event he or she is placed on a subsequent 72 hour hold pursuant to Section 5150 of the Welfare and Institutions Code.

SUBJECT: 1799 HOLDS IN THE EMERGENCY DEPARTMENT	SECTION: <i>[Enter manual section here]</i> Page 3 of 3
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- d. The amendments to this section made by the act adding this subdivision shall not be construed to limit any existing duties for psychotherapist contained in Section 43.92 of the Civil Code.
- e. Nothing in this section is intended to expand the scope of licensure of clinical psychologists.

POLICY:

When a patient presents as meeting criteria for a 5150 hold (danger to self, danger to others, or gravely disabled, due to a mental illness) a 1799 shall be ordered and a psychiatric evaluation is to be completed by SVMC's LCSW or designee, to evaluate for criteria. The 1799 allows a patient to be held for up to 24 hours to ensure their immediate safety while the evaluation can be completed.

AFFECTED PERSONNEL/AREAS: *NURSING, SECURITY, PHYSICIANS*

PROCEDURE:

If a patient presents to the emergency room and appears to meet the above criteria (danger to self, danger to others, or gravely disabled) by means of a mental disorder, the physician shall place that patient on a 1799 hold. To place a patient on a 1799 hold, MD shall go into the ED order section of Meditech and select "1799 hold." This will time and date stamp the time of the hold. The SVMC LCSW or designee is to be called at the time the patient is medically clear and ready for discharge.

For patients presenting as suicidal, suicide precautions shall be initiated and the "Suicidal Patient Assessment & Management" policy shall be followed. If at any time the patients attempts to leave, SVMC staff will not impede their movement, unless they are an imminent danger to themselves or others or do not have the capacity to understand the risks and benefits of leaving placing them in harm's way. If the patient elopes, a code green is to be initiated and documented.

REFERENCES:

- Welfare and Institutions Code 5150; 5152; CA Health & Safety Code Section 1799.111
- The Joint Commission. (2025). Comprehensive Accreditation Manual. (NPSG 15.01.01) Oakbrook Terrace, IL.

CROSS REFERENCES:

- [Suicidal Patient Assessment and Management Policy](#)
- [Code Green Policy – Missing patient or Resident](#)

SUBJECT: BLOOD SPECIMEN – COLLECTION OF	SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 1 of 5
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PURPOSE:

The purpose of this policy is for performing a venipuncture to obtain a blood specimen for the purpose of diagnostic testing.

POLICY:

Arm veins are the best source from which to obtain blood. Usually one or more veins in this area are visible. The veins appear blue and are slightly raised above the skin surface, except in obese people. The best veins are those which are full but well supported by subcutaneous tissue to prevent rolling during introduction of the needle. Hand veins may be used when the arms are bandaged, severely traumatized, edematous, burned, have casts on or if the patient is receiving IV fluids through the forearm. Note: NEVER draw above an IV; the intravenous fluid will dilute and contaminate the specimen. Use the other arm if possible, or use the hands.

SPECIAL CONSIDERATIONS FOR BLOOD BANK SPECIMENS

All blood specimens drawn from a **peripheral vein** for the purpose of blood bank testing will be obtained and labeled by a certified/licensed lab person or licensed nursing person or physician in the presence of a second certified/licensed lab person or licensed person. Both personnel involved in obtaining the specimen will each initial the specimen labels and/or additional forms as required, and confirm that the BBK# has been accurately transcribed from the patient's wrist band to the specimen label.

EXCEPTION: Outpatient laboratory services will utilize a two-person check when drawing blood bank specimens and the second person may be a non-licensed person.

AFFECTED AREAS/PERSONNEL: REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED LAB PERSONNEL, MEDICAL ASSISTANTS (MA)

EQUIPMENT NEEDED:

1. Alcohol prep
2. Vacutainer holder
3. Multi sample needles
4. Syringes
5. Needles
6. Tourniquet
7. Vacutainer tubes

SUBJECT: BLOOD SPECIMEN – COLLECTION OF	SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 2 of 5
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8. Bandage
9. Cotton balls
10. Gloves

PROCEDURE:

1. Check physician orders.
2. Identify patient using the two-patient identifier system.
3. Explain procedure to patient.
4. Position patient.
 - a. Reclining position is preferred. There is no way to predict how a patient is going to react to a needle puncture and some people may faint.
 - b. Sitting in a comfortable chair with arm supports is acceptable. **Never** draw blood from a patient who is standing up or sitting on a high stool.
 - c. Position the arm so the vein is accessible, and so you are able to work in a comfortable position. A small pillow or rolled towel may be used to help support the extended arm if needed.
5. Proper lighting is necessary.
6. Select vein.
7. Apply the tourniquet about midway between the elbow and the shoulder. Apply enough tension to compress the vein but not the artery.
8. Have the patient make a fist, or if needed, they may clench and unclench their hand a few times. Don't leave the tourniquet in place longer than two minutes before venipuncture or let the patient "pump" their fist to distend the veins. Either practice may cause "hemoconcentration" and alter some laboratory values.
9. Always palpate or feel for the vein, even when you can see it. This gives practice in finding deeper, unseen veins, the vein will feel like an elastic tube that "gives" under finger pressure. Be sure the structure you feel is not pulsating (artery).
10. Attach an unused sterile needle to a syringe or a Vacutainer blood collection holder, keeping the needle sterile at all times.

SUBJECT: BLOOD SPECIMEN – COLLECTION OF	SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 3 of 5
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- a. Use available assembled equipment.
 - b. Usually 21 or 22 gauge needles are used with occasionally a 23-gauge chosen for especially tiny veins. Care should be taken when using a 23-gauge to prevent hemolysis of the specimen. (Use 20cc syringe if more than one (1) tube of blood is necessary).
11. Apply gloves. Scrub the area for venipuncture with alcohol prep pad/betadine in a circular motion. Use betadine cleansing when drawing blood cultures.
 - a. Allow the area to dry to prevent pain and hemolysis.
 - b. Necessary to reduce the body's natural flora.
 12. The vein should be "fixed" or held taut during the procedure by placing your left thumb about an inch below the site and press down on the arm and at the same time pull the skin toward the hand. The fingers of the left hand should be around and underneath, grasping the arm as the thumb holds the vein in place. Alternatively, the vein may be held in place by placing your index finger above the site and your thumb below the site, slightly pulling on the skin.
 13. Hold the needle bevel up in line with the vein at about a 15-degree angle with the skin. Insert the needle through the skin and into the vein with a clean, smooth motion. Do not jab, stab, hesitate or insert the needle very slowly. As the needle enters the vein, a little "give" will be felt.
 14. While holding the needle steady, push collection tube into Vacutainer holder and let blood flow into the tube. The following order of draw is required:
 - Sterile tubes for culture (blood culture bottles)
 - Sodium Citrate tube (blue stopper)
 - Serum tubes (with or without clot activator)
 - Heparin tube (green stopper)
 - EDTA tube (lavender stopper and/or pink stopper)
 - Oxalate-fluoride tube (gray stopper)

When more than one type of additive tube is used, draw using the following order:

- Blue stoppered (Draw a "waste" tube prior to blue tube if this is the only tube being drawn)
- Green stoppered
- Purple stoppered
- Pink stoppered
- Gray stoppered

SUBJECT: BLOOD SPECIMEN – COLLECTION OF	SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 4 of 5
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15. Prior to syringe draw, move the plunger in the barrel before inserting needle. For a syringe draw, pull back on the plunger until the syringe is full.
 - a. Prevents plunger from sticking.
 - b. Immediately (DO NOT LET THE BLOOD SET) fill the collection tubes in the order indicated above.
16. The tourniquet should remain in place until the collection is complete. Release the tourniquet just before the needle is removed to avoid a hematoma (swelling filled with blood).
17. Withdraw the needle gently and immediately place a clean, dry cotton over the puncture site and apply pressure. Bending the arm to hold pressure may keep the needle puncture wound open and allow blood to escape freely through the wound into the tissues, causing a hematoma. Keeping the arm extended while applying pressure helps to minimize that risk.
18. Mark tubes with patient name, date, time, test and initial in the presence of the patient.
19. Dispose of sharps in sharp container. Do not recap used needles or attempt to remove the needle from the holder with your fingers.
20. Remove the needle from the Vacutainer holder by inserting it into the needle collection container and twisting.
21. Inspect the puncture wound. If all or most of the bleeding has stopped, apply an adhesive bandage. If the patient is on anticoagulants or their disease state slows their clotting process, you may need to hold pressure for five minutes or more. Do not leave the patient until bleeding is under control.
22. Transport specimen to blood processing area.
23. SPECIAL STATEMENT regarding Standards of Care Guidelines 31.1, Universal Precautions (referenced OSHA 1910. 1930).

These infection control precautions are mandated by the Occupational Safety and Health Administration (OSHA) and recommend that all blood and certain body fluids are treated as potentially infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), and other bloodborne pathogens:

- Employees are provided and required to wear appropriate personal protective equipment (PPE) and other engineering/work practice controls to eliminate or minimize employee exposure to bloodborne pathogens as mandated in OSHA regulation 1910.

SUBJECT: BLOOD SPECIMEN – COLLECTION OF	SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 5 of 5
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

- Gloves are to be worn when there is anticipation of contact with blood, other potentially infectious materials, mucous membranes, and nonintact skin.
- Gowns, aprons or other protective body clothing are to be worn when contamination of clothing with blood or other potentially infectious materials are anticipated.
- Masks or combinations with protective eyewear are to be worn when performing procedures likely to generate sprays or splashes of blood or other potentially infectious materials into the eyes, nose, or mouth.
- Hands and other skin surfaces are to be washed immediately if contaminated with blood or other potentially infectious materials.
- Utilize safety devices for needles and other sharps and do not manipulate by hand (e.g. recapping, purposely bending or breaking, or removing from syringes, etc.)
- Needles and other sharps are to be placed in puncture-resistant containers for disposal.
- All specimens and items with blood or other potentially infectious materials are to be transported in containers that prevent leakage.
- Blood and body fluids spills are to be cleaned up promptly with an appropriate germicide, such as bleach solution or phenolic.

REFERENCES:

- Nettina, S.M. (2019). *Lippincott Manual of Nursing Practice*. (11th Ed). Wolters Kluwers, Philadelphia.
- Standards of Care Guidelines 31.1. (1996). Universal Precautions. CFR §1910 & §1930 (Referenced OSHA).
- Order of Blood Draw Tubes and Additives (2019), CLSI.org

SUBJECT: CARE OF THE DYING PATIENT	SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 1 of 2
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define management of the acutely dying or palliative care patient in relation to the administration of comfort medications and guidelines for provision of emotional support.

DEFINITIONS:

1. **Acutely dying:** a patient with an incurable illness where all treatment to prolong life is ineffective or determined by the patient, family/significant others and physicians to no longer be of benefit. The patient is expected to expire within several hours to several days.
2. **Palliative care:** measures taken to improve quality of life of patients facing life-threatening illness through relief of suffering, treatment of pain and physical, psychosocial and spiritual support.

POLICY:

It is the policy of this facility to provide emotional and religious support to terminally ill patients and family as well as meeting their physical comfort needs. A Palliative Care Referral will be initiated on the patient identified as acutely dying or meeting criteria for Palliative Care and in conference with the provider, staff, patient and family as appropriate. Care will be directed toward maximizing comfort, maintaining dignity and providing support for patients, their families and significant others.

AFFECTED AREAS/ PERSONNEL: RN, LVN, CNA, *Palliative Care Team*

PROCEDURE:

A. Emotional and spiritual support.

1. Be aware of and attempt to understand the emotional stages of shock, denial, anger and acceptance that patient and family go through when facing death.
2. Allow patient and family to express their feelings. Be a good listener.
3. Do not offer false hope or false information to patient or family.
4. Show concern for patient and visitors and respect their desire for privacy.
5. When leaving patient's room, give assurance of return in an attempt to alleviate loneliness, isolation and/or fear.
6. If a patient's level of consciousness changes, continue to talk to the patient and conduct all conversations as though patient can hear and understand.
7. Maintain a personal objective approach.

SUBJECT: CARE OF THE DYING PATIENT	SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 2 of 2
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8. Smile and offer as calm and gentle a touch as possible.
9. Refer to social services or religious help as requested or needed.

B. Physical comfort

1. A Palliative Care Referral will be initiated if the patient meets criteria for Palliative Care and in conference with the provider, staff, patient and family as appropriate or if the patient is identified as acutely dying.
2. The Inpatient Palliative Care Team will evaluate the patient upon referral and implement Physician's Orders for Comfort Care.
3. Nursing will administer comfort care, accordingly, utilizing numeric scales for pain and anxiety when possible. When numeric scales are not feasible, non-verbal indicators will be utilized.

REFERENCES:

National Coalition for Hospice and Palliative Care. (2024). Care and comfort near the end of life: Guidelines for palliative care practice. <https://www.nationalcoalitionhpc.org/care-and-comfort-near-the-end-of-life/>

Boltz, M., Capezuti, E., & Fulmer, T. T. (2025). Care and comfort at the end of life. In Evidence-Based Geriatric Nursing Protocols for Best Practice (7th ed.). Springer Publishing.

Marshall, M. F., Davis, F. D., Fogelman, P. A., et al. (2025). Clinical practice guidelines on adult end-of-life care in the ICU. *Critical Care Medicine*, 53(12), e2734–e2746.

Cleveland Clinic. (2025). Comfort care symptom management guide – end of life.

<https://my.clevelandclinic.org/-/scassets/files/org/landing/preparing-for-coronavirus/covid-19-palliative-care-end-of-life-symptom-guide.ashx?la=en>

National Coalition for Hospice and Palliative Care. (2025). Clinical practice guidelines for quality palliative care (4th ed.). <https://www.nationalcoalitionhpc.org/ncp-guidelines/>

SUBJECT: CITATIONS/INTERVIEWS OF PATIENTS BY LAW ENFORCEMENT	SECTION: <i>Leadership (LD)</i>
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SECTION: <i>Leadership (LD)</i>	Page 1 of 3
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

- To provide guidelines for appropriate handling of patient citations or interviews with law enforcement personnel.
- To reduce the risk regarding the patient's condition.
- To ensure appropriate orientation of forensic law enforcement personnel to the hospital.

POLICY:

Physician will patient status review and provide clearance for interview if there is a concern for patient health and stability to participate in citation/ interview prior to law enforcement officers being their process. The hospital does not routinely care for in-custody patients. If this occurs, law enforcement personnel will be oriented to the hospital's protocols and procedures.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

1. Law enforcement officers requesting permission to interview or serve papers to a patient in the hospital will be referred to Risk Management during regular business hours and Nursing House Supervisor after hours.
2. Law enforcement officers must provide proper identification.
3. Law enforcement officers will request permission to interview any patient.
 - a. Applicable to all patients regardless of the patient's relationship with the police (i.e., arrested, under investigation, victim, witness).
 - b. Not applicable to patients who are receiving treatment for psychiatric disorders, alcohol or drug abuse, since such patients are afforded special statutory protection.
4. If the patient is listed in the Hospital Directory, law enforcement will be provided with the patient's room number and will be permitted to visit the patient.
5. Any patient who has "Opted Out" of the Hospital Directory will have that choice honored. Hospital personnel will use the standard script of "I have no patient listed in the Hospital Directory with that name. Federal Medical Privacy Laws permit us to disclose only the information in the Hospital Directory."

SUBJECT: CITATIONS/INTERVIEWS OF PATIENTS BY LAW ENFORCEMENT	SECTION: <i>Leadership (LD)</i> Page 2 of 3
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

6. Law enforcement officers will be oriented to policy regarding citations or interviews with patients by a member of the hospital's Risk Management staff or after hours with Nursing House Supervisor.
7. If patient stability needs to be reviewed by physician before citation/interview it is the unit staff that will be responsible for contacting the physician. The physician will need to document that the patient is stable for citation/interview in the patient medical record.
8. Law enforcement officers presenting with a Warrant or Subpoena shall be referred to Risk Management, Administration and/or the Nursing House Supervisor.

Patient's Consents to Law Officer Interview:

- If a competent patient consents to cooperate with law enforcement officers, the patient's desire should be respected.
- Patient will be informed of any possible adverse medical consequences at the direction of the physician
- The physician or nursing staff will document the patient's understanding of medical consequences in the patient's medical record.
- If it is medically inappropriate to conduct an interview, but patient wants to cooperate with law enforcement officers, hospital personnel will coordinate the transmission of information from patient to the officers.

Patient Objects to Interview:

- The hospital may object to non-consensual interrogations, but may not obstruct justice, which may include interview / interrogation.
- Hospital personnel should never attempt to physically prevent law enforcement officers from interrogating a patient.
- When a law enforcement officer insists on interrogating a patient, despite a warning that it may adversely affect the patient's medical condition, the hospital will contact the law enforcement agency for assistance.
- If interview / interrogation is conducted, hospital personnel may monitor as appropriate to protect therapeutic interest of the patient. Law enforcement shall honor patient's request to have hospital personnel present.
- If law enforcement officers do not permit the presence of hospital personnel, despite the patient's desire to have them present, an objection should be clearly stated and recorded in the patient's

SUBJECT: CITATIONS/INTERVIEWS OF PATIENTS BY LAW ENFORCEMENT	SECTION: <i>Leadership (LD)</i> Page 3 of 3
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medical record and the Commanding Officer of the law enforcement shall be notified by nursing personnel, Risk Management, Administration and/or House Supervisor.

- If the patient wants to exclude hospital personnel from interview / interrogation, it should be respected.

Release of Medical Information:

The California Medical Information Act (CMIA) establishes more stringent limits on disclosures to law enforcement than does HIPAA. CMIA prohibits the hospital from disclosing medical information without patient authorization unless the disclosure is compelled by:

- A subpoena or summons for release of medical information must be accompanied by, or be issued as a result of a court order.
- A search warrant lawfully issued to a governmental law enforcement agency.

REFERENCES:

- *Policy – Prisoners / Wards of Legal System Care of*
- *Brochure – Security Services Forensic Handout / Emergency Terms*
- 45 C.F.R. § 160.203
- 45 C.F.R. § 164.510(a)
- Civil Code § 56.16
- Penal Code §§ 69, 148
- Penal Code, Part Two, Title 12 Chapter 3.5, Section 1453
- *Consent manual*. California Hospital Association. (2024, June 25).
<https://calhospital.org/publications/consent-manual/>

SUBJECT: CLOSING / OPENING OF PATIENT CARE UNITS	SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 1 of 2
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish the process for consistent control and security of the medications and crash carts when a patient care unit opens or closes due to lack of census.

POLICY:

When closing or opening a patient care unit due to lack of census, the involved departments will ensure that appropriate precautions have been taken to preserve the integrity of the unit with specific attention to medications, medication refrigerator temperatures, and crash carts.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE UNITS; PHARMACY; AND NURSING*

PROCEDURE:

CLOSING A UNIT:

When it has been decided by the Department Leader or designee and/or the Nursing House Supervisor, after attempting to reach the Nursing Leader of that department, to close a particular patient care unit (e.g. 3North, 3 South, 3East, 3West, Pediatric area, Telemetry and/or ICU), the individual making the decision to **close** a particular unit shall notify the appropriate personal and departments

note:.. message maybe delivered in bed huddles

CN of unit closing will be responsible for securing all WOW's to active area or lock area within the closed department.

CRASH CARTS:

- The adult crash cart on the designated unit for closure shall be removed by either the Department leader or designee and/or the Nursing House Supervisor and returned to Central Processing Department (CPD) to be placed in circulation for use in the rest of the hospital.
- Note the defibrillator will remain in the department in a locked area. The Pediatric BRASLOW cart shall be moved to the unit where Pediatric patients are to be housed when hospitalized.

OPENING A UNIT:

When it has been decided by the Department Leader or designee and/or the Nursing House Supervisor to re-open a particular patient care unit (e.g. 3North, 3 South, 3East, 3West, Pediatric area, Telemetry and/or ICU), the individual making the decision shall notify appropriate personal and departments

note:.. message maybe delivered in bed huddles following:

SUBJECT: CLOSING / OPENING OF PATIENT CARE UNITS	SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 2 of 2
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

CN of unit opening the area will be responsible for securing all WOW's to active area for use

CRASH CARTS:

- The adult crash cart on the designated unit for opening shall be retrieved from CPD. The defibulator shall be checked and placed in the unit prior to the patients arriving to the area. If a pediatric crash cart is needed it will be retrieved from CPD prior to pediatric patients arrival.

REFERENCES:

The Joint Commission. (2023). Standard for Medical Equipment Maintenance and Safety. The Joint Commission. Retrieved from <https://www.jointcommission.org/>

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

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

PRINCIPLE:

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

SPECIMEN CONTAINER:

Total-Fix transport system

AFFECTED AREAS/PERSONNEL: *NURSING, LABORATORY STAFF*

PROCEDURE:

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

PROCEDURE NOTES:

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

CRITERIA FOR SPECIMEN REJECTION:

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

SUBJECT: CRITERIA FOR COLLECTION OF STOOL FOR OVA AND PARASITES #1020	SECTION: <div style="text-align: right;">Page 2 of 2</div>
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- Specimen received in improper transport container, or appears to be dry on the surface or edges. Protozoan trophozoites will not survive if the stool specimen begins to dry out.
- Specimen contaminated with urine or water from the toilet.
- Specimens contaminated with the materials listed in the table below.

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

REFERENCE:

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

SUBJECT: DIALYSATE MIXING	SECTION: <i>Renal Services</i> Page 1 of 2
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure safe practices for mixing of dialysate for patient care use.

POLICY:

- Bicarbonate will be mixed if premixed solutions are not available.
- Manufacture guidelines will be followed

AFFECTED PERSONNEL/AREAS: *Renal Service staff*

EQUIPMENT:

- **Manufacture guidelines**
- **Dry Bicarbonate for Dialysis**
- **Mixing containers**
- **Phoenix meter**
- **Bicarbonate pH strips for testing**
- **Goggles/face shield**
- **Gloves**
- **Gown**

PROCEDURE:**Bicarbonate Concentrations:**

1. Proper personal protective gear should be worn when mixing and handling any chemicals. This will include but is not limited to eye protections such as goggles or face shield, gown, and gloves.
2. Water used to mix bicarbonate concentrations must meet the AAMI standards for quality of water
3. Manufacture instructions will be followed for concentration mixing.
4. Manufacture instructions will be kept on the unit during preparation to use for guidelines
5. Final mixed dialysate will be tested for pH and conductivity using appropriate test methods per manufacture instructions. If the pH and /or conductivity readings are not within range the concentration will be discarded and the process will be restarted with a new mixture.
6. The pH and conductivity of bicarbonate will be documented per individual container.
7. Bicarbonate mixture will be used within 24 hours. After 24 hours the mix will be discarded.
8. Containers used for mixing will be rinsed daily and stored inverted to drain overnight. Containers will also be disinfected weekly. A log of disinfection will be kept.

SUBJECT: DIALYSATE MIXING	SECTION: <i>Renal Services</i> Page 2 of 2
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REFERENCES:

Water Quality Standard for Hemodialysis American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI) 13959:2014.

Quality of Dialysis Fluid for Hemodialysis and Related therapies, ANSI/AAMI/ISO 11663:2009.

Guidance for the Preparation and Quality Management of Fluids for Hemodialysis and Related Therapies ANSI/AAMI/ISO 23500:2011.

SUBJECT: DISCHARGE POLICIES AND PROCEDURES OF A MINOR	SECTION: Page 1 of 5
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PURPOSE:

To coordinate the patient discharge process; assure that the pediatric patient need for continuing treatment, continuing education and support for normal development is incorporated into the patient's home care maintenance and discharge and to safely conduct the patient to his/her means of transportation. To identify the mechanisms in place to comply with the legal requirements for the discharge of a minor from Sierra View Medical Center

POLICY:

1. Discharge planning will begin upon the admission of all pediatric patients. Evidence of this will be documented on the patient plan of care and admission assessment form under Discharge and Planning Screening by the admitting nurse. The patient plan of care will be consistent with the medical plan of care.
2. The medical plan of care is communicated verbally to the nurse and/or written in the patient's medical record. The nurse will coordinate the patient's plan of care during the patient's hospital stay. She or he will communicate this plan verbally in shift report and in writing on the patient's plan of care.
3. The infant or the child and family will be assessed for any need for special equipment or supplies for home use. Preparation such as contacting the appropriate resources (social worker, discharge planner, etc.) for arrangements to acquire the necessary equipment or supplies should begin when the need is identified.
4. Nurses will collaborate with the physician, parents and the multidisciplinary team to assure that the patient outcomes were achieved in a timely and efficient manner. In addition, collaboration should assure a smooth discharge process which results in member satisfaction with their hospital stay. The instructions given to the patients and parents/guardian of the hospitalized child will be consistent with those of the pediatrician and will be age appropriate.
5. Every patient discharge must have physician's order.
6. The nurse who discharges the patient is responsible for the final instructions to the patient and family. This includes medications; follow up appointments, reportable signs and symptoms, diet, activity and home treatments.
7. "Release of a Minor under 8 years of age or 4'9" in height or less" Form must be completed prior to leaving the floor. Under California law, only the parent(s) or legal guardian is entitled to custody of a minor upon the minor's release from a hospital. The parent may be a biological parent or an adoptive parent (i.e., one who has legally adopted the minor). The biological mother and father both have legal capacity to take custody of the minor. The following exceptions apply:

SUBJECT: DISCHARGE POLICIES AND PROCEDURES OF A MINOR	SECTION: <p style="text-align: right;">Page 2 of 5</p>
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- ***Child born to unmarried parents, -- When*** there is reason to doubt the status of someone holding himself out as the father, appropriate documentation is necessary.
- Child whose parents are divorced – the parent who has legal custody is entitled to receive the minor, unless such parent is not available. In such a case, release may be made to the parent who does not have legal custody, unless instructed otherwise in writing by the custodial parent.
- Child with legal guardian – if the legal guardian has been appointed for the minor and has been providing consent for treatment during the patient’s stay in the hospital, a copy of the official certified letters of guardianship should already be a part of the patient’s medical record.
- Minor with caregiver – a minor whose treatment has been authorized by a caregiver pursuant to Family Code Section 6550 may be released to the caregiver upon discharge. The caregiver’s
- authorization affidavit should already have been completed and made a part of the patient’s medical record.

NOTE: In those cases where the minor is authorized to give consent to hospitalization and medical treatment, the minor has the corresponding authority to leave the hospital unaccompanied by their parent or guardian. [Title 22, CCR, Section 70717(g)] However, the hospital should take proper precautions to assure that the minor leaves the hospital in a safe manner

AFFECTED PERSONNEL/AREAS:

MEDICAL/SURGICAL NURSING STAFF, SOCIAL WORKER, DISCHARGE PLANNER

EQUIPMENT:

1. Discharge education obtained from the discharge instructions
2. Release of a minor under 8 years of age or 4’9” in height or less form
3. 2 x 2 gauze or a band aid

PROCEDURE:

1. Obtain order for discharge. Collaborate with physician and multidisciplinary team to assure clarity of treatments and coordination of care.
2. Inform parents and/or legal guardian that patient is discharged and requires transportation home.

SUBJECT: DISCHARGE POLICIES AND PROCEDURES OF A MINOR	SECTION: Page 3 of 5
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3. Print out the discharge summary form from the patient education notes and fill out all the blanks. Discuss discharge instructions with the parents and/or legal guardian. Include the following information in the form:
 - a. Follow-up appointment: date, time and physician's office number.
 - b. Medications to be given at home: dosage, route, purpose, time of last dose received, possible side effects.
 - c. Diet
 - d. Activity: relaxation, diversion activity, activities of daily living.
 - e. When child can return to school or day care.
 - f. Treatment: dressing changes, skin care, aerosol treatments, glucose scan, warm packs, etc., observations needed for the child's specific problem, and when to notify the physician.
 - g. Home health visits (if applicable)
 - h. Community resources available (if applicable)
4. Review instructions with parents and/or legal guardian. Have them sign the discharge form after reviewing the information with them. Ascertain if they understand. Provide a copy of discharge instruction to the parents and/or legal guardian.
5. Discontinue all lines, unless specified.
6. Assist parents with dressing the infant and packing personal belongings.
7. Have parents or legal guardian sign the "Release of a minor under 8 years of age or 4'9" in height or less" and be provide copy.
8. Discharge patient via wheelchair.
9. After discharge, discard all opened and/or used supplies.
10. After the patient is discharged, complete the discharge summary in the EMR. Review patient plan of care and evaluate the status of the goals. Resolve all problems identified during hospitalization.

SUBJECT: DISCHARGE POLICIES AND PROCEDURES OF A MINOR	SECTION: Page 4 of 5
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RELEASE OF A MINOR UNDER THE AGE OF 16

1. Health and Safety Code Section 1283(a) prohibits a health facility from surrendering the physical custody of a minor under 16 years of age to any person unless the surrender is authorized in writing by the child's parent(s), the person who has legal custody of the child, or the caregiver of the child pursuant to the caregiver.
2. Recommended forms:
 - a. "Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent" includes an authorization for the release of the minor by the parent or legal guardian. Consequently, if this form has been completed, no additional form is necessary. The original should be placed in the patient's medical record. One copy should be given to the parent or guardian and one to the person who receives the child.
 - b. In instances where the above form is not used, a minor may be released to someone other than the parent only if the AD 22 "Health Facility Minor Release Form" is properly executed. The parent, legal guardian, or the caregiver identified on the caregiver authorization, must complete this form before release can be permitted. The original should be placed in the patient's medical record. One copy should be given to the parent, guardian, or caregiver and one to the person who receives the child. This is the form required to be used in the event of pre-adoption planning and placement. (See House wide policy on "Adoption").
 - c. The required forms must be completed by the designated person prior to the release of the minor. The original should be placed in the patient's medical record; a copy should be given to the person who receives the minor.

RELEASE OF A MINOR AGES 16 OR 17

1. While Health and Safety Code Section 1283 (requiring a written authorization for release) does not apply to the release of a minor age 16 or 17, the general rule that the release of a minor must be to either the parent, guardian or legally authorized caregiver does apply.
2. It is recommended that the facility obtain a written authorization for release of a minor age 16 or 17 (if the release will be to a person other than the parent, guardian or legally authorized caregiver) and an acknowledgement from the person who receives the minor.

MINOR ATTEMPTING TO LEAVE THE HOSPITAL WITHOUT AUTHORIZATION:

1. If a minor who may not consent to his/her medical treatment attempts to leave the hospital without the proper authorization for the release, the hospital should contact the person who is authorized to consent on behalf of the minor. (This will usually be the minor's parent, guardian or legally authorized caregiver.)

SUBJECT: DISCHARGE POLICIES AND PROCEDURES OF A MINOR	SECTION: Page 5 of 5
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2. The minor's attending physician should also be contacted.
3. The hospital's legal counsel should be consulted if the minor's legal guardian and physician recommend continued hospitalization despite the minor's objections.

RELEASE OF A MINOR UNDER 8 years of age or 4'9" in height or less

1. All hospitals, clinics, and birthing centers, as a condition of licensure, are required to provide and discuss information regarding California law mandating the use of child passenger restraint systems to the person to whom a child under the age of 8 or 4'9" in height or less is released.
2. This requirement applies to all releases from the facility, not just from an emergency room or maternity ward. Facilities fulfilling this obligation cannot be held responsible for the failure of the person to whom a child is released to use a child passenger restraint system. [Vehicle CodeSection 27363.5(b)]
3. The person to whom the child is released must be given the following:
 - a. A summary of current law requiring child passenger restraint systems to be used when transporting a child or children in motor vehicles. (See "Release of a Minor Under Eight Years of Age or 4'9" or less form which contains the required information)

Information provided without charge by the CHP, describing the risks of death or serious injury associated with the failure to use a child passenger restraint system

4. Hospitals are not required to, and should not, attempt to prevent a parent (or other authorized person) from transporting a child in a vehicle which does not have a child passenger restraint system.

REFERENCES:

- CA law requiring child restraint systems during transport of children in motor vehicles Vehicle Code section 27315(c), 27360(a,b,c,d), 27361, 37363(a,b,c),15620.
- CHA Consent Manual
- Health and Safety Code Sections 1204.3, 1212, 1268
- Vehicle Code Section 27363.5(A) (B)

SUBJECT:
**DNR PHYSICIAN ORDER –GUIDELINES FOR
USE**

SECTION:
***Patient Rights & Organizational Ethics
(RI)***

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 identifying “Code Status” on all patients if other than “Full Code”.
- To respect the patient’s right to self-determination of care and their wishes regarding their Code Status.

POLICY:

Upon admission, all patients admitted to Sierra View Medical Center (SVMC) are considered to be of “Full Code” status unless otherwise stated. Those patients identified as either “No Code” or “Limited Code” status will have their code status identified by the initiation and completion of the Code Status Order . For the purposes of this policy, the following definitions will apply:

Do Not Resuscitate (DNR): In the event of a cardiac, pulmonary or cardiopulmonary arrest, no automatic initiation of new medication, cardiopulmonary resuscitation (CPR), intubation, defibrillation, or other mechanical support will take place.

Limited Code: In the event of a cardiac, pulmonary or cardiopulmonary arrest, specific limitations should be taken at the request of the patient/family.

1. Specific Limitations:
 - a. No Chest Compressions
 - b. No Intubation
 - c. No Electrical Defibrillation or Cardioversion
 - d. No Medication Intervention
 - e. No Enteral Tube Feedings
 - f. Other (as indicated by the physician)
2. Treatment limitation may also induce orders to withdraw or discontinue measures as indicated on the Physician Order.

NOTE: The term *DNR* or *No Code* refers only to the suspension of the otherwise automatic initiation of *Cardiopulmonary Resuscitation (CPR)*.

AFFECTED AREAS/PERSONNEL: *NURSING; MEDICAL STAFF*

SUBJECT:
**DNR PHYSICIAN ORDER –GUIDELINES FOR
USE**

SECTION:
*Patient Rights & Organizational Ethics
(RI)*
Page 2 of 3

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

PROCEDURE:

1. Any limitation of life-sustaining treatment must be identified on the Physician Code Status Order
2. The status of the patient's Advance Directive is to be noted on the Code Status Order . A copy of the advanced directive should be place in the paper chart for review.This is to be done by Nursing or Social Services.

PHYSICIAN RESPONSIBILITY

1. If other than FULL CODE STATUS is required, document in the progress notes, at the time of entering the orders, the rationale for the order and the relevant discussions held with the patient and family.
2. Review and complete the Code Status Order
3. If a decision has been made to attempt resuscitation in the event of an arrest but to limit the resuscitative measures used (LIMITED CODE), this limitation should be specified on the order and the rationale detailed in the progress notes.
4. The Code Status Order must be signed by the attending physician or within 24 hours. A telephone order will be taken by 2 RNs as per policy. Verbal orders are not valid.

To change a code status order, a new order must be entered.

NOTE: If the order is being renewed or changed in any way, a new order must be completed with the current code status and a note made in the progress notes.

NURSING RESPONSIBILITY

1. The registered nurse will acknowledge the physician's order by acknowledging the order in the system or on paper if in downtime procedures.
2. Make the appropriate changes in the Patient Care Plan.

REFERENCES:

- California Code of Regulations. Title XXII Section 70203 (2019). Retrieved from [https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I D7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=\(sc.Default\)&bhcp=1](https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I D7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1).
- The Joint Commission. (2022). Hospital accreditation standards. Joint Commission Resources. <https://www.jointcommission.org>

SUBJECT: ELECTRONIC FETAL MONITORING TERMINOLOGY	SECTION: <div style="text-align: right;">Page 1 of 5</div>
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To facilitate appropriate clinical management of variant fetal heart rate (FHR) patterns through communication of FHR pattern interpretation and medical record documentation based on standardized terminology and classification.

POLICY:

National Institute of Child Health and Human Development (NICHD) definitions apply to fetal heart rate (FHR) patterns produced from either a direct fetal spiral electrode detecting the fetal electrocardiogram (FECG) or an external Doppler ultrasound device detecting the fetal heart events using the autocorrelation technique. Although the prime emphasis of the definitions is on Intrapartum patterns, they are also applicable to antepartum observations.

AFFECTED AREAS/ PERSONNEL: *MCH DEPT. /RNs*

NICHD DESCRIPTIVE TERMS:

1. **Baseline Rate:** Approximate mean FHR rounded to increments of 5 bpm (beats per minute) during a 10-minute segment, excluding accelerations, decelerations and periods of marked variability
 - a. In any 10-minute window, the minimum baseline duration must be at least 2 minutes (not necessarily contiguous) or the baseline for that period is indeterminate. In this case, one may need to refer to the previous 10-minute segment for determination of the baseline.
 - b. Normal FHR baseline: 110 - 160 beats per minute (bpm)
3. **Bradycardia:** baseline rate of less than 110 bpm
4. **Tachycardia:** baseline of greater than 160 bpm
5. **Baseline Variability:** Fluctuations in the baseline FHR are irregular in amplitude and frequency and are visually quantified as the amplitude of the peak-to-trough in bpm.
 - a. **Absent variability:** amplitude range undetectable
 - b. **Minimal variability:** amplitude range visually detectable (> undetectable) but \leq 5bpm.
 - c. **Moderate variability:** Amplitude range 6 – 25 bpm
 - d. **Marked variability:** Amplitude range > 25 bpm
6. **Acceleration:** Visually apparent abrupt increase (onset to peak is <30 seconds) in FHR above the adjacent baseline. Peak must be \geq 15 bpm above the baseline and lasts \geq 15 seconds but < 2 minutes from the onset to return to baseline.

<p>SUBJECT: ELECTRONIC FETAL MONITORING TERMINOLOGY</p>	<p>SECTION:</p>
--	-----------------

Page 2 of 5

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- a. Before 32 weeks of gestation, a peak ≥ 10 bpm above the baseline and duration of ≥ 10 seconds is an acceleration. .
7. **Prolonged Acceleration:** Acceleration ≥ 2 minutes but < 10 minutes duration.
8. **Early Deceleration:**
 - a. Visually apparent, usually symmetrical, gradual decrease (onset to nadir ≥ 30 seconds) of the FHR and return to baseline associated with a uterine contraction.
 - b. The decrease in FHR is calculated from the onset to the nadir of the deceleration.
 - c. The nadir of the deceleration occurs at the same time as the peak of the contraction.
 - d. In most cases the onset, nadir, and recovery of the deceleration are coincident with the beginning, peak and ending of the contraction, respectively.
3. **Late Deceleration:**
 - a. Visually apparent symmetrical gradual decrease (onset to nadir ≥ 30 seconds) of the FHR and return of the FHR associated with a uterine contraction.
 - b. The decrease in FHR is calculated from the onset to the nadir of the deceleration.
 - c. The deceleration is delayed in timing, with the nadir of the deceleration occurring after the peak of the contraction.
 - d. In most cases, the onset, nadir, and recovery of the deceleration occur after the beginning, peak, and ending of the contraction, respectively.
4. **Variable Deceleration:**
 - a. Visually apparent abrupt decrease (onset to beginning of nadir is < 30 seconds) in FHR below the baseline..
 - b. The decrease in FHR is calculated from the onset to the nadir of the deceleration.
 - c. The decrease is ≥ 15 bpm, lasting ≥ 15 seconds but < 2 minutes in duration.
 - d. When variable decelerations are associated with uterine contractions, their onset, depth, and duration commonly vary with successive uterine contractions.

<p>SUBJECT: ELECTRONIC FETAL MONITORING TERMINOLOGY</p>	<p>SECTION: Page 3 of 5</p>
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5. **Prolonged Deceleration:** Visually apparent decrease in FHR below the baseline. Decrease is \geq 15 bpm, lasting \geq 2 minutes but $<$ 10 minutes from onset to return to baseline. A deceleration that lasts greater than or equal to 10 minutes is a baseline change
6. **Recurrent:** Occurring with \geq 50% of contractions in a 20 minute period
7. **Intermittent:** Occurring with $<$ 50% of contractions in a 20 minute period
8. **Periodic and Episodic Changes:** Characteristic changes, *accelerations and decelerations*, from the FHR baseline. (P. 129 FHM Principles and Practices)
 - a. Periodic: Associated with uterine contractions
 - b. Episodic: Not associated with uterine contractions
9. **Sinusoidal:** Visually apparent undulating sine wave - like pattern in FHR baseline with a cycle frequency of 3-5 per minute which persist for \geq 20 minutes.
10. **Uterine Activity:** Uterine activity is assessed based on the number of contractions that are occurring in a 10 minute segment, averaged over a 30 minute period.
 - a. Normal Uterine Activity: 5 or less contractions in a 10 minute segment, averaged over a 30 minute period.
 - b. Tachysystole: Excessive uterine activity; more than 5 contractions in a 10 minute segment averaged over a 30 minute period. Tachysystole can be the result of both spontaneous and stimulated labor.

THREE TIER FETAL HEART RATE INTERPRETATION SYSTEM:

1. **Category I (normal)** – FHR tracings include all of the following:
 - Baseline rate: 110 – 160 bpm
 - Baseline FHR variability: Moderate
 - Late or variable decelerations: Absent
 - Early decelerations: Present or absent
 - Accelerations: Present or absent

SUBJECT: ELECTRONIC FETAL MONITORING TERMINOLOGY	SECTION: <div style="text-align: right;">Page 4 of 5</div>
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2. **Category II (indeterminate)** – FHR tracings include all FHR tracings not categorized as Category I or Category III. Category II tracings may represent an appreciable fraction of those encountered in clinical care. Examples of Category II FHR tracings include any of the following:

- Baseline rate
 - Bradycardia not accompanied by absent baseline variability
 - Tachycardia
- Baseline FHR Variability
 - Minimal baseline variability
 - Absent baseline variability not accompanied by recurrent decelerations
 - Marked baseline variability
- Accelerations
 - Absence of induced accelerations after fetal stimulation
 - Recurrent variable decelerations accompanied by minimal or moderate baseline variability.
 - Prolonged decelerations ≥ 2 minutes but < 10 minutes.
 - Recurrent late decelerations with moderate baseline variability.
 - Variable decelerations with other characteristics, such as a slow return to baseline.

3. **Category III (abnormal)** – FHR tracings include either:

- Absent baseline FHR variability WITH any of the following:
 - Recurrent late decelerations
 - Recurrent variable decelerations
 - Bradycardia

----- OR -----

- Sinusoidal pattern

SUBJECT: ELECTRONIC FETAL MONITORING TERMINOLOGY	SECTION: Page 5 of 5
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REFERENCE:

- American Academy of Pediatrics & American College of Obstetrics and Gynecologist. (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors.
- Lyndon, A., Wisner, K. (2021). *Fetal heart monitoring principles and practices* (6th ed). Dubuque, IA: Kendall Hunt.
- Simpson, K.R. (2021). *Fetal assessment and safe labor management monograph*. National Certification Corporation. Chicago, IL.

SUBJECT:
**IDENTIFICATION OF PATIENT'S REQUESTS
AND SAMPLES (BLOOD BANK)**

SECTION:

Page 1 of 3

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

PURPOSE:

To provide instructions on how to identify specimens for blood bank laboratory orders.

POLICY:

- A. Request Forms: Done in order entry on the hospital computer system.
1. The electronic requisitions requesting blood bank (BBK) studies contain the following information to ensure positive identification of the patient and accurate processing of the blood bank orders in adherence to the Association for the Advancement of Blood & Biotherapies (AABB) Standards and TJC Accreditation Requirements.

NOTE: All patients will be issued an ID wristband, which will include a unique BBK (Blood Bank) number for positive ID.

- a. Patient's first and last name
- b. Patient's medical record number
- c. Patient's account number
- d. Patient's date of birth (DOB)
- e. Physician of record
- f. Patient's location
- g. Test(s) required
- h. Blood products requested, if any
- i. Date/time specimen draw
- j. Two initials required on blood tubes labeled at bedside to validate witnessed phlebotomy with correct ID and correct BBK#.

(For Inpatient and Emergency Department (ED), any combination of phlebotomist, nurse, CNA, and/or physician initials are acceptable. For Outpatient, phlebotomist and lab clerk initials can be used.)
- k. If tests are to be performed on newborns, the medical record number of the mother is also available on the baby's requisition.

SUBJECT: IDENTIFICATION OF PATIENT'S REQUESTS AND SAMPLES (BLOOD BANK)	SECTION:
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Page 2 of 3

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- l. Additional information, such as clinical diagnosis, ordering physician, medication, date and time blood products are needed for transfusions and the initials of the nursing personnel placing the order, are also required.
- m. Incomplete orders will not be accepted by the blood bank for processing. This includes any sample missing a second set of initial's from witness, BBK number of the patient obtained from the wristband and time of collection.

B. Blood Samples:

1. The patient and the blood sample shall be positively identified at the time of collection by comparing the information on the blood bank specimen label with the information on the patient's ID wristband. The technician will verify the patient's name verbally with the patient, family member, or nurse when the patient is unable. In cases such as an ED emergency, a stat admit kit with temporary ID will be used. Blood specimens drawn will be labeled at the bedside with the computer generated or handwritten label containing the following:
 - a. Patient's first and last name
 - b. Patient's account number
 - c. Patient's DOB
 - d. BBK Number (handwritten by phlebotomist – found on patient's wristband)
All specimens drawn for blood bank testing will be obtained and labeled by a certified/licensed lab personnel or licensed personnel in the presence of a second licensed personnel. All personnel involved in obtaining the specimen will each initial the specimen labels and/or additional forms as required, and confirm that the BBK# has been transcribed correctly from the patient's wrist band to the specimen label. The outpatient lab setting may use a lab clerk as the second personnel.
 - e. Date/time specimen drawn (handwritten by phlebotomist)
 - f. Initial of phlebotomist (handwritten by phlebotomist)

C. Identifying Information:

1. Before a specimen is used for blood bank test processing, the blood bank CLS shall confirm that all identifying information on the blood bank order is in agreement with that on the blood bank sample tube label.

SUBJECT: IDENTIFICATION OF PATIENT'S REQUESTS AND SAMPLES (BLOOD BANK)	SECTION:
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Page 3 of 3

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2. A properly labeled BB specimen is defined as containing the above list of identification points. Any deviation from the above accurate identification will result in specimen rejection and another specimen must be obtained.

AFFECTED AREAS/PERSONNEL: *LABORATORY STAFF, NURSING, PHYSICIANS*

REFERENCES:

- Association for the Advancement of Blood and Biotherapies (AABB) STDS, 33rd Ed, pgs. 38-39, 5.11.1 - 5.11.3, 2022.
- The Joint Commission (2025). Hospital accreditation standards (DC.01.01.01 and DC.01.03.01). Joint Commission Resources. Oak Brook, IL.

SUBJECT: MALIGNANT HYPERTHERMIA (MH), PATIENT TREATMENT GUIDELINES	SECTION:
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Page 1 of 11

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

PURPOSE:

- To provide nursing staff with guidelines on how to recognize the patient who may be or is known to be at risk for Malignant Hyperthermia (MH).
- To recognize the presenting symptoms and recommended treatment for a patient in MH crisis.

POLICY:

This policy/procedure is intended to provide guidelines to ensure maximum patient safety in the treatment of a malignant hyperthermia crisis.

DEFINITIONS

- Malignant Hyperthermia – a rare genetic condition characterized by a severe hypermetabolic state and rigidity of the skeletal muscles.
- Triggering agent – succinylcholine and some inhaled anesthetics (i.e. sevoflurane, isoflurane, desflurane) are agents known to elicit a MH response. The triggering agent causes a series of chain reactions in the body related to an increase in skeletal muscle intracellular calcium ion (Ca⁺⁺) concentration.
- MH crisis – an overwhelming physical response to a triggering agent that may result in the death of the patient.

SYMPTOMS OF MALIGNANT HYPERTHERMIA

1. The following list represents symptoms that may present in the patient undergoing a MH crisis. These are not listed in any particular order.
 - a. Masseter muscle rigidity due to increased intracellular Ca⁺⁺ levels
 - b. Hypercarbia - doubling or tripling when minute ventilation is constant
 - c. Unexplained tachycardia - (sinus, ventricular, or even ventricular fibrillation)
 - d. Whole body muscle rigidity
 - e. Respiratory acidosis – (end-tidal carbon dioxide (CO₂) > 55 millimeters of mercury (mmHg) or arterial partial pressure of carbon dioxide (pCO₂) >60mmHg)
 - f. Metabolic acidosis - (base excess < -8, potential hydrogen (pH) <7.25)

<p>SUBJECT: MALIGNANT HYPERTHERMIA (MH), PATIENT TREATMENT GUIDELINES</p>	<p>SECTION:</p> <p style="text-align: right;">Page 2 of 11</p>
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- g. Core temperature elevation – (as much as 1° C [1.8° Fahrenheit (F)] every few minutes) (increase may be early or late sign)
- h. Skin changes - generalized erythematous flush or mottling, cyanosis, diaphoresis (lack of oxygenation to peripheral tissues due to oxygen consumption by muscle tissue; generalized vasoconstriction)
- i. Myoglobinuria – representing renal function change
- j. Sudden cardiac arrest – typically due to hyperkalemia
- k. Rhabdomyolysis - occurs when the muscle is damaged and intracellular contents begin to leak into the bloodstream.

Policy Statement

- 2. During preoperative interviews, the Registered Nurse (RN) should ask all patients who will be receiving general anesthesia if they have any personal or family history of MH, or if any family members have died in surgery.
- 3. The RN should alert the anesthesia provider about any positive patient or family MH history, or patients who describe a history of non-surgical related incidents of heat stroke or hyperthermia.
- 4. The patient with MH will require continual reassurance. The clinical team is responsible to inform the patient that everyone is aware of potential problems and that an anesthesia treatment plan has been developed to avoid any MH occurrence.

GUIDELINES

- 1. A MH supply cart will be located in locations where general anesthesia is performed. Unit Crash Carts will be used in conjunction with the MH Carts during a MH crisis. Additional supplies are stocked in each individual department, including the medication refrigerators.
- 2. Binders containing all necessary forms will be kept on top of the MH carts. Updating of the binders will be the responsibility of each individual department.
- 3. Each MH cart's medications will be stocked and checked for outdates at least monthly by Pharmacy. Red breakaway locks will be used to assure drawer security. In the event that expired, or soon to be expired, medications are discovered, pharmacy will have the responsibility of replacing the item(s) and to re-lock the cart.
- 4. Non-pharmaceutical supplies in each cart will be stocked and checked at least monthly by the individual units. (See Addendum Cart Inventory List.) Yellow breakaway locks will be used to ensure drawer security. In the event that expired, or soon to be expired, non-

SUBJECT: MALIGNANT HYPERTHERMIA (MH), PATIENT TREATMENT GUIDELINES	SECTION: <p align="right">Page 3 of 11</p>
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pharmaceutical supplies are discovered, Central Processing Department will have the responsibility of replacing the item(s) and to re-lock the cart. (all Pharmaceutical supplies will be restocked by the Pharmacy)

5. The cart is to be checked daily (when unit is open) by Nursing Staff to assure that the locks are intact. The cart lock number is recorded in the Malignant Hyperthermia Cart logbook kept on top of the MH cart. The earliest expiration dates of medications and supplies are to be noted on the front of the drawers and checked monthly.
6. In order to assure availability, the cold intravenous (IV) fluids, ice, irrigation fluids and specified dosages of regular insulin will be labeled as "MH Use Only". (The marked insulin will be kept in the Pyxis refrigerators in the Main OR and OB.

AFFECTED AREAS/ PERSONNEL:

ANESTHESIA SERVICES, SURGICAL SERVICES, ASD, MATERNAL CHILD HEALTH (MCH), EMERGENCY DEPARTMENT (ED), INTRAOPERATIVE RNs, MCH RNs, PACU RNs, INTENSIVE CARE UNIT (ICU) RNs, ED PHYSICIANS, RNs, LICENSED VOCATIONAL NURSES (LVNs), and SURGICAL TECHS

PROCEDURE:

ANESTHESIA

1. When MH symptoms are suspected:
 - a. Notify the surgeon to halt the procedure ASAP,
 - b. Stop the administration of anesthetic gas agents except oxygen (dependent on the point of advancement of the surgical procedure; nitrous oxide or propofol are safe alternatives to maintain general anesthesia).
 - c. The anesthesia circuit and the ventilator bag must be replaced immediately.
 - d. The patient is hyperventilated with 100% oxygen (O₂) in an attempt to meet the requirements of the body during the crisis period.
 - e. Give IV Dantrolene 2.5 mg/kg (10 mg/kg if at ASD)
2. The anesthetic vaporizer should be disabled as soon as possible. The machine is then flushed with 100% O₂ at 10 liters (L)/min through the circuit via the ventilator for 20 minutes.
3. The soda lime canisters will require replacement; care must be taken when changing as a patient in full blown crisis will exude so much CO₂ that these canisters will be very hot to the touch.

SUBJECT: MALIGNANT HYPERTHERMIA (MH), PATIENT TREATMENT GUIDELINES	SECTION:
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Page 4 of 11

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4. If possible, change out anesthesia machine.

NURSING

1. Call for help. In conjunction with the Charge Nurse, the staff RN will coordinate and communicate assignments of personnel responding to the crisis and assist anesthesia as needed.
2. Code Blue may be called if additional staff is needed. If after hours, the House Supervisor will be notified.
3. ASD, will call 911 for patient transport to the ED for continued care.
4. Obtain the MH Cart, the Crash Cart and the refrigerated fluids immediately.
5. At least two other nursing staff will be needed to assist with mixing the dantrolene sodium and at least one other runner will need to fill bags with ice and bring them to the OR or PACU (where the crisis is occurring.) Another individual must be able to stand-by to transport blood gasses and other lab-draw specimens.
6. Assign one (1) RN to document. The Malignant Hyperthermia Association of the United States (MHAUS) Malignant Hyperthermia Crisis Flow Sheet will be utilized to document the MH crisis. (See attachment.) Copies of the Flow Sheet are located in the MH cart binder.) In addition, a Code Blue record is completed if the patient experiences cardiac or respiratory arrest.
7. The MHAUS hotline, at (800) 644-9737, may be utilized at any time deemed necessary to assist the staff and any non-anesthesiologist physician responding to a crisis.
8. Insert a 3-way foley catheter with a urine meter bag if the patient does not already have one in place. Report to anesthesia the color and quantity of the patient's urine. Have cystoscopy tubing ready to attach to the infusion side of the 3-way to irrigate with chilled saline.
9. Cooling the patient is of vital importance to reduce body temperature:
 - a. Infusion of refrigerated IV solutions as fast as one liter/10 minutes for 30 minutes may be required. (These solutions are found in the medication refrigerators in the Main OR, OB and the ASD.) This infusion of cold IV fluid results in kidney diuresis and temperature reduction. **Do not use Lactated Ringer's Solution.**
 - b. Surface cooling, utilizing automatic cooling blankets and/or ice packs to the head, neck, axilla, and groin. Instant ice packs will be available in the carts. Additional ice

SUBJECT: MALIGNANT HYPERTHERMIA (MH), PATIENT TREATMENT GUIDELINES	SECTION: <p align="right">Page 6 of 11</p>
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lead to life-threatening hyperkalemia and myocardial depression. Avoid parenteral potassium as well. (Avoid lidocaine or procainamide in hyperkalemic patients)

6. For the correction of acidosis not being reversed by dantrolene sodium, sodium bicarbonate is administered at 1-2 milliequivalents (mEq)/kg if blood gas values are not yet available; otherwise per physician order.
7. Place arterial and additional IV lines as time permits.
8. IV Administration of titrated mixture of 50 cubic centimeters (cc) of 50% Dextrose and 10 units of Humulin R[®] insulin may be ordered to provide glucose for metabolism and reduce hyperkalemia by driving potassium back into the cells. The amount of this mixture administered will be titrated based on the potassium level results. (Humulin R[®] is the only type of insulin that may be administered IV) by driving potassium back into the cells.
9. Administration of 10mg/kg of calcium chloride I.V. or calcium gluconate 10-50mg/kg I.V. ,Bicarbonate 1-2 mEq/kg I.V. may be ordered to treat life-threatening hyperkalemia.
10. Arrangements for an ICU bed must be made. This patient will require close observation and frequent blood gasses and other blood work for the next 36 hours at a minimum.

AFTER THE CRISIS

1. An Anesthesiologist shall provide post-crisis instruction to the patient and family as he/she will be better able to describe what occurred and what will need to happen in the future.
 - a. Discuss possible side effects of dantrolene sodium that they may observe in their family member post-crisis treatment; these may include nausea, diarrhea, double vision, lightheadedness, and muscle weakness.
 - b. Have patient follow-up with primary physician for further blood work after discharge (creatin kinase [CK] levels, coagulation profile).
 - c. Advise the family to contact the Malignant Hyperthermia Association of the United States (www.mhaus.org) for additional information, voluntary registration, and support. The MHAUS website also has information as to where the family can acquire muscle biopsy testing for diagnosis. English and Spanish informational handouts are available in the back of the MH cart logbook.
 - d. Review susceptibility of malignant hyperthermia in blood relatives.
 - e. Advise patient and family to notify other healthcare providers (including dentists/oral surgeons) regarding malignant hyperthermia diagnosis or susceptibility.

SUBJECT: MALIGNANT HYPERTHERMIA (MH), PATIENT TREATMENT GUIDELINES	SECTION:
---	-----------------

Page 7 of 11

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- f. The anesthesia provider will complete the MHAUS reporting form for Adverse Metabolic Reaction to MHAUS.
2. The Charge Nurse or Circulator will submit a Datix report of the incident.
3. Once the patient has been transferred out of the OR and a comprehensive report has been given to the accepting nurse and physician, an assessment should be done to consider the availability of crisis management supplies to complete the remaining surgery schedule. If it is determined not safe to proceed with scheduled cases, patients may have to be rescheduled for a later time and date when mandated supplies are again available.
4. Immediate steps will be taken to reorder dantrolene and other crisis management supplies.
5. A debriefing should be held with all staff involved in the MH crisis as soon as possible to evaluate their response. The meeting should include areas in which the response team may need to improve for future cases of MH.

EDUCATION

Anesthesia Services, Surgical Services (ASD, Main OR, PACU), MCH, ICU and ED staff must participate in at least annual reviews of MH signs/symptoms and MH crisis response, including a mock MH code.

REFERENCES:

- AORN (2025) Perioperative Standards and Recommended Practices. Retrieved from <https://aornguidelines.org/glance/content?gbosid=483811>
- Malignant Hyperthermia Association of the United States, www.medical.mhaus.org; accessed January 2026.

SUBJECT: MALIGNANT HYPERTHERMIA (MH), PATIENT TREATMENT GUIDELINES	SECTION:
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Page 8 of 11**Printed copies are for reference only. Please refer to the electronic copy for the latest version.****Attachment A****SIERRA VIEW MEDICAL CENTER
MALIGNANT HYPERTHERMIA SUPPLY CART****Top of Cart:**

Laminated poster Emergency Therapy for MH
Binder

Drawer 1

- 1 Temperature Probe & Cable
- 1 CV Pressure Kit
- 1 Radial Arm Cath Set
- 1 NS 500 ml IV
- 1 Pressure Bag
- 1 NG Tube 12, 16, 18
- 1 Suction Tubing
- 1 Feeding Tube 8
- 2 Toomey Syringe
- 2 Irrigation Tray
- 1 Y Connector
- 1 5 in 1 Connector
- 4 Water soluble Jelly

Drawer 2

- Alcohol Wipes
- 1 3 way Stopcock
- 1 Wrist Support
- 2 IV Start Kit
- 3 IV Cath 16, 18, 20, 22 (3 each)
- 2 Primary IV tubing

SUBJECT: MALIGNANT HYPERTHERMIA (MH), PATIENT TREATMENT GUIDELINES	SECTION: <p align="right">Page 9 of 11</p>
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

- 1 Primary IV microdrip tubing
- 1 Secondary IV tubing
- 2 Syringe 20 ml
- 5 Syringe 10 ml
- 4 Syringe 3 ml
- 2 Syringe Insulin
- 4 ABG kits
- 2 Red top (lab tube)
- 2 Blue top
- 2 Purple top
- 2 Green Top
- 2 Urine Spec Container
- 4 21 g Needle for lab draw
- 2 Tourniquet
- 1 Tape: Silk 1", Foam 2", Transpore 1" (1 each)

Drawer 3

- 36 Dantrolene Inj 20mg/vial
- 50 Sterile Water for Injection 50mL
- 5 Sodium Bicarb 8.4% Inj 50mL
- 4 Furosemide 40mg/4mL
- 2 Dextrose 50% 50mL
- 2 Calcium Chloride 10% 10mL
- 3 Lidocaine 2% Inj 5mL
- 1 Regular Insulin 100U/mL 10mL(in designated refrigerator)
- 10 Needle 18g
- 4 Syringe 60 ml
- Medication Labels

Drawer 4

- 1 Sterile Drape
- 7 Instant Cold Packs
- 1 Soda Lime Canister Refill (Carbon dioxide absorber)
- 1 Foley Cath tray
- 1 Urometer
- 1 Urine Bag
- 1 Bladder Irrigation Tube
- 1 Catheter Stabilizing Device
- 1 3-way Foley Catheter 22 F / 30 ml
- 1 3-way Foley Catheter 20 G / 30 ml
- 1 Foley Catheter 8, 12, 16, 18 French (1 each)
- 1 Enema Kit

SUBJECT: MALIGNANT HYPERTHERMIA (MH), PATIENT TREATMENT GUIDELINES	SECTION:
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Page 11 of 11

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MHAUS Guidelines Therapy Info
Dantrolene Dosage Chart
SVMC Dantrolene Drug Protocol
Phone Extensions
MHAUS Adverse Medical Reaction to Anesthesia form

36 Dantrolene Inj 20mg/vial
50 Sterile Water for Injection 50mL
5 Sodium Bicarb 8.4% Inj 50mL
10 Needle 18g
4 Syringe 60 ml
Medication Labels
7 Instant Cold Packs

SUBJECT: <p style="text-align: center;">PATIENT DEATH</p>	SECTION: <p style="text-align: center;"><i>Provision of Care, Treatment and Services (PC)</i></p> <p style="text-align: right;">Page 1 of 8</p>
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To outline the process to be followed when a patient expires in the hospital.

POLICY:

All patients who expire in the hospital setting will be treated with respect and dignity. Nursing personnel will offer consolation/assistance to the family in their time of grief and will offer assistance in obtaining religious support as requested. Additionally, nursing personnel will report deaths to the appropriate authorities as indicated by the law and will facilitate the timely removal of the body to the appropriate mortuary.

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

PROCEDURE:

PRONOUNCEMENT

1. When a patient expires in the hospital, pronouncement of death will be made by a physician in attendance of the patient (i.e., Emergency Department (ED) physician, primary physician, Code Blue Team Leader).
2. Patients who have a “No Code” or “No Code with Comfort Measures” may be pronounced dead by a registered nurse (RN) who has successfully completed the Standardized Nursing Procedure for Pronouncement of Death.

ORGANIZATIONAL REPORTING

1. Notification of appropriate personnel, including:
 - a. Nursing Shift Manager – contacts administrative representative if necessary
 - b. Primary Care Physician and/or consulting staff– if not in attendance at death
 - c. Patient Unit– if patient is off the unit (i.e., Surgical Services Department, Radiology Department)
 - d. Admitting/Patient Registration Department
 - e. Clergy– if appropriate.
2. At or near the time of notification of death of any patient, the Donor Network will be contacted for assistance in determining organ donor potential. (*Complete information worksheet for reporting deaths.*)

<p>SUBJECT: PATIENT DEATH</p>	<p>SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 2 of 8</p>
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CORONER'S CASES

It is the decision of the Coroner to determine the extent of the investigation necessary. He/she may instruct how to release the body without investigation. (*See: Deaths Reportable to the Coroner policy*)

NOTIFICATION OF DEATH TO FAMILY/NEXT OF KIN

1. Before notifying the family, the nurse who will notify the family shall verify the identity of the decedent and the correct family member who is to be called.

2. Timing notification: Families desire to be contacted about a death immediately, regardless of how late at night it is.

3. Physical Surroundings: It is never a good idea to notify someone of a death in a public area. When families hear the news of death in a formal setting, they are more likely to be psychologically prepared to accept the reality of the death. Escort IMMEDIATE FAMILY to a private room. The room should be a place where the family can remain for some time, uninterrupted by other staff or visitors. For their own safety, have those present sit down before breaking the news. Interacting with family at the hospital may facilitate other matters (i.e., mortuary preference, tissue/organ donation, etc.).

4. Telephone Notification: Even though most initial family contacts are made by phone, the telephone is a poor instrument for ACTUAL notification of death. Statements such as "I'm told he isn't doing well" or "I'm told he has been badly injured – could you come in right now?" may be appropriate to facilitate prompt family responses. Plan to direct the conversation to avoid telling more than is appropriate for the circumstances. Do not force notification.

SUBJECT: PATIENT DEATH	SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 3 of 8
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- a. Make sure family members know exact address of the hospital and easy-to-follow directions, including both the route to the facility and where to go upon arrival.
 - b. Give the full name and location of the person to contact on arrival at the hospital and inform security to let them in.
 - c. If family members are adamant about receiving notification over the telephone, respect their right to know. If family member appears hesitant or unable to cope, offer to speak to someone else present. After the notification, find out if the person is home alone. If asked before, the person might suspect “crank” call or it could produce extreme anxiety. Never ignore reported thoughts of suicide or homicide. If someone threatens suicide at such a time, stay on the phone and talk it through. Try and locate a trained professional to go to the home while you continue on the phone. If the person hangs up, call local police immediately. If there is no adult in the home, ask the oldest child how to get in touch with an adult relative. If there is no address, depend on public personnel to obtain one via phone number. d. If the family lives more than one hour from the hospital, telephone notification should be considered.
5. Sequential Notification Technique
- a. The person reaching out to the family should ask the family members what they already know about the situation.
 - b. Give a BRIEF description of additional events that led up to the patient’s arrival at the hospital if known.
 - c. Give information regarding the resuscitative efforts made on behalf of the patient at the hospital.
 - d. Conclude with the victim’s response to the treatment, the statement of death, and a brief explanation of the cause of death if known.

<p>SUBJECT: PATIENT DEATH</p>	<p>SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 4 of 8</p>
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- e. NEVER START the death notification with the statement of death. NEVER begin with the statement, “I have bad news for you” or “I’m sorry, but...”.
 - f. Sit close, be willing to listen and give empathetic responses.
 - g. Do not reinforce denial. Speak of deceased person in appropriate terms such as “How was he?”
6. When information is of a sensitive nature, use terminology such as “alleged,” reportedly,” or “appears to be” – In case of homicide, DO NOT contact family members or notify anyone of the death without SPECIFIC permission from investigating law enforcement staff.

NOTIFICATION OF THE CORONER

1. Call the Tulare County Sheriff’s Department Dispatch Center as soon as possible to decrease waiting time. The appropriate person will be dispatched to take the report.
2. Do not release the body to the mortuary until instructed to do so by the Coroner’s investigators or Deputy Sheriff.
3. All known facts relating to significant health history, circumstances surrounding the death, or any other information should be documented on the patient’s chart.
4. Cases of special interest and all trauma deaths should be communicated to the staff pathologist by the attending physician and/or the ED Physician to provide first-hand information in the determination of cause of death and need and extent of autopsy.
5. In trauma deaths and/or for known autopsy requests, on the Release of Remains form, write “**DO NOT embalm until discussed with Pathologist**”. This alerts the mortuary to possible special circumstances.

CARE OF THE BODY

1. If the patient is **NOT** a Coroner’s Case, the lines can be removed and the patient prepared for family viewing and disposition to the mortuary.
2. A registered nurse (RN), licensed vocational nurse (LVN), certified nursing assistant (CNA), or operating room (OR) technician may perform post mortem care as outlined:
 - a. Body alignment, general cleanliness, and closure of the eyes

<p>SUBJECT: PATIENT DEATH</p>	<p>SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 5 of 8</p>
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

- b. Removal of tubes and catheters
 - c. Replacement of dentures or give to mortuary
 - d. Jewelry – note type and location on body. DO NOT remove if Coroner’s case (see below).
 - e. Labeling of body – ensure patient ID band is in place on patient’s body.
3. Postmortem care must not be given when the interventions conflict with the religious affiliation of the patient.

FOR CORONER’S CASES – CARE OF THE BODY

1. Once the patient has been pronounced dead, the body will **NOT** be searched. Determining the identification will be the responsibility of the Coroner’s Investigators. No valuables (money, jewelry, watches, wallets, etc.) should be removed or given to the family members if requested. Once the investigation is complete, the Coroner will handle release of effects.
2. All tubes, IV lines (fluids can be turned off), etc., should remain in place and undisturbed in all trauma related deaths and possible suicides or homicides. The investigating officer may request their removal on completion of their preliminary investigation.

FETAL DEATHS

1. Fetal deaths **beyond the 20th week** of gestation, which occur in the Emergency Department, will be reported to the Coroner. The gestational age is the interval from date of last normal menses to the estimated death date of the fetus.
2. For **inpatient settings** – the fetal death is reported for the following:
 - a. If the mother is involved with criminal activity or tests positive for illegal drugs.
 - b. Death involving trauma.
 - c. Death over **20 weeks** where the mother has **NOT** received prenatal care **AND** the cause of death is not apparent (i.e., nuchal cord around the neck).

NOTE: *The MD can choose to sign the death certificate and needs to state “Intrauterine Death, etiology undetermined”. If the MD is comfortable signing the death certificate based on autopsy findings, the Coroner does not need to be notified. If there is any doubt regarding the criteria, contact the Coroner.*

3. Fetal Burial will be necessary based on the following criteria:

SUBJECT: <p style="text-align: center;">PATIENT DEATH</p>	SECTION: <p style="text-align: center;"><i>Provision of Care, Treatment and Services (PC)</i></p> <p style="text-align: right;">Page 6 of 8</p>
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

- a. Any live birth must be buried by a mortician. A live birth has occurred when a heartbeat, breathing, crying or movement of voluntary muscle occurs.
- b. A stillbirth must be buried by a mortician if any two (2) of the following occur:
 - Over 20 weeks gestation.
 - Over 500 grams in weight (17 oz.)
 - Over 28 cms in length (11 in.)

CARE OF THE FAMILY

1. Persons accompanying the patient will be made comfortable in a quiet room.
2. If family is not present at the hospital and does not know of the patient's accident, illness, or death, they should be contacted by phone and asked to come to the hospital. Notification of death by phone should be avoided. If identification of the patient or family's location is unknown, it will become the responsibility of the Coroner's Office to make the notification.
3. Always be sure that the next of kin have been notified before giving out names of the deceased to news media.
4. Informing the family of the death should be the duty of the physician. Support of nursing personnel is important. If prolonged resuscitation efforts are being done, a nurse should see that the family is kept informed of what is being done and the patient's response and prognosis. Such preparation for the final announcement may be helpful to the family and staff.
5. Family members who wish to view the body will be assisted to do so, if possible. Nursing and physician judgment is important.
6. A staff member should be assigned to assist the family in calling religious assistance, other family members, obtaining transportation, etc.
7. Prior to leaving the hospital, a responsible family member should be asked to make known their preference for mortuary.
8. The family member should be asked to sign the "Authority for Release of Remains" form. This form remains on the patient's chart. The mortuary also signs the form when the body is picked up.

NO MORTUARY PREFERENCE / NO FAMILY AVAILABLE / MORGUE SERVICES:

SUBJECT: <p style="text-align: center;">PATIENT DEATH</p>	SECTION: <p style="text-align: center;"><i>Provision of Care, Treatment and Services (PC)</i></p> <p style="text-align: right;">Page 7 of 8</p>
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If there is no mortuary preference given or family is not available to make a preference known, the on-call mortuary should be contacted (see schedule below) to remove the deceased and placed in their Morgue. ***At no time should the body remain in the hospital setting longer than 4 hours.***

Porterville

Myers – EVEN months
 248 North E. Street
 784-5454

Porterville Funeral & Cremation – ODD months
 765 W. Henderson
 784-6485

Lindsay

Webb-Sanders – EVEN months
 163 S. Mirage Avenue
 562-3084

Myers – ODD months
 199 Honolulu Street
 562-7015

At the time of signing the “Release of Remains”, an inquiry will be made to the family regarding the patient’s possible desire to be a tissue donor (bone, skin, corneas). The responses will be documented on the form. Donor Network will reach out to the family of the patient.

DOCUMENTATION

1. The physician is responsible for the following:
 - a. Completing the Death Certificate or Medical Examiner’s form, whichever is appropriate.
 - b. Completing a note in the patient chart.
 - c. Obtaining an autopsy permit if applicable.

2. It is the responsibility of the nurse to complete the patient record (i.e., Code Blue Form, Operating Room Nurses Notes, Emergency Department Flow Sheet). The documentation will include:
 - a. the sequence of events,
 - b. time of death,
 - c. name of physician who officially pronounced the patient dead, and
 - d. disposition of the body.

REFERENCE:

- Title XXII, §70829 (2019). Retrieved from [https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=\(sc.Default\)&bhcp=1](https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1).

SUBJECT: PATIENT DEATH	SECTION: <i>Provision of Care, Treatment and Services (PC)</i> Page 8 of 8
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

CROSS REFERENCES:

- Patient Care Services Manual -- (1) Standardized Nursing Procedure for Pronouncement of Death, Code Status Order Form, Potential Organ & Tissue Donor.
- [Deaths Reportable to the Coroner](#)

SUBJECT	Physician Medical Record Documentation & Dictation Requirements.	SECTION: <i>Record of Care, Treatment & Services (RC)</i>
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure that all members of the Medical Staff complete required medical record documentation in a timely, accurate, and compliant manner in accordance with Joint Commission, CMS Conditions of Participation (CoPs), and California Title 22 regulations. Timely physician documentation is essential to patient care, regulatory readiness, coding, billing, continuity of care, and medico-legal integrity.

SCOPE:

This policy applies to all licensed independent practitioners (LIPs), including physicians, advanced practice providers, and contracted/telemedicine providers who generate or authenticate documentation in the patient's legal medical record at Sierra View Medical Center.

POLICY:

❖ **History & Physical (H&P)**

- Regulatory Basis: TJC RC.02.01.03, CMS §482.24(c)(4), Title 22 §70751

➤ **Acute Inpatient Admissions**

- H&P must be completed within 24 hours of admission.
- May be completed up to 30 days prior if:
 - Reviews the H&P within 24 hours of admission, and
 - Documents an update/internal note that includes:
 - ◆ Confirmation of the H&P was reviewed.
 - ◆ Any changes in condition
 - ◆ Any new findings affecting care.

➤ **Surgical/Procedural Cases**

Applies to inpatient and outpatient procedures, including anesthesia cases.

- **Timing Requirements**
 - H&P must be completed no more than 30 days prior to the procedure.
 - A current H&P must be available in the chart prior to the procedure.
 - If the H&P is older than 30 days, a new H&P is required.
- **Update Requirement Prior to the Procedure**
 Regardless of when the H&P was completed (same day or up to 30 days prior), an Update/Interval Note is required immediately prior to the procedure.
 - The Update note must include:
 - ◆ Confirm the H&P has been reviewed.
 - ◆ Review of Systems

SUBJECT	Physician Medical Record Documentation & Dictation Requirements.	SECTION: <i>Record of Care, Treatment & Services (RC)</i>
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- ◆ Document whether there are no changes or identify any changes in the patient's condition.
- ◆ Be completed by a privileged provider (physician, PA, NP)
- ◆ Be documented before the patient enters the operating room/procedural suite.

➤ **A full H&P is required for:**

- Inpatient Admissions
- Procedures requiring general anesthesia
- Procedures requiring deep or moderate sedation
- High-risk procedures
- Significant change in patient condition

➤ **When a New H&P is Required**

- The patient's condition has changed significantly requiring a new full H&P
- No prior H&P exists.
- The existing H&P is >30 days old.
- The update note identifies significant changes requiring a new full H&P

➤ **Emergency Procedures**

- In true emergencies, an H&P may be deferred until the procedure, but must be documented as soon as possible following stabilization, consistent with CMS and TJC requirements.

❖ **Short Form History and Physical**

When a comprehensive History and Physical Examination is not clinically indicated, a Short Form H&P may be used for outpatient and clinic-based services, provided the nature of the service does not require a full H&P under CMS, Joint Commission, or California Title 22 regulations.

The Short Form H&P must be:

- Appropriate to the patient's condition and procedure
- Completed prior to the service
- Dated, timed, and authenticated by the privileged provider

A Short Form H&P **may not be used** in lieu of a full H&P for inpatient admissions, procedures requiring general or deep sedation, or when the patient's condition warrants comprehensive evaluation.

- At a minimum, the Short Form H&P must include:
 - Chief complaint/reason for visit
 - Focused history relevant to the procedure
 - Relevant past medical/surgical history
 - Medication and allergy review
 - Focused physical exam related to the procedure
 - Assessment and plan

SUBJECT	Physician Medical Record Documentation & Dictation Requirements.	SECTION: <i>Record of Care, Treatment & Services (RC)</i>
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- Statement of medical necessity
- Date, time, and authentication provider signature.

❖ **Operative/Procedural Report**

- Immediate Operative Note (Handwritten or Electronic)
Must be entered immediately following surgery before the patient leaves the PACU or procedure suite and must include:
 - Pre-op diagnosis
 - Post-op diagnosis
 - Procedure performed
 - Primary surgeon and assistants
 - Estimated blood loss.
 - Findings
 - Complications
 - Specimens removed
 - Condition of patient
- Final Operative Report
Must be dictated or completed within 24 hours of the surgery or invasive procedure.

❖ **Verbal/Telephone Orders**

- Must be authenticated/signed within 48 hours.
(CMS §482.24(c)(1), Title 22 §71539)

❖ **Progress Notes**

Regulatory Basis: Title 22 §70749; CMS §482.24(c)(1)

- Physicians must document progress notes daily for inpatients.
- Notes must reflect:
 - Assessment and plan
 - Clinical status
 - Response to treatment
 - Medical Decision-making
- For high-acuity or frequent assessment areas (ICU, L&D), frequency must meet clinical need.

❖ **Consultations**

- Consult notes must be completed within 24 hours of consultation request unless needed state (then must be documented same shift).

❖ **Discharge Summary**

SUBJECT	Physician Medical Record Documentation & Dictation Requirements.	SECTION: <i>Record of Care, Treatment & Services (RC)</i>
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Regulatory Basis: Title 22 §70753; CMS §482.24(c)(4); TJC RC Standards

- **Timeline**
 - Must be dictated or entered the EMR within 48 hours of discharge.
 - **Required Elements:**
 - ◆ Admission reason
 - ◆ Significant findings
 - ◆ Procedures
 - ◆ Treatment provided
 - ◆ Patient condition at discharge
 - ◆ Discharge medications
 - ◆ Follow-up instructions
 - ◆ Pending test results (with follow-up plan)
 - ◆ Final Diagnosis
- **Short Stay Option**
 - For hospital stays <48 hours with minor diagnoses, dictated discharge summary may be replaced by:
 - ◆ Final progress note
 - ◆ Must include the same required elements.

❖ **Death Summary**

Requirement depends on circumstances:

- Death within 24 hours of admission: Documented by the physician within 24 hours.
- All other deaths: Discharge summary completed within 48 hours.

❖ **Emergency Department Documentation**

Regulatory Basis: CMS §482.24(c)(1), Title 22 §71539

- ED provider note completed before patient discharge or transfer.
- If patient admitted →ED note must be completed within the same shift

❖ **Outpatient Visit Documentation**

Regulatory Basis: CMS §482.24 (timely), TJC RC.02.01.01

- Office Visit/Progress note must be completed within 24-48 hours
- Authentication/Signature must be authenticated within 48 hours
- Procedure notes must be completed immediately post-procedure

❖ **Authentication of Documentation**

SUBJECT Physician Medical Record Documentation & Dictation Requirements.	SECTION: <i>Record of Care, Treatment & Services (RC)</i>
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Regulatory Basis: CMS §482.24(c)(1), Title 22 §71539

- All entries must be dated, timed, and signed (electronic authentication permitted)
- Providers must authenticate all dictations, completions, or verbal orders within 48 hours.
- Use of stamps, signature delegation, or proxy authentication is not permitted.

❖ **Delinquent Medical Records**

➤ Definition

A medical record becomes “delinquent” when required documentation remains incomplete after 30 days from the discharge or service date.

➤ Delinquency Consequences

In alignment with Medical Staff Bylaws:

- Provider placed on Suspension of Admitting/Clinical Privileges once delinquency limits are exceeded.
- Continued noncompliance may result in:
 - Removal from call schedule
 - Administrative suspension
 - Reporting to Medical Executive Committee
 - Correction action per bylaws

❖ **Responsibilities**

➤ Physician/LIPs

- Complete documentation within required timeliness.
- Respond to HIM Deficiencies promptly.
- Authenticate all dictated/transcribed records within 48 hours.

➤ Health Information Management (HIM)

- Monitor delinquent records daily.
- Notify physicians of outstanding deficiencies.

➤ Medical Staff/Chief of Staff

- Enforce suspension policies by Medical Staff Bylaws

➤ Department Director/Medical Directors

- Support monitoring
- Facilitate corrective actions.
- Educate providers on documentation compliance.

AFFECTED PERSONNEL/AREAS: *Medical Staff, All Clinics, Patient Care Areas and Health Information Management.*

REFERENCES:

SUBJECT	Physician Medical Record Documentation & Dictation Requirements.	SECTION:	<i>Record of Care, Treatment & Services (RC)</i>
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- **Centers for Medicare & Medicaid Services. (2025).** *State Operations Manual: Appendix A – Survey protocol, regulations, and interpretive guidelines for hospitals (42 CFR Part 482).* U.S. Department of Health and Human Services. <https://www.cms.gov>
- **Joint Commission. (2025).** *Comprehensive Accreditation Manual for Hospitals: The record of care, treatment, and services (RC) standards.* The Joint Commission. <https://www.jointcommission.org>
- **California Department of Public Health. (2025).** *California Code of Regulations, Title 22, Division 5: Licensing and certification of health facilities, home health agencies, clinics, and referral agencies.* California Health and Human Services Agency. <https://www.cdph.ca.gov>
 - §70749 – Progress Notes
 - §70751 – History and Physical Examination
 - §70753 – Discharge Summary
 - §71539 – Authentication of Medical Record Entries
- **Centers for Medicare & Medicaid Services. (2025).** *Conditions of Participation for Hospitals (42 CFR §482.24 – Medical Record Services).* U.S. Department of Health and Human Services. <https://www.ecfr.gov>
- **Centers for Medicare & Medicaid Services. (2025).** *Conditions of Participation for Surgical Services (42 CFR §482.51).* U.S. Department of Health and Human Services. <https://www.ecfr.gov>
- **State of California. (2025).** *Business and Professions Code & Health and Safety Code (as related to medical record documentation and provider responsibilities).* California Legislature. <https://leginfo.legislature.ca.gov>

SUBJECT: PROFESSIONAL PRACTICE COUNCIL NURSING PEER REVIEW	SECTION: <i>Leadership (LD)</i>
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SECTION: <i>Leadership (LD)</i>	Page 1 of 5
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure that the hospital, through the activities of its nursing staff, assesses the performance of individuals (employee or contractor) and uses the results of such assessments to improve care.

AFFECTED AREAS/PERSONNEL:

NURSING SERVICES; PERFORMANCE IMPROVEMENT

GOALS:

1. Improve the quality of care provided by individual nurses
2. Monitor nurses' performance
3. Identify opportunities for performance improvement
4. Identify system process issues
5. Monitor significant trends by analyzing aggregate data
6. Ensure that the process for peer review is clearly defined, fair, defensible, timely, and useful

DEFINITIONS**Peer review:**

Peer review is the evaluation of an individual nurse's professional performance and includes the identification of opportunities to improve care. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual nurse's performance, rather than appraising the quality of care rendered by a group of professionals or a system.

Peer review is conducted using multiple sources of information, including:

1. The review of individual cases;
2. The review of aggregate data for compliance with general rules of the nursing staff; and
3. Clinical standards and use of rates in comparison with established benchmarks or norms.

The individual's evaluation is based on generally recognized standards of care. Through this process, nurses receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

Peer:

SUBJECT: PROFESSIONAL PRACTICE COUNCIL NURSING PEER REVIEW	SECTION: <i>Leadership (LD)</i> Page 2 of 5
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A peer is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a nurse's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example, for quality issues related to general nursing care, a nurse may review the care of another nurse (RN to RN). For specialty-specific clinical issues, such as evaluating the technique of a specialized procedure, a peer is an individual who is well trained and competent in that specialty.

The degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the hospital will be determined by the *Professional Practice Council* unless otherwise designated for specific circumstances by nursing leadership.

Conflict of interest:

A conflict of interest exists if a member of the nursing staff is not able to render an unbiased opinion. Automatic conflict of interests would result if the nurse on the *Professional Practice Council* is the nurse under review. Relative conflicts of interest are due to the reviewer either being involved in the patient's care or having a familial relationship with the nurse involved, and similar situations.

It is the obligation of the individual reviewer to disclose to the peer review committee the potential conflict. The responsibility of the peer review body is to determine whether the conflict would prevent the individual from participating or the extent of the individual's participation. Individuals determined to have a conflict may not be present during peer review body discussions or decisions other than to provide information if requested.

Collaboration with Organized Medical Staff

The organized Medical Staff and Nursing Division of Sierra View Local Healthcare District (Sierra View Medical Center) support an environment of collegial relationships. To sustain this environment of continuous improvement for the quality of care offered patients at Sierra View Local Healthcare District, the V.P. of Patient Care Services will serve as chair of the Nursing Professional Practice Council. To facilitate Council meetings and Nursing Peer Review, the Chair may delegate an RN to chair the meeting. The VP of Patient Care Services will be responsible for reporting the outcomes of Nursing Peer Review activities at the Performance Improvement Committee. In the event the results of the peer review require "Letters of Education", system issue identification or other corrective action, the VP of Patient Care Services will maintain responsibility for initiation and follow-up with the identified member of the Nursing Division.

Issues referred to the Nursing Professional Practice council for review from the Departments of the organized Medical Staff will be reported back to that Department through the organization's Performance Improvement Department when Nursing Peer Review is completed

POLICY:

1. All peer review information is privileged and confidential in accordance with nursing and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

SUBJECT: PROFESSIONAL PRACTICE COUNCIL NURSING PEER REVIEW	SECTION: <i>Leadership (LD)</i> Page 3 of 5
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2. The involved nurse will receive specific feedback on a case-by-case basis.
3. The hospital will use the nurse-specific peer review results in its annual evaluation process, and as appropriate, in its performance improvement activities. This also meets the standards established by the Leap Frog organization.
4. The hospital will keep nurse-specific peer review and other quality information concerning a nurse in a secure, locked file archived or in a secure digital file within the Performance Improvement Department. The peer review and quality information will be kept separate from the employment file. Nurse-specific peer review information consists of information related to Performance data for all dimensions of performance measured for that individual nurse.
 - a. The individual nurse's role in sentinel events, significant incidents, or near misses; and or
 - b. Correspondence to the nurse regarding commendations, comments regarding practice performance, or corrective action.
5. Peer review information is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a nursing leader or hospital employee. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall have access to nurse-specific peer review information and only for purposes of quality improvement:
 - a. Vice President, Nursing Division
 - b. Vice President, Performance Improvement
 - c. Department Director(s) or Manager if no Director level to include Risk Management
 - d. Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g., The Joint Commission or state/federal regulatory bodies)
 - e. Individuals with a legitimate purpose for access as determined by the Hospital CEO or designee
6. No copies of peer review documents will be created and distributed unless authorized by Vice President, Nursing Division, or per hospital policy.

CIRCUMSTANCES REQUIRING PEER REVIEW

Peer review is conducted on an ongoing basis and reported for review and action. The procedure for conducting peer review is described in the "Process and time frames" document. Evaluation of a case will be conducted through the following means:

- Through reporting processes such as occurrence reports

SUBJECT: PROFESSIONAL PRACTICE COUNCIL NURSING PEER REVIEW	SECTION: <i>Leadership (LD)</i> Page 4 of 5
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- When there is a sentinel event or “near miss” identified during concurrent or retrospective review
- When there is an unusual individual case or clinical pattern of care identified during a quality review

CIRCUMSTANCES REQUIRING EXTERNAL PEER REVIEW:

The *Professional Practice Council* will make recommendations on the need for external peer review to Nursing Leadership. External peer review will take place under the following circumstances if deemed appropriate by Nursing Leadership or by the Board of Directors. A nurse cannot require the hospital to obtain external peer review if it is not deemed appropriate by the Nursing Leadership or Board of Directors.

Circumstances requiring external peer review include:

- Litigation—when dealing with the potential for a lawsuit.
- Ambiguity—when dealing with vague or conflicting recommendations from internal reviewers and conclusions from this review will directly affect a nurse’s employment.
- Lack of internal expertise—when no one on the nursing staff has adequate expertise in the specialty under review, or when the only nurse with that expertise is determined to have a conflict of interest regarding the nurse under review as described above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by nursing leadership.
- Miscellaneous issues—when the nursing staff needs an expert for purposes of establishing nursing standards.

PARTICIPANTS IN THE REVIEW PROCESS:

Participants in the review process will be selected according to the nursing policies and procedures. Medical staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities the *Professional Practice Council* will consider and record the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual, as long as the individual responds in the time frame outlined.

In the event of a conflict of interest or circumstances that would suggest a biased review, the *Professional Practice Council* and Nursing Leadership will determine who will participate in the process. Participants with a conflict of interest may not be present.

THRESHOLDS FOR INTENSIVE REVIEW:

If the results of individual case reviews for a nurse exceed thresholds established by the nursing staff (described below), the *Professional Practice Council* will review the findings to determine whether further intensive review is needed to identify a potential pattern of care.

<p>SUBJECT: PROFESSIONAL PRACTICE COUNCIL NURSING PEER REVIEW</p>	<p>SECTION: <i>Leadership (LD)</i></p> <p style="text-align: right;">Page 5 of 5</p>
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Thresholds:

1. Any single egregious case;
2. Within any 12-month period of time, any one of the following criteria:
 - a. Three cases rated “care inappropriate”
 - b. Five cases rated either care controversial or inappropriate
 - c. Five cases rated as having documentation issues regardless of care rating

PEER REVIEW FOR SPECIFIC CIRCUMSTANCES:

A request for nurse peer review can come through several sources to the Chief Nurse Officer. The Chief Nurse Officer has ultimate authority to engage and start the nursing peer review process.

PEER REVIEW TIME FRAMES:

Peer review will be conducted by the *Professional Practice Council* in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the PI coordinator and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability.

STATUTORY AUTHORITY:

California Legislature. (n.d.). Senate Bill 1157 (SB 1157), California State Legislature.

California Board of Registered Nursing. (2023). Nurse peer review guidelines. California Department of Consumer Affairs. Retrieved from <https://www.rn.ca.gov>

SUBJECT: RESTRICTION OF COMMUNICATION	SECTION: <i>Ethics, Rights and Responsibilities (RI)</i> Page 1 of 1
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To safeguard patients' health, well-being and recovery, by limiting communication when deemed necessary by the healthcare team.

AFFECTED AREAS/PERSONNEL: ALL PATIENT CARE AREAS

POLICY:

It is the policy of Sierra View Medical Center (SVMC) for staff to support and foster each patient's right to free communication, be it through visits, telephone (conventional and adaptive), television, mail, and/or other use of audio and video tapes.

In the event that a patient's health or well-being is thought to be at risk due to the impact of certain forms of communication, it is the responsibility of the healthcare team to determine if the effect of that communication is sufficiently grave to warrant a limitation of that communication.

For the competent patient, a member of the healthcare team, usually the Charge Nurse or as applicable, the social worker will discuss with the patient and/or family the perceived detrimental consequences of a particular mode of communication. The goal of this therapeutic exchange is to develop a plan that will affirm the patient's self-determination, maximize self-expression and communication, and support the patient's health, promoting behaviors that may include limitations of some communications. Documentation of this discussion shall be noted in the appropriate section of the patient's record, and on the plan of care.

Limitations on communications will be implemented, in consultation with available family members, to the extent necessary to preserve the well-being of the patient.

The Charge Nurse, Social Worker, and/or physician will communicate the plan and reason for the restriction to the patient as appropriate.

REFERENCE:

- **American Medical Association (AMA).** (2020). *AMA Code of Medical Ethics*. American Medical Association. Retrieved from <https://www.ama-assn.org/delivering-care/public-health/ama-code-medical-ethics>
- **The Joint Commission.** (2023). *Hospital Accreditation Standards*. The Joint Commission. Retrieved from <https://www.jointcommission.org/standards/>
- **National Alliance on Mental Illness (NAMI).** (2020). *The Role of Communication in Mental Health Care*. National Alliance on Mental Illness. Retrieved from <https://www.nami.org/>

SUBJECT: RN STAFFING POLICY	SECTION: <i>Patient Care Services</i> Page 1 of 8
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

- To ensure there is appropriately qualified staff available to meet mandatory State nurse to patient ratios in all areas served by registered nurses (inpatient and ambulatory settings) and that patient acuity is a factor in staffing.
- To define the standards which serve as the basis for staffing practices at Sierra View Medical Center (SVMC).
- To ensure that nursing ratios are maintained in compliance with SB 596 and addresses staffing shortages through the use of a call list and float pool shift coverage.

POLICY:Plan for Provision of Nursing Care

SVMC has a plan for the provision of nursing care, which is aligned to support nursing standards of practice; based on the need of the patients. Registered Nurses use the nursing process model, delegation as appropriate to peers and supportive staff, and coordinate the patient's care provided throughout the hospital for their length of stay.

Nursing Philosophy

The Nursing Division is committed to providing quality and outstanding nursing services to meet the needs of the patients. Nurses believe nursing practice should be guided by respect for human dignity and the recognition of individual uniqueness. Nursing accomplishes its goal through humanistic outcome-oriented patient care programs, as supported by clinical standards. Educational opportunities and resources are available for fostering nursing professional growth, state of the art knowledge and clinical skills in a constantly changing health care environment.

AFFECTED PERSONNEL/AREAS: *ALL NURSING SERVICES*

PROCEDURE:

- A. The Nursing Administration Office staff is defined for the purpose of coordinating appropriate nursing resources to a given unit on a daily or per shift basis. The roles of staffing office coordinator; bed coordinator and Nursing Supervisor comprise the Nursing Administration Office staff.
- B. The day-to-day staffing functions will be centralized in the Nursing Administration Office for all inpatient units. The Surgical Services Department staffing is arranged and coordinated through the leadership team of the surgical services department. An on-call schedule is provided to The Nursing Administration Office daily and for weekend/holiday coverage.

SUBJECT: <p style="text-align: center;">RN STAFFING POLICY</p>	SECTION: <p style="text-align: center;"><i>Patient Care Services</i></p> <p style="text-align: right;">Page 2 of 8</p>
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- C. The Float Pool will be used as a call list for nursing units at risk of staffing shortages and ratio violations. The float pool nurses must be trained in multiple units and will be deployed to units where staffing is most needed.
 - 1. The foundation for daily staffing procedures will be a census matrix that is derived from the annual labor budget. (examples: nursing hours per visit; nursing hours per patient per day)
 - 2. Based upon the State mandated nursing ratios and the consideration of the acuity of the patient(s) on any given unit, staffing levels will be adjusted accordingly.
 - 3. Any variation between the *budgeted* staffing pattern at a given unit census and the *actual* staffing pattern provided will require justification through documentation by the Nursing Administration Office Staff and/or Department Leaders.
- D. The Nursing Administrative Office will conduct the daily staffing process for all shifts in all units within the Nursing Services Division with the exception of the Surgical Services.
- E. Determination of the placement of nursing resources within a unit or service for a given shift will depend upon the collaboration of the Nursing Administration Office and the Department leader(s) or their designee(s) after careful consideration of house-wide staffing requirements in light of patient census, patient needs, and acuity levels.
- F. The Department leader or designee will be responsible for reviewing and anticipating the staffing requirements for a unit on a daily basis with the Staffing Coordinator and assisting the Nursing Administrative Office in locating personnel to cover staffing vacancies.
- G. Schedule changes are to be recorded on the 24-hour Staffing Roster and in the Electronic Master Schedule by the Staffing Coordinator only after authorization has been given. All changes to be recorded. All requests for schedule changes after the master schedule have been posted must be in completed within the electronic scheduling system.

SCHEDULING

- A. The scheduling of nursing personnel shall be the direct responsibility of the Department leader or designee who will be responsible for the actual completion of the schedule. Ideally, schedules will be posted at least two weeks prior to the start of a new schedule cycle.
- B. The schedule is made for a six (8) week period, and shall be posted one (1) week before the next six (8) week period.
- C. Special requests for specific time off should be made two (2) weeks prior to schedule posting. Every consideration will be given to each request.

SUBJECT: RN STAFFING POLICY	SECTION: <i>Patient Care Services</i> Page 3 of 8
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- D. Vacation requests must be submitted in writing to the Department leader or designee within the specific department designated time frame. Every consideration will be given to each request, and a response will be given to the employee within a reasonable time frame.

STAFFING

- A. SVMC maintains a system to assure that the appropriate levels of staffing are maintained to provide optimal patient care. Staffing levels have been developed based on:
1. Comparisons to other facilities;
 2. Internal experience over time;
 3. Patient population;
 4. Patient requirements;
 5. Patient acuity;
 6. Staff competency;
 7. Work competency;
 8. Work locations;
 9. Availability of support from other areas;
 10. Regulatory requirements as appropriate;
 11. Electronic Patient Acuity System
- B. These levels are required regularly and adjusted for changes based on the above consideration. Staffing schedules are reviewed and adjusted as necessary via the monthly and weekly schedules, as well as daily, and each shift to meet the defined patient needs and unusual occurrences.
- C. During periods of high acuity and/or census or low staffing, every attempt will be made to provide appropriate staffing. Attempts may include but are not limited to:
1. Utilization of extra shifts from all category of staff;
 2. Utilization of overtime or double time;
 3. Instituting alternative staffing patterns with approval of the Vice-President of Patient Care Services & Chief Nurse Officer;
 4. Utilization of agency (contracted) staff.

SUBJECT: RN STAFFING POLICY	SECTION: <i>Patient Care Services</i> Page 4 of 8
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DAYS OFF

A. Schedule

Assignments of nursing personnel to patient care areas shall be planned in such a manner that all personnel receive an equal share of weekends and other preferred time off, whenever possible.

B. Weekends

Weekends off shall be scheduled on a regular basis according to the needs of the department. ***All Full-time and Part-time staff will be scheduled a minimum of every other weekend.*** As far as possible, this schedule will not be changed, except to meet the staffing needs during such times as holiday, weekends and vacation periods.

C. Request / Schedule Changes

1. A request is just a request and may **not be automatically granted.** It is the responsibility of the employee to be sure that a request has been granted ***before*** planning to take off on the day requested. Requests are to be submitted to the employee's Department leader or designee in writing.

Request(s) of an immediate emergency nature, i.e. personal or family illness, family death, transportation emergencies, etc., will be submitted to the Department leader/designee as soon as the emergency arises. Written documentation may be requested. As appropriate, HR should be consulted by the employee for guidance regarding a potential leave of absence³. All adjustment(s) of requested days off, other than the above, must be done by the proper trading of days, utilizing the electronic scheduling system or appropriate forms if the system is down. These forms will be kept in the house supervisor's office for use.

SCHEDULE CHANGE REQUEST / TRADE PROCEDURE

- A. If the eight (8) week schedule has been posted, a Schedule Change Request is to be completed and submitted in the electronic scheduling system. All trades must meet the following requirements:
 1. Alternate may be an employee who normally would be doing the same category of work and is willing to trade days off; **or** an employee who normally works part-time and is willing to work another day.
 2. Alternate may NOT be an employee who will be required to work over 40 hours in a 7-day period, except at the discretion of the Department leader/designee or House Supervisor.

SUBJECT: RN STAFFING POLICY	SECTION: <i>Patient Care Services</i> Page 5 of 8
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3. Each Trade Agreement is to be documented, the electronic scheduling system or signed by the involved parties using the "Schedule Change Request" Form and submitted to the Department leader/designee to start the approval process.

B. Vacations

1. All requests for vacations are to be submitted in writing via time off request form to the respective leader/Director/designee. Once the initial vac/hol schedule has been completed by the leader the staffing office will take vacation requests on a first come first serve basis. It is imperative to remember: A request is just a request and may **not be automatically granted.**
2. Requests will be considered as they are submitted.
3. Employees must have Vac/Hol time available to take the requested time off. If employees do NOT have adequate Vac/Hol time to cover the requested time off, authorization that had previously been given to take the time off will be rescinded and the approved time off will either be reduced to the number of available Vac/Hol hours or it will be cancelled.
4. No more than two (2) weeks of vacation will be approved at one time for each employee. Up to three (3) weeks of vacation may be approved for trips out of the United States. Exceptions may be granted at the discretion of the Department leader.
5. No more than one employee per category (e.g. RN, LVN, CNA, UC/MT) per shift may be off at one time without prior approval from the Department leader or designee

C. Holidays

1. Unless a specific day has been requested off before the schedule is completed, the Department leader or designee will arrange holidays. This includes scheduled hospital approved holiday weekend days.
2. Scheduled weekend days are not to be requested as Holiday time off.
3. Holidays will be rotated per unit leader and are defined by the house-wide holiday policy. (Refer to Human Resources Policy & Procedure Manual: "Holiday Pay".)

D. Sick Calls

1. If employees become ill and are not able to report for work as scheduled, they must notify the Administrative House Supervisor/Staffing Coordinator a minimum of two (2) hours before the beginning of their scheduled shift.

<p>SUBJECT: RN STAFFING POLICY</p>	<p>SECTION: <i>Patient Care Services</i> Page 6 of 8</p>
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2. If employees call in “sick” or “off-duty” on either one or both of their scheduled weekend days, they will **automatically** be scheduled to work the following weekend, one or both days, depending upon which one(s) they called in sick/off-duty. ***Employees may be required to work a number of weekends in a row if they have missed more than one weekend commitment. Those Make Up shifts will be eligible for overtime calculation only.***

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

1. ***Exception: Those employees who regularly work every weekend and call in sick will be required to complete their “make-up day” (MUD) at the discretion of the Department leader..***
2. When the employee is assigned to work the following weekend, they will be ***first to float*** (as per Section F. “Floating”) before Part-time and other staff. They will also be the ***last to be cancelled*** unless they will be displacing a staff member on their regular shift. In this case, the employee making up the shift can be placed on “call”.

Note: If census is low and the staff employee who is on a “make-up day” will cause an employee who is scheduled for a regular shift to lose that day, then the M.U.D. employee is to be cancelled to allow staff to work their regular shifts.

3. Failure to actually work on the following scheduled weekend will result in disciplinary action. Exceptions may be pre-authorized only by the V.P. of Patient Care Services.

E. Late Calls

Employee(s) called in to work after the shift has started will be paid from the time they arrive. Employee must notify the House Supervisor as soon as they arrive to the hospital. Employee must check in with the Charge Nurse upon arrival to the unit.

F. Floating:

Nursing personnel may be asked to float to another department. Nursing Administration will consider skills and competencies of individual staff members as well as overall patient safety when assigning staff to float. The Nursing House Supervisor/Staff Coordinator will work with Department Directors and Clinical Managers to look at the department they are floating from to ensure there are an adequate number of competent nurses to cover the area that they are leaving, i.e. nursery/NICU (See “Floating Policy & Procedure” – Patient Care Manual)

G. Flexing

1. A drop in census may necessitate a reduction in scheduled personnel.

<p>SUBJECT: RN STAFFING POLICY</p>	<p>SECTION: <i>Patient Care Services</i> Page 7 of 8</p>
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2. The Nursing departments will maintain a call-off/Hospital Cancellation Log.
3. Cancellation time will be rotated on a fair and consistent basis. Qualifications of personnel are to be considered to ensure safe patient care.
4. Cancellation Sequence in the absence of volunteers or special requests:
 - a. External Registry Per Diem Staff Scheduled for Extra Shift
 - b. Regular Per Diem Staff
 - c. Part-time staff
 - d. Full-time staff
5. Cancellation will begin One to two hours prior to the start of each scheduled shift. Every effort will be made to contact the employee timely. .

H. Overtime Authorization

1. Every effort will be made by the Department leader as well as Nursing Administration Office to reduce the utilization of overtime through the reallocation of resources.

I. Time and Attendance

1. All employees must clock “in” before reporting to their assigned unit. If the employee forgets their badge or if the badge does not work properly at the time clock, they must immediately check in with the Charge Nurse and submit a missed punch as soon as possible.
2. Employees will be considered tardy if they clock-in after the start of their shift.

NOTE: The grace period pertains to payroll practices only and does not absolve the employee from being punctual and starting their shift at the designated time.
3. Should an employee need to leave the hospital for any reason, prior approval needs to be obtained from the Department leader/designee or Nursing Supervisor. The employee must clock “out” before leaving and clock “in” when returning to work. NOTE: This does not include protected meal times.

REFERENCES:

- AB 394. CA (1999) (2008). California Mandatory RN Staffing Ratio Law.

SUBJECT: RN STAFFING POLICY	SECTION: <i>Patient Care Services</i> Page 8 of 8
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- AB 394 in 1999
- California State Legislature. (2023). SB 596: Nursing staffing ratios: float pool and on-call list. Retrieved from <https://leginfo.legislature.ca.gov>

SUBJECT: STANDARDIZED PROCEDURES	SECTION: <i>Nursing Administration; From the Office of the Chief Nurse Executive</i> Page 1 of 4
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

This is a defined approval process for new and renewed standardized procedures that nurses are able to perform across the organization (Title 22, § 70706.2, 2019). The Board of Registered Nursing in conjunction with the Medical Board of California (see the requirements of the Medical Board of California, Article 9.5, Chapter 13, Title 16 of the California Code of Regulations) intends, by adopting the regulations contained in the article, to jointly promulgate guidelines for the development of standardized procedures to be used in organized health care systems which are subject to this rule (Board of Registered Nursing, 2019). The purpose of these guidelines is:

- To protect consumers by providing evidence that the nurse meets all requirements to practice safely.
- To provide uniformity in development of standardized procedures.

DEFINITIONS:

1. “Standardized procedure functions” means those functions specified in Business and Professions Code Section 2725(c) and (d) which are to be performed according to “standardized procedures”;
2. “Organized health care system” means a health facility which is not licensed pursuant to Chapter 2 (commencing with Section 1250), Division 2 of the Health and Safety Code and includes, but is not limited to, clinics, home health agencies, physicians’ offices and public or community health services;
3. “Standardized procedures” means policies and protocols formulated by organized health care systems for the performance of standardized procedure functions

POLICY:

- A. An organized health care system, such as SVMC, must develop standardized procedures before permitting registered nurses to perform standardized procedure and functions. A registered nurse may perform standardized procedure functions only under the conditions specified in a health care system’s (SVMC) standardized procedures; and must provide the system with a satisfactory evidence that the nurse meets its experience, training, and/or education requirements to perform such functions.

§ 1474 Standardized Procedure Guidelines – Board of Registered Nursing

Following are the standardized procedure guidelines jointly promulgated by the Medical Board of California and by the Board of Registered Nursing:

1. Standardized procedures shall include a written description of the method used in developing and approving them and revision thereof.
2. Each standardized procedure shall:

SUBJECT: STANDARDIZED PROCEDURES	SECTION: <i>Nursing Administration; From the Office of the Chief Nurse Executive</i> Page 2 of 4
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- a. Be in writing, dated and signed by the organized health care system personnel authorized to approve it.
- b. Specify which standardized procedure functions registered nurses may perform and under what circumstances
- c. State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.
- d. Specify any experience, training, and/or education requirements for performance of standardized procedure functions.
- e. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.
- f. Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.
- g. Specify the scope of supervision required for performance of standardized procedure functions, for example, immediate supervision by a physician.
- h. Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.
- i. State the limitations on settings, if any, in which standardized procedures functions may be performed.
- j. Specify patient record keeping requirements.
- k. Provide for a method of periodic review of the standardized procedures.

B. Title 22 - § 70706.2 Standardized Procedures

- a. The Committee on Interdisciplinary Practice shall be responsible for:
 - i. Identifying functions and/or procedures which require the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the facility, and initiating the preparation of such standardized procedures in accordance with this section.
 - ii. The review and approval of all such standardized procedures covering practice by registered nurses in the facility.
 - iii. Recommending policies and procedures for the authorization of employee staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee on Interdisciplinary Practice or by delegation to the director of nursing.
- b. Each standardized procedure shall:
 - i. Be in writing and show date or dates of approval including approval by the Committee on Interdisciplinary Practice.
 - ii. Specify the standard procedure functions which registered nurses are authorized to perform and under what circumstances.

<p>SUBJECT: STANDARDIZED PROCEDURES</p>	<p>SECTION: <i>Nursing Administration; From the Office of the Chief Nurse Executive</i> Page 3 of 4</p>
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

- iii. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure.
- iv. Specify any experience, training or special education requirements for performance of the functions.
- v. Establish a method for initial and continuing education evaluation of the competence of those registered nurses authorized to perform the functions.
- vi. Provide for a method of maintaining a written record of those persons authorized to perform the functions.
- vii. Specify the nature and scope of review and/or supervision required for the performance of the standardized procedure functions; for example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated, if physician is not required, that fact should be clearly stated.
- viii. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition.
- ix. State any limitations on settings or departments within the facility where the standardized procedure functions may be performed.
- x. Specify any special requirements for procedures relating to patient recordkeeping.
- xi. Provide for periodic review of the standardized procedure.

C. If nurses have been approved to perform procedures pursuant to a standardized procedure, the names of the nurses so approved shall be on file in the office of the director of nursing.

AFFECTED PERSONNEL/AREAS: *AFFECTED NURSES AND PHYSICIANS*

PROCEDURE:

- A. The Committee on Interdisciplinary Practice will meet yearly, but the Committee may be called at the discretion of the Chief Nurse Executive and/or the President of the Medical Staff.
 - 1. Composition of the Committee
 - a. Chief Nurse Officer (Chair)
 - b. Physician Appointed by the President of the Medical Staff (Co-Chair)
 - c. Physician appointed by the President of the Medical Staff
 - d. Advanced Practice Nurse
 - e. Staff Registered Nurse
 - f. Staff Registered Nurse
 - g. Nurse Leader
 - 2. The Committee has an agenda prepared by the Chair and/or Co-Chair.
 - 3. Standardized Procedures are initially presented, revised, or on their routine review.

SUBJECT: STANDARDIZED PROCEDURES	SECTION: <i>Nursing Administration; From the Office of the Chief Nurse Executive</i> Page 4 of 4
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

4. The Committee can approve, send back for revision, an/or reject.
5. After approval by the Committee, the standardized procedures are sent to the Medical Executive Committee; and then the Board of Directors for final approval.

REFERENCES:

- California Code of Regulations, Title 22, § 70706.2 (2025). Standardized Procedures. *California Administrative Code*. Retrieved December 22, 2025, from <https://regulations.justia.com/states/california/title-22/division-5/chapter-1/article-7/section-70706-2/>
- Board of Registered Nursing. (2025). California nursing practice act with regulations and related statutes (2025 ed.). LexisNexis. <https://store.lexisnexis.com/en-us/products/california-nursing-practice-act-with-regulations-and-related-statutes-sku49091.html>
- Medical Board of California. (2025). Laws relating to the Medical Board of California: Physicians and surgeons, doctors of podiatric medicine, registered dispensing opticians, research psychoanalysts, medical assistants, perfusionists, dietitians, licensed midwives (2025 ed.). LexisNexis. <https://store.lexisnexis.com/en-us/products/laws-relating-to-the-medical-board-of-california-sku56919.html>

SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	SECTION: <i>Leadership (LD)</i> Page 1 of 13
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the standards of nursing practice and professional performance for the Registered Nurses of Sierra View Local Healthcare District & Medical Center as stated by the American Nurses Association.

POLICY:

“Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations” – ANA (2015)

AFFECTED PERSONNEL/AREAS: *ALL REGISTERED NURSES*

PROCEDURE:**STANDARDS OF PRACTICE:**

The Standards of Practice: “describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and form the foundation of the nurse’s decision-making” (ANA, 2015, p. 4).

- A. **Standard 1. Assessment:** The registered nurse collects pertinent data and information relative to the healthcare consumer’s health or the situation.
1. Collects pertinent data, including but not limited to demographics, social determinants of health, health disparities, and physical functional, psychosocial, emotional, cognitive, sexual, cultural, age-related, environmental, spiritual/transpersonal, and economic assessments in a systematic, ongoing process with compassion and respect for the inherent dignity, worth, and unique attributes of every person.
 2. Recognizes the importance of the assessment parameters identified by WHO (World Health Organization), *Health People 2020*, or other organizations that influence nursing practice.
 3. Integrates knowledge from global and environmental factors into the assessment process.
 4. Elicits the healthcare consumer’s values, preferences, expressed and unexpressed needs, and knowledge of the healthcare situation.
 5. Recognizes the impact of one’s own personal attitudes, values, and beliefs on the assessment process.
 6. Assesses family dynamics and impact on healthcare consumer health and wellness. Identifies barriers to effective communication based on psychosocial, literacy, financial, and cultural considerations.

SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	SECTION: <i>Leadership (LD)</i> Page 2 of 13
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7. Assesses the impact of family dynamics on healthcare consumer health and wellness.
8. Engages the healthcare consumer and other interprofessional team members in holistic, culturally sensitive data collection.
9. Prioritizes data collection based on the healthcare consumer's immediate condition or the anticipated needs of the healthcare consumer or situation.
10. Uses evidence-based assessment techniques, instruments, tools, available data, information, and knowledge relevant to the situation to identify patterns and variances.
11. Applies ethical, legal, and privacy guidelines and policies to the collection, maintenance, use, and dissemination of data and information.
12. Recognizes the healthcare consumer as the authority on their own health by honoring their care preferences.
13. Documents relevant data accurately and in a manner accessible to the interprofessional team.

ADDITIONAL COMPETENCIES FOR THE GRAUDATE-LEVEL PREPARED REGISTERED NURSE:

1. Assess the effect of interaction among individuals, family, community, and social systems on health illness.
 2. Synthesize the results and information leading to clinical understanding.
- B. Standard 2. Diagnosis:** The registered nurse analyzes the assessment data to determine the actual or potential diagnoses problems, and issues. The registered nurse:
1. Identifies actual or potential risks to the healthcare consumer's health and safety or barriers to health, which may include but are not limited to interpersonal, systematic, cultural, or environmental circumstances.
 2. Uses assessment data, standardized classification systems, technology, and clinical decision support tools to articulate actual or potential diagnoses, problems, and issues.
 3. Verifies the diagnoses, problems, and issues with the individual, family, group, community, population, and interprofessional colleagues.
 4. Prioritizes diagnoses, problems, and issues based on mutually established goals to meet the needs of the healthcare consumer across the health-illness continuum.
 5. Document diagnoses, problems, and issues in a manner that facilitates the determination of the expected outcomes and plan.

<p>SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE</p>	<p>SECTION: <i>Leadership (LD)</i></p> <p style="text-align: right;">Page 3 of 13</p>
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

ADDITIONAL COMPETENCIES FOR THE GRAUDATE-LEVEL PREPARED REGISTERED NURSE:

1. Uses information and communication technologies to analyze diagnostic practice patterns of nurses and other members of the interprofessional team.
 2. Employs aggregate-level data to articulate diagnoses, problems, and issues of healthcare consumers and organizational systems.
 3. Formulates a differential diagnosis based on the assessment, history, physical examination, and diagnostic test results.
- C. **Standard 3. Outcomes Identification:** The registered nurse identifies expected outcomes for a plan individualized to the patient or the situation and will:
1. Engages the healthcare consumer, interprofessional team, and others in partnership to identify expected outcomes
 2. Formulates culturally sensitive expected outcomes derived from assessments and diagnoses.
 3. Uses clinical expertise and current evidence-based practice to identify health risks, benefits, costs, and/or expected trajectory of the condition.
 4. Collaborates with the healthcare consumer to define expected outcomes integrating the healthcare culture, values and ethical considerations.
 5. Generates a time for the attainment of expected outcomes.
 6. Develop expected outcomes that facilitate continuity of care.
 7. Modify expected outcomes based on the evaluation of the status of the healthcare consumer and situation.
 8. Document expected outcomes as measurable goals.
 9. Evaluates the actual outcomes in relation to expected outcomes, safety, and quality standards.

ADDITIONAL COMPETENCIES FOR THE GRAUDATE-LEVEL PREPARED REGISTERED NURSE, INCLUDING THE APRN:

1. Defines expected outcomes that incorporate cost, clinical effectiveness, and are aligned with the outcomes identified by members of the interprofessional team.

SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	SECTION: <i>Leadership (LD)</i> Page 4 of 13
--	--

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2. Differentiates outcomes that require care process interventions from those that require system-level actions.
 3. Integrates scientific evidence and best practices to achieve expected outcomes.
 4. Advocates for outcomes that reflect the healthcare consumer's culture, values, and ethical concerns.
- D. **Standard 4. Planning:** The registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes and will:
1. Develop an individualized plan in partnership with the person, family, and others considering the person's characteristics or situation, including but not limited to, values, beliefs, spiritual and health practices, preferences, choices, developmental level, coping style, culture and environment, and available technology.
 2. Establish the plan priorities with the patient, family, and others as appropriate.
 3. Include strategies in the plan that address each of the identified diagnoses or issues. These may include, but are not limited to, strategies for:
 - a. Promotion and restoration of health;
 - b. Prevention of illness, injury, and disease;
 - c. The alleviation of suffering; and
 - d. Supportive care for those who are dying.
 4. Include strategies for health and wholeness across the lifespan.
 5. Provide for continuity in the plan.
 6. Incorporate an implementation pathway or timeline in the plan.
 7. Consider the economic impact of the plan on the patient, family, caregivers, or other affected parties.
 8. Integrate current scientific evidence, trends and research.
 9. Utilize the plan to provide direction to other members of the healthcare team.
 10. Explore practice settings and safe space and time for the nurse and the patient to explore suggested, potential, and alternative options.
 11. Define the plan to reflect current statues, rules and regulations, and standards.

SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	SECTION: <i>Leadership (LD)</i>
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SECTION: <i>Leadership (LD)</i>	Page 5 of 13
---	---------------------

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12. Modify the plan according to the ongoing assessment of the patient's response and other outcome indicators.
 13. Document the plan in a manner that uses standardized language or recognized terminology.
- E. **Standard 5. Implementation:** The registered nurse implements the identified plan and will:
1. Partner with the patient, family, significant others, and caregivers as appropriate to implement the plan in a safe, realistic, and timely manner.
 2. Demonstrate caring behaviors toward patients, significant others, and groups of people receiving care.
 3. Utilize technology to measure, record, and retrieve patient data, implement the nursing process, and enhance nursing practice.
 4. Utilize evidence-based interventions and treatments specific to the diagnosis or problem.
 5. Provide holistic care that addresses the needs of diverse populations across the lifespan.
 6. Advocate for health care that is sensitive to the needs of patients, with particular emphasis on the needs of diverse populations.
 7. Apply appropriate knowledge of major health problems and cultural diversity in implementing the plan of care.
 8. Apply available healthcare technologies to maximize access and optimize outcomes for patients.
 9. Utilize community resources and systems to implement the plan.
 10. Collaborate with healthcare providers from diverse backgrounds to implement and integrate the plan.
 11. Accommodate for different styles of communication used by patients, families, and health providers.
 12. Integrate traditional and complementary healthcare practices as appropriate.
 13. Implement the plan in a timely manner in accordance with patient safety goals.
 14. Promote the patient's capacity for the optimal level of participation and problem-solving.

<p>SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE</p>	<p>SECTION: <i>Leadership (LD)</i></p> <p style="text-align: right;">Page 6 of 13</p>
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15. Document implementation and any modifications, including changes or omissions, of the identified plan.

F. **Standard 5A. Coordination of Care:** The registered nurse coordinates care delivery and will:

1. Organize the components of the plan.
2. Manage a patient's care in order to maximize independence and quality of life.
3. Assist the patient in identifying options for alternative care.
4. Communicate with the patient, family, and system during transitions in care.
5. Advocate for the delivery of dignified and humane care by the interprofessional team.
6. Document the coordination of care.

G. **Standard 5B. Health Teaching and Health Promotion:** The registered nurse employs strategies to promote health and a safe environment and will:

1. Provide health teaching that addresses such topics as healthy lifestyles, risk-reducing behaviors, developmental needs, activities of daily living, and preventive self-care.
2. Use health promotion and health teaching methods appropriate to the situation and the patient's values, beliefs, health practices, developmental level, learning needs, readiness and ability to learn, language preference, spirituality, culture, and socioeconomic status.
3. Seek opportunities for feedback and evaluation of the effectiveness of the strategies used.
4. Use information technologies to communicate health promotion and disease prevention information to the healthcare consumer in a variety of settings.
5. Provide patients with information about intended effects and potential adverse effects of proposed therapies.

H. **Standard 6. Evaluation:** The registered nurse evaluates progress toward attainment of outcomes and will:

1. Conduct a systematic, ongoing, and criterion-based evaluation of the outcomes in relation to the structures and processes prescribed by the plan of care and the indicated timeline.
2. Collaborate with the patient and others involved in the care or situation in the evaluation process.
3. Evaluate, in partnership with the patient, the effectiveness of the planned strategies in relation to the patient's responses and the attainment of the expected outcomes.

SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	SECTION: <i>Leadership (LD)</i> Page 7 of 13
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

4. Use ongoing assessment data to revise the diagnoses, outcomes, the plan, and the implementation as needed.
5. Disseminate the results to the patients, family, and others involved, in accordance with federal and state regulations.
6. Participate in assessing and assuring the responsible and appropriate use of interventions in order to minimize unwarranted or unwanted treatment and healthcare consumer suffering.
7. Document the results of the evaluation.

STANDARDS OF PROFESSIONAL PERFORMANCE

The Standards of Professional Performance: *“Describe a competent level of behavior in the professional role, including activities related to ethics, education, evidence-based practice and research, quality of practice, communication, leadership, collaboration, professional practice evaluation, resource utilization, and environmental health. All registered nurses are expected to engage in professional role activities, including leadership, appropriate to their education and position. Registered nurses are accountable for their professional actions to themselves, their healthcare consumers, their peers, and ultimately to society”*(ANA, 2015, p. 5)

- A. **Standard 7. Ethics:** The registered nurse practices ethically and will:
- A. Use *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001) to guide practice.
 - B. Deliver care in a manner that preserves and protects patient autonomy, dignity, rights, values, and beliefs.
 - C. Recognize the centrality of the healthcare consumer and family as core members of any healthcare team.
 - D. Uphold patient confidentiality within legal and regulatory parameters.
 - E. Assist patients in self-determination and informed decision-making.
 - F. Maintain a therapeutic and professional patient-nurse relationship within appropriate professional role boundaries.
 - G. Contribute to resolving ethical issues involving patients, colleagues, community groups, systems, and other stakeholders.
 - H. Take appropriate action regarding instances of illegal, unethical, or inappropriate behavior that can endanger or jeopardize the best interests of the patient or situation.

SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	SECTION: <i>Leadership (LD)</i>
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SECTION: <i>Leadership (LD)</i>	Page 8 of 13
---	---------------------

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

- I. Speak up when appropriate to question healthcare practice when necessary for safety and quality improvement.
- J. Advocate for equitable patient care.

Standard 8. Culturally Congruent Practice.

B. Standard 12. Education: The registered nurse attains knowledge and competence that reflects current nursing practice.

1. Participate in ongoing educational activities related to appropriate knowledge base and professional issues.
2. Demonstrate a commitment to lifelong learning through self-reflection and inquiry to address learning and personal growth needs.
3. Seek experiences that reflect current practice to maintain knowledge, skills, abilities, and judgment in clinical practice or role performance.
4. Acquire knowledge and skills appropriate to the role, population, specialty, setting, role, or situation.
5. Seek formal and independent learning experiences to develop and maintain clinical and professional skills and knowledge.
6. Identify learning needs based on nursing knowledge, the various roles the nurse may assume, and the changing needs of the population.
7. Participates in formal or informal consultations to address issues in nursing practice as an application of education and knowledge base.
8. Share educational findings, experiences, and ideas with peers.
9. Contribute to a work environment conducive to the education of healthcare professionals.
10. Maintain professional records that provide evidence of competence and lifelong learning.

C. Standard 13. Evidence-Based Practice and Research: The registered nurse integrates evidence and research findings into practice and will:

1. Utilize current evidence-based nursing knowledge, including research findings, to guide practice.

SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	SECTION: <i>Leadership (LD)</i>
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SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	SECTION: <i>Leadership (LD)</i>
--	---

Page 9 of 13

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

2. Incorporate evidence when initiating changes in nursing practice.
 3. Participate, appropriate to education level and position, in the formulation of evidence-based practice through research.
 4. Share personal or third-party research findings with colleagues and peers.
- D. Standard 14. Quality of Practice:** The registered nurse contributes to quality nursing practice and will:
1. Demonstrate quality by documenting the application of the nursing process in a responsible, accountable, and ethical manner.
 2. Use creativity and innovation to enhance nursing care.
 3. Participates in quality improvement. Activities may include:
 - a. Identify aspects of practice important for quality monitoring;
 - b. Use of indicators to monitor quality, safety, and effectiveness of nursing practice;
 - c. Collect data to monitor quality and effectiveness of nursing practice;
 - d. Analyze quality data to identify opportunities for improving nursing practice;
 - e. Formulate recommendations to improve nursing practice or outcomes;
 - f. Implement activities to enhance the quality of nursing practice;
 - g. Develop, implement, and/or evaluate policies, procedures, and guidelines to improve the quality of practice;
 - h. Participate on and/or lead interprofessional teams to evaluate clinical care or health services;
 - i. Participate in and/or lead efforts to minimize costs and unnecessary duplication;
 - j. Identify problems that occur in day-to-day work routines in order to correct process inefficiencies;
 - k. Analyze factors related to quality, safety, and effectiveness,
 - l. Analyze organizational systems for barriers to quality patient outcomes; and
 - m. Implement processes to remove or weaken barriers within organizational systems.

SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	SECTION: <i>Leadership (LD)</i> Page 10 of 13
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- E. **Standard 9. Communication:** The registered nurse communicates effectively in a variety of formats in all areas of practice and will:
1. Assess communication format preferences of patients, families, and colleagues.
 2. Assess her/his own communication skills in encounters with patients, families, and colleagues.
 3. Seek continuous improvement of communication and conflict resolution skills.
 4. Convey information to patients, families, the interprofessional team, and others in communication formats that promote accuracy.
 5. Question the rationale supporting care processes and decisions when they do not appear to be in the best interest of the patient.
 6. Disclose observations or concerns related to hazards and error in care or the practice environment to the appropriate level.
 7. Maintain communication with other providers to minimize risks associated with transfers and transition in care delivery.
 8. Contribute his/her own professional perspective in discussions with the interprofessional team.
- F. **Standard 11. Leadership:** The registered nurse demonstrates leadership in the professional practice setting and the profession and will:
1. Oversee the nursing care given by others while retaining accountability for the quality of care given to the patient.
 2. Abide by the vision, the associated goals, and the plan to implement and measure progress of an individual patient or progress of an individual patient or progress within the context of the healthcare organization.
 3. Demonstrate a commitment to continuous, lifelong learning and education for self and others.
 4. Mentor colleagues for the advancement of nursing practice, the profession, and quality health care.
 5. Treat colleagues with respect, trust, and dignity.
 6. Develop communication and conflict resolution skills.

<p>SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE</p>	<p>SECTION: <i>Leadership (LD)</i> Page 11 of 13</p>
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7. Participate in professional organizations.
8. Communicate effectively with the patient and colleagues.
9. Seek ways to advance nursing autonomy and accountability.
10. Participates in efforts to influence healthcare policy involving patients and the profession.

G. **Standard 10. Collaboration:** The registered nurse collaborates with the patient, family, and others in the conduct of nursing practice and will:

1. Partner with others to effect change and produce positive outcomes through the sharing of knowledge of the patient and/or situation.
2. Communicate with the patient, the family, and healthcare providers regarding patient care and the nurse's role in the provision of that care.
3. Promote conflict management and engagement.
4. Participate in building consensus or resolving conflict in the context of patient care.
5. Apply group process and negotiation techniques with patients and colleagues.
6. Adhere to standards and applicable codes of conduct that govern behavior among peers and colleague to create a work environment that promotes cooperation, respect, and trust.
7. Cooperate in creating a documented plan focused on outcomes and decisions related to care and delivery of services that indicates communication with patients, families, and others.
8. Engage in teamwork and team-building process.

H. **Standard 15. Professional Practice Evaluation:** The registered nurse evaluates her/his own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations and will:

1. Provide age-appropriate and developmentally appropriate care in a culturally and ethnically sensitive manner.
2. Engage in self-evaluation of practice on a regular basis, identifying areas of strength as well as areas in which professional growth would be beneficial.
3. Obtain informal feedback regarding her/his own practice from patients, peers, professional colleagues, and others.
4. Participates in peer review as appropriate.

SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	SECTION: <i>Leadership (LD)</i> Page 12 of 13
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5. Take action to achieve goals identified during the evaluation process.
 6. Provide the evidence for practice decisions and actions as part of the informal and formal evaluation processes.
 7. Interact with peers and colleagues to enhance her/his own professional nursing practice or role performance.
 8. Provide peers with formal or informal constructive feedback regarding their practice or role performance.
- I. **Standard 16. Resource Utilization:** The registered nurse utilizes appropriate resources to plan and provide nursing services that are safe, effective, and financially responsible and will:
1. Assess individual patient care needs and resources available to achieve desired outcomes.
 2. Identify patient care needs, potential for harm, complexity of the task, and desired outcome when considering resource allocation.
 3. Delegate elements of care to appropriate healthcare workers in accordance with any applicable legal or policy parameters or principles.
 4. Identify the evidence when evaluating resources.
 5. Advocate for resources, including technology, that enhance nursing practice.
 6. Modify practice when necessary to promote positive interaction between healthcare consumers, care providers, and technology.
 7. Assist the patient and family in identifying and securing appropriate services to address needs across the healthcare continuum.
 8. Assist the patient and family in factoring costs, risks, and benefits in decisions about treatment and care.
- J. **Standard 17. Environmental Health:** The registered nurse practices in an environmentally safe and healthy manner and will:
1. Attain knowledge of environmental health concepts, such as implementation of environmental health strategies.
 2. Promote a practice environment that reduces environmental health risks for workers and patients.

SUBJECT: STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	SECTION: <i>Leadership (LD)</i> Page 13 of 13
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3. Assess the practice environment for factors such as sound, odor, noise, and light that threaten health.
4. Advocate for the judicious and appropriate use of products in health care.
5. Communicate environmental health risks and exposure reduction strategies to patients, families, colleagues, and communities.
6. Utilize scientific evidence to determine if a product or treatment is an environmental threat.
7. Participate in strategies to promote healthy communities.

REFERENCE:

- “
American Nurses Association. (2021). Nursing: Scope and standards of practice (4th ed.). American Nurses Association. <https://www.nursingworld.org>

SUBJECT: TREATMENT OF PATIENT WITH CHEST PAIN - NSTEMI/STEMI	SECTION: <p style="text-align: right;">Page 1 of 4</p>
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POLICY:

- A. **Function(s):** To provide immediate diagnostic procedures and treatment to patients with chest pain (cardiac) when the Emergency Department Physician is not readily available.
- B. **Circumstance**
1. **Setting:** Patient presenting to the Emergency Department with chest pain
 2. **Supervision:** Emergency Department Physician
 3. **Patient Condition/Contraindications:** As indicated by patient triage and history of co-morbidities. Allergies to be assessed.

AFFECTED AREAS: *EMERGENCY DEPARTMENT PROVIDERS; REGISTERED NURSES, LICENSED VOCATIONAL NURSES*

PROCEDURE:

- A. **Definition:** To provide immediate diagnostic procedures and treatment to patients with chest pain and related co-morbidities when the Emergency Department Physician is not readily available. Patients presenting with one or more of the following signs and symptoms, suspect a cardiac origin.
1. Chest pain radiating to the neck, jaw, back or left arm
 2. Chest Pressure or “fullness”
 3. Illicit Drug Use
 4. Palpitations
 5. Nausea/vomiting
 6. Diaphoresis
 7. Shortness of breath
 8. Pallor
 9. History of any of the above or “cardiac problems”

SUBJECT: TREATMENT OF PATIENT WITH CHEST PAIN - NSTEMI/STEMI	SECTION: <p style="text-align: right;">Page 2 of 4</p>
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B. Plan:

1. Interventions:

a. Presumed Cardiac

- Vital signs including, blood pressure, pulse, respirations, temperature, and present pain scale
- Cardiac Monitor
- Place chart in rack for physician
- Stat EKG (To be reviewed by Emergency Department physician immediately). Inform physician if patient has history of recent use of stimulant medications or medications commonly abused.

If ED physician determines STEMI, Consult with Cardiologist on-call and follow Cardiologist's orders.

- Oxygen at 2 LPM via nasal cannula if SpO₂ is less than 93%
- Establish , intravenous line
- Draw blood for lab
- Order the following:
 - CBC, CMP
 - CK, CK-MB, Troponin I
 - DIGOXIN level (if indicated)
 - Magnesium level
 - PT, PTT
 - BNP
 - AP Chest X-ray

SUBJECT:
**TREATMENT OF PATIENT WITH CHEST PAIN -
NSTEMI/STEMI**

SECTION:

Page 3 of 4

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- EKG **Note: to be done immediately upon arrival**
 - IVL
 - Cardiac Monitor
 - Pulse Oximetry
 - Give ASA 324 mg chewable (4-81 mg chewable), unless contraindicated by patient history or allergy.
 - Nitroglycerin 0.4 mg sublingual, every 5 minutes, to a total of 3 doses for chest discomfort/pain. Do not give if systolic blood pressure is less than 100mm Hg.
 - Notify physician if chest discomfort is not relieved after 3 doses of nitroglycerin.
- C. Consultation Required:** Patient's known Cardiologist or Cardiologist on call.
- D. Patient Education:** Inform patient of plan of care.
- E. Follow-up:** Re-evaluation as appropriate for patient condition. Notify ED Physician if patient's condition changes or if additional immediate intervention is required.
- F. Documentation:** All orders to be performed by Emergency Department RN will be documented in the Electronic Health Record. RN will use the physician on duty at time of patient presentation to place the orders and will do so under the standardized procedure order source option.

STAFF AUTHORIZED TO PERFORM THE FUNCTION: REGISTERED NURSE (RN)

REQUIREMENTS FOR REGISTERED NURSE:

- A. Education:** Valid California Registered Nurse License
- B. Training:** Meets initial and annual competency for the standardized procedure
- C. Experience:** Actively employed as an Emergency Department Registered Nurse, having passed the 90 day probationary period

SUBJECT: TREATMENT OF PATIENT WITH CHEST PAIN - NSTEMI/STEMI	SECTION: Page 4 of 4
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DEVELOPMENT & APPROVAL OF THE STANDARDIZED PROCEDURE:

- A. Method:** Approval of Emergency Department Committee, Emergency Department Director, and Emergency Department Medical Director

REFERENCES:

- Walls, R. et al. (Eds.). (2018). Rosen's Emergency Medicine: Concepts and Clinical Practice: Volume 1&2, (9th ed.). Philadelphia: Elsevier.

SUBJECT: TRANSFER OF PATIENT TO HIGHER LEVEL OF CARE FROM CARDIAC CATH LAB	SECTION:
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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 patient from the Cardiac Cath Lab (CCL) 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:

- A. Patients treated at the CCL who require a higher level of care due to unexpected complications, or who are in need of medical services not offered at SVMC, will be transferred to the accepting hospital for further medical treatment.

AFFECTED PERSONNEL/AREAS: *CARDIAC CATH LAB, RESPIRATORY THERAPY*

EQUIPMENT:

- Intra-Aortic Balloon Pump (IABP)
- Portable Ventilator

PROCEDURE:

- A. Emergency Transfer
1. Immediately contact the Transfer Center Coordinator.
 2. Obtain order from attending Cardiologist to transfer patient to desired Hospital.
 3. Transfer Center Coordinator will contact contracted facilities for higher level of care and obtain acceptance from the facility and physician.
 4. Cath Lab RN will call accepting facility and give report to accepting facility transfer center or emergency department RN.
 5. Contact EMS and advise dispatcher of need for emergency transfer from CCL to the accepting facility.
 6. Stabilize and prepare patient for transfer.
 7. Obtain the following documentation:
 - Physician Transfer Certification Form (Pink) completed by RN and MD (copy goes with patient)

SUBJECT: TRANSFER OF PATIENT TO HIGHER LEVEL OF CARE FROM CARDIAC CATH LAB	SECTION:
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Page 2 of 2

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- Physician Certification Statement (White copy stays at SVMC, yellow copy goes with ambulance)
 - Written copy of Transfer Agreement (copy goes with patient)
 - CD of Images
 - Copy of MAC lab reports
 - Copy of patient's face sheet
 - List of medications
 - Copy of patient's history and physical
8. Notify patient's family if Physician has not already done so.
9. Patients requiring an IABP will be accompanied by a SVMC RN competent with management of IABP.
- a. If patient requires transfer with IABP, notify Biomed to arrange for a loaner from Getinge/Maquet.
10. Patients requiring portable ventilators will be accompanied by a respiratory therapist.

REFERENCES:

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

SUBJECT: VASCULAR ACCESS DEVICE–BLOOD DRAW	SECTION: <i>Nursing Procedures (NR)</i> Page 1 of 3
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PURPOSE:

Obtain blood for laboratory analysis without performing a venipuncture.

POLICY:

Prevention of blood clotting within the catheter is extremely important during this procedure. Catheter occlusion can be prevented by maintaining positive pressure within the catheter at all times and by vigorously flushing after aspirating blood.

SPECIAL CONSIDERATIONS FOR BLOOD BANK SPECIMENS

All blood specimens drawn from a vascular access device for the purpose of blood bank testing will be obtained and labeled by a registered nurse (RN) or physician in the presence of a second licensed person or certified/licensed lab person, with each person initialing the specimen labels and/or additional forms as required, and both confirming that the BBK# has been transcribed correctly from the patient's wrist band to the specimen label.

AFFECTED AREAS/ PERSONNEL: *RN, LVN, CERTIFIED/LICENSED LAB PERSONNEL*

EQUIPMENT NEEDED:

1. One pair sterile gloves
2. Three betadine/ chlorhexidine swab sticks
3. Alcohol wipes
4. "Gripper" non-coring needle with attached extension tubing
5. Two 11cc syringes filled with normal saline
6. Assorted lab collection tubes
7. One 12cc empty syringe
8. One 19 gauge sterile needle
9. One Band-Aid
10. One clamping type needleless system adapter
11. One needleless helplock cap

SUBJECT: VASCULAR ACCESS DEVICE--BLOOD DRAW	SECTION: <i>Nursing Procedures (NR)</i> Page 2 of 3
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PROCEDURE:

NON-ACCESSED PORT

1. Check physician orders.
2. Identify patient using the two-patient identifier system.
3. Observe and palpate vascular access device site for post septum. Look for possible complications such as: edema, erosion of tissue over port, signs of infection and dislodgment of port within subcutaneous pocket.
4. Explain procedure to patient. Have patient report any change in sensation during infusion.
5. Prepare the injection site:
 - a. Done sterile gloves.
 - b. Cleanse area thoroughly with alcohol wipes. Let dry.
12. Paint area with betadine or chlorhexidine swab sticks starting over the port and moving outward in a spiral motion to cover an area 5 inches in diameter. Repeat in same manner with remaining two swab sticks and let dry.
6. Prepare non-coring needle by flushing with normal saline and clamp extension tubing. Leave normal saline syringe firmly attached during insertion procedure.
7. Clamp tubing to prevent air embolism.
8. Use the first and second fingers of one hand and place on either side of port to stabilize it during puncture. Insert the non-coring needle perpendicular to the septum and push it firmly through the skin and port septum until it makes contact with the bottom of the port chamber. It should make a "clicking" sound as the metal needle contacts the metal base of the port. Once the septum is punctured, do not tilt or rock the needle as this may cause fluid leakage or damage to the septum.
9. Open clamp and pull slightly on syringe plunger. If blood return is present, flush catheter with entire 12cc of normal saline.
10. Immediately withdraw 6cc of blood/saline into same syringe and clamp tubing. Remove syringe and discard.
11. Attach 12cc empty sterile syringe, open clamp and quickly withdraw at least 6cc of blood for lab specimen. Clamp tubing. Remove syringe and hand off to lab technician. The blood specimen will then be labeled in the presence of the patient.

SUBJECT: VASCULAR ACCESS DEVICE--BLOOD DRAW	SECTION: <i>Nursing Procedures (NR)</i> Page 3 of 3
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

If lab tech is unavailable, complete #10, then attach 19-gauge needle to syringe and fill lab collection tubes.

12. Attach 12cc syringe of normal saline and quickly flush tubing. Clamp tubing.
13. Withdraw needle while firmly stabilizing port with two fingers of other hand.
14. Cleanse site with alcohol preps and apply Band-Aid.

ACCESSED PORT WITH CONTINUOUS INFUSION

1. Check physician orders.
2. Identify patient using the two-patient identifier system.
3. Stop infusion and clamp Porta-Cath extension tubing. Disconnect IV tubing and replace needle with new clamping-type needleless system adapter.
4. Maintaining aseptic technique to prevent catheter line infection, attach 12cc pre-filled normal saline syringe to Porta-Cath extension tubing. Open clamp and flush system.
5. Immediately withdraw 6cc of blood/saline into same syringe and clamp tubing. Remove syringe and discard.
6. Attach 12cc empty sterile syringe, open clamp and quickly withdraw at least 6cc blood for lab specimen. Clamp tubing. Remove syringe and hand off t lab technician.
7. If lab technician is unavailable, complete #5, then attach 19-gauge needle to syringe and fill lab collection tubes.
8. Attach 12cc syringe of normal saline and quickly flush tubing. Re-clamp.
9. Remove syringe and attach new sterile needleless connector. Re-attach IV tubing and check IV flow rate.

NOTE: Needleless connectors need to be changed every time a blood specimen is taken.

REFERENCE:

- Moureau, N. (2019) The peer reviewed journal of nursing excellence. *Drawing blood through a central venous catheter*. Retrieved from https://journals.lww.com/nursing/Fulltext/2004/02000/Drawing_blood_through_a_central_venous_catheter.27.aspx.

SUBJECT: VASCULAR ACCESS DEVICE –BOLUS INJECTIONS	SECTION: <i>Nursing Procedures (NR)</i> Page 1 of 2
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

Short-term venous access for administration of vesicant/irritating chemotherapy drugs, usually on an outpatient basis, but can be used as inpatient. Also to ensure patency of catheter during periods of non-use by flushing with heparized saline every four weeks.

POLICY:

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

AFFECTED AREAS/ PERSONNEL: *NURSING*

EQUIPMENT NEEDED:

1. One pair sterile gloves
2. Three Betadine or chlorhexidine swabs
3. “Gripper” non-coring needle with attached extension tubing
4. Two 12cc syringes filled with normal saline
5. One 6cc syringe filled with Heparin 100u/cc
6. One Band-Aid
7. 100-500cc bag of normal saline for vesicant drugs
8. One IV administration set
9. Syringes of medication supplied by Pharmacy (if ordered)
10. Alcohol wipes

PROCEDURE:

1. Observe and palpate vascular access device site for post septum. Observe site for possible complications such as: edema, erosion of tissue over port, signs of infection and dislodgment of port within subcutaneous pocket.
2. Explain procedure to patient. Have patient report any change in sensation during infusion. Stop infusion if any changes are noted, and request X-ray confirmation of port functional capability. Patient may experience slight discomfort when port is accessed.

SUBJECT: VASCULAR ACCESS DEVICE –BOLUS INJECTIONS	SECTION: <i>Nursing Procedures (NR)</i> Page 2 of 2
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

3. Prepare the injection site:
 - a. Don sterile gloves.
 - b. Cleanse area thoroughly with alcohol wipes. Let dry.
 - c. Paint area with Betadine/chlorhexidine swabs starting over the port and moving outward in a spiral motion to cover an area five inches in diameter. Repeat in the same manner with remaining two swabs and let dry.
4. Prepare non-coring needle by flushing with normal saline and clamp extension tubing. Leave normal saline syringe firmly attached during procedure.
5. Clamp tubing to prevent air embolism.
6. Use the first and second fingers of one hand and place on either side of port to stabilize it during puncture. Insert the non-coring needle perpendicular to the septum and push it firmly through the skin and port septum until it makes contact with bottom part of the port chamber. It should make a “clicking” sound as the metal needle contacts the metal base of the port.
7. Open clamp and pull slightly on attached syringe plunger. If blood return is present, flush catheter with entire 12cc of normal saline. To flush port only to maintain patency, proceed directly to Number 11. For intra-peritoneal port, proceed directly to Number 12.
8. Clamp extension tubing and attach IV line of normal saline using sterile technique
9. Open all clamps to start normal saline flowing. Using chemotherapy gloves, administer the drugs slowly, stopping every 2-3ml to check for blood return. Flush with at least 20cc of normal saline between each drug to prevent incompatibility.
10. Clamp extension tubing and disconnect IV tubing.
11. Attach physician ordered heparin . Open clamp, flush extension tubing slowly. Re-clamp tubing while maintaining positive pressure on syringe plunger as the last ml of heparin is injected.
12. Withdraw needle while firmly stabilizing port with two fingers of other hand.
13. Remove Betadine/ chlorhexidine solution from patient’s skin with alcohol wipes. Apply Band-Aid.

REFERENCE:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Nettina, S. (2019) Lippincott Manuel of Nursing Practice 11th ed: Amber, PA: Williams & Wilkins

SUBJECT: WAIVED & POINT OF CARE TESTING: ABBOTT ID NOW COVID-19, INFLUENZA A & B, RSV, AND STREP A	SECTION: <i>Waived Testing</i> Page 1 of 7
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

INTENDED USE:

The ID NOW Instrument is a fluorescence-based instrument for the processing and analysis of ID NOW tests for Covid-19, Influenza A and B, RSV, and Group A strep. The ID NOW instrument and testing kits are intended to aid in the diagnosis of these diseases.

SUMMARY AND EXPLANATION OF THE TEST:

ID NOW utilizes nucleic acid amplification technology for the qualitative detection of infectious diseases. Consumables such as Test Bases and Sample Receivers are required to run each assay. The reaction tubes in the Test Base contain the reagents required for amplification of the target nucleic acid and an internal control, ID NOW utilizes a pair of templates (similar to primers) for the specific amplification of the target nucleic acid and a fluorescently-labeled molecular beacon designed to specifically identify the amplified targets. To perform the assay, the Sample Receiver and the Test Base is inserted into the ID NOW Instrument. The sample is added to the Sample Receiver and transferred via the Transfer Cartridge to the Test Base, initiating target amplification. Heating, rotation, and detection is provided by the instrument, with results automatically reported.

POLICY:

- A. The ID NOW testing packet will be used in the Emergency Department for the rapid detection of Covid-19, Influenza A and B, RSV, and Group A strep.
- B. Nursing personnel and/or Emergency Department Technicians performing Covid-19, Influenza A and B, RSV, or Group A strep testing will be trained utilizing this policy and procedure, and complete competency prior to performance. Training will include reading Waived and Point of Care Testing: ID NOW policy.
- C. Nursing and Emergency Department Technician personnel will have competency validated initially and annually.
- D. Emergency Department will maintain records of all individuals who have completed training and completed validation.
- E. Quality Control procedures will be completed with each new shipment received, once for each untrained operator, and with software updates. Emergency Department is responsible for completing the Quality Control on each new shipment and keeping a log. Emergency Department is responsible for ensuring a quality control is completed with each newly trained operator during their training and competency validation upon hire.

AFFECTED PERSONNEL/AREAS: *SVMC EMERGENCY DEPARTMENT REGISTERED NURSES, LICENSED VOCATIONAL NURSES, AND EMERGENCY DEPARTMENT TECHNICIANS*

SUBJECT: WAIVED & POINT OF CARE TESTING: ABBOTT ID NOW COVID-19, INFLUENZA A & B, RSV, AND STREP A	SECTION: <i>Waived Testing</i> Page 2 of 7
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

EQUIPMENT:

- Packet 1 and 2 for the specific test (Covid-19, Influenza A and B, RSV, or Group A Strep), which includes Test Base, Sample Receiver, and Transfer Cartridge.
- Specific swab for test to be run:
 Nasal swab for Covid-19
 Nasal swab for Influenza A and B
 Nasopharyngeal swab for RSV
 Throat swab for Group A Strep
- Transport tube for Covid-19 swab
- ID NOW Instrument

PRECAUTIONS:

- For in vitro diagnostic use.
- Treat all specimens as potentially infectious.
- Visibly bloody samples **MUST NOT** be used when testing for Covid-19 or Influenza.
- Leave test components in their sealed pouches until just prior to use. Make sure all test components are a room temperature before using.
- **DO NOT** use sharp object or scissors to open foil packages, you may damage the contents.
- Do not remove blue Sample Receiver from machine once warm up has started.
- Do not remove foil seal from blue Sample Receiver until prompted to do so. Place two fingers along the outer edge of the blue Sample Receiver when removing the foil seal to keep the blue Sample Receiver in place.
- Orange indicator should rise to top of the white Transfer Cartridge when pressed into the blue Sample Receiver. The orange indicator should descend back down when the white Transfer Cartridge is pressed into the orange Test Base. Always visually check this when running the procedure, **DO NOT** rely on listening for clicks.
- Test components are designed as single use only. Test components should be clicked together and must be removed from the instrument according to removal instructions displayed on the screen. **DO NOT** separate components once they are clicked together after test completion.
- Must wear gloves when running test(s) with the ID NOW Instrument and components.
- If any test component is dropped, cracked, found to be damaged, or open when received, it should not be used and should be discarded.
- Do not use components that are expired.
- Do not mix components from different lots.
- Use swabs provided in testing kits for best results.

STORAGE AND STABILITY:

- A. Store testing components between 2-30 C (35.6 F to 86 F).

SUBJECT: WAIVED & POINT OF CARE TESTING: ABBOTT ID NOW COVID-19, INFLUENZA A & B, RSV, AND STREP A	SECTION: <i>Waived Testing</i> Page 3 of 7
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

- B. Ensure all test components are at room temperature before use.
- C. Kits are stable until expiration date marked on the package.

SPECIMEN COLLECTION AND HANDLING:

- A. Test specimens immediately after collection for optimal test performance.
- B. Wear clean gloves when running each test. Change gloves between handling of each specimen.
- C. Use swabs provided in test kit for best results.
- D. Swab BOTH NARES for Covid and Influenza A and B using sterile foam tipped applicator.
- E. RSV requires nasopharyngeal swab.
- F. Swab throat for Group A-Strep using sterile foam tipped applicator.
- G. Only two tests can be run off one swab.

SPECIMEN STORAGE AND TRANSPORT:

- A. Covid swabs – DO NOT return swab to original packaging. Must put in clear transport tube with lid from patient to instrument. Run test ASAP.
- B. Influenza and RSV swabs can be returned to the original packaging and stored at room temperature up to two hours before testing.
- C. Strep swab can be returned to the original packaging and held up to 72 hours at room temperature prior to testing.

CREAT NEW USER:

From home screen go to Setup, users, new user: When prompted scan hospital ID badge bar code.

PROCEDURE:

- A. Follow the step-by-step instructions shown on the instrument screen.
- B. Before testing put on clean set of gloves.
- C. Make sure swab and testing packets are at room temperature.

SUBJECT: WAIVED & POINT OF CARE TESTING: ABBOTT ID NOW COVID-19, INFLUENZA A & B, RSV, AND STREP A	SECTION: <i>Waived Testing</i> Page 4 of 7
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- D. Check for reagent pellet in the bottom of both sides of the Test Base.
- E. From home screen:
1. If user required scan hospital badge bar code
 2. Select run test
 3. Select test (Covid, Influenza A and B, RSV, Group A strep
 4. Scan patient ID white label and press okay.
 5. Open lid when prompted.
 6. Tear open foil pouch label #1 at the notch (orange Test Base). Remove orange base making sure not to touch inside or the two clear reaction tubes on the bottom, as this could contaminate the device.
 7. Insert orange Test Base into orange base holder of machine.
 8. Select okay to confirm. (You now have 3-10 minutes to start the test, with Covid test timing out after 3 minutes).
 9. Tear open foil pouch #2 (blue Sample Receiver and white Transfer Cartridge) and remove blue Sample Receiver and insert into blue holder. Make sure firmly seated in the holder.
 10. Covid 19, Influenza A and B, and RSV require a 3-minute warm up time. This will start automatically once Blue Sample Receiver inserted properly into blue base. Group A strep does not require a warm-up time.
 11. After minimal warm up, remove foil cover of blue Sample Receiver. You must hold the blue Sample Receiver with one hand, use other hand to remove foil cover (this prevents the blue Sample Receiver from being dislodged from machine).
 12. Immerse swab head in liquid completely, stirring for 10 seconds, pressing swab against sides of container. Dispose of used swab in appropriate biohazard receptacle, then press okay.
 13. Place white Transfer Cartridge into blue Sample Receiver and press down firmly. You will hear clicks and the orange indicator on the top will rise up (signaling the sample was proper drawn up into the pipets).
 14. Grab white Transfer Cartridge and place into orange Test Base. Press down firmly with both hands. You will hear clicks. When seated properly the orange test button on top will fall back to original position.
 15. Instrument will prompt you to close lid. Test starts automatically.
 16. Results will be displayed on result screen.
 17. Chart results in patient's EMR including lot number, expiration of test device, and result.
- F. How to remove test device:
- Grab white/orange transfer cartridge/test base assembly.
 - Insert into blue Sample Receiver
 - Rock back and forth gently to lock into place.

SUBJECT: WAIVED & POINT OF CARE TESTING: ABBOTT ID NOW COVID-19, INFLUENZA A & B, RSV, AND STREP A	SECTION: <i>Waived Testing</i> Page 5 of 7
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- Remove from test base, wrap in gloves (as gloves removed), and dispose in appropriate biohazard receptacle.
- Close lid on device.

G. RUN COVID/INFLUENZA OFF SAME SAMPLE

- Run Covid test fist (follow direction in #5)
- After results are shown select actions then combo (covid/influenza)
- Select okay. DO NOT remove anything from instrument yet.
- Open Influenza A and B foil pouch and remove blue Sample receiver.
- Hold new Sample Receiver on flat surface and remove foil cover. Be careful not to spill.
- Remove used white/orange transfer cartridge from machine and lock into blue Sample Receiver being held outside the machine. Rock back and forth to lock in.
- Dispose of completed assembly by wrapping in gloves as gloves are removed. Dispose in appropriate biohazard receptacle.
- Follow on screen prompts to close lid. Instrument will run self-test.
- Put on new set of gloves.
- Confirm patient ID and select okay.
- Open lid.
- Open pouch #1 for Influenza A and B, remove orange Test Base and insert into orange Test base holder in machine.
- No warm up needed. DO NOT restir sample.
- Place white Transfer Cartridge in blue Sample Receiver and press down firmly with both hands. You will hear clicks and the orange indicator on the top will rise up.
- Grab white Transfer Cartridge and place into orange Test Base. Press down firmly with both hands. You will hear clicks. When seated properly the orange test button on top will fall back to original position.
- Instrument will prompt you to close lid. Test starts automatically.
- Results will be displayed on result screen.
- Remove test pieces following instruction in #6 above.
- Chart results in patient's EMR including lot number, expiration of test device, and result.

H. MAINTENANCE AND CLEANING

- Clean the exterior of instrument surfaces and surfaces visible under the lid daily along with counters around the machine(s).
- Log cleaning into cleaning log for each instrument daily.
- Solutions okay to use for cleaning include 70% ethanol wipes, 70 % isopropanol wipes, or 10% bleach on a damp, lint free cloth.
- DO NOT spray or pour solutions directly on the instrument.
- DO NOT disassemble the instrument for cleaning.

SUBJECT: WAIVED & POINT OF CARE TESTING: ABBOTT ID NOW COVID-19, INFLUENZA A & B, RSV, AND STREP A	SECTION: <i>Waived Testing</i> Page 6 of 7
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- DO NOT immerse in water or cleaning solutions.
- DO NOT clean with soap or other solutions.

I. PROCEDURE FOR REPEATING TEST:

- Open a new Sample Receiver/Transfer Cartridge pouch #2.
- Remove the blue Sample Receiver, hold on flat surface, remove foil seal.
- Remove the used, connected orange Test Base and white Transfer Cartridge and put into new, unused blue Sample receiver. Rock back and forth to lock in
- Dispose of the Test Base by wrapping in gloves as gloves removed and dispose in appropriate biohazard receptacle.
- Retain the used blue Sample Receiver for repeat testing by removing carefully from machine, held upright to prevent spilling.

J. REPEAT TEST

- Close lid to initiate self-test.
- From home screen begin new test.
- Use new orange Test base and white Transfer Cartridge.
- Follow on screen prompts, but when asked to insert the blue Sample Receiver, reuse the existing Blue Sample Receiver from the initial test.
- DO NOT re-elute the swab or add additional sample.
- Complete as normal for results, recording in chart, and disposal.

COMPETENCY ASSESSMENT:

- A. All operators must read waived point of care testing: Covid 19, Influenza A/B, RSV, Group A strep (ID NOW System) and complete training and competency validation during initial training.
- B. Competency validation is completed at orientation and annually using at least two of the following methods:
- Observation of test performance
 - Written test
 - Each user's quality control performance is monitored.
 - Performing a test on a blind specimen
- C. Only approved operators are allowed to perform the test(s) and report results.
- D. Competency validation is tracked electronically in the learning management system and in the employee e-files.

SUBJECT: WAIVED & POINT OF CARE TESTING: ABBOTT ID NOW COVID-19, INFLUENZA A & B, RSV, AND STREP A	SECTION: <i>Waived Testing</i> Page 7 of 7
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

QUALITY CONTROL

- A. Done with each new shipment, each new untrained operator, and with software updates, with provided positive swab(s).
- B. Negative sample from new, unused swab.
- C. Emergency Department is responsible for completing the Quality Control on each new shipment and maintaining a log.
- D. Emergency Department is responsible for ensuring a Quality Control will be completed with each newly trained operator during their training and competency validation upon hire.

LIMITATION OF THE PROCEDURE

- A. Improper sample collection can result in false negative result.
- B. Opening testing pouches before needed can result in false negative or positive result.
- C. When doing Covid 19 and Influenza testing on same sample: both must be completed within 30 minutes of start time.
- D. Each instrument retains memory of up to 999 test results and/or quality control results, before will delete oldest tests as subsequent testing is done.
- E. Influenza – false negative results may occur if RSV is present as a co-infecting organism.

REFERENCES:

- Abbott Diagnostics Scarborough, INC. (2024). *ID NOW Instrument User Manual* [Review of *ID NOW Instrument User Manual*].
- Abbott. (2025). ID NOW Training Video's [Review of *ID NOW Training Video's*]. In Abbott . <https://www.globalpointofcare.abbott>
- Abbott. (2023). *ID NOW Covid-19 2.0 Product Insert* . AbbotT
- Abbott. (2020). *ID NOW Influenza A & B 2 Product Insert*. Abbott.
- Abbott. (2020). *ID NOW RSV Product Insert*. Abbott.
- Abbott. (2020). *ID NOW sTREP a 2 Product Insert*. Abbott.

	TIMMING	Y	N	NA	RN INT TIME
DOOR ARRIVAL TIME: _____					
CHEST PAIN START TIME PER PATIENT: _____					
Perform 12 lead EKG immediately upon arrival	0 min				
Positive Ekg Changes - confirmed by MD within 10 mins of arrival	10 min				
Cardiologist Notified _____					
If ED physician determines STEMI					
ACTIVATE HEART ALERT PROTOCOL - PAGE HEART ALERT	10 min				
Notify Cath Lab Charge RN EXT 2109					
Insert 2 large bore (18g or 20g) IV's - Avoid Right Wrist					
Initiate Code STEMI Order Set	15 min				
Labs Drawn (Females of childbearing age - blood qualitative pregnancy test)					
Door to Lab Resulted	45 min				
CXR performed					
Aspirin 324 non-enteric PO unless contraindicated					
Heparin bolus 5000 units IV					
Nursing Interventions: Vital Signs abd Cardiac Monitoring Provide ST segment monitoring/repeat EKG Q1H per MD/Pain SpO2 - 2-3 L/Min O2 to maintain SpO2 > 95% If SpO2 < 90% and no history of COPD, increase O2 upt ° 15L/min via NRM & notify MD.					
CATH LAB STAFF					
Time of Transfer					
Cath Lab: _____ Cardiologist Arrival: _____	50 min				
Guidewire Time: _____ Balloon Time: _____	90 min				
METRIC MET: DTBT 90 minutes YES/NO					
Delay Reason:					

**NOT A PERMANENT PART OF THE MEDICAL RECORD.
PLEASE SEND TO THE DIRECTOR OF SURGICAL SERVICES.**



Porterville, California 93257
HEART / CHEST PAIN ALERT

PATIENT'S LABEL

109

PRE-OP DIAGNOSIS:

POST-OP DIAGNOSIS:

Surgeon:

Assistant:

PROCEDURE PERFORMED (Brief Description):

FINDINGS:

COMPLICATIONS

EBL: Minimal <50 mL 50-100 mL >100 mL (estimate):

SPECIMENS REMOVED: None Sent to pathology (specify):

CONDITION OF PATIENT:

Physician Signature: _____ Date: _____ Time: _____



Porterville, California 93257
IMMEDIATE POST-OP NOTE



Form # 013412 REV.12/25

CHART - MEDICAL RECORD

ROOM NO. _____

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

PATIENT'S LABEL

110

Review of History and Physical:

- Reviewed the patient's complete medical history, including past surgeries, chronic conditions, allergies, current medications, and relevant family history.
- No significant changes in the patient's medical condition since the last visit.

Review of Systems:

- Reviewed physical examination findings, including cardiovascular, respiratory, and musculoskeletal assessments.
- All exam findings are consistent with the patient's preoperative status and suitability for surgery.

Review of Preoperative Tests:

- Reviewed all relevant preoperative tests, including [lab results, imaging, EKG, etc..

Signature: _____

Provider Name: _____

Date: _____ Time: _____



Porterville, California 93257

Provider's Review of History and Physical (H&P)



Form # 027279 REV 1/26

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

PATIENT'S LABEL

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SIERRA VIEW MEDICAL CENTER

SHORT FORM HISTORY & PHYSICAL

PROPOSED SURGERY/PROCEDURE:

SURGICAL/PROCEDURAL INDICATIONS AND PRESENT ILLNESS:

DIAGNOSIS:

RELEVANT PAST HISTORY: Non-contributory

ALLERGIES: NONE

CURRENT DRUGS:

Review of Systems (Recent History)

Neg		Relevant History	Neg		Relevant History
	General:			GU:	
	EENT:			MUSCULOSKELETAL:	
	RESP:			NEURO:	
	CV:			PSYCH:	
	GI:			OTHER:	

Blood Pressure	Temp	Pulse	Resp
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Physical Exam

	Within Normal Limits	Significant Physical Findings:
Heart	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	

Examination relative to Surgery / Procedure:

Reviewed and verified history as reported above

Physician's Signature _____ Date _____ Time _____



Porterville, California 93257

SHORT FORM HISTORY & PHYSICAL



Form # 014432 REV 1/26

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

PATIENT'S LABEL

112

MEETING MINUTES

MINUTES FROM PREVIOUS MEETING SUBMITTED FOR APPROVAL

MEETING MINUTES

BOARD OF DIRECTORS ANNUAL MEETING SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly January 27, 2026 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 5:00 p.m.

Board Attendance:

- Liberty Lomeli, Chair - Present
- Bindusagar Reddy, Vice Chair - Present
- Areli Martinez, Secretary – Present
- Hans Kashyap, Director – Arrived at 5:42 p.m.
- Martha A. Flores, Director - Present

Others Present: Donna Hefner, President/Chief Executive Officer, Craig McDonald, Chief Financial Officer, Melissa Crippen, Vice President of Quality and Regulatory Affairs, Ron Wheaton, Vice President of Professional Services & Physician Recruitment, Brandy Irwin, Chief Nursing Officer, Tracy Canales, Vice President of Human Resources and Marketing, Kim Pryor-DeShazo, Director of Marketing, Crystal Lucas, Director of Food and Nutrition, Silvia Robert, Director of Care Integration, Gary Wilbur, Administrative Director of General Services, Jerome Alcoba, Manager of Patient Safety and Risk, Rosalva Gonzalez, Infection Prevention Manager, Jennifer Regalado, Compliance Privacy Manager, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

Meeting time under announcements for the group photo of the Board will change from 4:30pm to 5:45pm, and resolution number on the agenda for Business Item G will be corrected to 12-16-2025/02. Chair LOMELI inquired if there was a motion to approve the agenda. Director FLORES moved to approve the agenda with the modifications mentioned, the motion was seconded by Vice Chair REDDY. The motion was carried with the following vote:

FLORES	Yes
KASHYAP	Absent
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:01 p.m. to discuss the following items:

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

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

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

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

Closed Session Items D & E were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session's scheduled start time.

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

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

A. Chief of Staff Report:

1. General Report

Recommended Action: Information only; no action taken

2. Report on Peer Review/Credentials

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

FLORES	Yes
KASHYAP	Absent
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

B. Quality Division Update

1. Quality Division Report

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

FLORES	Yes
KASHYAP	Absent

MARTINEZ Yes
REDDY Yes
LOMELI Yes

C. Discussion Regarding Trade Secrets Pertaining to Services and Facilities
Information Only: No Action Taken

IV. Public Comments
None

V. Consent Agenda
The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). Following review and discussion, it was moved by Director MARTINEZ, seconded by Director FLORES, and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

FLORES Yes
KASHYAP Absent
MARTINEZ Yes
REDDY Yes
LOMELI Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director FLORES and seconded by Vice Chair REDDY to approve the December 16, 2025 Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

FLORES Yes
KASHYAP Absent
MARTINEZ Yes
REDDY Yes
LOMELI Yes

VII. Business Items

A. Award of Public Bid for Parking Lot Resurfacing

Following review and discussion Central Valley Asphalt was identified as the lowest qualifying bid received. Director MARTINEZ made a motion to approve the lowest qualifying bid, seconded by Director FLORES and carried to approve. The vote of the Board is as follows:

FLORES Yes
KASHYAP Absent

MARTINEZ Yes
REDDY Yes
LOMELI Yes

B. Sierra View Foundation Check Presentation

Foundation Chair Debbie Landers presented Sierra View Medical Center with a \$250,000 contribution in support of expanding orthopedic care for the community. The funds, raised through donor sponsors, community partners and members, will assist with the purchase of the Stryker Mako robotic system. This technology will enhance SVMC's ability to provide minimally invasive total hip and knee replacement procedures locally.

C. December 2025 Financials

Craig McDonald, CFO presented the Financials for December 2025.

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

FLORES Yes
KASHYAP Absent
MARTINEZ Yes
REDDY Yes
LOMELI Yes

- *Director Kashyap arrived to the meeting at 5:42pm towards the end of the monthly financial report.*
- *A brief recess was taken at 5:53 pm for the Board to take a professional group photo.*
- *At 5:59pm the meeting resumed with Chair Lomeli, Vice Chair Reddy and Director Flores.*

D. Investment Report – Quarter Ending December 31, 2025

Craig McDonald presented the Investment Report

Following review and discussion, it was moved by Vice Chair REDDY, seconded by Director FLORES and carried to approve the Quarterly Investment Report as presented. The vote of the Board is as follows:

Director Martinez returned to the Board Room at 6:00pm.

FLORES Yes
KASHYAP Absent
MARTINEZ Abstain

REDDY Yes
LOMELI Yes

E. Capital Report – Quarter Ending December 31, 2025

Craig McDonald presented the quarterly capital report.

Following review and discussion, it was moved by Vice Chair REDDY, seconded by Director FLORES and carried to approve the Quarterly Capital Report as presented. The vote of the Board is as follows:

FLORES Yes
KASHYAP Absent
MARTINEZ Yes
REDDY Yes
LOMELI Yes

F. Annual Appointments

1. Food and Dietetic Services Director-Crystal Lucas

Ron Wheaton, Vice President of Physician Recruitment and Professional Services presented credentials for Crystal Lucas, Director of Food and Nutrition.

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

Director Kashyap returned to the Board Room at 6:03pm

FLORES Yes
KASHYAP Abstain
MARTINEZ Yes
REDDY Yes
LOMELI Yes

2. Environmental Safety/Security Officer- Gary Wilbur

Craig McDonald, Vice President and Chief Financial Officer presented credentials for Gary Wilbur, Administrative Director of General Services.

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

FLORES Yes
KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

3. Patient Safety Officer-Jerome Acoba

Melissa Crippen, VP of Quality and Regulatory Affairs, presented credentials for Jerome Acoba, Patient Safety Manager.

Following review and discussion, it was moved by Director FLORES, seconded by Director MARTINEZ and carried to approve Jerome Alcoba as the Patient Safety Officer as presented. The vote of the Board is as follows:

FLORES Yes
KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

4. Infection Control Officer- Rosalva Gonzalez

Melissa Creppin, Vice President of Quality and Regulatory Affairs presented credentials for Rosalva Gonzalez, Infection Prevention Manager.

Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Director KASHYAP and carried to approve Rosalva Gonzalez as the Infection Control Officer as presented. The vote of the Board is as follows:

FLORES Yes
KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

G. Ratification of Resolution 12-16-2025/02 Appointing CFO as Treasurer of the Board

Following review and discussion, Director Kashyap made a motion to approve the ratification of Resolution 12-16-2025/02, appointing Sierra View Medical Center CFO as Treasurer of the Board, seconded by Vice Chair REDDY. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

H. Board Self Evaluation and 2026 Goals According to 7.2 Bylaw Requirement Information Only; No Action Taken

VIII. SVLHCD Board Chair Report

No Report Given

IX. CEO Report

- Brandy Irwin has been appointed as Vice President of Patient Care Services and Chief Nursing Officer.
- Sierra View Medical Center earned a Gold designation from the California Department of Public Health for its Antimicrobial Stewardship Program, recognizing excellence in responsible antibiotic use and infection prevention efforts.
- The SVMC End of Year Report is now available on the hospital’s website.
- SVMC welcomed its New Year’s Baby, delivered at 9:57 a.m. on January 1. The newborn weighed 8 pounds, 13 ounces and measured 20.5 inches long.
- Employee of the Month recognition was awarded to:
 - Tyson Harness, Senior Data Analyst
 - Elvia, Infection Prevention RN
- The Awards and Recognition Committee hosted a hot chocolate bar as a festive moment of appreciation for staff.
- Congratulations and best wishes were extended to retiring employees:
 - Olga, Patient Registration Clerk, retiring after 30 years of service
 - Gloria, Regulatory and Quality RN, retiring after more than two decades of service
- Dr. Simon Kim, M.D., author of Dream Along Anesthesia Adventures, generously donated 100 copies of his book for pediatric surgery patients.
- The next Blood Drive will be held on Thursday, February 19.
- CEO Donna Hefner attended a Central Valley healthcare roundtable at Kern Medical in Bakersfield. The event was hosted by Congressman David Valadao and Congressman Vince Fong and welcomed Centers for Medicare & Medicaid Services Administrator Dr. Mehmet Oz.

X. Announcements:

Regular Board of Directors Meeting – January 27, 2026, at 5:00 p.m.

- XI. Closed Session: Board adjourned Open Session at 6:25 p.m., reconvening in Closed Session at 6:25 p.m. to discuss the following items:

- D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning. Estimated date of disclosure December 1, 2026.
 - 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 Items).
- XII. Open Session: Chairman REDDY adjourned Closed Session at 7:04 p.m., reconvening in Open Session at 7:04 p.m.
- D. Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning Information Only; No Action Taken
 - E. Conference with Legal Counsel Information Only; No Action Taken
- XIII. Adjournment
- The meeting was adjourned at 7:05 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

FINANCIALS

FINANCIAL REPORTS FROM THE PREVIOUS MONTH

FINANCIAL PACKAGE
Jan-26

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

	Pages
Statistics	1-2
Balance Sheet	3-4
Income Statement	5
Statement of Cash Flow	6
Monthly Cash Receipts	7

Sierra View Medical Center
Financial Statistics Summary Report
January 2026

Statistic	Jan-26				YTD				Fiscal 25 YTD	Increase/ (Decrease)	
	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.		Jan-25	% Change
Utilization											
SNF Patient Days											
Total	-	-	-	0.0%	93	-	93	0.0%	127	(34)	-26.8%
Medi-Cal	-	-	-	0.0%	93	-	93	0.0%	127	(34)	-26.8%
Sub-Acute Patient Days											
Total	1,072	1,000	72	7.2%	7,199	7,391	(192)	-2.6%	7,062	137	1.9%
Medi-Cal	514	476	38	7.9%	3,304	3,698	(394)	-10.6%	3,533	(229)	-6.5%
Acute Patient Days	1,688	1,882	(194)	-10.3%	11,478	11,814	(336)	-2.8%	11,679	(201)	-1.7%
Acute Discharges	483	499	(16)	-3.2%	3,218	3,132	86	2.7%	3,132	86	2.7%
Medicare	206	201	5	2.5%	1,185	1,227	(42)	-3.4%	1,227	(42)	-3.4%
Medi-Cal	207	228	(21)	-9.2%	1,566	1,484	82	5.5%	1,484	82	5.5%
Contract	67	66	1	1.5%	440	401	39	9.7%	401	39	9.7%
Other	3	4	(1)	-25%	27	20	7	35.0%	20	7	35.0%
Average Length of Stay	3.49	3.77	(0.28)	-7.3%	3.57	3.77	(0.21)	-5.4%	3.73	(0.16)	-4.3%
Newborn Patient Days											
Medi-Cal	159	173	(14)	-8.1%	1,163	1,121	42	3.8%	1,081	82	7.6%
Other	38	33	5	15.2%	303	228	75	32.7%	268	35	13.1%
Total	197	206	(9)	-4.4%	1,466	1,349	117	8.7%	1,349	117	8.7%
Total Deliveries	105	104	1	1.0%	796	697	99	14.2%	701	95	13.6%
Medi-Cal %	80.00%	83.43%	-3.43%	-4.1%	78.84%	83.43%	-4.59%	-5.5%	80.91%	-2.07%	-2.6%
Case Mix Index											
Medicare	1.2793	1.6368	(0.3575)	-21.8%	1.5467	1.6368	(0.0901)	-5.5%	1.6099	(0.0632)	-3.9%
Medi-Cal	1.0990	1.1975	(0.0985)	-8.2%	1.1379	1.1975	(0.0596)	-5.0%	1.2076	(0.0697)	-5.8%
Overall	1.1804	1.3724	(0.1920)	-14.0%	1.2849	1.3724	(0.0875)	-6.4%	1.3656	(0.0807)	-5.9%
Ancillary Services											
Inpatient											
Surgery Minutes	5,492	7,621	(2,129)	-27.9%	51,838	54,797	(2,959)	-5.4%	53,689	(1,851)	-3.4%
Surgery Cases	72	91	(19)	-20.8%	607	638	(31)	-4.9%	644	(37)	-5.7%
Imaging Procedures	1,769	1,437	332	23.1%	11,103	10,473	630	6.0%	10,775	328	3.0%
Outpatient											
Surgery Minutes	14,853	13,476	1,377	10.2%	104,099	98,186	5,913	6.0%	95,789	8,310	8.7%
Surgery Cases	189	187	2	1.2%	1,328	1,361	(33)	-2.4%	1,334	(6)	-0.4%
Endoscopy Procedures	155	178	(23)	-12.9%	1,214	1,297	(83)	-6.4%	1,271	(57)	-4.5%
Imaging Procedures	4,382	4,004	378	9.5%	29,137	29,168	(31)	-0.1%	28,813	324	1.1%
MRI Procedures	337	290	47	16.2%	2,230	2,112	118	5.6%	2,106	124	5.9%
CT Procedures	1,386	1,204	182	15.1%	9,993	8,775	1,218	13.9%	8,734	1,259	14.4%
Ultrasound Procedures	1,515	1,298	217	16.7%	10,384	9,456	928	9.8%	9,191	1,193	13.0%
Lab Tests	35,469	30,839	4,630	15.0%	243,502	224,683	18,819	8.4%	218,902	24,600	11.2%
Dialysis	4	3	1	24.3%	41	23	18	74.9%	24	17	70.8%

Sierra View Medical Center
Financial Statistics Summary Report
January 2026

Statistic	Jan-26				YTD				Fiscal 25 YTD	Increase/ (Decrease)	
	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.		Jan-25	% Change
Cancer Treatment Center											
Chemo Treatments	2,074	1,922	152	7.9%	13,938	14,004	(66)	-0.5%	13,301	637	4.8%
Radiation Treatments	1,526	1,833	(307)	-16.7%	11,836	13,353	(1,517)	-11.4%	12,741	(905)	-7.1%
Cardiac Cath Lab											
Cath Lab IP Procedures	19	13	6	42.3%	109	97	12	12.0%	88	21	23.9%
Cath Lab OP Procedures	25	32	(7)	-21.3%	210	232	(22)	-9.3%	247	(37)	-15.0%
Total Cardiac Cath Lab	44	45	(1)	-2.5%	319	329	(10)	-3.0%	335	(16)	-4.8%
Outpatient Visits											
Emergency	3,718	3,691	27	0.7%	24,598	24,335	263	1.1%	24,312	286	1.2%
Total Outpatient	14,969	13,663	1,306	9.6%	102,544	99,543	3,001	3.0%	97,690	4,854	5.0%
Staffing											
Paid FTE's	855.11	900.16	(45.05)	-5.0%	874.66	900.16	(25.50)	-2.8%	870.07	4.59	0.5%
Productive FTE's	751.70	772.13	(20.43)	-2.6%	752.96	772.13	(19.17)	-2.5%	744.65	8.31	1.1%
Paid FTE's/AOB	5.06	4.98	0.08	1.6%	5.01	5.20	(0.20)	-3.7%	5.15	(0.14)	-2.7%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj. Patient Day	11,857	10,395	1,462	14.1%	11,336	11,120	216	1.9%	11,273	64	0.6%
Cost/Adj. Patient Day	2,918	2,762	155	5.6%	2,862	2,889	(27)	-0.9%	2,781	81	2.9%
Revenue/Adj. Discharge	54,539	49,622	4,917	9.9%	53,045	55,068	(2,023)	-3.7%	54,693	(1,648)	-3.0%
Cost/Adj. Discharge	13,421	13,186	235	1.8%	13,391	14,306	(915)	-6.4%	13,491	(99)	-0.7%
Adj. Discharge	1,138	1,173	(35)	-3.0%	8,023	7,510	514	6.8%	7,486	537	7.2%
Net Op. Gain/(Loss) %	1.60%	-3.49%	5.09%	-145.8%	1.46%	-3.49%	4.95%	-141.7%	-2.40%	3.85%	-160.8%
Net Op. Gain/(Loss) \$	248,320	(522,084)	770,404	-147.6%	1,588,885	(1,808,898)	3,397,783	-187.8%	(2,364,072)	3,952,957	-167.2%
Gross Days in Accts Rec.	109.09	95.03	14.06	14.8%	109.09	95.03	14.06	14.8%	84.29	24.80	29.4%
Net Days in Accts. Rec.	50.90	57.75	(6.85)	-11.9%	50.90	57.75	(6.85)	-11.9%	40.78	10.12	24.8%

Sierra View Local Health Care District

Balance Sheet

	Jan-26	Dec-25
Assets		
Current Assets:		
Cash & Cash Equivalents	7,655,278	5,217,445
Short-Term Investments	1,318,521	134,495
Assets Limited As To Use	3,293,988	3,417,604
Patient Accounts Receivable	215,526,614	205,653,588
Less Uncollectables	(16,015,977)	(12,701,926)
Contractual Allowances	(176,066,396)	(170,919,348)
Other Receivables	31,099,891	33,231,461
Inventories	4,527,053	4,604,703
Prepaid Expenses and Deposits	3,078,830	3,178,904
Less Receivable - Current	301,020	301,020
Total Current Assets	74,718,824	72,117,945
Assets Limited as to use, Less		
Current Requirements	32,690,723	32,613,942
Long-Term Investments	141,101,624	142,083,402
Property, Plant and Equipment, Net	70,254,015	70,529,548
Intangible Right of use Assets	198,242	208,563
SBITA Right of use Assets	2,350,136	2,479,390
Lease Receivable - LT	532,473	557,615
Other Investments	250,000	250,000
Prepaid Loss on Bonds	1,111,920	1,132,899
Total Assets	323,207,955	321,973,304
Liabilities and Funds Balances		
Current Liabilities		
Bond Interest Payable	101,471	608,825
Current Maturities of Bonds Payable	4,235,000	4,235,000
Current Maturities of Long Term Debt	342,973	428,497
Account Payable and Accrued Expenses	5,558,796	4,873,393
Accrued Payroll and Related Costs	7,316,910	6,546,853
Estimated Third-Party Payor Settlements	4,365,134	4,395,134
Lease Liability - Current	129,125	129,125
SBITA Liability - Current	1,472,212	1,472,212
Total Current Liabilities	23,521,620	22,689,038
Self-Insurance Reserves	2,084,541	2,085,274
Capital Lease Liab LT	0	0
Bonds Payable, Less Curr Reqt	29,040,000	29,040,000
Bonds Premium Liability - LT	1,759,936	1,805,456
Lease Liability - LT	90,389	101,176
SBITA Liability - LT	1,383,795	1,532,856
Other Non Current Liabilities	-	-
Deferred Inflow - Leases	774,551	799,048
Total Liabilities	58,654,832	58,052,848
Unrestricted Fund	258,350,395	258,350,395
Profit or (Loss)	6,202,728	5,570,062
Total Liabilities and Fund Balance	323,207,955	321,973,304

Sierra View Local Health Care District

Income Statement

For Period

Jan-26

	ACTUAL	BUDGET	VARIANCE	% VARIANCE	ACTUAL YTD	BUDGET YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	5,740,843	6,031,643	(290,800)	(5%)	38,949,918	39,067,940	(118,022)	(0%)
Inpatient - Ancillary	20,628,880	18,729,805	1,899,075	10%	132,238,742	133,405,530	(1,166,788)	(1%)
Total Inpatient Revenue	26,369,723	24,761,448	1,608,275	6%	171,188,660	172,473,470	(1,284,810)	(1%)
Outpatient - Ancillary	35,721,385	33,464,437	2,256,948	7%	254,395,878	241,065,013	13,330,865	6%
Total Patient Revenue	62,091,108	58,225,885	3,865,223	7%	425,584,538	413,538,483	12,046,055	3%
Medicare	(18,663,144)	(19,091,961)	428,817	(2%)	(130,178,449)	(136,204,635)	6,026,186	(4%)
Medi-Cal	(18,766,922)	(17,982,169)	(784,753)	4%	(142,739,612)	(127,289,807)	(15,449,805)	12%
Other/Charity	(6,067,632)	(6,767,964)	700,332	(10%)	(41,343,777)	(48,433,424)	7,089,647	(15%)
Discounts & Allowances	(523,059)	(18,222)	(504,837)	2,770%	(1,139,245)	(129,418)	(1,009,827)	780%
Bad Debts	(4,128,440)	(232,904)	(3,895,536)	1,673%	(7,231,855)	(1,654,154)	(5,577,701)	337%
Total Deductions	(48,149,197)	(44,093,220)	(4,055,977)	9%	(322,632,937)	(313,711,438)	(8,921,499)	3%
Net Service Revenue	13,941,912	14,132,665	(190,753)	(1%)	102,951,601	99,827,045	3,124,556	3%
Other Operating Revenue	1,585,995	818,039	767,956	94%	6,078,055	5,797,848	280,207	5%
Total Operating Revenue	15,527,907	14,950,704	577,203	4%	109,029,656	105,624,893	3,404,763	3%
Salaries	6,193,648	6,235,095	41,447	1%	42,310,127	42,641,850	331,723	1%
S&W PTO	601,680	738,190	136,510	18%	4,822,360	5,052,379	230,019	5%
Employee Benefits	1,529,325	1,460,204	(69,121)	(5%)	10,639,833	10,221,428	(418,405)	(4%)
Professional Fees	1,673,130	1,907,882	234,752	12%	12,728,108	13,262,383	534,275	4%
Purchased Services	882,790	904,743	21,953	2%	6,342,086	6,352,134	10,048	0%
Supplies & Expenses	2,520,839	2,257,296	(263,543)	(12%)	16,900,268	16,070,455	(829,813)	(5%)
Maintenance & Repairs	290,023	303,754	13,731	5%	2,027,549	2,126,278	98,729	5%
Utilities	252,641	306,217	53,577	17%	2,150,981	2,143,519	(7,462)	(0%)
Rent/Lease	54,056	30,041	(24,015)	(80%)	281,716	210,287	(71,429)	(34%)
Insurance	119,837	122,727	2,890	2%	830,285	859,089	28,804	3%
Depreciation/Amortization	785,001	811,079	26,078	3%	5,660,705	5,677,553	16,848	0%
Other Expense	376,615	395,560	18,945	5%	2,746,755	2,816,436	69,681	2%
Impaired Costs	-	-	-	0%	-	-	-	0%
Total Operating Expense	15,279,587	15,472,788	193,201	1%	107,440,771	107,433,791	(6,980)	(0%)
Net Gain/(Loss) From Operations	248,320	(522,084)	770,404	(148%)	1,588,885	(1,808,898)	3,397,783	(188%)
District Taxes	138,477	138,477	-	0%	969,339	969,339	-	0%
Investment Income	485,286	488,226	(2,940)	(1%)	3,703,188	3,417,582	285,606	8%
Other Non - Operating Income	34,139	40,308	(6,169)	(15%)	204,268	282,156	(77,888)	(28%)
Interest Expense	(70,627)	(70,649)	22	0%	(502,592)	(494,543)	(8,049)	(2%)
Non-Operating Expense	(62,716)	(39,854)	(22,862)	(57%)	(273,835)	(278,973)	5,138	2%
Total Non-Operating Income	524,560	556,508	(31,948)	(6%)	4,100,367	3,895,561	204,806	5%
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	772,880	34,424	738,456	2,145%	5,689,252	2,086,663	3,602,589	173%
Net Incr/(Decr) in the Fair Value Invstmt	(140,213)	162,500	(302,713)	(186%)	513,476	1,137,500	(624,024)	(55%)
Net Gain/(Loss)	632,666	196,924	435,742	221%	6,202,728	3,224,163	2,978,565	92%
review	8,324,653	8,433,489	108,836		57,772,320	57,915,657	143,337	

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
January-26

	Current Month	YTD
Cash flows from operating activities:		
Operating Income/(Loss)	248,320	1,588,885
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation/Amortization	785,001	5,660,705
Provision for bad debts	3,314,051	1,795,180
		-
Change in assets and liabilities:		-
Patient accounts receivable, net	(4,725,979)	(5,843,080)
Other receivables	2,131,570	(10,831,436)
Inventories	77,650	(34,142)
Prepaid expenses and deposits	100,074	(458,912)
Advance refunding of bonds payable, net	20,980	146,857
Accounts payable and accrued expenses	685,403	60,848
Deferred inflows - leases	(24,497)	(171,479)
Accrued payroll and related costs	770,057	(1,878,525)
Estimated third-party payor settlements	(30,000)	(43,579)
Self-insurance reserves	(732)	(44,547)
Total adjustments	3,103,576	(11,642,112)
Net cash provided by (used in) operating activities	3,351,896	(10,053,227)
Cash flows from noncapital financing activities:		
District tax revenues	138,477	969,339
Noncapital grants and contributions, net of other expenses	(47,814)	(180,594)
Net cash provided by (used in) noncapital financing activities	90,663	788,745
Cash flows from capital and related financing activities:		
Purchase of capital assets	(499,146)	(4,386,379)
Proceeds from sale of assets	5,000	5,000
Proceeds from debt borrowings	-	-
Proceeds from lease receivable, net	25,142	174,162
Principal payments on debt borrowings	-	(4,235,000)
Interest payments	(609,264)	(1,307,260)
Issuance of bonds payable and bond premium liability	-	-
Net change in notes payable and lease liability	(116,118)	(525,618)
Net changes in assets limited as to use	46,835	1,793,412
Net cash provided by (used in) capital and related financing activities	(1,147,551)	(8,481,683)
Cash flows from investing activities:		
Net (purchase) or sale of investments	841,565	(1,532,420)
Investment income	485,286	3,703,188
Net cash provided by (used in) investing activities	1,326,851	2,170,768
Net increase (decrease) in cash and cash equivalents:	3,621,859	(15,575,396)
Cash and cash equivalents at beginning of month/year	5,351,940	24,549,196
Cash and cash equivalents at end of month	8,973,799	8,973,799
	8,973,799	8,973,799
	0.00	0.00

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS

January 2026

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Feb-25	9,516,870	8,335,277	17,852,147
Mar-25	13,111,820	451,259	13,563,079
Apr-25	13,460,422	8,143,789	21,604,211
May-25	12,344,513	9,292,615	21,637,128
Jun-25	10,549,177	4,753,556	15,302,733
Jul-25	13,219,919	932,239	14,152,158
Aug-25	9,922,993	1,161,531	11,084,524
Sep-25	12,323,268	233,998	12,557,266
Oct-25	12,181,755	7,001,985	19,183,740
Nov-25	10,154,998	601,439	10,756,437
Dec-25	13,361,348	2,861,896	16,223,244
Jan-26	10,470,878	6,040,603	16,511,481

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - Receipts for Café, rebates, refunds, and miscellaneous funding sources
- Non-Operating Revenues - rental income, property tax revenues, 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

January 2026 Summary of Other Activity:

3,651,022	Health Net QIP IGT CY24
501,531	HHS Rural Floor Calculation FY20
253,428	M-Care interim payments
280	Aetna Inc DHDP CY23 PH 1
1,172,620	Property Taxes
461,722	Miscellaneous
<u>6,040,603</u>	01/26 Total Other Activity