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

AGENDA
April 28, 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

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MONTHLY MEETING AGENDA
April 28, 2026

III. Closed Session Business

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

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

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

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

D. **Designation of Sierra View Local Health Care District Real Property Negotiations**
Cal. Gov. Code § 54956.8.
Property: 380 N Putnam Avenue, Porterville, CA 93257.
Proposed Negotiator: Ron Wheaton

E. 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.

F. 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.

G. Pursuant to Gov. Code Section 54957(b): **Discussion Regarding Confidential Personnel Matter** – One (1) Item. Estimated Date of Disclosure January 1, 2029, for materials that are not part of an individual's private personnel file.

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

A. Chief of Staff Report:

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

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

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

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

D. Designation of Sierra View Local Health Care District Real Property Negotiator
Recommended Action: Approve/Disapprove Appointment of Ron Wheaton as Negotiator for negotiations pertaining to the purchase of real property located at 380 N Putnam Avenue, Porterville, CA 93257

E. Discussion Regarding Trade Secrets Pertaining to Financial Services and Strategic Planning
Recommended Action: Approve/Disapprove Motion for Direction to Senior Team regarding Financial Strategies

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

G. Discussion Regarding Confidential Personnel Matter
Recommended Action: Information Only; No Action Taken

H. 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

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. March 24, 2026, Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove March 24, 2026, Minutes of the Annual Meeting of the Board of Directors

IX. Business Items

A. Porterville Academy of Health Science (PAHS) Health Career Scholarship
Recommended Action: Board to Provide Direction

B. March 2026 Financials
Recommended Action: Approve/Disapprove March Report as Presented

C. Capital Report – Quarter Ending March 31, 2026
Recommended Action: Approve/Disapprove Report as Presented

D. Investment Report – Quarter Ending March 31, 2026
Recommended Action: Approve/Disapprove Report as Presented

X. SVLHCD Board Chair Report

XI. SVMC CEO Report

XII. Announcements:

- Regular Board of Directors Meeting – May 26, 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.

PUBLIC NOTICE ABOUT COPIES

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

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

HOSPITAL POLICIES AND REPORTS FOR REVIEW
APPROVED BY SENIOR LEADERSHIP TEAM

Senior Leadership Team	4/28/2026
Board of Director's Approval	
Liberty Lomeli, Chairman	4/28/2026

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
April 28, 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
Forms:		Approve ↓
• 015403 Pre Discharge English/Spanish	1-2	
• 027314 Obstetric Clinical Transfer Summary	3-4	
Policies:		
• Admissions and Bed Capacity	5-10	
• Authorization for Volunteer Caregivers During Disasters	12-14	
• Community Clergy Access to Patient	15-16	
• Compliance Issue Reporting	17-19	
• Compliance Office and Legal Counsel Protocol	20-21	
• Control of Combustible Materials	22	
• Designated Record Set	23-27	
• Environmental Tours	28-29	
• Evacuation Procedures	30-35	
• Exempt Staff Working Extra Shifts	36-37	
• False Claims Act and Whistleblower Protection	38-43	
• Hospital Lockdown Code Strong	44-46	
• Injury and Illness Prevention Plan	47-52	
• Investigations and Government Search Warrants, Unannounced	53-57	
• Non-Retaliation Compliance Issue Reporting	58-60	
• Non-Discrimination – Patient Care	61-63	
• Patient Portal Access by Age Policy	64-67	
• Patient's Right to Amend	68-75	
• Protection of Patient Privacy	76-88	
• Purpose and Authority	89-90	
• Recording Hours Worked	91-94	
• Recovery from Disaster Response	95-96	
• Right to Request Confidential Communication	97-100	
• Sanction Screening	101-104	

Senior Leadership Team	4/28/2026
Board of Director's Approval	
Liberty Lomeli, Chairman	4/28/2026

SIERRA VIEW MEDICAL CENTER

PRE-DISCHARGE MONITORING IN CAR SEAT DATA COLLECTION FORM

Date: _____ Time: _____
Present Weight: _____ Gestational Age: _____
Diagnosis: _____
Time of last feed: _____
Supplemental Oxygen in use: _____
Medications: _____

Family educated about car seat challenge? YES _____ No _____
Is family bringing in their own seat? YES _____ No _____

Patient Parameter	Baseline	10 min.	30 min.	60 .min	90 .min
Heart Rate					
Respiratory Effort					
Color					
Pulse Oximeter					
Comments					
Interventions					

INSTRUCTIONS PROVIDED: **Nurses Initial**

Parents instructed to review car seat **AND** car owner's manual instructions for child safety seat installation _____
Always secure infants rear facing **IN THE BACK SEAT** _____
(Until child age 2 years and 40 lbs)
Never place an infant in front of an air bag _____
Informed of California Law for car seat use for children under 6 yrs. _____

Parent/Guardian Signature _____ Date _____

Nurse Signature _____ Date _____

____ **PASS**
____ **FAIL**

***Note: Infant cannot be discharged home until a satisfactory car seat challenge has been performed and documented.**

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

PATIENT'S LABEL

PRE-DISCHARGE MONITORING IN CAR SEAT DATA COLLECTION FORM
Form # 015403 REV 11/25

Fecha: _____ Hora: _____
Peso Actual: _____ Edad de Gestación: _____
Diagnóstico: _____
Hora de última alimentación: _____
Oxígeno Suplementario en uso: _____
Medicamentos: _____

¿Se preparó a los familiares con relación al reto presentado por el asiento para el automóvil? Si _____ No _____
¿Traen los familiares su propio asiento? Si _____ No _____

Parámetro del Paciente	Baseline	10 min.	30 min.	60 .min	90 .min
Ritmo Cardiaco					
Esfuerzo Respiratorio					
Color					
Oxímetro de Pulso					
Comentarios					
Intervenciones					

INSTRUCCIONES PROPORCIONADAS: **Enfermeras Inicial**

Los padres recibieron instrucciones de revisar el asiento para el automóvil **Y** el manual de instrucciones para el usuario en relación con la instalación del asiento de seguridad para niños _____

Asegure siempre a los bebés mirando hacia atrás **EN EL ASIENTO TRASERO**
(Hasta que el bebé tenga 2 año Y pese más de 40 libras) _____

Nunca coloque a un bebé frente a una bolsa de aire _____

Está informado acerca de la Ley de California con relación al uso del asiento para automóvil para niños menores de 6 años de edad . _____

Firma del Padre/Tutor _____ Fecha _____

Firma de la Enfermera _____ Fecha _____

____ **APROBADO**
____ **REPROBADO**

***Nota: El bebé no puede ser dado de alta para ir a casa hasta que se haya llevado a cabo y documentado un cuestionario satisfactorio relacionado con el asiento para el automóvil.**

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

MONITOREO ANTES DE OAR DE ALTA EN EL ASIENTO PARA AUTOMÓVIL FORMATO PARA LA RECOPILACIÒN DE INFORMACIÒN

Form # 015403 REV. 11/25

ETIQUETA DEL PACIENTE

SIERRA VIEW MEDICAL CENTER **OBSTETRIC CLINICAL TRANSFER SUMMARY**

Patient Name: _____ DOB: _____

Estimated Due Date (EDD):_____(Final)

Late Transfer: ☐ Yes ☐ No Reason for Late Transfer: _____

LMP Date	EDD by LMP	Early Ultrasound Date	EDD by Ultrasound	Final EDD (by) ☐ LMP ☐ Ultrasound

Gravida/ Para G_____ P _____ T_____ A _____ L _____

Prior Cesarean or Uterine Surgery? ☐ Yes ☐ No If yes, specify: _____

Risk Category: ☐ High Risk _____

☐ Low Risk

Initial Prenatal Labs Attached: ☐ Yes ☐ No

Ultrasound Reports Attached: ☐ Yes ☐ No

Genetic Screening Completed: ☐ Yes ☐ No

Growth Curve Attached: ☐ Yes ☐ No

Notes or Special Considerations:

_____

_____

_____

_____

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

OBSTETRIC CLINICAL TRANSFER SUMMARY

Form # 27314 REV 02/26

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

PATIENT'S LABEL

Timing	Test Name	Lab Value	Date of Testing
Initial Prenatal	CBC		
	Blood Type & Rh		
	Antibody Screen		
	RPR		
	HIV		
	Hepatitis C		
	Hepatitis B		
	Rubella		
	Varicella		
	UA/UCx		
	GC/CT		
	Pap (if indicated)		
	NIPT/AFP		
	Urinalysis/Tox		
	Additional Genetic Screening (SMA/CF etc)		
Second Trimester			
	1-hour Glucose Tolerance Test		
	2/3-hour Glucose Tolerance Test (if done)		
Third Trimester			
	Group B Strep		
	Repeat HIV		
	Repeat RPR/CBC		
	NST/BPP (if indicated)		
Any additional information			

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

OBSTETRIC CLINICAL TRANSFER SUMMARY

Form # 27314 REV 02/26

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

PATIENT'S LABEL

SUBJECT:	SECTION:
ADMISSIONS AND BED CAPACITY	***Patient Management***

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

POLICY:

In the event of a disaster which requires assessment and admission of victims, the hospital will assess availability of treatment beds in the Emergency Department and admission beds on the in-patient units and facilitate the increased availability of beds to accommodate disaster victims by the transfer or early discharge of patients.

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

PROCEDURE:

1. The Emergency Department Physician and Charge Nurse will assess the patient's in the Emergency Department at the time of the disaster and consider:

    a. Facilitating discharge of patients who have completed Medical Screening Examination and treatment.

    b. Facilitating transfer of patients in need of admission to the in-patient units.

    c. Re-prioritizing existing patients to open up treatment rooms for higher priority disaster victims.

    d. Notify Operations Chief/Medical Care Director of need to open alternate sites for care of victims triaged as delayed and minimal.

2. The Utilization Review/Discharge Planning Department will coordinate with the in-patient units in determining those patients that may be transferred or discharged with the concurrence of the patient's attending physician.

    a. Patients may be held in Flex Care awaiting transportation arrangements.

    b. Patient's families will be notified of the transfer or discharge as soon as possible.

    c. Transfer or discharge shall not be carried out if, in the opinion of the patient's physician, such transfer or discharge would create a medical hazard for the patient.

3. Operating Room and Imaging Services will evaluate, in consultation with physicians, which cases or procedures may be cancelled or delayed during the disaster response. This information is to be communicated to the Operations Section.

4. All elective (non-casualty) admissions shall be suspended until the disaster response is terminated.

5. Tracking of bed availability will be documented on the forms:

a. "*Hospital Cumulative Inventory Status*" – This form lists treatment capacity and in-patient bed availability of surrounding hospitals. It is completed by the ED after contact with surrounding facilities on the Priority Plus Disaster Radio channel and routed to Planning section. (see "Disaster Communications")

b. "*In-Patient Bed Availability Worksheet*" –This form identifies available and potentially available beds in-house. It is completed by UR/DP and routed to Planning section. It is compiled from the *Unit Report of Available Beds* submitted by each in-patient unit. The *Unit Report of Available Beds* may be requested periodically during the disaster implementation to update status.

6. Requests for beds for disaster patients identified for admission will be made to the Planning Section. See *Admission Request List*.

7. Requests for Operating Room use will be made by the treatment unit directly to the Operating Room.

8. Requests for acceptance of patients in transfer will be made through regular channels. If the disaster incident is wide spread and affects other facilities (as in earthquake or other natural disaster, etc. requests must be made by the Liaison Officer through County OES Operations Center.

REFERENCES:

- Title 22: Section 70741, 70743, 70745, 70746
- The Joint Commission (2026~~3~~). Hospital accreditation standards. EM.09.01.01 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Disaster Communications – SVMC Policies and Procedures

Attachment A

IN-PATIENT BED AVAILABILITY WORK SHEET

TIME	UNIT	AVAILABLE BEDS (list by rm no.)	empty	potential	TIME	Bed Assigned to patient: (list by name and tag no.)

11-99

Attachment B

EMPTY BEDS: **(list all empty bed room numbers):**

PATIENTS FOR POTENTIAL DISCHARGE/TRANSFER:

RM NO.	NAME	DIAGNOSIS	AMBULANCE	W/C	COMMENTS:

PREPARED BY:_____

11-99

Attachment C

DISASTER ADMISSION REQUEST LIST

DATE:_____

TIME	REQUESTING TREATMENT UNIT	TAG NO. / PATIENT NAME	DIAGNOSIS	ADMITTING PHYSICIAN	CARE NEEDS/ SPECIALTY UNIT/EQUIP	BED ASSIGNMENT	TIME

11-99

Attachment D

HOSPITAL CUMULATIVE INVENTORY STATUS

TIME	FACILITY	AVAILABLE BEDS	EMPTY	POTENTIAL

SUBJECT:	SECTION:
AUTHORIZATION FOR VOLUNTEER CAREGIVERS DURING DISASTERS~~AUTHORIZATION FOR VOLUNTEER CAREGIVERS DURING DISASTERS~~	***Response and Assignment of Personnel*** **Page 1 of 4**

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

PURPOSE:

To establish guidelines for authorization of volunteer caregivers during disasters.

POLICY:

Upon activation of the Disaster Plan, the Incident Commander is empowered to authorize the use of volunteer caregivers to assist hospital staff in the event that the organization is unable to fully meet immediate patient needs without such volunteers. Such authorization may be given on a case-by-case basis.

Occupations considered volunteer caregivers are listed below. Occupations that fall under Licensed Independent Practitioner (LIP) and Allied Health Professional (AHP) are covered under the Medical Staff Bylaws Article 5.6 covering disaster privileges.

LIP	AHP
Physician (MD or DO)	Nurse Practitioner/Physician Asst.
Dentist	Certified RN Anesthetist
Psychologist	Certified Nurse Midwife
Podiatrist	

Clinical staff in these specialties:

- Lab sciences
- Pharmacy
- Imaging and diagnostics
- Dietitian
- Rehab services
- Behavioral health services

Volunteer Caregivers:

- Registered Nurse

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- LVN
- CNA

PROCEDURE:

Once the volunteer caregiver has been authorized to assist, he/she will be under the direct supervision of the department manager or his/her designee to whom the volunteer caregiver has been assigned. The department manager or his/her designee must oversee the "just in time orientation" and professional performance of the volunteer care-giver who has been assigned disaster responsibilities through direct observation, mentoring, and/or clinical record review. Based on situation and need, consider assigning volunteer physicians in a "buddy" situation until competency is clearly evaluated. When possible, utilize volunteers in a secondary triage, and handling family of injured patients, phone advice and other useful, but low risk, assignments.

At a minimum, volunteer caregivers must present a valid government-issued photo identification issued by the state or federal agency (example, a driver's license or passport) and at least one of the following:

- A current hospital picture identification card that clearly identifies professional designation.
- A current license, certification, or registration.
- Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession).
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal emergency response organizations or groups.
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
- Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications.

The Human Resources and/or the Medical Staff departments will begin the verification process within 72 hours from the time the volunteer caregiver presents him/herself to the organization and has been authorized to provide care by the incident commander or designee. In the extraordinary circumstances that primary source verification of licensure, certification, or registration (if required by law and

regulation to practice a profession) cannot be completed within 72 hours (e.g. no means of communication or lack of resources), it is expected to be completed as soon as possible.
The following must be documented:

- Why primary source verification could not be performed in the required time frame.
- Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services.
- An attempt to rectify the situation as soon as possible.

The hospital makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours from the start of the assignment of the volunteer caregiver if the services of the volunteer caregiver are still needed.

Authorized volunteer caregivers will be provided with an identification badge indicating their name, professional degree, and specialty. The volunteer caregiver's assignment and authorization to provide patient care will be automatically terminated when the incident commander determines the hospital's emergency plan is no longer in effect or when the immediate needs of the patients can be met by the hospital without the volunteer caregiver's assistance.

Sierra View Medical Center Temporary Disaster Privileges Application			
Name of Non-physician Practitioner:			
Name of Agency Represented ☐DMAT ☐MRC ☐ESAR-VHP ☐Other			
Credential	**Photocopy Obtained**	**Verified Date/Time Verified By**	**Comment**
License			
Hospital Photo ID identifying professional designation			
Identification indication authorization to render patient care, treatment, and services in disaster circumstances.			

Identification by current organization member(s) who possesses personal knowledge regarding volunteer's qualifications.			
Name of hospital where practitioner actively practices:			
Other Information		**Completed**	**Comment**
Current CPR certification			
Verification/Approval Signatures and Dates			
Human Resource/Medical Staff Representative: **Date:**	**Incident Commander/ Designee:** **Date:**	**Comments:**	
Assignment:			
Acting Supervisor/Manager:			
Security Badge issued:			

DMAT: Disaster Medical Assistance Team

MRC: Medical Reserve Corps

ESAR-VHP: Emergency System for Advance Registration of Volunteer Health Professionals

REFERENCE:

- The Joint Commission (2026~~3~~). Hospital accreditation standards. EM.12.02.03 Joint Commission Resources. Oak
- Brook, IL.

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SUBJECT:	SECTION:
COMMUNITY CLERGY ACCESS TO PATIENT LISTINGS UNDER THE HIPAA PRIVACY STANDRDS	**Page 1 of 2**

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

PURPOSE:

To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and all Federal regulations and interpretive guidelines promulgated thereunder. To establish guidelines regarding community clergy access to facility directory information.

POLICY:

The following are requirements for releases of directory information and patient listings to community clergy under the HIPAA Privacy Standards (§164.510).

Health care providers are required to inform an individual of the protected health information (PHI) that it may include in their facility directory, those persons to whom it may disclose such information, and provide the individual with the opportunity to restrict or prohibit all of the uses or disclosures. This includes disclosures of directory information, including religious affiliation, to community clergy.

Providing directory information to community clergy is completely voluntary, and is a decision made by the facility. Facilities that choose to provide their facility directory information to members of the community clergy must implement a mechanism to verify, in good faith, the requestor is actually a member of the clergy.

State laws concerning clergy access to patient directory information should be followed if more stringent than HIPAA.

Definitions:

Community clergy - Not a hospital employee, volunteer or workforce member; instead, they are a member of the clergy in the community at large.

Staff chaplains - Actual employees of the hospital or are hospital chaplain volunteers operating under the specific direction of a hospital employee (primarily the staff chaplain); thus, are actual workforce members.

Community clergy and staff chaplains are not synonymous terms under HIPAA.

PROCEDURE:

1. **Verification of Community Clergy Members**

   a. A verification process is in place to verify that each community member of the clergy is indeed an actual member of the clergy.

   b. Community clergy should each be given a badge or other identification from the facility once the facility has verified his or her clergy membership.

c. Each clergy member must be asked to show the facility ID badge or other identification before being given access to any patient lists.

2. **Releases to Community Clergy Members**

a. The HIPAA Privacy rule permits facilities to disclose the facility directory; including the individual's name, location (room number, bed number, department), condition in general terms and religious affiliation (if captured) to members of the clergy.

b. Community clergy do not need to ask for the patient by name to receive the directory information

c. The names of patients who have "opted out" of the facility directory must not be included in the listing given to the community clergy. Each patient must be notified of his or her right to opt out of being listed in the facility directory via the Notice of Privacy Practices. To invoke this right, the patient will need to request to opt out consistent with the facility's Directory Policy. When a patient opts out of the directory, he or she must be suppressed from any general clergy listings released.

3. The patient, during the nursing assessment, asks for his or her clergy to be notified, the nursing staff should handle notification according to the facility's current process.

REFERENCES:

- The Joint Commission (2026). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- PATIENT PRIVACY- PROGRAM REQUIREMENTS

SUBJECT: **COMPLIANCE ISSUE REPORTING**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide structure and mechanisms for Sierra View Medical Center (SVMC) employees, contingent work force, medical staff, and agents to report suspected violations of federal and state laws, regulations, SVMC policies and procedures, and any compliance-related concerns without fear of retaliation, retribution, or harassment.

POLICY:

SVMC recognizes that a critical aspect of its Compliance Program is the establishment of a culture that promotes prevention, detection, and resolution of instances of conduct that does not conform to federal and state laws and regulations, requirements of federal, state, and private payer health care programs, ethical business practices, and SVMC policies and procedures. To promote this culture, SVMC maintains mechanisms to encourage reporting of suspected violations, perceived misconduct, as well as compliance-related concerns. SVMC adheres to a strict non-retaliation policy to protect employees and others who report compliance-related concerns in good faith.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

1. SVMC employees, contingent work force, medical staff, and agents have an affirmative duty and responsibility to report in good faith perceived misconduct, suspected violations of laws, regulations, policies and procedures, and the SVMC Code of Conduct.

2. SVMC employees, contingent work force, medical staff, and agents may choose the communication channel he/she deems appropriate to ask a compliance question or submit a report. Reporting ~~M~~mechanisms ~~to report~~ include:
   ~~an individual's usual chain of command,~~
   a. ~~d~~Department leadership,
   b. Senior ~~l~~leadership,
   c. Human Resources,
   d. ~~the~~ Compliance Hotline (559)791-4777 or ext. 4777,
   e. Electronic Compliance issue report form link – Compliance ~~I~~intranet ~~Link~~page,
   f. Compliance Officer Inbox email
   g. ~~the~~ Compliance/Privacy Officer (CPO) at (559)791-3838 or ext. 3838,
   h. ~~the~~ Compliance/Privacy ~~Audit~~ Analyst at (559)~~791-3917 or ext. 3917~~788-6119 or ext. 6119
   i. ~~via the~~ Locked Compliance drop ~~B~~box. ~~I~~Locat~~ed~~ions:
      i. ~~in the mailroom~~Mailroom
      ii. By the time clock outside of the 1st floor EVS office
      ~~2.~~iii. By the time clock on the 1st floor of the Medical Office Building.

3. An "open-door policy" will be maintained at all levels of SVMC leadership to encourage individuals to report problems and concerns.

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4. All compliance-related issues will be reported to the Compliance/Privacy Officer ~~CPO~~ when received by sources other than direct reporting mechanisms to the Compliance Officer~~CPO~~.
~~4. or Compliance Hotline or Compliance Electronic Link reporting.~~

5. The ~~CPO~~ Compliance/Privacy Officer may redirect noncompliance-related issues to the appropriate department or individual for resolution.

6. To the extent practicable or allowed by law, the ~~CPO~~ Compliance/Privacy Officer will, when requested, maintain the confidentiality or anonymity of an employee reporting compliance-related concerns. See the Compliance Hotline policy regarding anonymous reporting.

7. Employees cannot exempt themselves from the consequences of his/her own misconduct by reporting the misconduct, although self-reporting may be taken into account in determining the appropriate course of action.

8. Failure to report suspected violations in accordance with this Compliance Issue Reporting policy is, in itself, a violation of the Compliance Program that will subject an employee failing to make such a report to discipline, in accordance with the Progressive Discipline policy.

PROCEDURES THAT APPLY TO ALL EMPLOYEES:

1. Knowledge of misconduct, including suspected, actual or potential violations of laws, regulations, policies, procedures, or SVMC's Code of Conduct must be immediately reported~~-~~ via a reporting mechanism referenced in section 2 above. ~~to one of the following: department leadership, senior leadership, Human Resources, the CO, the Compliance Audit Analyst, the Compliance Hotline, Compliance Intranet Link or the Locked Box located in the mailroom.~~

2. Knowledge of a violation or potential violation of this policy must be reported via a reporting mechanism directly to the ~~CPO~~ Compliance Officer ~~or the Compliance Hotline or Compliance Intranet Link.~~

3. ~~If a~~An employee~~'s~~ with a ~~-~~concern or problem ~~cannot be, or~~ that has ~~is~~ not ~~;~~been ~~-~~resolved to the employee's satisfaction, or~~-~~ with a special circumstance~~s exist~~, ~~the employee~~ should be promptly reported ~~such concern or problem~~ via a reporting mechanism directly to the ~~CPO~~Compliance Officer. ~~or to the Compliance Hotline.~~

PROCEDURES THAT APPLY TO ALL LEADERSHIP:

1. Compliance is everyone's responsibility. All levels of leadership will take appropriate measures to support the Compliance Program and this policy to encourage employee reporting. At a minimum, the following actions will be taken and become an ongoing aspect of the leadership process:

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a. Promoting a culture of compliance within departments by providing on-going education and support to staff regarding the reporting mechanisms and processes discussed within this policy;

b. Forwarding all compliance-related concerns and reports of suspected violations to the CPO for review and further Compliance investigation and follow-up when deemed necessary by the CPO.

REFERENCES:

- ~~Federal Register / Vol. 70, No. 19 / Monday, January 31, 2005, OIG: Supplemental~~ U.S. Department of Health and Human Services, Office of Inspector General, General Compliance Program Guidance -2023~~for Hospitals~~.

CROSS REFERENCES:

- Compliance Program/Plan
- Compliance Hotline
- ~~Compliance Issue Reporting Policy~~Non-Retaliation - Compliance Issue Reporting

SUBJECT:	SECTION:
COMPLIANCE OFFICE AND LEGAL COUNSEL PROTOCOL AND PROCEDURES	**Page 1 of 2**

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

PURPOSE:

The Compliance Office (CO) and/or Human Resources address the majority of allegations of workplace misconduct that might constitute a violation of criminal, civil or administrative law. Issues occasionally arise that necessitate engagement and direction of legal counsel. This policy establishes guidelines for the coordination of activities between legal counsel and the Compliance Office, related to compliance investigations of potential violations of laws or regulations. For purposes of this policy, the term "legal counsel" refers to outside counsel.

POLICY:

1. Upon independent investigation and reasonable evidence of suspected noncompliance with any criminal, civil, or administrative law or regulation, the Compliance Officer (CO) shall engage legal counsel to:

    a) Conduct legal analyses of risk areas identified in connection with the Compliance Program and provide legal opinions with respect to those areas;
    b) Respond to specific concerns and provide legal opinions in connection with those concerns;
    c) Conduct or oversee investigations based on specifically identified problem areas and render legal advice based on the results of those investigations.

2. The CO may also engage legal counsel to:

    a) Review and approve the Compliance Program, including compliance policies, all supporting organization-wide polices and all compliance plans for legal content;
    b) Conduct education programs for the employees, and certain agents and contractors involving areas of risk identified by the CO; and
    c) Retain outside consultants and auditors to review specific areas of compliance concern.

3. In light of timely reporting requirements, the CO shall consult with legal counsel as expeditiously as possible regarding credible allegations of misconduct related to billing and reimbursement.

4. During the course of investigation of misconduct that might constitute a violation of criminal, civil or administrative law, the CO shall ensure that all relevant evidence is preserved.

5. To the greatest extent possible, communications with legal counsel relating to any compliance investigation shall be conducted in such a way as to preserve the attorney-client privilege and the attorney-work product privilege.

AFFECTED AREAS/PERSONNEL: *COMPLIANCE OFFICER AND COMPLIANCE STAFF*

PROCEDURE:

1. Upon report or notice of suspected noncompliance with any criminal, civil, or administrative law or regulation, the CO will conduct an "initial inquiry" into the alleged misconduct. The purpose of the initial inquiry is to determine whether there is sufficient evidence of possible noncompliance to warrant further independent investigation and notification to legal counsel under attorney-client privilege.

2. If, during the independent investigation, the CO determines that there is sufficient evidence of possible noncompliance, the CO shall fully engage legal counsel.

3. The CO shall coordinate with legal counsel during the investigation and ensure that the results of legal counsel's analysis and recommended course of action is communicated to senior leadership and board of directors, as appropriate.

4. The OIG acknowledges the role of legal counsel in determining whether reporting misconduct to the government is necessary, stating that "The Compliance Officer, under advice of counsel, and with guidance from the governmental authorities, could be requested to continue to investigate the reported violation. As such, legal counsel's involvement is necessary in any case involving a potential violation of law, and in such cases, the investigation may be conducted under legal counsel".

REFERENCES:

- DHHS Federal Register, OIG Supplemental Program Guidance for Hospitals, Notice 63, February 23, 1998
- U.S. Department of Health and Human Services, Office of Inspector General. (2023, November 6). *General Compliance Program Guidance*. https://oig.hhs.gov/compliance/general-compliance-program-guidance/
- Health Care Compliance Association. (2025). *Complete healthcare compliance manual* (2025 ed.).

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SUBJECT: **CONTROL OF COMBUSTIBLE MATERIALS**	SECTION: ***Life Safety Management*** **Page 1 of 1**

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PURPOSE:

To reduce the amount of combustible materials and prevent the spread of fire.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to review the flame spread and smoke density ratings of all materials subject to purchase by Sierra View Medical Center. All materials shall comply with the standards set forth in National Fire Protection Association (NFPA) 101 2012 edition. It is the responsibility of Materials Management to obtain tests results from manufacturers for review by the Safety Officer and Safety Committee. Examples of materials to be checked are; Carpets, upholstery material, drapes, waste receptacles, wall covering material. Testing results shall be provided by the manufacturer from an independent qualified testing laboratory. All tests shall comply with the NFPA – approved testing methods.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

All materials proposed for purchase shall be checked for proper ratings of flame spread and smoke density. Acquisition of the product's test results from an approved testing lab shall be reviewed for compliance and kept on file in the Engineering Department. All materials that fail to meet NFPA 101 2012 standards shall be rejected.

REFERENCES:

- The Joint Commission (2026~~4~~) Hospital Accreditation Standards. PE.03.01.01 Joint Commission Resources. Oak Brook IL.

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- NFPA Life Safety Code 101 2012 Edition 19.7.5

SUBJECT: **DESIGNATED RECORD SET**	SECTION: **Page 1 of 5**

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

PURPOSE:

To ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and all Federal regulations and interpretative guidelines. To establish guidelines for the definition and content of the designated record set (§164.501).

POLICY:

Sierra View Medical Center (SVMC) must specifically define, maintain and allow patient's/patient's personal representative (as defined by state law) certain rights to a designated record set (DRS) per the procedure outlined below. The DRS will encompass information beyond the traditional medical record and billing record. SVMC must include information received from another facility during the patient's visit in their DRS unless they have documented facts that the information was not used in whole or in part to make a decision about the patient. Information received from other facilities after the patient is discharged must be sent back to the originator, placed into the shredding bin and destroyed or incorporated into the DRS.

DEFINITION:

Designated Record Set (DRS): A group of records maintained by or for a facility that is the medical records and billing records about individuals maintained by or for a covered health care provider, the enrollment, payment, claims, adjudication, and case or medical management record systems maintained by or for a health plan; or used, in whole or in part, by or for the facility to make decisions about the individuals.

Record: Any item, collection, or grouping of information that includes protected health information (PHI) and is maintained, collected, used or disseminated by or for a facility.

PROCEDURE:

1. SVMC must identify which forms and reports, when present in a patient's paper or electronic file, will be included in the DRS based on the HIPAA DRS definition. At a minimum, the following forms and reports must be included in the facility's DRS:

    a. Facesheet

    b. Coding Summary

    c. Discharge summary or labor and delivery summary

    d. History and physical examination report or prenatal record

    e. Obstetrical and newborn forms

    f. Consultation report

g. Operative, surgery or procedure report

h. Pathology reports

i. Results of any special tests or treatments (depending on the study, the results may or may not include tracings, but when final will include the interpretation (e.g., EKG/ECGs, holter monitors, stress test, pulmonary function study, blood transfusion records, or sleep study))

j. Progress Notes

k. Order or prescription for test/treatment

l. Nursing documentation, including items such as vital sign graphics, intake and output records, neurocheck, medication sheets, intravenous fluid flow sheets, shift assessments, nursing notes, telemetry, admission history, care plan, discharge instructions, and release of body form.

m. Interdisciplinary education record

n. Laboratory reports, including blood typing or crossmatching

o. Imaging/Radiology reports

p. Cardiology reports

q. Fetal and newborn monitoring strips

r. Peri-operative documentation, including items such as surgery checklist, anesthesia records, intraoperative nursing forms and recovery room forms

s. Documentation of miscellaneous services, including social service, case management, food and nutrition, physical therapy, speech therapy, occupational therapy, respiratory treatments, arterial blood gas reports, and ventilator sheets

t. Medication administration records

u. Transfer forms

v. Emergency Room (ER) records, including items such as Facesheet, triage sheet, order sheet, T-Chart, EMS form, and ER point form

w. Consent to treat and any other admission forms signed by the patient

x. A form acknowledging a patient is leaving against medical advice

y. Informed consent forms for items such as surgery, blood, and dialysis

z. Patient Education records/discharge instructions

aa. Copies from physician offices or other healthcare facilities used to make health care decisions, such as history and physical examination or surgical records

bb. Hospital issued Denials or Advance Beneficiary Notice forms

cc. Advance Directives (e.g., durable power of attiring or living will), power of attorney, custody papers or other legal papers

dd. Detail bill (include detail of charges; also known as "itemized statement")

ee. Uniform Bill (UB-04)

2. The following information is usually considered part of the source data of the DRS. A narrative of the interpretation from the source data would generally be acceptable. In most cases, individuals cannot interpret source data, so such data is meaningless. There may be times, however, when an individual has a legitimate need to access source data. When such a need arises, the covered entity will want to provide the individual with greater rights of access, allowing the individual access to or copies of the source data when possible. A specific request, authorization or subpoena is required to produce the original or obtain a copy (if retained and/or able to copy) of this information:

a. Birth certificates, birth certificate worksheets, paternity papers

b. Imaging/Radiology films

c. Electrocardiology tracings (EKG or fetal/newborn monitoring)

d. Videotapes and digital recordings of procedures

e. Photographs that are not maintained as part of the medical record.

f. All release of information related correspondence (e.g., requests for copies from insurance companies, authorization forms, interdepartmental requests for records, and fax cover sheets)

g. Copies of driver's licenses, insurance or social security cards

h. Clarification notes to/from physicians (i.e., physician query), etc.

3. The following are not part of the DRS:

a. Psychotherapy notes as defined by the Standards for Privacy of Individually Identifiable

Health Information (§164.501)

b. Peer review information

c. Incident reports

d. Infection control reports

e. Administrative, attorney-client privileged and any other protected reports

f. Temporary notes or worksheets, reminders, and concurrent coding worksheets

g. Incomplete record coversheets

4. The facility must have a process in place for the patient/patient's personal representative to access, amend or request restrictions on the use or disclosure of their DRS. In addition, a process must be in place to track and provide an accounting of disclosures made for the DRS.

REFERENCES:

- The Joint Commission (2026~~1~~). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 164. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164/subpart-E/section-164.501
- Hughes, Gwen. "Defining the Designated Record Set." *Journal of AHIMA* 74, no. 1 (Jan. 2003): 64A-D. Available online in the AHIMA Body of Knowledge at www.ahima.org.
- Privacy Act of 1974. 5 USC, Section 552A.

CROSS-REFERENCE

- PATIENT PRIVACY – PATIENT'S RIGHT TO ACCESS
- PATIENT PRIVACY – PATIENT'S RIGHT TO AMEND
- PATIENT PRIVACY – RIGHT TO REQUEST PRIVACY RESTRICTIONS
- PATIENT PRIVACY – ACCOUNTING OF DISCLOSURE
- AUTHORIZATION FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

- MEDICAL RECORD RETENTION AND DESTRUCTION: DISPOSAL OF PROTECTED HEALTH INFORMATION
- LEGAL MEDICAL RECORD STANDARDS

SUBJECT:	SECTION:
ENVIRONMENTAL TOURS	***Safety Management***

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to conduct regular environmental tours of all areas of the organization to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks.

PROCEDURE:

1. As part of an ongoing Environment of Care Program, the Safety Officer or designee shall coordinate the environmental tours of the facility, to identify and evaluate information concerning safety, fire safety, hazardous conditions, exposure to hazardous materials and wastes, security, utilities, medical equipment and staff knowledge.

2. An Environmental Tour Team will be utilized in conducting the tours and documentation of the inspections. The team members will perform the tours as scheduled by the Safety Officer or designee. The Team will consist of representatives from at least the following departments:

   - Security/Life Safety
   - Infection Control
   - Environmental Services
   - Engineering

3. Environmental tours will be conducted in all patient care areas every six months.

4. Environmental tours will be conducted in all non-patient care areas annually.

5. Inspections will be performed and documented by area, clinical or non-clinical, utilizing the My Rounding Tool

6. All identified discrepancies and issues will be documented on the My Rounding Tool and submitted to the named “resolver” in the My Rounding Tool. During the tour, if the charge nurse, department manager, or director is available, indicate the issues and show them where they are located.

7. The Safety Officer or designee will document the inspection for completion, and the identified deficiencies or issues will be addressed, dependent on the issue and responsibility, by the following resolvers:

   - Affected Department Director/Managers
   - Engineering Department
   - Bio Med Department
   - Environmental Services

8. The resolver will review the information sent and work on the issues and deficiencies that have been identified for the department to correct as soon as possible. Once the corrections have been

completed for the issues identified, the issue or finding will be noted as completed in the My Rounding Tool.

9. The environmental tour inspections will be scheduled, tracked, and completion, data, and issues will be reported to the Safety Committee on a quarterly basis.

REFERENCES:

- The Joint Commission (2025) Hospital accreditation standards. EC.04.04.01 Joint Commission Resources. Oak Brook, IL.
- ~~The Joint Commission (2021) Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.~~

SUBJECT: **EVACUATION PROCEDURES**	SECTION: ***Evacuation*** **Page 1 of 6**

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POLICY:

Evacuating patients, staff, and visitors may be necessary in response to a situation which renders the facility unsafe for occupancy or prevents the delivery of necessary patient care. Evacuation may be partial, as in horizontally or vertically from one section of the building to another, or may involve a complete evacuation of the facility (i.e., bomb threat, fire, building collapse, earthquake, and flood). Maps indicating evacuation routes are posted throughout the facility.

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

PROCEDURE:

1. Authority to Evacuate:

    a. Evacuation of the facility or a portion thereof can only be authorized by:

    - Public Safety Officer (Fire or Police)
    - Chief Executive Officer (CEO) or designee
    - Safety Officer
    - Nursing House Supervisor

    b. In the event of an acute and life threatening emergency situation, such as fire on a unit, the decision to evacuate the immediate area will be made by the nurse in charge.

    c. The decision to evacuate from unsafe or damaged areas will be based on the following:

    - The Engineering Department's evaluation of the utilities and/or structure of the department.
    - The medical staff and/or Nursing Department's determination of whether adequate patient care can continue.
    - Evacuation should only be attempted when you are certain the areas chosen for the evacuees is safer than the area you are leaving.

2. Communication of Evacuation:

    a. If the Emergency Operations Plan has not already been initiated at the time of the evacuation decision, then it must be initiated prior to evacuation in order to establish the Command Center.

b. The switchboard should be asked to page "Triage Code I" for Internal Disaster.

c. The City of Porterville Command Center will be notified of any evacuation.

3. Complete Evacuation – patients are transferred from SVMC to an outside area, other hospital, or alternative sites.

   a. Complete Evacuation may be indicated in the event of a natural disaster or major structural damage that threatens the safety and welfare of patients and staff, or in the event of a disruption of the ability to provide services.

   b. In the event of a complete evacuation, the Emergency Department will notify Tulare County Ambulance Dispatch (TCAD), Tulare County EMS, and surrounding Base Hospitals that ambulance patients must be diverted to another facility due to internal disruption of services.

   c. The building should be evacuated from the top down as evacuation at lower levels can be more easily accelerated if the danger increases rapidly.

4. Partial Evacuation – Patients are transferred within the hospital in situations in which a specific area of the hospital is uninhabitable for patient and staff safety.

   a. Horizontal – initial response. Patients are moved horizontally on the same floor to one side of a set of fire barrier doors.

   b. Vertical – Patients are moved to a safe area on another floor or outside the building. This evacuation is more difficult due to stairways and will require the use of an Evacu-Chair and two staff members.

5. Preparation of an Evacuation:

   a. Place all portions of the patient medical record and medications cassette with the patient.

   b. Place all personal belongings in bag with the patient.

   c. Instruct nursing staff to prepare all patients for evacuation by securing lines and equipment.

   - IVs: Convert to Saline Lock or remove from pump and adjust to TKO. If the patient requires fluid volume infusion to maintain vital signs, remove pump from pole and place on bed.

   - Continuous Drug Infusions: Place pump on bed and take with the patient.

- Chest Tube: Disconnect from suction source and carry bottle below level of patient.
- Nasogastric (NG) tubes: Disconnect from suction and maintain open to gravity.
- Oxygen: Use portable "E" cylinder if patient cannot be removed for transport.
- Traction: Slowly disconnect weights and apparatus for transport.
- Incubators: Remove patient and wrap in blankets. Babies and mothers should be moved together if at all possible.
- Respiratory Isolation: Mask the patient prior to moving.
- Ventilator Patients: Obtain portable O_2 tanks and bag the patient.
- Art Lines/Swan-Ganz: Disconnect transducer from patient cable and take pressure bag with the patient.
- Operating Room Patients: If anesthesia has begun, but the surgical procedure has not started, the anesthesiologist shall terminate the anesthetic as soon as it is safe to do so and accompany the patient to a predetermined safe location. If a surgical procedure is in progress, the surgeon and anesthesiologist shall determine when it is safe to terminate the procedure and accompany the patient to a predetermined safe location.

d. Assign patients to a member of the staff for movement to specified location. If evacuating for fire, move patients to a location behind the fire doors that provide compartmentalization to the unit.

e. Follow the directions of the Engineering Department or Fire Department. They will identify the immediate re-location areas. The Command Center will assume responsibility for identification of re-location points, facilities accepting transfers, or other holding locations.

6. Evacuation Procedures for Patient Units:

a. Patients in immediate danger will be evacuated first.

b. Patients who are ambulatory will be evacuated second. Assign staff to escort group of patients from the area.

c. Non-ambulatory patients can be moved by pushing the bed or by utilizing mattresses from beds or stretchers. A blanket or sheet under the patient will provide a means of moving the patient away from danger. An Evacu-Chair can also be utilized to move non-ambulatory patients down stairs in the event of a vertical evacuation.

d. Infants may be moved by wheeling them in basinets or placing several infants in a bath blanket or sheet and carrying the blanket or sheet with the infants in it, taking care to not obstruct infant airways.

e. If a vertical evacuation (between floors or down stairs) is necessary, non-ambulatory patients will be placed on an Evacu-Chair and taken to a designated safe area. Elevators MUST NOT BE USED during a fire or significant seismic activity.

f. Visitors or other patients may be used to assist with the evacuation.

g. Fire Department or non-nursing staff assisting with evacuation will need instructions to assist with patients as they may be unfamiliar with equipment and lines.

h. The on duty nurse in charge of the unit will be the last to leave the patient care area.

i. The unit census sheet listing all patients should be taken to utilize in checking those evacuated. The nurse in charge should account for all patients, visitors, and staff.

j. If the situation allows for planned evacuation, all patients will be evaluated by the attending physician or physician assigned by the Medical Staff Officer and categorized for discharge or transfer. Patients who may be discharged or transferred will be prepared and evacuated as soon as possible by Discharge Planning Staff.

k. The patient's family will be notified of the discharge/transfer and the location of the patient.

l. Transportation will be necessary to relocate patients to other facilities. Local ambulance companies will be contacted for assistance.

7. Hospital Incident Command Responsibilities:

a. Command Center:

Evaluate available information and establish evacuation schedule in coordination with Section Chiefs. Consideration to be given to:

- Structural, non-structural, and utility evaluation from Engineering
- Patient status reports from Planning Section
- Evaluate manpower levels and authorized activation of staff call-in plans as needed.

b. Liaison Officer:

Maintain contact with Public Safety Officials, Department of Public Health, and EMS Agency.

c. Logistics Section:

- Advise Command Center regarding safe areas to be used for relocation within the facility.
- Assign and assemble transportation teams from the labor pool.
- Obtain equipment/supplies needed for use in areas where evacuated patients are relocated as necessary. (Portable toilets, Privacy Screens, supply cart, etc.)

d. Transportation Officer:

- Ensure coordination of any off-campus patient transportation with County EMS in coordination with Liaison Officer.
- Assign six people to each floor for evacuation manpower.
- Arrange for transportation devices (gurneys, wheelchairs, etc.)
- Coordinate evacuation with the Nurse Manager/Charge Nurse.

e. Nursing House Manager/Vice President of Patient Care Services (VPPCS):

- Designate holding areas for patients in cooperation with Engineering.
- Organize efforts to meet the medical needs and staffing needs of the holding areas.
- Request Medical Staff Officer to notify physicians of need for transfer/discharge orders.
- Contact other hospitals in the county and local extended care facilities to determine places to relocate patients. In cooperation with the Liaison Officer, contact Tulare County EMS for out of county resources.

f. Nurse Managers/Charge Nurses:

- Coordinate patient readiness for evacuation and staffing needs to provide continued care.
- Using unit census sheet, account for all patients after relocation.

- Assign a person to record the Evacuation Activity including name of patient, time and method of evacuation, current location of patient and number of evacuated room and forward information to the Command Center.

g. Safety Officer:

- Assign a security person (for traffic control) to each area being evacuated.
- Turn off oxygen and lights as the situation demands.
- Verify complete evacuation of a unit has taken place and that no patients or staff remain.
- Notify command Center of completed evacuation. Place sign on door to unit indicating Date and Time of Evacuation completed.

h. Labor Pool:

- Secure all available Environmental Services and general hospital staff not previously assigned to incident to assist in the movement of patients.
- Initiate staff call-in as needed.

8. Directions and plans for relocation of patients and services back into the facility will be issued from the Incident Commander.

REFERENCES:

- Title 22: Section 70741, 70743, 70746
- The Joint Commission (2026) Hospital accreditation standards. EM.12.01.01 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Emergency Operations Plan — Field Code Changed
- Activation of the Command Center — Field Code Changed

SUBJECT: **EXEMPT STAFF WORKING EXTRA SHIFTS**	SECTION: ***Human Resources*** **Page 1 of 2**

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

PURPOSE:

To define the process for allowing exempt staff to work extra shifts and determine compensation associated with those extra shifts.

POLICY:

SVMC provides an opportunity for exempt clinicians to cover non-exempt clinical positions due to staffing vacancies, and maintain clinical skills while meeting the Hospital staffing requirements, by working additional clinical non-exempt shifts for designated positions under structured terms and conditions at the discretion of the President/CEO or respective Vice President.

AFFECTED PERSONNEL/AREAS: *CLINICAL AND ANCILLARY EXEMPT MANAGEMENT STAFF*

PROCEDURE:

Upon approval by the President/CEO or the respective Vice President, clinical and ancillary exempt management staff may be offered the opportunity to work additional hours to provide direct patient care services with extra compensation.

1. A Vice President or Administrative Director will not be eligible for extra compensation.

2. To be eligible for extra compensation, the following criteria must be met:

   a) The President/CEO must designate the clinical/ancillary position as eligible for exempt staff participation as non-exempt staff additional compensation.

   b) The clinical/ancillary shift(s) must be scheduled outside of the normal hours of the staff member's regular hours of responsibility of the exempt position. (*For example: If the exempt employee typically works during the day shift, the extra non-exempt shift must be performed during hours outside of the exempt manager's normally scheduled day shift*).~~.)~~

   c) The exempt employee must have a secondary job code and department designation assigned to their ~~Kronos~~ timekeeping record so hours and compensation for the non-exempt pay code can be tracked appropriately.

   d) The exempt employee may not use unscheduled Vacation/Holiday or unprotected Sick Leave during the 7-day work week in which the clinical shift is worked.

   e) No more than 24 hours per pay period will be compensated under this policy.

   f) The exempt employee, when working an extra shift under the secondary job code as a clinician must clock "in" and "out" for each extra shift worked, and must follow the meal period and rest period policy~~.~~

3. Clinical/ancillary management staff will be compensated at a rate equivalent to time and one-half their "hourly rate of pay" when working the extra shift on the floor. The "hourly rate of pay" shall be calculated by dividing their weekly compensation by the number of hours they are expected to work in a normal work week.

4. All hours worked are to be coded to the department and the job code of the position for which they are covering.

5. Performance of duties in the exempt position shall remain the employee's primary responsibility. A decline in performance of these responsibilities, as determined by the responsible Vice President or Administrative Director, may result in the employee's ineligibility to work clinical shifts.

6. Clinical/ancillary extra shift opportunities will be made available at the Hospital's discretion based on staffing requirements and other criteria.

7. No clinical shift will be scheduled for exempt licensed staff until at least 72 hours prior to the start of the shift.

In a declared emergency, the CEO may approve discretionary pay for exempt staff who are working extra shifts specifically in relation to the emergency.

CROSS REFERENCES:

- Employment Status Policy
- Sick Leave Policy
- Meal Periods and Rest Periods Policy

SUBJECT: **FALSE CLAIMS ACT AND WHISTLEBLOWER PROTECTION**	SECTION: **Page 1 of 6**

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

PURPOSE:

To provide a summary of federal and state law regarding the False Claims Act (FCA), whistleblower protection as it relates to healthcare organizations, and specific policies and procedures on how Sierra View Medical Center (SVMC) prevents false claims.

POLICY:

Sierra View Medical Center (SVMC) employees, contractors and agents each have a responsibility to ensure their actions and those of their co-workers are in compliance with all federal and state laws and regulations. Particularly important are the provisions of the FCA, the most heavily penalized form of healthcare-related misconduct, which warrants special attention.

To ensure that healthcare organizations have strong incentives to police their own actions, the government provides special protection to whistleblowers who provide incriminating evidence of their company's misconduct to the government. Employees are encouraged to report any observations regarding potential violations to their supervisor, the Compliance Officer or through the Compliance Hotline (559)791-4777.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES, CONTRACTORS, AND AGENTS.*

DEFINITIONS:

Claim: Any request or demand for money submitted for reimbursement to the U. S. Government or its contractors.

Liability: Health care providers and suppliers (persons and organizations) who violate the FCA can be subject to civil monetary penalties for each false claim submitted. In addition to this civil penalty, providers and suppliers can be required to pay three (3) times the amount of damages sustained by the U.S. Government. If a provider or supplier is convicted of a FCA violation, the Office of Inspector General may seek to exclude the provider/supplier fro~~or~~m participation~~,~~ in government health care programs.

Knowing/Knowingly: A person, with respect to information, that:

- Has actual knowledge of the information.
- Acts in deliberate ignorance of the truth or falsity of the information.
- Acts in reckless disregard of the truth or falsity of the information. Proof of specific intent to defraud is not required.

Person: Any employee, contractor, agent, department, or group of employees of or representing SVMC.

Qui Tam Action: An action that is brought by a person on behalf of a government against a party alleged to have violated a statute especially against defrauding the government through false claims and

that provides employment protection and for part of a penalty to go to the person bringing the action. Also known as Whistleblower protection.

STATE PROVISIONS:

The California False Claims Act, Ca. Govt. Code 12651 -provides a civil remedy for the submission of false and fraudulent claims to state health care programs, primarily Medi-Cal. Like the federal FCA, the California False Claims Act includes whistleblower provisions that allow enforcement through *qui tam* actions, and protect whistleblowers from retaliation. Key provisions of the California False Claims Act as it relates to the healthcare industry are as follows:

A. **Application**

1. Any person who commits any of the following acts shall be liable for three times the amount of damages sustained due to the act of that person. A person who commits any of the following acts shall also be liable for the costs of a civil action brought to recover any of those penalties or damages, and may be liable for a civil penalty of not less than five thousand five hundred ($5,500) and not more than ~~up to ten~~ eleven thousand dollars ($1~~0~~1,000) for each false claim (there is currently no floor in the state of CA for civil penalties):

    a. Knowingly presents or causes to be presented to an officer, employee or intermediary of the government, a false claim for payment or approval.

    b. Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false claim paid or approved.

    c. Conspires to defraud the government by getting a false claim allowed or paid.

    d. Is a beneficiary of an inadvertent submission of a false claim to the government, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the government within a reasonable time after discovery of the false claim.

2. If false claims are found to have been submitted, the court may assess *minimal* civil monetary penalties if the following criteria are met:

    a. The person committing the violation furnished officials of the government responsible for investigating false claims violations with all information known to that person about the violation within 30 days after the date on which the person first obtained the information.

    b. The person fully cooperated with any investigation by the government of the violation.

c. At the time the person furnished the government with information about the violation, no criminal prosecution, civil action, or administrative action had commenced with respect to the violation, and the person did not have actual knowledge of the existence of an investigation into the violation.

3. Liability under this section shall be joint and several for any act committed by two or more persons in an organized conspiracy.

4. This section does not apply to any controversy involving an amount of less than five hundred dollars ($500) in value. For purposes of this subdivision, "controversy" means any one or more false claims submitted by the same person in violation of this article.

FEDERAL PROVISIONS

A. Enforcement: The Federal False Claims Act is enforced by the filing and prosecution of a civil complaint. Under the Act, civil actions must be brought within six years after a violation or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than ten years after the date on which the violation was committed.

B. Penalties assessed after ~~1/20/2023~~7/3/2025. Individuals or companies found to have violated the statute are liable for a civil penalty for each claim of not less than $~~5,500~~ ~~13,508~~14,308 and not more than $~~11,000~~28,619~~27,018~~, plus up to three times the amount of damages sustained by the federal government.

EMPLOYEE PROTECTION – *QUI TAM ACTION* "WHISTLEBLOWER PROTECTION"

1. SVMC shall not make, adopt, or enforce any rule, regulation, or policy preventing an employee from disclosing information to a government or law enforcement agency or from acting in furtherance of a false claims action, including investigating, initiating, testifying, or assisting in an action filed or to be filed under Section 12652 (State of California).

2. SVMC shall not discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against, an employee in the terms and conditions of employment because of lawful acts done by the employee on behalf of the employee or others in disclosing information to a government or law enforcement agency or in furthering a false claims action, including investigation for, initiation of, testimony for, or assistance in, an action filed or to be filed under Section 12652.

3. If SVMC were to violate subdivision 2 (above), SVMC would be liable for all relief necessary to make the employee whole, including reinstatement with the same seniority status that the employee would have had but for the discrimination, two times the amount

of back pay, interest on the back pay, compensation for any special damage sustained as a result of the discrimination, and, where appropriate, punitive damages. In addition, SVMC would be required to pay litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate superior court of the state for the relief provided in this subdivision.

4. An employee who is discharged, demoted, suspended, harassed, denied promotion, or in any other manner discriminated against in the terms and conditions of employment by SVMC because of participation in conduct which directly or indirectly resulted in a false claim being submitted to the government shall be entitled to the remedies under subdivision 3 (above) if, and only if, both of the following occur:

   a. The employee voluntarily disclosed information to a government or law enforcement agency or acted in furtherance of a false claims action, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed.

   b. The employee had been harassed, threatened with termination or demotion, or otherwise coerced by SVMC management into engaging in the fraudulent activity in the first place.

DETECTING AND PREVENTING FRAUD, WASTE AND ABUSE

Detailed information with regards to detection, prevention and resolution of false claims is provided in specific SVMC policies such as (1) Auditing and Monitoring, (2) Compliance Issue Reporting, (3) Correction of Errors Related to Government Reimbursement, (4) Code of Conduct, and (5) Non Retaliation – Compliance Issue Reporting. Additionally, SVMC staff members receive compliance training during their annual orientation, which emphasizes false claims prevention and whistleblower protection.

SVMC RESPONSE TO FALSE CLAIMS VIOLATIONS

This policy has thus far focused on government response to false claims allegations. The response of SVMC in the event of false claims violations by a SVMC employee, contractor, or agent shall be as follows.

1. Any officer, employee, contractor or agent of SVMC who believes another officer, employee, contractor or agent of SVMC has committed a False Claims violation should immediately report it to his or her supervisor or the Compliance Officer (CO). Supervisors receiving such reports should immediately forward all information to the CO.

2. The CO will conduct a thorough and confidential investigation into the allegations.

3. As noted in the Employee Handbook, SVMC has a progressive discipline policy under which sanctions become more severe for repeated infractions. At the discretion of management, SVMC

may terminate an employee for the first breach of any False Claim related policies and/or standards if the seriousness of the offense warrants such action, and may also be obligated to report the offense to law enforcement agencies, depending on the severity. An employee could expect to be terminated for willful or grossly negligent False Claims violations. For less serious violations (such as innocent mistakes or indications of small-scale negligence), management may impose a lesser sanction, depending on the circumstances, such as training, verbal or written warning, verbal or written reprimand, suspension without pay, or demotion.

4. SVMC will seek to include such violations by contractors as grounds for termination of the contract and/or imposition of contract penalties.

5. Significant False Claims violations (grossly negligent, intentional, and/or numerous) will likely constitute a criminal offense, in which case SVMC will provide information concerning the violation to appropriate law enforcement agencies and will cooperate with any law enforcement investigation or prosecution.

REFERENCES:

- Code of Federal Regulations Civil Monetary Penalties Inflation Adjustment https://www.ecfr.gov/current/title-28/chapter-I/part-85
- Deficit Reduction Act of 2005: https://www.govinfo.gov/content/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf
- California False Claims Act: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=12650&lawCode=GOV
- Federal False Claims Act: ~~https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title31-section3729&num=0&edition=prelim\~~https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title31-section3729&num=0&edition=prelim

CROSS REFERENCES:

- COMPLIANCE AUDITING AND MONITORING
- COMPLIANCE ISSUE REPORTING
- CORRECTION OF ERRORS RELATED TO GOVERNMENT REIMBURSEMENT
- CODE OF CONDUCT

Field Code Changed

Field Code Changed

- NON RETALIATION- COMPLIANCE ISSUE REPORTING
- ~~INTRODUCTORY PERIODS~~

SUBJECT: **HOSPITAL LOCKDOWN - CODE STRONG**	SECTION: ***Security Management***

PURPOSE:

- To define the steps to handle either a "full" or "modified" lockdown within the hospital.

POLICY:

When circumstances exist which place the safety and security of patients, staff and the general public at risk from exterior sources, the facility will implement "lockdown" procedures.

Only the Administrator, Administrator-On-Call, Nursing House Supervisor, Safety/Security Officer and/or local law enforcement have the authority to order a facility lockdown. A lockdown can encompass the entire facility or a specific area such as the Emergency Department.

- A *Full Lockdown Situation* will require that no individuals are allowed to enter or exit the facility.

- A *Modified Lockdown Situation* may allow selected access and egress of the facility. Caution must be taken during a modified lockdown, as the facility is at risk from persons wishing to enter the facility with ulterior motives.

The Administrator or their designee has responsibility for defining the extent of lockdown.

Examples of situations which may require implementation of either a modified or full lockdown include but are not limited to:

- Violent Crime
- Terrorist acts
- Gang activity
- Treatment of victims of violent crime
- Weapons on campus
- Threats of violence
- VIP's

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

GENERAL

1. As soon as it is determined or suspected that a person with no official business or medically-related reason for being in the hospital is circulating within the premises, he/she shall be contacted, preferably by hospital security, and escorted out of the building as discreetly as possible.

2. If he/she objects, hospital security shall notify Administration or their designee and call the Porterville Police Department, who will be requested to escort the individual away from the property.

3. When it has been determined that a group of individuals are in the hospital on other than official or medically-related business, all entrances shall be secured and, where possible, the group shall be isolated and prevented from circulating through the rest of the hospital.

4. The Porterville Police Department shall be contacted by order of the Administrator or designee to investigate the circumstance and remove the persons from the facility as appropriate.

5. When exterior circumstances disrupt treatment of patients or threaten the safety of patients, staff and guests within Sierra View Medical Center, lockdown procedures will be implemented.

RESPONSIBILITIES – POTENTIALLY VIOLENT SITUATION

1. **Administrator or designee, Nursing House Supervisor, Safety / Security Officer**

   - Only these persons have authority to order a Code Strong and determine whether a "full" or "modified" facility lockdown is to be implemented.

   - Will communicate the Code Strong Lockdown and extent of lockdown, **"Full"** or **"Modified"**, including the location if "modified," to Security and the PBX for overhead page notification.

2. **Security Department**

   - Shall notify the Administrator or designee when circumstances occur which may require lockdown.

   - Make and maintain contact with the Police and Fire Department designee.

   - Since Security Department personnel are often the first contact with participants in any type of civil disturbance, it is most important that they correctly estimate the situation and avoid aggravation of the existing situation. Security Department personnel will be the first and most reliable sources of information needed by the Police to properly respond to a potentially violent situation. Information regarding the circumstances surrounding the situation of unrest shall help hospital officials in dealing with the group or individuals in the early stages of the controversy. In the case of an organized group attempting to reach a patient or a member of the hospital staff with intent to harm, Security's only recourse is to prevent entry to the area where the target individual is located.

- Be prepared to call the police if a trouble situation appears to be developing. If there is any doubt, it is better to inform them early rather than late, as the situation can often be resolved before violence occurs.

- Be prepared to report any disturbance in accurate detail. It is essential that the true nature of the disturbance be reported, in order that the appropriate course of action and corrective measures can be applied.

- When the order is given to implement a "lockdown", Security and Engineering staff will lock and guard all exterior doors to prevent unwanted access to the facility.

3. **Engineering Department**

- All entrances to the hospital shall be locked to prevent persons from entering and exiting during the Code Strong.

- Engineering will assist Security as needed.

4. **PBX Operator**

- When directed by the Administrator or their designee, page overhead and announce the lockdown by calling Code Strong. For modified lockdowns, the affected department will follow the code announcement. (For example, "Code Strong -- Emergency Department"). Repeat the announcement three times.

- Once the Code has been cancelled, page overhead "Code Strong -- All Clear." Repeat the announcement three times.

CROSS REFERENCES:

- SECURITY MANAGEMENT PLAN

- STANDARDIZED EMERGENCY CODES

SUBJECT:	SECTION:
INJURY AND ILLNESS PREVENTION PROGRAM	***Safety Management***

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

PURPOSE:

To prevent injuries, illnesses and accidents within the facility. To ensure the safety and health of all personnel and to provide a safe and healthful work environment.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that the personal safety of each employee is of primary importance. Prevention of occupationally-induced injuries and illness of such consequence is that it will be given precedence over operations, whenever necessary. To the greatest degree possible, management will provide all mechanical and physical activities required for personal safety and health, in keeping with the highest standards.

We will maintain a safety and health program conforming to the best practices available. To be successful, such a program must embody proper attitudes toward injury and illness prevention on the part of the supervisors and employees. It also requires cooperation for all safety and health matters; not only between supervisors and employees, but also between each employee and his or her co-workers. Only through such a cooperative effort can a safety program in the best interest of all be established and pursued.

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

PROCEDURE:

OBJECTIVES:

1. To identify and assign responsibilities to the person(s) to implement the program.

2. To provide means to identify and evaluate occupational safety and health hazards through periodic scheduled inspections and investigations of occupational injuries and illnesses.

3. To institute methods for timely correction of unsafe conditions detected based on severity of the hazard.

4. To provide safety training to current, new, and reassigned personnel.

5. To provide a system for communicating with employees on safety matters by clearly indicating how compliance with safe work practices will be ensured.

6. To encourage employees to participate in reporting unsafe conditions without fear of reprisal.

7. To coordinate the functions of this program with an Employee Health Program, the Infection Control Program, and Risk Management through the Safety Management Program.

SUBJECT:	SECTION:
INJURY AND ILLNESS PREVENTION PROGRAM	***Safety Management***

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

AUTHORITY:

1. The Chief Financial Officer (CFO) and the Board of Directors (BOD) of Sierra View Medical Center are responsible for providing the financial support necessary for specific services, equipment and personnel required to maintain the Injury/Illness Prevention Program.

2. The Sierra View Medical Center Chief Executive Officer (CEO) delegates the management and implementation of the program to the Safety Committee.

3. The Safety Officer is responsible for reviewing all applicable general industry safety orders and other safety orders applicable to the operations of this program.

HAZARD SURVEILLANCE/LIFE SAFETY ROUNDS
SUBJECT: ACCIDENT, ILLNESS AND INJURY INVESTIGATIONS

It is the policy of the Injury and Illness Prevention Program to establish a protocol for employees to follow in the event of a work-related injury or illness and to investigate and correct any significant hazards.

PROCEDURES:

1. Any employee who becomes injured or ill on duty must report his or her condition to the department manager or supervisor immediately.

2. The Employee or Supervisor must enter an electronic event report.

3. If the supervisor or employee believes that an evaluation by a physician is required, the Employee must report to Employee Health during the hours of 7:00 a.m. to 3:30 p.m. Monday through Friday. After hours and on weekends or holidays, the employee should report to the Emergency Department if medical treatment is urgent or necessary.

4. The Manager/Director of the employee's department will complete a review and action plan in the electronic event report.

5. When an employee identifies a hazard, they will report it in the electronic event reporting system.

6. Employee Health will compile reports on occupational injury and illness and report significant trends and incidents to the Safety Committee and Management.

7. The Safety Committee, with the assistance and input of Directors and Managers of affected areas will investigate the causes of the incidents, make corrective recommendations and carry out corrective actions based on reports provided by Employee Health.

SUBJECT: ACCIDENT INVESTIGATION

Accident investigations will be conducted by trained individuals. The primary focus will be on understanding why the accident or near miss occurred and what actions can be taken to preclude its recurrence. Furthermore, the investigation will be in writing and identify the cause(s) of the accident or near miss.

The following questions will be answered during the investigation of an occurrence:

1. WHAT HAPPENED? WHAT NORMALLY HAPPENS? WHAT DOES PROCEDURE REQUIRE? (IF APPLICABLE)

   The investigation must obtain all the facts surrounding the occurrence. For example, what caused the situation to occur, who was involved; was/were the employee(s) qualified to perform the function involved in the accident; were they properly trained; were proper operating procedures established for the task involved; were those procedures followed, and if not, why not; does this situation exist in other departments; how can it be corrected?

2. WHY DID IT HAPPEN?

   The Safety Officer or designee must determine which aspects of the operation or process require additional attention. It is important to note that the purpose here is not to establish blame, but to determine what type of constructive action can eliminate the cause(s) of the accident or near miss.

3. HOW WAS THE ORGANIZATION MANAGING THE RISK?

   Actions already taken to reduce or eliminate the exposures being investigated will be noted, along with those remaining to be addressed. Any interim or temporary precautions will also be noted. Additionally, any pending corrective action or reason for delay will be noted.

JUST CULTURE:

Sierra View Medical Center's philosophy for building and supporting the culture of patient safety includes promoting a fair, just and supportive environment for those employees that self-report potential or actual safety risk, hazard events and/or ethical risks.

COACHING:

Coaching discussions are recommended for making constructive suggestions to improve individual competency or skills where some improvement is required to improve performance, and formal discipline may not yet be appropriate. Employee coaching is considered to be educational and is not considered to be disciplinary. However, if the employee's performance does not improve following coaching, disciplinary action may result per SVMC policy.

SUBJECT: EMPLOYEE TRAINING AND DOCUMENTATION

It is the policy of Sierra View Medical Center to define the requirements and responsibilities for safety education and training as means to minimize injuries, illnesses and accidents.

PROCEDURES:

1. Mandatory Education – all Sierra View Medical Center Department Leaders will ensure that their employees will complete the E-learning modules specified below:

   A. Fire Safety (annually)

   B. Safe Lifting Procedures and Use of Mechanical Aids To Decrease Risk of Injury (annually)

   C. Infection Control/Universal Precautions and Blood Borne Pathogen Standard (annually)

   D. Safe Patient Handling

   E. Electrical Safety (annually)

   F. Equipment Safety (annually)

   G. Hazardous Materials and Waste Safety Communication (annually)

   H. Workplace Violence Prevention (annually)

   I. Health and Safety Handbook (annually)

   J. Worker's Compensation (annually)

2. Departmental Specific Training

   A. Department Leaders must orient their employees to any potential occupational hazards related to their departments and conduct a refresher orientation at least annually.

   B. Department Leaders must in-service employees of new hazards introduced by a change in equipment, processes, raw materials, etc.

   C. Department Leaders must provide safe work conditions, practices and personal protective equipment as a means of minimizing departmental specific hazards.

3. Education Records

   Records of all completed education programs are maintained by the employee's department managers and/or the Education Department.

SUBJECT: EMPLOYER-EMPLOYEE SAFETY COMMUNICATION SYSTEM

It is the policy of Sierra View Medical Center to establish a communication network between staff and appropriate administrative contacts regarding any safety concerns.

PROCEDURES:

1. Employee compliance with safe work practices is assessed through his or her annual job performance evaluation.

2. Safety rules and information on occupational hazards are communicated through the following means:

   A. Annual or as needed

   B. Department's specific training

   C. Self-study modules

   D. Other means of communication

3. Employees are encouraged to report safety concerns to their immediate supervisor.

4. Employees are also encouraged to inform the Safety Officer about workplace hazards without fear of reprisal or other discrimination.

5. Employees may use the Electronic Reporting System anonymously to report safety concerns or workplace hazards.

6. The Safety Officer will discuss and evaluate the Employee Safety Reports on a quarterly basis at the Safety Committee meeting.

SUBJECT: GENERAL SAFETY RULES

1. Department Leaders are responsible for maintaining safety standards, developing safety rules, and supervising and training personnel in the department standards.

2. Department Leaders are responsible for notifying the Safety Officer in case of any unsafe condition or hazard.

3. All department employees will report defective equipment, unsafe conditions, acts, or safety hazards to their supervisor. This may be done using the Electronic Reporting System.

4. Employees will keep all electrical cords clear of passageways. Electrical extension cords will not be used without written approval of Engineering.

5. All equipment and supplies must be properly stored. All personal electrical appliances will be safety inspected by Engineering prior to use.

6. Scissors, knives, pins, razor blades and other sharp instruments must be safely stored and used.

7. All electric machines with heat producing elements must be turned off when not in use.

8. Smoking is prohibited on Hospital property.

9. Rubbish or trash will not be permitted to accumulate.

10. Advise Engineering immediately of improper illumination and ventilation.

11. Furniture and equipment must be arranged to allow passage and access to exits at all times.

12. Minor spills (i.e., water) should be cleaned by the employee who discovers the spill. This should be done immediately. Major spills will be cleaned by the Environmental Services (EVS) Department. Spill kits are available for spills involving hazardous waste.

13. Report all faulty equipment to the Engineering Department and apply "defective-Do Not Use" tag.

14. All warning signs will be obeyed.

15. File drawers and cabinet doors should be kept closed when not in use.

16. Suitable clothing will be worn (High heels or jewelry that may catch in machinery will be avoided).

REFERENCES:

- The Joint Commission (20264) Hospital accreditation standards. ~~EC.04.01.05 EP1~~PE.01.01.01 & PE.04.01.01 Joint Commission Resources. Oak Brook, IL.

- Occupational Safety and Health. (n.d.). Injury and Illness Prevention Program . Retrieved from https://www.dir.ca.gov/dosh/etools/09-031/.

- Giso. (n.d.). Retrieved from https://www.dir.ca.gov/title8/3203.html.

SUBJECT:	SECTION:
INVESTIGATIONS AND GOVERNMENT SEARCH WARRANTS, UNANNOUNCED	**Page 1 of 5**

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

PURPOSE:

To provide guidance and establish a process for appropriately responding to a government investigation or search warrant by federal, state or local law enforcement pursuant to a government investigation.

POLICY:

Sierra View Medical Center (SVMC) will cooperate with all law enforcement or government requests and investigations while protecting the legal rights of the organization and individual employees. In order to ensure those protections and the proper conduct of the investigation, the Compliance Officer (CO) or designee shall oversee and direct, to the extent possible, the response to a government search warrant. Searches by law enforcement or government agents are not allowed unless a search warrant is presented. Do not verbally or otherwise agree to allow a search in the absence of a search warrant.

Documents, computer files/media etc. related to the investigation shall not be destroyed, hidden or altered.

Any employee who participates or otherwise has knowledge that a government search warrant, investigation or audit has been executed that relates to SVMC should keep the matter confidential and refrain from discussing the written order or related events with any other individuals except those authorized by the CO or legal counsel.

DEFINITION:

Government investigation: May include, but is not limited to, investigation by the Office of the Inspector General of the United States Department of Health and Human Services, United States Attorney General's Office, the Federal Bureau of Investigation, the State Attorney General's Office, the Office of Civil Rights, State Medi-Cal Fraud Control Unit, or the District Attorney.

Search Warrant: Means a written court order that entitles law enforcement to search a defined area and seize property that is described in the search warrant or located in an area specifically identified as covered by the search warrant.

PROCEDURE:

If federal, state, or local authorities enter a SVMC facility to conduct a government investigation or presents a search warrant, employees shall take the following steps:

1. Escort the agents/investigators to a conference room or private office in order to minimize disruption to patients and/or caregivers.

2. Identify the agent in charge.

a. Ask for identification, such as a business card of the agent/investigator in charge which includes name, title, agency, and telephone number of agent.

b. Immediately contact the Administrator On-Call (AOC), CO and CEO and politely ask the agent/investigator to wait for one of these SVMC representatives to arrive. The AOC, CEO, CO, or designee will be the SVMC representative responsible to coordinate SVMC's response to the government investigation.

AOC - Refer to house supervisor for number
Compliance Officer (559) 791-3838
Chief Executive Officer (559) 788-6100

Do not leave a voice mail or message. Rather make every possible effort to reach the AOC, CO and CEO on their cell phones. If unsuccessful, contact any senior leadership team member. Provide all the information collected in step #2 above.

IN THE CASE OF A SEARCH WARRANT

3. Follow the steps in #2 above. Ask for a copy of the search warrant, and any accompanying affidavit. The agents/investigators presenting the search warrant do not have an obligation to wait for the AOC, CEO, or CO or designee, but request this in any event.

4. Do not consent to the search or sign a form acknowledging consent. Politely decline. Consenting to the search and/or signing the form may jeopardize the ability of SVMC to challenge the legality of the search at a later time. **HOWEVER, NO EMPLOYEE SHOULD OBSTRUCT THE SEARCH IN ANY WAY.**

5. Notify the responsible director or manager of the entity or department to which the search warrant has been presented that agents are on the premises and have issued a search warrant and who else has been notified. The responsible director or manager should make every effort to be present at the site for the execution of the search warrant.

6. The responding AOC, CO, CEO or designee will take the following steps:

a. Contact the hospital's general counsel.

b. Carefully read the search warrant and confirm that the search warrant is signed by a judge. If there is a discrepancy, notify the agent in charge.

c. Ask for the name and phone number of the prosecutor, if not indicated on the documents provided.

d. Identify the essential employees that are knowledgeable and can assist in retrieving documents, computer information, etc.

e. Move all non-essential employees to another site for the length of the search. Exercise discretion to ensure that the facility continues to operate at an acceptable level.

f. Ensure that at least one employee accompanies the agents/investigators at all times.

g. The search warrant will describe, often in detail, the areas of the facility that the agents/ investigators have been authorized to search and the documents and other items authorized to seize. Give the agents/investigators access to the areas identified in the search warrant. If the agents/investigators want to inspect an area of the facility, or seize a document or object outside the scope of the warrant, do not prevent the agents/investigators from doing so, and do not argue with the agents/investigators about the scope of the warrant. Instead, state to the agent/investigator that the area, documents or items are not covered by the warrant and you are permitting the search under protest. If the search exceeds the scope of the warrant, SVMC may later challenge the legality of the search.

h. SVMC has no obligation to assist the agents/investigators in conducting the search. Should the agents/investigators inquire about the location of documents or objects, answer their questions truthfully. For example, unlocking a file cabinet upon request is reasonable, however, taking the agents/investigators on a tour of the facility, explaining operations, or the documents they have been authorized to seize is not required or recommended. It is the agents'/investigators' obligation to specify the documents or objects sought, and it is SVMC's obligation to not obstruct the agents/investigators access to such documents or objects covered in the search warrant.

i. Should the agents/investigators ask to see client/attorney privileged documents ask them to wait until SVMC attorneys arrive to speak with them about this issue. If the agents/investigators refuse to wait, make note of any such information reviewed or seized.

j. Should the agents wish to see patient medical records, or other confidential patients' records, remind them of the highly confidential nature of such information and request that they take precautions to preserve confidentiality. Make careful note of any such information seized.

k. Monitor/record the search without interfering with the agents (video recording is an option). Keep a detailed list of the areas searched, documents and objects removed. Ask to copy the documents before they are removed. SVMC does not have the right to stop the search; however, SVMC has the right to observe the search at all times and make a record of everything the agents/investigators have searched.

l. Advise employees that, during the search, questions may be asked of them regarding not only the documents or other items that are seized by the government, but also their and others' duties and responsibilities within the facility. Employees should be advised that they are not required to speak with the agents and that SVMC will provide counsel for the employees if they wish.

m. At the conclusion of the search, the agents/investigators are obligated to provide SVMC with an inventory of all documents seized.

n. In the event of media coverage, immediately notify the Director of Marketing.

7. EMPLOYEE RIGHTS FOR OFF-SITE VISITS OR CONTACTS BY GOVERNMENT AGENTS/INVESTIGATORS: *Employees are free to speak to government agents/investigators; however, are not required to submit to questioning.*

a. Individuals are free to talk to government agents/investigators if they wish, but also have the right to decline an interview or to postpone an interview until they have had an opportunity to seek legal counsel or other advice.

b. Only a government attorney working with an attorney representing the person to be interviewed can make promises binding the government.

c. If an employee chooses to be interviewed, he or she has the following rights:

i. To have an attorney or someone else present as a witness
ii. To take notes, including questions asked and responses
iii. To know the full identify of all persons who conduct the interview (name, position, and government agency)
iv. To end an interview at any time, without providing a reason
v. To decline to answer any questions

Employees who agree to be interviewed should always tell the government agent/investigator the truth, be completely accurate, and not guess or speculate. If employees do not know the answer to a question, stating such is acceptable.

Employees are requested to immediately report any off-site visits by government agents/investigators to the CO.

REFERENCES:

- ~~Wolters Klower (2019).~~HCCA - Health Care Compliance Professional's Manual, 2025. ePublication, Chapter 4: During an Investigation.~~1,~~ ~~Volume 11., pages 574 – 584.~~ ~~United States: Wolters Klower.~~

- United States Sentencing Commission Guidelines Manual 20~~18~~25~~1~~: Appendix B (20~~18~~25~~1~~). Retrieved from ~~https://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2018/APPENDIX_B.pdf~~ https://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2025/APPENDIX_B_PART_II.pdf~~https://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2021/APPENDIX_B.pdf~~.

SUBJECT: **NON RETALIATION - COMPLIANCE ISSUE REPORTING**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish a culture and process in which employees may report ~~known~~actual, potential ~~-~~or suspected compliance issues~~instances of inappropriate conduct or activities~~, in good faith, without fear of retaliation.

POLICY:

Sierra View Medical Center (SVMC) is committed to the establishment of a culture that promotes prevention, detection, mitigation and resolution of instances of conduct that does not conform to federal and state laws and regulations, requirements of private payer health care programs, SVMC policies and SVMC's Code of Conduct. SVMC has established an environment and process for employees who report concerns in good faith to be protected from retaliation~~, retribution or harassment~~.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

DEFINITIONS:

Retaliation: ~~Any action, statement, or behavior that is designed to punish an individual for filing a compliance report, cooperating with a compliance investigation, seeking guidance regarding a compliance concern or to deter one from taking such action. Retaliation includes, but is not limited to, intimidation, adverse action against an employee regarding the terms and conditions of employment, such as termination, demotion, or suspension~~ Any adverse action, or the threat of adverse action, against an employee because they file a complaint, raise a concern, provide information to investigators, or otherwise assist in an investigation or proceeding relating to an issue they believed "in good faith" to violate the SVMC Code of Conduct, any SVMC policy, or any applicable law or regulation. Retaliation is designed to punish or penalize an individual for raising concerns or assisting in investigations.

Retaliation includes, but is not limited to: termination; being transferred to a less desirable shift, location, or position; reduction in duties or demotion; threats or harassment; and negative performance reviews solely as a result of reporting a concern.

Other forms of retaliation may be more subtle including: not being invited to business calls, meetings or social gatherings or~~;~~ no longer having input into projects.~~; or being ignored and iced out by coworkers.~~

All forms of retaliation create a hostile, threatening, or uncomfortable environment that can negatively affect employment conditions for all staff.

~~***Retribution:*** Something done to get back at someone or the act of punishing someone for their actions~~

In good faith: The individual reasonably believes or perceives the information reported to be true.

PROCEDURE:

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1. All SVMC employees have an affirmative duty and responsibility ~~for~~ to report~~ing~~ actual, potential or ~~perceived~~ suspected misconduct, violations of laws, regulations, policies, procedures, or the SVMC Code of Conduct. See Compliance Issue Reporting policy.

2. To the extent practicable or allowed by law, the Compliance Officer (CO) must, when requested, maintain the confidentiality or anonymity of an employee who reports a compliance-related concern.

3. Any form of retaliation~~, retribution or harassment~~ against any employee who reports an actual, potential or perceived problem or concern in good faith is strictly prohibited.

4. Any employee who commits or condones any form of retaliation ~~, retribution or harassment~~ will be subject to discipline up to, and including, termination.

5. Employees cannot exempt themselves from the consequences of their own misconduct by reporting the misconduct, although self-reporting may be taken into account in determining the appropriate course of action.

6. Any employee who intentionally provides false information may be subject to disciplinary action up to and including termination.

PROCEDURES THAT APPLY TO LEADERSHIP
(Executives, vice presidents, directors, managers, and supervisors):

All levels of leadership will support and adhere to this strict non-retaliation policy in an effort to protect employees who report problems and concerns, in good faith, from retaliation. Any form of retaliation~~, retribution or harassment~~ can undermine the problem-reporting process and result in a failure of communication channels in the organization.

1. Leadership will take appropriate measures to safeguard employees against retaliation~~, retribution or harassment~~. At a minimum, the following actions should be taken and become an ongoing aspect of the leadership process:

    a. Maintain an "open door" policy to support and encourage employee's reporting of work-related issues or concerns;
    b. Communicate to employees that they may, without fear of retaliation, report violations and concerns to the CO;
    c. Ensure that reports are handled confidentially;
    Focus on the issue raised and not the individual(s) involved;
    d. Report to the CO or Compliance Hotline any instance of retaliation~~, retribution or harassment~~ against an employee for reporting a compliance-related concern.

PROCEDURES THAT APPLY TO THE CO:

1. The CO will be responsible for the investigation and follow-up of any reported retaliation against

an employee.

2. The CO will report the results of an investigation into suspected retaliation to the Chief Executive Officer and/or the Board of Directors.

REFERENCES:

- Federal Register/Vol. 63, No. 35/Monday, February 23, 1998 https://www.govinfo.gov/content/pkg/FR-1998-02-23/pdf/98-4490.pdf

CROSS REFERENCES:

- CODE OF CONDUCT
- COMPLIANCE ISSUE REPORTING

SUBJECT:	SECTION:
NON-DISCRIMINATION PATIENT CARE	***House Wide Policy***
	Page 1 of 3

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

PURPOSE:

To demonstrate compliance with applicable Federal and State requirements pertaining to non-discriminatory practices.

POLICY:

Sierra View Medical Center (SVMC) complies with applicable Federal and State civil rights laws and does not discriminate, on the basis of a person's race, religion, color, sex, national origin, sexual orientation, ancestry, age, marital status, registered domestic partner status, medical condition or genetic information, pregnancy, veteran status, culture, primary language, citizenship, socioeconomic status, immigration status (unless required by federal law), gender identity or expression or physical or mental disability or handicap, be knowingly excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provision of any care or service, whether carried out by SVMC directly or through a contractor or any other entity with which SVMC arranges to carry out its program or activities.

This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges.

This allows patients with physical, intellectual, developmental, or cognitive disabilities- including dementia- to have a family member or caregiver present as needed outside of regular visiting hours.

SVMC also prohibits unlawful discrimination based on the perception that anyone has any of those characteristics, or is associated with a person who has or is perceived as having any of those characteristics.

Nondiscriminatory policies that prohibit discrimination based on gender identity and gender expression are a first and necessary step toward ensuring that transgender patients have equal access to respectful, knowledgeable treatment and care. Section 1557 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) prohibits sex discrimination in any hospital or health program that receives federal funds, and in May 2016, the U.S. Department of health & Human Services (HHS), Office for Civil Rights (OCR), issued regulations explaining that this prohibition extends to claims of discrimination based on gender identity and sex stereotyping.

The Joint Commission (TJC) standard RI.01.01.01, EP 29 requires nondiscrimination policies.

The patient has the right to competent, considerate and respectful care in a safe setting that fosters the patient's comfort and dignity and is free from all forms of abuse and harassment, including abuse or harassment based on gender identity or gender expression. Please refer to the Patient Rights Policy.

SVMC makes reasonable modifications in policies, practices, or procedures when such modifications are necessary to afford equal access to its services, programs, and activities.

Specifically, the above includes (but is not limited to) the following:

1. Inpatient, outpatient and emergency care will be provided in a non-discriminatory basis;

2. All patients will be assigned and/or transferred to rooms, floors, and sections in accordance with their medical need on a non-discriminatory basis.

3. Employee assignments will be made on a non-discriminatory basis, where neither the employee nor the patient suffers discriminatory conditions.

4. Medical staff privileges will be granted on a non-discriminatory basis.

5. Training programs sponsored or carried on by SVMC shall be without discrimination.

6. Human Resource practices will be carried out in a non-discriminatory manner. Refer to Human Resource Policy & Procedure, Equal Employment Opportunity.

AFFECTED PERSONNEL/AREAS: *ALL HOSPITAL PERSONNEL*

REFERENCES:

- California Code of Regulations (2019). Title 22, §70715. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- The Americans with Disabilities Amendments Act of 2008 (2008). Retrieved from
    - https://www.ada.gov/pubs/adastatue08.htm.
- The Americans with Disabilities Act of 1990as Amended. Retrieved from
    - http://xn--https-ix3b//www.ada.gov/law-and-regs/ada/%20California%20Civil%20Code,%20Section%2051%20(2016).%20Retrieved%20from%20https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV&sectionNum=51.
- The Immigration and Nationality Act (1952). Retrieved from
    - https://www.uscis.gov/legal-resources/immigration-and-nationality-act.
- The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Section 504 of the Rehabilitation Act of 1973 (1973). Retrieved from
- https://www.dol.gov/agencies/oasam/civil-rights-center/statutes/section-504-rehabilitation-act-of-1973.
- Title VII Civil Rights Act of 1964 (1964). Retrieved from https://www.eeoc.gov/laws/statutes/titlevii.cfm.
- Affordable Care Act, 42 U.S.C. § 1811(a) (2010)
- California State Ch. 172 AB 960 Statues of 2025

- Lambda Legal (2016) Transgender rights toolkit: Transition-related health care. Retrieved at http://www.lambdalegal.org/publications/trt-transition-related-health-care

CROSS REFERENCE:

- Anti-Discrimination, Harassment & Non-Retaliation Policy
- Equal Employment Opportunity Policy
- Gender Identity & Gender Expression Non-Discrimination Policy
- Interpretive Services: Language Assistance Program Policy
- Non-Discrimination on the DP/SNF Policy
- Reasonable Accommodations Policy
- The Joint Commission. (2017). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

PATIENT PORTAL ACCESS BY AGE POLICY	SECTION: *[Enter manual section here]* **Page 1 of 2**

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

PURPOSE:

This policy establishes guidelines for granting, restricting, and revoking patient portal access based on patient age. It ensures compliance with HIPAA, the 21st Century Cures Act, and California state confidentiality laws while protecting patient privacy and supporting patient engagement.

SCOPE:

This policy applies to all patients of Sierra View Medical Center (SVMC), their legally authorized representatives, and any hospital staff involved in enrollment, proxy setup, and support for the Meditech Patient Portal.

AFFECTED PERSONNEL/AREAS: *All SVMC Staff*

DEFINITION:

- Patient Portal: The secure online platform (Meditech Expanse) providing patients access to portions of their electronic health record.
- Proxy Access: Authorized access to a patient's portal account by another individual (e.g., parent, guardian, caregiver).
- Sensitive Health Information: Information related to reproductive health, mental health, substance use, or other categories protected under California law for minors.

POLICY:

SVMC supports patient rights to access their health information electronically. Portal access will be provided according to the age of the patient and applicable state and federal privacy regulations.

PROCEDURE:

1. Patients Age 18 and older
   - Full portal access is automatically available.
   - May self-enroll during registration or through online activation.
   - May grant proxy access to another adult by submitting written consent.
   - Proxy access may be revoked by the patient at any time.
   - Durable Power of Attorney (DPOA) documentation must be provided for incapacitated adults.
2. Patients Age 12-17 (Adolescents)
   - Adolescents may request their own direct portal access with verified identity.

- Meditech configuration allows suppression of sensitive results to comply with confidentiality laws.
- Proxy access is restricted or denied for this age group to protect adolescent confidentiality.
- Legal exceptions (court orders, guardianship arrangements) must be reviewed by HIM/Compliance before access is granted.

3. Patients Age 11 and under

- No direct portal access is provided to children under 11.
- Full proxy access is granted to parents or legal guardians with appropriate documentation (birth certificate, guardianship order).
- Proxy access will be automatically terminated upon the child's 12th birthday.
- At age 12, the patient may be evaluated for adolescent direct access as described in # 2.

PROXY ACCESS MANAGEMENT

- All requests for proxy access are submitted through HIM or the Patient Portal Support team.
- All requests require identity verification and, if applicable, legal documentation (DOPA, guardianship papers, court orders).
- All activity is monitored and audited; inappropriate access may result in revocation.

SECURITY AND COMPLIANCE

- Meditech Expanse is configured to follow these age rules system-wide
- Regular audits to ensure correct configuration and use.

REFERENCES:

- 21st Century Cures Act, Public Law 114–255, December 13, 2016. https://www.healthit.gov/topic/oncs-cures-act-final-rule
- Office of the National Coordinator for Health Information Technology (ONC). Cures Act Final Rule - Information Blocking. https://www.healthit.gov/topic/information-blocking
- California Family Code § 6925 et seq.; Health & Safety Code § 123110, 123115; Civil Code §§ 56.10 and 56.11.
- California Hospital Association. Minors' Consent and Confidentiality Reference Guide. https://calhospital.org/
- National Center for Youth Law. California Minor Consent and Confidentiality Laws. https://teenhealthlaw.org/
- Stanford Medicine – Confidentiality & Consent for Teens. https://www.stanfordchildrens.org/

- PHI Toolkit: Understanding Confidentiality and Minor Consent in California. https://www.phi.org/
- NASPAG & SAHM Position Statement: 21st Century Cures Act and Adolescent Confidentiality. https://www.naspag.org/
- Pediatrics (AAP) 2023. 'Challenges to Developing and Implementing Policies for Adolescent Portal Access'. https://publications.aap.org/pediatrics/

ADDENDUM A

ED Level of Care Scoring Tool

Use this tool to determine the appropriate ED facility level of care based on nursing interventions, monitoring, and resources utilized. Check the applicable criteria in each category and total the score.

Category	Criteria & Checkboxes	Points
Nursing Assessment/Monitoring	☐ Basic assessment only (0 pts) ☐ Moderate monitoring (3 pts) ☐ Frequent/complex monitoring (6 pts)	_____
IV Therapy	☐ None (0 pts) ☐ Single IV start/med (2 pts)	_____

	☐ Multiple IV meds/continuous infusion (4 pts)	
Medications	☐ Oral meds only (0 pts) ☐ IM/SC injections (1 pts) ☐ Multiple IV meds (3 pts)	_____
Procedures	☐ Simple procedure (e.g., wound care) (2 pts) ☐ Complex procedure (e.g., splinting, catheter) (4 pts) ☐ Multiple procedures (6 pts)	_____
Care Coordination	☐ None (0 pts) ☐ Case mgmt/social work consult (2 pts) ☐ Multiple care team involvement (4 pts)	_____
Isolation/Precautions	☐ No isolation (0 pts) ☐ Standard/contact isolation (2 pts) ☐ Airborne or special precautions (3 pts)	_____
Time in Department	☐ < 60 min (0 pts) ☐ 1-3 hours (2 pts) ☐ > 3 hours (4 pts)	_____
TOTAL SCORE		_____

ED Level Assignment (based on total score):
• 0–5 points: Level 1
• 6–10 points: Level 2
• 11–15 points: Level 3
• 16–20 points: Level 4
• >20 points: Level 5

SUBJECT: **PATIENT PRIVACY – PATIENT'S RIGHT TO AMEND**	SECTION: **Page 1 of 8**

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

PURPOSE:

To ensure patients the right to amend Protected Health Information (PHI) stored in the designated record set as required by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, and any and all other Federal regulations and interpretive guidelines.

POLICY:

Patients will be provided the right to have the facility amend their PHI that is contained within the designated record set for as long as the information is maintained by the facility. The right to request an amendment and the process for making a request must be outlined in the Notice of Privacy Practices.

The facility may deny a patient's request for amendment, if it determines that the PHI that is the subject of the request:

1. Was not created by the facility, unless the originator of the information is no longer available to act on the requested amendment;

2. Is not part of the designated record set;

3. Is accurate and complete; or

4. Would not be available for access pursuant to the Patients' Right to Access Policy.

If the facility denies the request for amendment, the Privacy Officer must provide the patient with a written denial that outlines the reason for the denial.

Definition: For the purpose of this policy, "**amend"** is defined as the patients right to add to (or append) information with which he/she disagrees. It does not include deleting, removing, or otherwise changing the content of the record.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

Requests for Amendment and Timely Action

1. The facility must permit a patient to request an amendment to PHI as contained in the designated record set. The facility must require requests for amendment to be presented in writing. The sample Request for Amendment (attached) form may be used.

2. The facility must act on a request to amend no later than 60 days after receipt.

3. Extenuating Circumstances

   a. If the facility is not able to meet the request to amend the record in 60 days, the Privacy Officer must provide the patient with a written statement outlining the reasons for the delay and the date by which the request will be met.

   b. If it is foreseeable that the request cannot be met within 90 days, the Compliance Officer and Risk Manager must be informed of the delay by the Privacy Officer no later than 5 business days prior to the deadline and must act to remediate the situation.

Accepting the Amendment

The following steps should be followed when accepting amendments to patient records:

1. The facility must make the appropriate amendment to the PHI by, at a minimum, identifying the records in the designated record set that are affected and appending or otherwise providing a link to the location of the amendment. In the case where the information is stored in another medium (e.g., microfilm, microfiche) a record of the link will be filed.

2. The facility must inform the patient in a timely fashion that the amendment has been accepted.

3. The facility must make reasonable efforts to inform and provide the amendment in a reasonable time to:

   a. Persons identified by the individual as needing the amendment; or

   b. Persons, including business associates, whom the facility knows, have the unamended information and who may have relied or could foreseeably rely on such information to the detriment of the individual.

4. Amendments regarding services provided to the patient will be communicated to appropriate individuals in the billing department for review of potential billing issues.

Denying the Amendment

1. If the facility denies the request, the Privacy Officer must provide a timely, written denial to the patient. A sample Denial Letter is attached. The denial must contain:

   a. The basis for the denial in accordance with the policy statement;

   b. The patient's right to submit a written disagreement and how the patient may file such a statement;

   c. A statement that the patient may request the facility include the request and denial with any future disclosures of the information included in the request for amendment; and

d. A description of how the patient may discuss the denial with the Privacy Officer, including his/her name and telephone number, and the Secretary of HHS.

2. Statement of Disagreement or Rebuttal

a. If the patient submits a statement of disagreement, the Privacy Officer may provide a response statement to the patient. The Privacy Officer is encouraged to discuss the disagreement with legal counsel.

b. The facility must append or link the patient's request for an amendment, the denial, the statement of disagreement, and the written rebuttal to the specified designated record set.

c. Any future releases must include:

- The request for amendment and its denial; and
- The statement of disagreement and its rebuttal.
- If a release is made in a standard electronic transaction, the amendment may be separately transmitted via paper or fax.

Accepting Forwarded Amendments

A facility that is informed by another entity of an amendment must accept the amendment into its designated record set.

Required Documentation

1. A covered entity must document and retain the following:

a. The designated record sets that are subject to amendment by individuals.

b. The titles of the persons or offices responsible for receiving and processing requests for amendment by individuals.

2. All correspondence and associated documentation related to patient amendment of the designated record set must be maintained/retained per the Records Management Policy or for six (6) years, whichever is longer.

ATTACHMENTS:

A: Sample Letter-Denial of Amendment to Protected Health Information

B: Sample Request for Amendment Form Instructions

C: SVMC Request for Amendment of Health Information

REFERENCES:

- Health Insurance Portability and Accountability Act (HIPPA), Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164)

CROSS REFERENCES:

- Patient Privacy – Protection Policy
- Patient Privacy – Patients' Right to Access Policy
- Records Management Policy

ATTACHMENT A
SAMPLE LETTER: DENIAL OF AMENDMENT
TO PROTECTED HEALTH INFORMATION

Patient Name:
Social Security Number:
Date of Birth:
Patient Medical Record Number:

Dear (patient):

At Sierra View Medical Center, each patient is provided the right to amend his/her protected health information that is contained within the designated record set for as long as the information is maintained. Each request is reviewed subject to the limitations outlined in HIPAA Federal Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164).

The Privacy Standard outlines the following circumstances where the facility may deny the amendment. Your request has been denied due to the following (circle one):

1. *The information was not created by the facility;*

2. *The information is accurate as documented;*

3. *The information is not part of the record set that qualifies for amendment; or*

4. *The information is not available for access.*

You may provide a statement of disagreement. If you provide a statement of disagreement, any future releases of the information outlined in your proposed amendment will include your request for amendment and this denial. The facility's written response will also be included in the release.

If you choose not to provide a statement of disagreement, you may request that all future releases include your Request for Amendment and the Denial thereof. The request should be made in writing to the Privacy Official at the address below.

You also have the right to contact the Secretary of HHS to discuss this denial.

Please contact me with questions or concerns.

(Signature of Privacy Officer)

Privacy Officer
Phone: (xxx)
Address: (XXX) cc: (Attending Physician)

ATTACHMENT B
SAMPLE REQUEST FOR AMENDMENT FORM INSTRUCTIONS

Items for discussion when updating / using the Amendment Form attached:

1. Whenever a patient asks to amend his health information, document the request and your response to it by having the patient complete a request form.

2. The form you utilize should ask the patient for the following information:

   - date of the request;
   - patient's name, birth date, address, and patient number;
   - health information at issue and date or dates of its entry;
   - reason for the amendment and what the amendment should include;
   - names and addresses of anyone who should receive the information at issue; and
   - patient's signature.

3. The form also should include an area for your organization to record whether the patient's request was approved or denied; any comments; and the Privacy Official signature.

4. Please refer to the Patient Privacy – Patients' Right to Amend Policy for further information and guidance on the requirements related to amendment.

ATTACHMENT C

SIERRA VIEW DISTRICT HOSPITAL
REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Please complete the following information:

1. Today's date _____
2. Patient Full Legal Name _____
3. Birth date _____ 4. Patient # _____
5. Patient street address _____

   City _____ State _____ Zip _____
6. Describe the information you want amended (e.g., lab test results, physician notes)
   _____
7. Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services) _____
8. What is your reason for making this request? _____
   _____
9. How is the entry incorrect or incomplete? _____
   _____
10. **Please attach written amendment.**
11. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)?
    If yes, please specify the name(s) and address (es) of the organization(s) or individual(s).
12. If amendment is accepted, do we have your permission to share amendment with individuals who have received this information? _____

Signature of patient/legal representative: _____

Date: _____

Individual other than patient: _____ Relationship: _____

Date: _____

Page 2 of REQUEST FOR AMENDMENT OF HEALTH INFORMATION form

FOR HEALTHCARE ORGANIZATION USE ONLY

Amendment has been Accepted Denied

Signature of Facility Privacy Official: _____

Date: _____

- ☐ Patient has not filed a Statement of Disagreement, but requests that any future releases include the requested amendment and denial information.
- ☐ Patient has filed a Statement of Disagreement that **must** be released along with other documentation with any future releases of information.
- ☐ Facility/provider appended written response (rebuttal) and forwarded to patient.
- ☐ Facility/provider did not provide a response/rebuttal.

SUBJECT: **PROTECTION OF PATIENT PRIVACY**	SECTION: **Page 1 of 13**

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

PURPOSE:

To ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy and 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 of 2009 (ARRA), and all other Federal and State regulations and interpretative guidelines.

This policy sets forth guidelines for protecting and maintaining the confidentiality of individually identifiable patient health information (referred to hereafter as "Protected Health Information" or "PHI").

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to protect each patient's right to privacy and confidentiality by following applicable state and federal laws. SVMC recognizes that employees have access to private and confidential information about patients. As such, it is incumbent upon the organization to inform and educate staff about their moral, ethical and legal responsibility to ensure the confidentiality of such information.

No officers, employees, volunteers, students, instructors, vendors, contractors, or physicians (individuals) shall use, disclose or access the medical information of any Sierra View Medical Center (SVMC) patient (including themselves or family members) unless they are directly involved in the treatment, payment or healthcare operations regarding that patient, or as otherwise permitted by Patient Privacy policies. SVMC's Patient Privacy policies provide that the amount of PHI that shall be used, accessed or disclosed on any patient shall consist only of the minimum necessary to complete the assigned duties, except for purposes of treatment. Any individual who engages in behaviors inconsistent with these standards violates this policy, and such violations constitute grounds for disciplinary action up to and including termination, professional discipline, and civil or criminal prosecution. All individuals are expected to comply and cooperate with the facility's administration of this policy and other Patient Privacy Policies.

DEFINITIONS:

Protected Health Information (PHI) – Any individually identifiable health information, in any format, including verbal communications. "Individually identifiable" means that the health or medical information includes or contains an element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity. PHI includes patient billing and health information and applies to a patient's past, current or future physical or mental health or treatment.

Electronic Protected Health Information or ePHI – PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all data that may be transmitted over the Internet or stored on a computer, a CD, a disk, magnetic tape or other media

Personal Information (PI) – an individual's first name or first initial and last name combined with any one of the following:

Social security number,

Driver's license number or California identification card number,

Account number, credit, or debit card number, in combination with any required security code, access code, or password that would permit access to an individual's financial account,

Medical information, or

Health insurance information.

Medical information – means any information, in either electronic or physical form, regarding an individual's medical history, mental or physical condition, or medical treatment or diagnosis by a health care professional and which may be in the possession of or derived from a health care provider, health care service plan, pharmaceutical company or contractor.

Health insurance information – means an individual's health insurance policy number or subscriber identification number, any unique identifier used by a health insurer to identify the individual, or any information in an individual's application and claims history, including any appeals records.

Restricted information – describes any confidential or personal information that is protected by law or policy and that requires the highest level of access control and security protection, whether in storage or transit. This includes Personal Information, PHI, and ePHI as defined in this section but could also include other types of information such as research data.

Disclosure – is the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Health care operations – covers a broad range of activities such as quality assessment, patient education, and training, student training, contracting for health care services, medical review, legal services, auditing functions, compliance, business planning and development, licensing and accreditation, business management and general administrative activities.

Payment – can be defined as activities related to being paid for services rendered. These include eligibility determinations, billing, claims management, utilization review, etc. It also includes using debt collection and location agencies.

Treatment – under the Privacy Rule is defined to include all the preventive, diagnostic, therapeutic, rehabilitation, maintenance and palliative care provided to an individual as well as the provision,

coordination, and management of health care and related services by one or more health care providers, including the coordination of management of health care provider with a third party, consultation between health care providers relating to patient, or the referral of a patient for health care from one provider to another.

Use – means the sharing, employment, application, utilization, examination, or analysis of information within an entity that maintains such information.

Workforce – means employees, volunteers, and other persons who conduct, in the performance of their work for SVMC, are under the direct control of SVMC whether or not SVMC pays them. The workforce includes employees, medical staff, and other health care professionals, agency, temporary and registry personnel, and trainees, house staff, students and interns, regardless of whether they are SVMC trainees or rotating through SVMC locations from another institution.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES, AGENTS, AND PROFESSIONALS OF SVMC*

PROCEDURE:

I. Protection of Individually Identifiable Health Information (PHI)

Members of the SVMC workforce may not disclose, share, or otherwise use any individually identifiable health information except for Treatment, Payment, and Health Care Operations (referred to as "TPO") unless expressly authorized by the patient or otherwise permitted by law.

II. Classification of PHI information

All information contained within patient medical and billing records is confidential regardless of format (i.e. print medium, audio recording, electronic display or storage). These confidentiality protections extend not only to the patient's medical record but also to information from the record. Thus, abstracts of charts, medical record numbers, diagnoses, case histories, or descriptions of medical procedures that include or refer to the patient's name, social security number, or identifying information, as well as information orally communicated about a particular patient, must be maintained as confidential PHI.

Also, special laws govern mental health, substance abuse, gender affirming care, and HIV test results information. Questions regarding the release of sensitive medical information should be referred to the Health Information Management department.

III. Notice of Privacy Practices

The Privacy Rule requires that providers give patients detailed information about their privacy practices. The "Notice of Privacy Practices" shall be given to all SVMC patients upon admission or, in the case of outpatients, at the time of service, as further described in SVMC policy "Notice of Privacy Practices."

IV. Authorization to use PHI

The Privacy Rule requires providers to obtain a written authorization from an individual before using or disclosing a patient's PHI for purposes other than TPO.

V. Patient Access to PHI

The Privacy Rule gives an individual (or that person's representative) the right to access to inspect and obtain a copy of the individual's own PHI. Providers may deny an individual access to his or her information under certain circumstances only if specified procedures are followed.

All requests from patients for information from medical records should be referred to or coordinated with the Health Information Management Department.

VI. Restrictions on the Use of PHI

The Privacy Rule and California law generally allow a provider to use or disclose PHI to carry out TPO. An individual, however, has the right to request that providers restrict their use or disclosure of PHI to carry out TPO – that is, a patient may request that the provider voluntarily agree not to use or disclose PHI in a way that the law would otherwise allow. The Privacy Rule also gives individuals the right to request restrictions on the information that may be released to family or friends.

VII. SVMC Workforce (Employee) Responsibilities to Maintain Confidentiality of PHI

All members of the SVMC Workforce are responsible for maintaining the security and confidentiality of PHI on behalf of SVMC patients. This responsibility includes both the physical (electronic or paper) record and all information contained in or derived from the medical record, including information disclosed or transmitted orally.

A. Minimum Necessary

When using or disclosing PHI, or when requesting PHI from another entity, a Workforce member must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. This requirement does not apply to:

a. Disclosure to, or requests by, a health care provider for treatment;

b. Uses or disclosures made to the individual, as permitted or required.

c. Uses or disclosures made under an authorization;

d. Disclosures made to the Secretary of the Department of Health and Human Services under an investigation or compliance review; or

e. Other use or disclosures that are required by law and are compliant with the requirements of the law.

Note: If the request for PHI constitutes the use of information (for example the sharing of information between two SVMC physicians), the minimum necessary provision still applies.

B. Workforce Access to PHI

All members of the SVMC Workforce should only access and use PHI as necessary for their job functions. Repeating or any way disseminating patient information, either by oral communication or in writing except as permitted herein or required by law, is considered an unauthorized release of medical information and is a serious offense, which may have personal civil and/or criminal liability. Violation of this policy constitutes grounds for disciplinary action up to and including termination.

VIII. Release of PHI to Third Parties

A. Requests for PHI by Outside Entities

SVMC receives numerous requests for copies of medical records daily from outside entities such as health plans, law enforcement agencies, licensing and regulatory agencies, attorneys, etc. Because of the specific accounting and disclosure requirements imposed by HIPAA, all copies of medical records for release to third parties or agencies must be completed or coordinated by the Health Information Management Department.

For example, when releasing PHI to third parties, except for purposes of TPO and those other instances in which the accounting requirements do not apply (i.e. disclosures under patient written authorization) as stated in the HIPAA Privacy Rule, SVMC is required to document all of the following:

i. The date of the disclosure;

ii. The name of the entity or person who received the PHI and the address of such entity or person (if known);

iii. A brief description of the PHI disclosed;

iv. The name of the individual and/or dependent who completed the disclosure; and

v. A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or a copy of the patient's authorization for such disclosure.

Also, PHI records shall be screened before their release to ensure that: (1) only the minimum necessary information is released; and (2) no privileged information (e.g. attorney-client, peer-review information) is released except as permitted or required by law.

IX. Mandatory Reporting Requirements

Although a patient has the right to refuse to disclose and to prevent others, including physicians, from disclosing confidential communications between the patient and his/her physicians, there are certain laws, which require or permit a provider to disclose patient records without the patient's written authorization. These circumstances, which are outlined in the Notice of Privacy Practices (See the Notice of Privacy Practices policy), include, but are not limited to:

i. Public health activities that involve safety or communicable disease;

ii. Reporting victims of abuse, neglect, or domestic violence;

iii. Judicial and administrative proceedings;

iv. Law enforcement purposes;

v. Organ and tissue donations;

vi. National security and intelligence activities;

vii. Workers' compensation; or

viii. Requests related to decedents.

X. Mental health, Substances Abuse, and HIV Test Result information

Special laws govern mental health, substance abuse, and HIV test result information. Questions regarding the release of sensitive medical information should be referred to the Health Information Management Department.

XI. Psychotherapy Notes

Psychotherapy notes receive stricter treatment under the Privacy Rule than other types of PHI. A health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session that is separated from

the rest of the individual's medical record, but excludes certain records, narrowly defines psychotherapy notes under the Privacy Rule to include notes. Before releasing any psychotherapy notes without patient authorization, an employee should first consult with the Health Information Management Department.

XII. Privacy Requirements Relating to Research

Research is not considered a part of TPO under the Privacy Rule, except for certain studies related to health care operations, such as quality assurance and utilization management activities. Consequently, the use or disclosure of PHI for research purposes requires either:

i. Written authorization from the individual about whom the information is collected;

ii. A waiver of authorization from SVMC Compliance Committee;

iii. The satisfaction of another research exception under the Privacy Rule.

XIII. De-Identified Information

According to the Privacy Rule, health information that does not identify an individual (referred to as "de-identified information") is generally not considered PHI and may be disclosed without the patient's authorization. To de-identify PHI, SVMC must remove all eighteen of the HIPAA identifiers specified in the Privacy Rule. Also, before using any such de-identified information for research purposes, there must be no means to re-identify the data by the recipient of the de-identified data set.

XIV. Limited Data Sets

The Privacy Rule permits the use and disclosure of a limited data set of information for research purposes without patient authorization provided certain requirements be met, including entering into a Data Use Agreement with the recipient of the information.

XV. Disclosure to Business Associates

The Privacy Rule requires providers to enter into a written agreement with certain third parties (individuals or entities) that provide services and functions on behalf of SVMC, which involves using, accessing, disclosing, or maintaining PHI.

XVI. Marketing

In general, PHI may not be disclosed for marketing purposes without the patient's authorization. If the marketing involves direct or indirect payment to SVMC from a third party, the

authorization form that the individual signs must include a statement that SVMC received payment for using and/or disclosing PHI for marketing purposes.

XVII. Fundraising

SVMC may use or disclose limited PHI to a Business Associate (see Section XIII, above) or to an institutionally related foundation to raise funds for its benefit, provided the PHI used or disclosed must be limited to demographic information and the dates of health care provided to the individual. Demographic information includes the individual's name, age, gender, insurance status, address, and other contact information. SVMC must obtain the individual's prior written authorization to use or disclose any other information (such as the treating or referring physician, the department or practice area, illness or treatment) for fundraising purposes. Since only the individual's demographic information may be used, reports cannot be generated for fundraising purposes from an information system using non-demographic information fields, such as a physician, medical condition or clinical department.

Also, all fundraising materials sent to an individual must describe, in a conspicuous place, how the individual can opt-out of receiving further fundraising communications.

XVIII. Media Inquiries

Both California law and the Privacy Rule restrict the amount of information that may be provided to the media without the patient's authorization. In general, if the patient has not requested that information be withheld, SVMC may release the condition and location of the inpatient, outpatient or emergency patient, but only if the inquiry specifically contains the patient's name. No information can be given if a request does not include the patient's name or if the patient has requested that information be withheld.

A patient's condition may only be described in general terms that do not communicate specific medical information about the individual. For example, "undetermined", " good", "fair", "serious", "critical", or "deceased". All inquiries from the media should be referred to the SVMC Marketing Department.

XIX. Safeguards to Protect PHI

In addition to protecting the privacy of a patient's health information by complying with regulations regarding the use and disclosure of PHI, Workforce members are responsible to protect PHI with reasonable physical, electronic and administrative safeguards. It is the responsibility of all Workforce members to secure PHI that they have access to or are using to complete assigned responsibilities.

Reasonable safeguards are to be used at all times to ensure that confidential information is not disclosed to individuals who are not authorized to receive the information and to minimize incidental disclosure of PHI.

XX. Physical Safeguards

Each Workforce member is responsible to protect the physical security of the PHI he/she is using, accessing or maintaining in his/her work area, including but not limited to:

i. Ensuring that PHI is not readily visible to visitors or the public;

ii. Maintaining charts in designated secure areas and not leaving charts unattended in areas to which the public has access;

iii. Locking areas in which there are medical and billing records at the end of the day or when no staff are in the area.

iv. Never taking paper PHI records of any kind offsite (i.e. home) unless the individual's supervisor, Privacy Officer and/or Health Information Management Director through a documented and auditable process, approves doing so.

v. Checking that all PHI is removed upon leaving conference rooms and other meeting locations and the unwanted materials are properly disposed (i.e. shredded); Taking reasonable measures (i.e. lower voices, draw curtains) to provide auditory privacy to individuals in areas where interviews or other conversations including PHI are being conducted and have the potential to be overheard. Examples of such situations include:

-Conversations among caregivers that involve patients;

-Discussion of a patient's condition or lab tests with the patient, either in person or over the phone; and/or

-Discussing a patient's condition during teaching rounds with SVMC;

-Positioning computer screens so that the information is not visible to passersby;

-Leaving minimal information for patients on answering machines and voice mail;

-Locating printers and fax machines in secure areas;

-Retrieving and distributing faxed PHI promptly; and

-Using professional judgment when calling out patient names in the waiting room areas.

-At times, minimally necessary information may be displayed and incidentally available within patient treatment areas in the following circumstances:

-Information related to the patient's treatment and condition supports patient safety;

-Information to display within patient treatment areas to support staff safety; and/or

-Workforce members continue to use physical safeguards to protect all PHI.

XXI. Electronic Safeguards

Workforce members are responsible for ensuring compliance with safeguards to protect electronic information including but not limited to:

i. Not sharing passwords for computer systems;

ii. Not maintaining passwords in locations where they can be obtained and used by others (i.e. post-it notes on computer monitors, stored in a Rolodex, placed under computer keyboards); and

iii. Using time out functions or locked screen savers to auto-logout of computer functions when not in use.

XXII. Administrative Safeguards

i. Departmental managers are responsible for orientating Workforce members under their direction with requirements to secure PHI in their specific areas or units.

ii. Workforce members who are responsible for maintaining both PHI and non-PHI must assure that if the data is co-mingled, it is all maintained consistent with HIPAA standards or the data must be maintained in separate formats.

XXIII. Workforce (Employee) Training and Education

The Privacy Rule requires that covered entities such as SVMC train their Workforce on privacy policies and procedures at a level appropriate for the Workforce members to carry out their roles and responsibilities. All members at SVMC Workforce will be provided with training on the HIPAA Privacy and Security Rules consistent with their job responsibilities.

XXIV. Patient Privacy Violations

A patient privacy violation is unauthorized access, disclosure, or use of medical information or PHI. Any individual, who believes another individual has breached the facility's Patient Privacy policies, or otherwise breached the integrity or confidentiality of PHI, should immediately report such breach to his/her supervisor, the PO, the CO, the ISO, or Risk Management. Supervisors receiving such reports should immediately forward all information to the PO, the CO, the ISO, or Risk Management. Such violations may include, but are not limited to:

i. An individual reviewing their medical information, or that of a family member, without filling out the appropriate Release of Information form with the Health Information Management (HIM) Department;

ii. Open discussions of PHI within public areas such as the Café, hallways, or elevators;

iii. Reviewing medical records of patients to obtain personal demographic information or for other purposes not authorized by Patient Privacy Policies;

iv. Discussing PHI with other hospital personnel who are not involved in the care of the patient or otherwise authorized to receive such information by Patient Privacy Policies; or

v. Reviewing patient information because of personal interest.

SVMC will conduct a thorough and confidential investigation into any reported violation of Patient Privacy Policies. The facility will inform the complainant of the results of the investigation (an exception being if the complaint was received anonymously, then no follow up will be attempted). SVMC will not retaliate against or permit reprisals against a complainant who has filed a complaint in good faith. SVMC will provide information concerning the violation to appropriate law enforcement personnel and will cooperate with any law enforcement investigation or prosecution.

XXV. Unauthorized Access to Patent Information

It is important to understand that, for purposes of this policy, "unauthorized" does not mean "without a patient's written or verbal authorization." Instead, "unauthorized" means, in essence, the inappropriate accessing of medical information without a direct need for that information for lawful use and as permitted by Patient Privacy Policies. An example of a reportable "unauthorized access" is a situation in which an individual peeks at a patient's medical record merely to satisfy his or her curiosity, or an individual is seeking information about neighbors, fellow employees, church members, etc.

Complaints of breaches will be thoroughly investigated by the appropriate personnel. Any confirmed breaches of this nature will be reported to the CDPH within 15 business days of notification. No proof of patient harm is required for the breach to be reportable, or for CDPH to fine the facility. The patient, whose record was involved in the breach, will also be notified.

All individuals need to realize that the California Department of Health (CDPH) may forward any reports from the hospital of breaches by individuals to California Office of Health Information Integrity (CalOHII). CalOHII may investigate individuals involved in the breach (in addition to the investigation that will be conducted by SVMC). CalOHII may assess its fines against the individual including recommendations of disciplinary actions to that individual's licensing board if the individual is licensed. Fines levied by the CalOHII range from $2,500.00 up to $250,000.00 per violation. Determination of the fine will be made by CalOHII and will be based on an individual's intent, time of the violation, and the individual's assets, liability and net worth.

Breaches affecting less than 500 patients will be reported to the Office of Civil Rights of the U.S. Department of Health and Human Services annually.

Breaches affecting 500 or more patients will be reported to the Office of Civil Rights of the U.S. Department of Health and Human Service at the time the incident is confirmed.

XXVI. Disciplinary Procedure

Employees/Officers: If an investigation of any reported or suspected violation of Patient Privacy Policies substantiates the violation by any individual, appropriate disciplinary action will be taken, which could include termination upon the first offense.

Medical Staff Members/Physicians: If a medical staff member or physician is determined to have violated Patient Privacy policies, the matter will be referred to the Medical Staff Office for appropriate action. Confirmed breaches will be reported to the applicable state agencies as mandated by law without deference to any pending disciplinary actions against the accused medical staff member or physician.

Contractors/Vendors: SVMC will seek to include such violations by contractors or vendors as grounds for termination of the contract and/or imposition of contract penalties.

Students/Instructors/Volunteers: Violations by students, instructors, or volunteers will be subject to having their access to the hospital systems terminated. Additionally, their continued association with any educational or volunteer program at SVMC will be reviewed and could be discontinued upon first offense.

Violation of SVMC Patient Privacy policies and/or standards by any individual may constitute a civil or criminal offense under HIPAA and/or other federal or state laws. Any individual who

violates such laws may expect that SVMC will provide information concerning the violation to appropriate law enforcement personnel and will cooperate with any law enforcement investigation or prosecution.

REFERENCES:

- Health Insurance Portability and Accountability Act, 45 CFR 160-164
- Health Information Technology for Economic and Clinical Health Act (HITECH) component of the American Recovery and Reinvestment Act of 2009 (ARRA)
- California Medical Information Act, California Civil Code Section 56 et seq.
- Information Practices Act of 1977, California Civil Code Sections 1798.29 and 1798.82
- California Health and Safety Code Sections 1280.15 and 130203
- California Lanterman-Petris Short Act ("LPS Act")

CROSS-REFERENCES:

- Release of Patient Information Policy
- Marketing under the HIPAA Privacy Standards/HITECH
- Minimum Necessary
- Patient Privacy – Program Requirements

SUBJECT: **PURPOSE AND AUTHORITY**	SECTION: ***General Information*** **Page 1 of 2**

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

PURPOSE:

Disasters can and do occur anytime and anywhere. They may vary in severity, number of victims involved and impact on the physical plant of the hospital facility. The community expects that its hospital will always be ready and able to respond efficiently and effectively to any and all situations.

The objective of the Emergency Operations Plan is to provide a structured method for hospital personnel to follow in mobilizing for response to a disaster situation. The plan is designed to provide for maintaining a high standard of care when normal demands for service are exceeded and to provide for a safe working environment for staff. The plan establishes procedures for the maximum utilization of our facilities and personnel, as well as integration with local community, county, and regional resources.

POLICY:

Sierra View Medical Center (SVMC) shall establish and maintain an emergency action plan, referred to as the Emergency Operations Plan, to permit appropriate response to internal and external disasters. The staff shall be trained to respond to the incident in accordance with guidance provided in the plan. A Disaster Exercise will be conducted at least twice a year to test and evaluate the plan

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

ORGANIZATION:

In times of crisis, the facility will operate under the Hospital Incident Command System (HICS) as developed by the State of California Emergency Medical Services Authority.

The HICS Plan consists of a chain of command, which incorporates four sections under the overall leadership of an Emergency Incident Commander. Each of the four sections: Logistics, Planning, Finance, and Operations, has a chief appointed by the Incident Commander and responsible for their sections. The Chiefs in turn designate directors and unit leaders to sub-functions. This structure limits the span of control of each manager in an attempt to distribute the work.

Each position on the organizational chart has a prioritized Job Action sheet written to describe the important duties of each particular role. The duties on the Job Action sheets are put into categories of "Immediate", "Intermediate", and "Extended".

AUTHORITY:

The overall authority and direction of the SVMC Emergency Preparedness Plan rests with the Chief Executive Officer, Safety Officer or Administrator On-Call. In the absence of the Chief Executive

Officer, Safety Officer, or the Administrator On-Call the Nursing House Manager on duty will be in charge.

This person is responsible for declaring the phase of the disaster and will direct and coordinate all hospital activities until relieved by Administrative Authority.

REFERENCES:

- The Joint Commission (20~~1~~26~~9~~). Hospital accreditation standards. EM.09.01.01 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **RECORDING HOURS WORKED**	SECTION: **Page 1 of 4**

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

PURPOSE:

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

POLICY:

Exempt Employees:

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

Non-Exempt Employees:

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

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

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

CLOCKING IN AND OUT

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

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

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

EMPLOYEE REVIEW OF TIME RECORDS

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

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

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

LEADERSHIP REVIEW OF TIME RECORDS

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

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

FALSIFICATION OF RECORDS PROHIBITED

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

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

HOURS WORKED

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

Payment for time worked will be calculated by the minute as recorded in the timekeeping system.

There will be no rounding of time by fifteen minute increments. Early clock ins prior to an employee's scheduled shift and/or late clock outs at the end of an employee's scheduled shift that result in overtime is prohibited unless approved by their leader. Any pattern of intentionally gaining unapproved time will result in disciplinary action.

PRE OR POST-SHIFT ACTIVITIES

Any activity that non-exempt employees are required to perform before they can begin their jobs or before they can leave the premises must, by law, be considered time worked. Such activities may include, but are not limited to:

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

VOLUNTEERED TIME – (Non-exempt)

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

DIRECTOR RESPONSIBILITY FOR ADMINISTRATION OF SALARY POLICIES

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

REFERENCES:

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

CROSS REFERENCES:

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

SUBJECT: **RECOVERY FROM DISASTER RESPONSE**	SECTION: ***Termination of Disaster Response*** **Page 1 of 2**

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

POLICY:

Following the termination of a Disaster Response, Sierra View Medical Center (SVMC) will work to return the provisions of services to a normal level as soon as possible.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

1. Recovery will depend on the type of disaster and the degree of internal damage, if any, caused by the event.

2. Emergency Incident Commander will direct recovery efforts in a planned and programmed manner.

3. Major internal damage must be assessed and portions of the Hospital safe to occupy while rebuilding or repairing must be identified.

4. Assessment must be made of the level of services which may be delivered. Any restriction on normal levels of provision of care must be communicated to the Department of Health and any other agency affected.

5. Structural damage will need to be reported to insurance carriers.

6. Consideration must be given to the reasonable timeframes in which staff may return to normal schedules. During a disaster, staff may have worked long hours and recovery time for them should be considered. Opportunities for Critical Incident Stress Debriefing should be coordinated with the Administrative Director of Quality and Care and Pastoral Care for staff members as the need is identified.

7. The Finance Section Chief is an integral part of the recovery team for input on cash flow, availability of funds for rebuilding, and the use of other public funds.

8. Title 19 of California Code of Regulations, Office of Emergency Services, provides for state funding of response-related personnel costs for officially declared disasters incidents. To qualify, the facility must participate with local governmental agencies in the Standard Emergency Management system for disaster response. Application for reimbursement should be submitted through the Tulare County Operational Area/Tulare County Department of Health EMS Division. Information submitted must include personnel hours, costs and damage losses.

REFERENCES:

- Title 19: Section 2900
- The Joint Commission (2026~~19~~). Hospital accreditation standards. EM.09.01.01 Joint Commission Resources. Oak Brook, IL

SUBJECT:	SECTION:
PATIENT PRIVACY – RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION	***Ethics, Rights & Responsibilities (RI)***

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

PURPOSE:

To ensure the patient's right to request Confidential Communications by alternative means or to alternative locations 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, and any and all other Federal regulations and interpretative guidelines.

POLICY:

Patients will be provided the right to request Confidential Communications by alternative means or to alternative locations. Requests for Confidential Communications must be accommodated by the facility if reasonable. Confidential Communications pertain to all future billing correspondence and communication related to the specific visit(s) stated in the request.

Acceptable alternate means of communication include mail and telephone. Any requests for communication via phone only must also include a mailing address (permanent or alternate) for purposes of billing and collections. Unacceptable means include fax, e-mail and Internet communications (as security of the transmission cannot be guaranteed).

Acceptable alternate locations include all U.S. mailing addresses and all U.S. phone numbers. Patients requesting an alternate address must also provide their regular mailing address so that it may be maintained in their record.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE

1. The right to request confidential communications and the process for making the request must be outlined in the Notice of Privacy Practices.

2. The patient or patient's legal representative shall complete and sign the "Request for Confidential Communications" form (see attachment A). The form may be submitted to the facility or patient access representative.

3. The employee receiving the form from the patient will review it to verify that it has been completed satisfactorily. The employee may not ask for an explanation from the individual as to why the request is being made. Once the employee has verified the form, a copy of it will be provided to the patient or patient's legal representative.

4. Depending upon where the form is received (facility or patient access); the remaining copies of it will be routed to either the facility's Patient Access/Registration Department or Patient Financial Services department. Once they receive the form, they will follow the standard procedure for system entry and forward the remaining copies as designated on the request form. Upon receipt of their copy, the Chief Privacy Officer (CPO) will be responsible for notifying any additional parties that may need to take appropriate action.

5. Each department within SVMC shall develop a process to ensure that the appropriate patient address/phone as reflected in the system/record is used when communicating with the patient.

6. If the alternate phone number is not in service, or the correspondence sent to the alternate address is returned undeliverable, the situation should be reported to the CPO immediately. The CPO will notify the patient, via alternate address (if the phone is disconnected) or alternate phone (if the mail was returned undeliverable) that they must response within seven (7) calendar days or the facility will begin communicating with them via other means and addresses as provided. The CPO will be responsible for notifying all applicable parties to take appropriate action.

7. If the individual fails to respond to communications sent to an alternate address or by alternate means within a timeframe acceptable to the facility, the situation should be reported to the CPO immediately. The CPO will notify the patient, via the original alternate means and/or alternate location, that they must respond within seven (7) calendar days or the facility will begin communicating with them via other means and addresses as provided. The CPO will be responsible for notifying all applicable parties to take appropriate action.

8. The patient must complete another "Request for Confidential Communication" form to revise the alternate means or alternate address. When the form is received by the facility, it will be processed beginning with Step 2 of this same procedure.

9. The patient must complete a "Confidential Communications Revocation" form to revoke the alternate address or alternate means. When the form is received by the facility, it will be processed beginning with Step 2 of this same procedure.

10. All forms/requests for confidential communications must be maintained for a minimum of six (6) years.

REFERENCES:

- Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164

CROSS REFERENCES:

- Patient Privacy Program Requirements Policy
- Notice of Privacy Practices Policy

Attachment A

SIERRA VIEW MEDICAL CENTER — **REQUEST FOR ALTERNATIVE MEANS OF COMMUNICATION**

Date: _____

Patient name: _____

Date of birth: _____ Medical Record#: _____

You may request to receive confidential communications of protected health information (PHI) by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home where a family member might see it.

We may not ask you the reason for your request. We will accommodate all reasonable requests.

If you make a special request, you must give us an alternative address or other method of contacting you (phone number, email address, etc.). Please specify how or where you wish to be contacted:

_____

_____

Date: _____ Time: _____ AM/PM

Signature:_____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name:_____
(legal representative)

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at www.Sierra-View.com or by sending a written request to:

The Privacy Officer,
C/O HIM Department at
Sierra View Medical Center
465 W. Putnam Ave
Porterville CA 93257

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the hospital, contact the Privacy Officer (559) 788-6066. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
REQUEST FOR ALTERNATIVE MEANS OF COMMUNICATION
Form # 021299 REV 9/17

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

PATIENT'S LABEL

SIERRA VIEW MEDICAL CENTER — **REQUEST FOR ALTERNATIVE MEANS OF COMMUNICATION**

❑ Request APPROVED ❑ Request DENIED

By: _____
Signature

Date: _____ Time: _____ AM/PM

Reason for Denial:

- ❑ Administratively impractical to accommodate request.
- ❑ You failed to provide information as to how payment, if applicable, will be handled.
- ❑ You failed to specify an alternative address or method.
- ❑ Too expensive to accommodate request.

Additional explanation:

_____

_____

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
REQUEST FOR ALTERNATIVE MEANS OF COMMUNICATION
Form # 021299 REV 9/17

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

PATIENT'S LABEL

SUBJECT:	SECTION:
SANCTION SCREENING – EXCLUDED INDIVIDUALS/ENTITIES	**Page 1 of 4**

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

PURPOSE:

To establish procedures to prevent Sierra View Medical Center's (SVMC) hiring, employing, contracting with and/or giving the provision of Medical Staff privileges to anyone excluded from participation in a Federal or State Health Care Program or Procurement Program.

POLICY:

All current and prospective employees, Medical Staff members, independent contractors, vendors, suppliers, and consultants shall at a minimum be searched against the Department of Health and Human Services/Office of Inspector General's List of Excluded Individuals/Entities (OIG) the General Systems Administration (GSA) List of Excluded Individuals/Entities and the California Department of Health Care Services Suspended and Ineligible Provider List based on the frequency outlined in this policy. A third party vendor may be used to perform the exclusion checks and monitoring. The Compliance Officer or designee will manage the uploading of reports to the third party vendor and perform adjudication, if necessary.

Following investigation, once an individual or entity is confirmed as being ineligible to participate in a Federal or State Health Care Program or procurement program, the individual or entity will immediately be relieved by SVMC from responsibilities at SVMC. Any instance of identifying an ineligible individual or entity shall be reported to the Compliance Office.

Definition of an Excluded Person/Entity: An excluded person can be an employee, Medical Staff member, independent contractor, vendor, supplier, consultant, or entity who has been identified by the Federal or State government as committing an act that excludes the individual/entity from participating in a Federal or State Health Care Program, or Federal/State procurement program. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES/MEDICAL STAFF MEMBERS/ INDEPENDENT CONTRACTORS/VENDORS/SUPPLIERS/CONSULTANTS*

PROCEDURE:

1. Employment Applicants:

    a. Human Resources shall initiate a background investigation, post-employment offer, which includes a search of the OIG/GSA/State Exclusion Lists. In the event the applicant is on the OIG/GSA/State Exclusion List, the offer of employment shall be postponed pending an investigation and determination from the VP of Human Resources and Compliance Officer. If it is confirmed that an individual is excluded from a federal or state healthcare program, the offer of employment will be rescinded.

2. New Contingency Staff:

   a. Human Resources requires companies providing SVMC contingency staff to search the OIG/GSA/State Exclusion Lists and validate the individual is not excluded, prior to placement with SVMC.

3. Current Employees/Volunteers/Contracted Individuals/Contingency Staff:

   a. Human Resources staff shall send a monthly list of all current employees, volunteers, contracted individuals and contingency staff to the Compliance Officer or designee. The OIG/GSA/State Exclusion Lists shall be searched monthly to determine if a SVMC employee has been identified as an Excluded Person.

   b. In the event that an employee, volunteer, contracted individual or contingency staff member is identified as an Excluded Person, the VP of Human Resources and Compliance Officer will investigate and/or review the findings. Confirmation of the excluded status will be cause for immediate termination of employment or service.

4. Medical Staff/Allied Health Staff:

   a. Before approving a physician for Medical Staff privileges or authorizing an allied health staff person to provide services, the Director of Medical Staff Services Department or designee shall ensure that the individual is not an Excluded Person.

   b. If a physician or allied health professional is identified on the OIG/GSA/State Exclusion List, Medical Staff privileges/authorization to provide services shall not be granted.

   c. Any physician or allied health professional with a change in status, such as an exclusion from Federal or State Health Care Program participation, shall immediately report such change to the Chief of Staff and the CEO in writing and no later than 7 calendar days of action per Medical Staff Bylaws 2.6 (O). Failure to provide the notice required under Section 2.6 (O) regarding exclusions from a federal or stated program in a timely manner shall result in automatic termination of the member's membership and privileges,

   d. For ongoing exclusion monitoring, the Medical Staff Services Director or designee shall send a list of all current providers to the Compliance Officer or designee. The OIG/GSA/State Exclusion lists shall be searched monthly to ensure that any SVMC Medical Staff or allied health professional is not an Excluded Person.

e. In the event that a physician or allied health professional is on the OIG/GSA/State Exclusion List, the Director of Medical Staff Services Department and the Compliance Officer will review the findings and once exclusion is confirmed, the provider shall be automatically terminated from the medical staff per Medical Staff Bylaws 6.4-6

5. Non SVMC Staff Ordering and Referring Providers

a. The Compliance Officer or designee will compile a monthly list of ordering and referring providers using the Business Clinical Analytics application. This list will be used to search the OIG/GSA/State Exclusion lists monthly to ensure that the providers are not an excluded person/entity.

b. In the event that an ordering or referring provider is on the OIG/GSA/State Exclusion List, the Compliance Officer or designee will investigate and review the findings. Confirmation of the excluded status will be cause for immediate suspension of ordering privileges.

~~5.~~6. Vendors/Suppliers:

a. Before entering into a contract or agreement with a vendor or supplier the Contract Administrator or designee shall ensure that the vendor or supplier is not an Excluded Person/Entity. If a vendor/supplier is identified on the OIG/GSA/State Exclusion List, the contract shall not be executed.

b. All new or renewed contracts shall have a clause which requires the vendor/suppliers to notify SVMC immediately should they become ineligible to participate in a Federal or State Health Care Program or Procurement Program. The contract shall also specify SVMC's authority to immediately terminate the agreement in the event that the vendor becomes excluded.

c. Before Accounts Payable adds a new non-contracted vendor in the Vendor Master, Accounts payable staff shall access the third party vendor to search the OIG/GSA/State Exclusion Lists to ensure that the applicant is not an Excluded Person/Entity. In the event the vendor/supplier is on the OIG/GSA/State Exclusion List, the Director of General Accounting/Controller and Compliance Officer will investigate and review the findings. Confirmation of the excluded status will be cause for the Vendor/Supplier to not be added to the Master Vendor List.

d. ~~The Director of Materials Management or designee shall send the master vendor list to the Compliance Officer or designee~~ The Compliance Officer or designee will compile a monthly vendor list using the Business Clinical Analytics application to search the OIG/GSA/State Exclusion Lists monthly~~periodically~~ to ensure the vendor/supplier is not an Excluded Person/Entity. In the event that a vendor/supplier is on the OIG/GSA/State Exclusion List, the Director of Materials Management or designee and the Compliance Officer will investigate

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and review the findings. Confirmation of the excluded status will be cause for immediate termination of the vendor's/supplier's services.

e. Any vendor/supplier found to be excluded shall be immediately notified that their contract with SVMC is terminated.

~~6.~~7. Investigations of Excluded Person(s)/Entity(ies):

a. In the event that an Excluded Person/Entity is identified, the Compliance Officer or designee and appropriate leadership shall conduct an investigation with the excluded individual or entity and make a recommendation for resolution.

b. In the event that an Excluded Person/Entity is identified, Insurance Plan Sponsors and/or payors will be notified (when appropriate).

REFERENCES:

- 42 U.S.C. 1320A-7B (2006) https://www.govinfo.gov/content/pkg/USCODE-2023-title42/pdf/USCODE-2023-title42-chap7-subchapXI-partA-sec1320a-7b.pdf
- ~~Department of Health and Human Services Office of Inspector General. OIG Supplemental Compliance Program Guidance for Hospitals. (January 31, 2005)~~
- Department of Health and Human Services Office of Inspector General. OIG Compliance Program Guidance for Hospitals. (~~February 23, 1998~~November, 2023) https://oig.hhs.gov/compliance/general-compliance-program-guidance/

CROSS REFERENCES:

- CRIMINAL BACKGROUND SCREENS FOR EMPLOYMENT
- VENDOR MANAGEMENT
- VENDOR DICTIONARY

Field Code Changed

SUBJECT:	SECTION:
STANDARDIZED EMERGENCY CODES	***Initiation of Emergency Operations Procedures***

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

PURPOSE:

To provide appropriate staff notification to emergency situations utilizing the overhead paging system and standardized emergency codes.

POLICY:

In the event of an emergency situation, a standardized emergency code will be used to alert staff via the overhead paging system and prompt an appropriate, predetermined response.

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

A. Response & Recovery

1. Initiating an emergency code:

   a. When an emergency occurs, dial ext. “55” to report emergency code situation and location to the switchboard operator.

   b. The switchboard operator will immediately notify the management authority and response personnel in accordance with the corresponding policy on the attached “Emergency Situation Code Summary”.

   c. If an overhead page is required, the emergency page operator will use the appropriate emergency code and repeat it three times via the overhead paging system.

2. Terminating an emergency code:

   a. When the incident response is complete, the appropriate authority (Incident Commander, Administrator On Call or Safety Officer) or their designee will call the switchboard operator and request that they announce an “All Clear”.

   b. The switchboard operator will announce “the (Code Name) is “All Clear” three times via the overhead paging system.

B. Education & Training:

1. All staff members must be familiar with the following:

   a. Code names.

   b. Code definitions.

c. Appropriate ext. to call when notifying of an emergency situation.

d. Their specific responsibilities and procedures during an emergency code situation.

2. Emergency codes will be taught in each new hire orientation and to all staff at their mandated annual orientation update training or skills lab.

3. Law enforcement agencies must be briefed according to the existing policies and procedures as to the appropriate response to each emergency code.

REFERENCES:

- The Joint Commission, (2026~~3~~) Hospital Accreditation Standards EM.12.02.01 Joint Commission Resources. Oak Brook, IL.

EMERGENCY SITUATION CODE SUMMARY

Dial ext. "55" to report emergency code situation & location to the switchboard operator!

All code announcements followed by incident location are to be repeated 3 times in a clear, calm voice.

CODE BLUE *Patient Care Manual*	**Medical Emergency – Adult Patient** Announced with overhead page giving location. All appropriate staff responds to incident location.
CODE WHITE *Patient Care Services*	**Medical Emergency – Pediatric Patient** Announced with overhead page giving location. All appropriate staff responds to incident location.
CODE RED *EOC Manual / Life Safety*	**Fire Alert – Actual or suspected fire** Announced with overhead page giving location. Staff should implement R.A.C.E. procedures when necessary
CODE PINK *EOC Manual / Security*	**Infant Abduction** Announced with overhead page. All appropriate staff respond a monitor all building exits, parking lots. Police Department and Administration notified.
CODE PURPLE *EOC Manual / Security*	**Child Abduction** Announced with overhead page All appropriate staff respond & monitor all building exits, parking lots. Police Department and Administration notified.
CODE ORANGE *EOC Manual / Haz Mat*	**Hazardous Material Spill Alert** Announce over internal two-way radio only. Engineering/EVS to respond. Administration notified
CODE GRAY *EOC Manual / Security*	**Combative Patient / Person** Announce with overhead page. Non-essential personnel to remain out of the area. Switchboard to announce code over the internal two-way radio. Engineering/Security to respond. Administration notified.
CODE YELLOW *EOC Manual / Security*	**Bomb Threat** Notify Administration, House Supervisor (after hours), Engineering/Security. Notify Police Department Immediately. When directed, announce with overhead page. Department representatives to respond for briefing and instructions. DO NOT USE ANY ELECTRONIC DEVICES, CELL PHONES, PAGERS OR TWO-WAY RADIOS.
CODE GREEN *EOC Manual / Security*	**Missing Patient / Resident** Announced with overhead page All appropriate personnel, Engineering / Security respond to location.
CODE STRONG *EOC Manual / Security*	**Emergency Situation/Hospital Lock Down – Entire facility or localized** Announced with overhead page. Non-essential staff to remain out of the area. Switchboard to announce code over the internal two-way radio. Security to respond. PBX to notify Police Department. *Requires Administrative approval*.
CODE SILVER *EOC Manual / Security*	**Person in house with weapon / Hostage situation** Announced with overhead page & internal two-way radio. Non-essential staff to remain out of the area. Security to respond / PPD notified. *Requires Administrative approval.*
TRIAGE CODE I *EOP Manual / Section 4*	**Internal Disaster** Announced with overhead page as "*Triage Code one, Triage Code one, Triage Code one. All Directors and Managers report to designated area for briefing".*
TRIAGE CODE 2 *EOP Manual / Section 4*	**External Disaster** Announced with overhead page as "*Triage Code two, Triage Code two, Triage Code two. All Directors and Managers report to designated area for briefing.*"

SUBJECT:	SECTION:
STANDARDIZED EMERGENCY CODES	***Initiation of Emergency Operations Procedures***
	Page 4 of 4

SUBJECT:	SECTION:
STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	***Leadership (LD)***

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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:

- ~~"Nursing: Scope and Standards of Practice", American Nurses Association, 2015, 3rd Edition. Silver Spring, MD.~~
- American Nurses Association. (2021). Nursing: Scope and standards of practice (4th ed.). American Nurses Association. https://www.nursingworld.org

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SUBJECT:	SECTION:
SURGE CAPACITY PLAN	***Emergency Management Program*** ***Patient Management*** **Page 1 of 4**

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

PURPOSE:

The Surge Capacity Plan is an enhancement to the existing Emergency Operations Plan found in the Emergency Operations Procedures Manual.

POLICY:

The Sierra View Medical Center (SVMC) will provide a Surge Capacity Plan that will be utilized during major mass-casualty incidents or other times of anticipated hospital surge.

Sierra View Medical Center surge capacity is defined as the hospital's ability to handle an influx of casualties during major mass-casualty incidents (MCI) or disease outbreaks.

Categories for Surge Capacity

1. Short term (12-24 hours): Circumstances include accidents, earthquakes and similar disasters

2. Long term (24 hours to 24 months): Circumstances include outbreaks and epidemics

Anticipated Surge

The Local Emergency Medical Services Agency has defined for the County the anticipated surge capacity:

1. 500 cases per million population for patients with symptoms of acute infectious disease-especially smallpox, anthrax, plague, tularemia, and influenza;

2. 50 cases per million population for patients with symptoms of acute botulinum intoxication or other acute chemical poisoning – especially that result from nerve agent exposure;

3. 50 cases per million population for patients suffering burn or trauma; and

4. 50 cases per million population for patients manifesting the symptoms of radiation induced injury – especially bone marrow suppression.

SVMC Facilities Bed Capacity

SVMC is licensed for 132 General Acute Beds of which 10 are ICU, 10 are Perinatal, 4 Intensive Care Newborn Nursery, and 108 Unspecified General Acute. There are 2 negative pressure patient rooms throughout the campus. SVMC is licensed for 35 Skilled Nursing beds.

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

PROCEDURE:

Notification / Activation

Once the Sierra View Medical Center's Emergency Operations Plan is activated (partial or full activation) according to SVMC's activation policies, the following will occur to provide the surge capacity capabilities:

Incident Commander – upon identifying need for call back of all essential staff, will activate the Staff Call In policy and instruct the Labor Pool accordingly. The essential staff will include, but is not limited to:

- Medical Providers
- Infection Control
- Nursing
- Laboratory Personnel
- Respiratory Personnel
- Radiology Personnel
- Pharmacy Personnel
- Dietary
- Admitting
- Social Workers
- EVS Personnel
- Security Personnel
- Engineering Personnel
- Central Supply
- Risk Management

Mobilization

A staff pool may need to be activated to support the Emergency Operation Center's efforts to manage the disaster event either short term or long term. The Labor Pool is activated according to the Emergency Operations Plan and managed via the Hospital Incident Command System (HICS). Personnel will be assigned to perform functions to prepare logistically for the influx and the discharge of the patients and to support the operations.

Discharge Team Implementation

The Chief of Staff (COS) will assign all Medical Department Chairs to oversee the administrative process of discharging patients on the various inpatient units as well as organizing the discharge teams who will immediately conduct the discharge assessment.

The Chief of Staff and Vice President of Patient Care Services will consult and determine the discharge process for patients. Patients will be identified in two groups: **Rapid Discharge** and **Intervention Discharge.**

Rapid Discharge: Requires prescription and discharge instructions.

Intervention Discharge: Requires additional medical intervention before discharge.

One physician and one nurse will be assigned to form a Triage Discharge Team. Each inpatient unit will be assigned a Triage Discharge Team in the hospital setting. If the inpatient floors are logistically identified by East or West, North or South, a Triage Discharge Team will be formed and assigned to each unit East as well as West, North as well as South. All other units are generally set-up by service. Where services exist, a Triage Discharge Team will be assigned to that service.

The Triage Discharge Teams will assess and determine whether the patients can be discharged from the hospital.

The team will document and communicate this information to an assigned Department Medical Chair who will be responsible for identifying systems problems and creating an action plan to immediately address the patient's discharge.

The discharge plans will be communicated through the Hospital Incident Command System.

Discharge Communication Process

Department Medical Chairs must communicate their assigned inpatient unit's status to Chief of Staff (COS) in the Incident Command Center on a continuous basis.

The Incident Command Center will develop a short term plan and/or long term plan as necessary. Either plan must be communicated to the County's Emergency Operations Center.

The Medical Officer will communicate with Tulare County's Health Officer or designee, to report the hospital's patient acuity, bed status and to seek advice on safety precautions.

Equipment Inventory

The Logistics Chief will immediately call for an inventory of essential equipment (linen, PPE, Ventilators, etc.) and any additional Surge Capacity equipment must be identified (MCI Tent, Cots, Decontamination Equipment). The Logistics Chief will manage this process.

Infection Control Consultation

The Infection Control staff will communicate all pertinent communication received from the CDC, DHS and local health department to the Incident Command Center and various departments of SVMC. Infection Control staff will serve as the Public Health Liaison.

Staff Safety

When appropriate, SVMC will dispense approved prophylaxis to its staff. This process will be initiated by the Chief of Staff in consultation with Tulare County's Health Officer, or designee. The proper PPE to be worn will be recommended by the Infection Control staff.

Integration of Outside Agencies

This plan will be made known to local authorities and health care facilities for additional planning and improvement opportunities.

REFERENCES:

- The Joint Commission (2026~~3~~). EM.12.01.01 Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Title 22: Section 70741, 70743, 70745, 70746

CROSS REFERENCES:

- Staff Call-In

SUBJECT:	SECTION:
SYSTEM-WIDE PLAN FOR THE PROVISION OF PATIENT CARE, TREATMENT AND SERVICES- OFFICE OF THE VICE PRESIDENT PATIENT CARE SERVICES & CHIEF NURSE EXECUTIVE	***Leadership (LD)***

OVERVIEW

Patient care services provided by Sierra View Medical Center (SVMC) and Sierra View Local Healthcare District (SVLHD) are based on its Mission, Vision, Values, and patient care philosophy as well as on the needs of the community it serves. The patient care services are organized in response to patient needs as identified through the SVMC planning process. This plan outlines organization components integral to the provision of effective patient care.

The plan for providing patient care considers the following:

- The areas of the organization in which patient and/or resident care is provided;
    - The terms "patient/resident" are appropriate for areas of the hospital. For the practical purpose of this policy, the word "patient" is used for general language in this policy, with the exception when specifically addressing "residents" when discussing the Distinct Part Skilled Nursing Unit (DP/SNF).
- The mechanism(s) used in each area to identify patient care needs; and
- The number and mix of staff members in each area to provide for patient needs; and
- The process used for assessing and acting on staffing variances; and
- The interdisciplinary plan for improving the quality of care; and
- The goals established in the Hospital Strategic Plan.

Annually, during the organizational planning process, the Plan for Provision of Patient Care will be reviewed and revised as necessary. Changes in patient care needs or findings from performance improvement activities, risk management, infection control, safety and other integral assessments may also trigger a review and revision.

This plan has been linked to the organization's planning process and considers the following:

- Assessment of patient / family / significant other(s) needs, expectations, and satisfaction
- Provision of care, treatment and services that are appropriate to the scope and level required by the patients to be served
- The organization's determination of the essential services necessary to meet the needs of its patient population

- The planning of the provision of those essential services, either directly or through referral or contract.
- Establishing annual goals that are consistent with the organization's mission and vision, and which are based on a collaborative assessment of patient care needs.
- The organization's ability to recruit, retain, and/or develop competent staff.
- Relevant information from staffing variance reports.
- Ongoing evaluation of services provided through a formalized, systematic, and ongoing process, i.e. performance assessment and improvement activities budgeting and staffing plans.
- The provision of a uniform level of care throughout the organization.
- Opportunities to improve processes in the design and delivery of patient care. The leadership team of SVMC provides and improves health care services. These services are based on assessed and identified needs and are designed to improve patient health outcomes.
- The organization's ability and commitment to ensure that patient/ family and/or significant other(s) receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

MISSION, VISION, STANDARDS OF PERFORMANCE

The Mission and Vision of SVMC demonstrates the organizational commitment to serving as a foundation for all processes that involve planning, implementation and evaluation of its goals and objectives.

A. MISSION STATEMENT

Sierra View Medical Center promotes health and ensures high quality health care 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

B. VISION STATEMENT

Be the preferred choice for health care by providing excellent, patient-centered care through engaged/caring physician 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.~~

C. OUR VALUES

Compassion: Caring from the heart

Collaboration: Partnering for a common purpose

Accountability: Accepting ownership of our actions

Integrity: Inspiring trust and honesty

Respect: Embracing and appreciating others

STRATEGIC PLAN

The organization has planned, implemented, and provides a written strategic plan that outlines clear goals, and provides the framework to operationalize the plan(s) by the hospital leadership team in collaboration with the staff, physicians, volunteers, and other internal and external parties.

PATIENT CARE PHILOSOPHY

Sierra View Medical Center is committed to professional excellence. Embedded within the nursing profession is the accountability for evidence-based practice, quality-based measurements and outcomes connected to individual competence, which is achieved by clinical advancement from the novice to expert framework ~~(Brykczynski, 2014)~~ (Patricia Benner, 1983 & 2024).

The Nursing Division has adopted the Code of Ethics from the American Nurses Association (2015) to guide our actions.

In our adaptation of Orem's "Self-Care Framework"(Berbiglia & Banfield, 2019), patient care encompasses being responsive to the patient's need achieved through the harmony of client participation. Inherent in the delivery of care are the values of commitment, strength and compassion, which support the continual advancement of the profession of nursing.

~~A.~~ PATIENT-FOCUSED STANDARDS (The Joint Commission, 2020)

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1. ***Rights & Responsibilities of the Individual (RI)***

The goal of this function is to improve care, treatment, services, and outcomes by recognizing and respecting the rights of each patient and by conducting business in an ethical manner. Care**,** treatment, and services are

provided in a manner that respects and fosters the patient's dignity, autonomy, positive self-regard, civil rights, and involvement in their care. Care, treatment, and services as carefully planned and provided with regard to the patient's personal values, beliefs and preferences. With the patient's approval, the family may be involved in the patient's care, treatment, and service decisions. Patients also have the obligation to take on certain responsibilities. These are defined by the hospital and relayed to the patient. The patients are supported with their rights through the hospital's interactions with patients and by involving them in decisions about their care, treatment, and services.

2. ***Provision of Care, Treatment, and Service (PC)s***

Care, treatment, and services are provided through the successful coordination and completion of a series of processes that include appropriate initial assessment of needs; development of a plan for care, treatment, and services; the provision of care, treatment, and services; ongoing assessment of whether the care, treatment, and services provided are meeting the patient's needs, and either the successful discharge of the patient or referral or transfer of the patient for continuing care, treatment, and services.

3. ***Medication Management (MM)***

Medication management is an important component in the palliative, symptomatic, and curative treatment of many diseases and conditions. However, medications are also capable of causing great harm if the incorrect dose of medication is inadvertently administered to a patient. To eliminate any potential harm that could be caused by medications, SVMC developed an effective and safe medication management system.

An effective and safe medication management system addresses medication processes, which includes the following (as applicable):

a. Planning

b. Selection and procurement

c. Storage

d. Ordering

e. Preparing and dispensing

f. Administration

g. Monitoring

h. Evaluating

Effective and safe medication management involves multiple services and disciplines working closely together and includes mechanisms for reporting potential and actual medication-related errors, and a process to improve medication management processes and patient safety with this information.

4. ***Infection Prevention and Control (IC)***

Infection prevention is an integral part of every decision and plan in the hospital. Infection prevention is the responsibility of every staff member. Coordinated processes are in place to reduce the risks of endemic and epidemic healthcare acquired infections in patients, personnel, volunteers, licensed independent practitioners and the community. The Infection Prevention Program incorporates and conducts surveillance, prevention and control of infections throughout the organization, develops alternative techniques to address the real and potential exposures, selects and implements the best interventions to minimize adverse processes/outcomes, and evaluates and monitors the results and revises techniques as needed.

5. ***National P~~atient Safety~~erformance Goals (NP~~S~~Gs)***

These ~~are patient safety~~ are designed to elevate patient safety and quality standards across hospitals and health systems by organization standard that exceed regulatory minimums. The NGPs are focused on measurable goals the help improve safety, quality, and outcomes with a particular emphasis on staffing adequacy and nurse executive oversight. ~~established to promote specific improvements in patient safety. They highlight problematic areas in health care and describe evidence and expert based consensus as solutions to these problems. Because system design is intrinsic to the delivery of safe, high quality health care, the goals generally focus on system wide solutions, whenever possible.~~

6. ***Transplant Safety (TS)***

Policies and procedures are developed for safe organ and tissue donation, procurement, and transplantation.

7. ***Waived Testing (WT)***

Processes, policies and procedures are in place governing the identification of staff performing and supervising waived testing competency of the identified staff, performing the waived tests, performance of quality control (QC) checks and the required record keeping. The policies and procedures also address how testing is to be performed by staff on patients using instruments owned by staff, owned by the organization, or owned by the patient in performing waived laboratory tests.

~~B.~~ ORGANIZATIONAL STANDARDS

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1. ***Performance Improvement (PI)***

Performance improvement (PI) is a continuous process involving the measurement of important processes and services (data collection), analyzing the data to identify trends, patterns and performance levels suggesting opportunity for improvement, and when indicated, identifying and incorporating identified changes that enhance performance, which in turn is monitored to ensure that the improvements are sustained. Performance improvement focuses on outcomes of care, treatment, and services. An important aspect of improving organization performance is effectively reducing factors that contribute to unanticipated adverse events and/or outcomes.

2. ***Leadership (LD)***

Frameworks are provided for planning, directing, coordinating, and improving care, treatment, and services that respond to community and patient needs, and establish a culture that fosters, as a priority, improved patient health outcomes for everyone in the hospital. Effective leadership depends on the following:

a. Governance;

b. Management;

c. Planning, designing, and providing services;

d. Improving safety and quality of care;

e. Use of clinical practice guidelines;

f. Teaching and coaching staff;

g. Effective communication and collaboration.

3. ***Life Safety (LS)***

Policies and procedures will be in place to define how the organization will effectively create a fire-safe environment for patients, staff members, and other individuals in the hospital.

a. Performing strategic and ongoing master planning by hospital leaders;

b. Educating staff about the role of the environment in safely, sensitively, and effectively supporting patient care;

c. Developing standards to measure staff and hospital performance in managing and improving the environment of care;

d. Implementing plans to create and manage the hospital's environment of care.

4. ***Emergency Management (EM)***

The Emergency Management Program is developed to respond to the effects of potential emergencies that fall on a continuum from disruptive to disastrous. Planning involves those activities that must be done in order to put together a comprehensive Emergency Operations Plan (EOP) that includes mitigation, preparedness, response and recovery from emergencies. This document defines the facilities' response to emergencies and to help position it for recovery after the emergency has passed.

5. ***Environment of Care (EC)***

A safe, functional and supportive environment is provided within the hospital so that quality and safety are preserved. The environment of care is made up of 3 basic elements: (1) the building or space, (2) the equipment, and (3) the people. Importance of minimizing risks in the EOC, and are different and distinct from those risks associated with the provision of care, treatment and services. Written plans for managing risks in the EOC are: Safety & Security; Hazardous Materials & Waste; Fire Safety; Medical Equipment; and Utilities.

6. ***Human Resources (HR)***

The goal of the human resources function is to ensure that the hospital determines the qualifications and competencies for all staff positions (e.g. employees, contractors, temporary agency personnel) based on its mission, population(s), and care, treatment, and services. Processes and activities that must be present to ensure that the hospital establish and verify staff qualifications, orient staff, and provide staff with the training they need to support the care, treatment and services the hospital provides. After staff are on the job, HR must provide for the assessment, validation and documentation of staff competence and performance.

7. ***Information Management (IM)***

The facility develops a system by which health information is managed systematically, and meets the internal and external information needs of the hospital with efficiency and accuracy. The system provides for continuity in the event that the hospital's operations are disrupted or fail. The system provides for protecting the privacy, security and integrity of the data and information it collects, which results in preserving confidentiality; it also provides for the capturing, storing and retrieving of data, preserving knowledge-based information as well as monitoring data and health information management processes.

8. ***Record of Care, Treatment and Services (RC)***

Processes policies and procedures that guide the compilation, completion, authentication, retention and release of records.

~~C.~~ STRUCTURES WITH STANDARDS

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1. ***Medical Staff (MS)***

The organized medical staff is a self-governing body that is charged with oversight of the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged through the medical staff process. The organized medical staff is also responsible for the ongoing evaluation of the competency of practitioners who are privileged, delineating the scope of privileges that will be granted to practitioners, and providing leadership in performance improvement activities within the organization. The medical staff is accountable to the Board of Directors to strive to ensure the adequacy and quality of medical care rendered to all of the hospital's patients.

2. ***Nursing (NR)***

The quality of a hospital's nursing services is built upon the leadership of a nurse executive and the work of a qualified staff. The nurse executive promotes quality by incorporating current nursing research findings, nationally recognized professional standards, and other expert literature into policy and procedures governing the provision of nursing care, treatment and services

DEFINITION OF PATIENT CARE, PATIENT SERVICES AND PATIENT SUPPORT

Patient services at SVMC occur through an organized and systematic process designed to ensure the delivery of safe, effective, and timely care and treatment. The provision of patient care services requires specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioral, psychosocial and medical sciences. As such, patient services will be planned, coordinated, provided, delegated and supervised by professional health care providers who recognize the unique physical, emotional, cultural and spiritual needs of each person. Patient care encompasses the recognition of disease and health, patient and family teaching and patient advocacy. Under the auspices of SVMC, physicians, registered nurses and allied healthcare professionals function collaboratively as part of an interdisciplinary team to achieve optimal patient outcomes.

The scope of patient care is provided only by those professionals who are also charged with the additional functions of assessment and planning care based on findings from the assessment. Patient services and patient care are provided primarily by licensed staff. Patient support is provided by a variety of individuals and departments, who may not have direct contact with patients, but who support the care provided by the hands-on care providers.

Processes exist for the ongoing evaluation of patient services, including performance improvement activities, medication and patient safety activities, oversight committees' activities, departmental quality control processes, the notification system, and patient, staff and physician surveys. Results of such activities are reported to the governing body, medical staff and employees.

SCOPE OF HOSPITAL CARE

SVMC, with 167-licensed beds (132 acute care beds & 35 rehab skilled nursing), is a non-smoking environment. We provide patient care services 24-hours a day, seven days a week, 365 days a year. Each patient care ~~program~~ service line and department ~~that~~ provides support for patient care has a defined scope of practice that is integrated in the overall plan to provide patient care.

A. SERVICE AREA

SVMC provides comprehensive health services to a culturally diverse population. It is located in the southeastern portion of Tulare County. – SVMC's primary service area is populated with approximately

115,000 people. The primary service areas include the towns of Porterville, Springville, Terra Bella, Lindsay, Strathmore, and California Hot Springs.

B. SCOPE OF SERVICES PROVIDED

SVMC is a community-based hospital and system with a medical and nursing resident teaching program. We provide continuing care through service lines as well as contractual agreements with other providers. The service lines include:

1. Medical/Surgical, Critical Care
2. OB/GYN, Neonatal Intensive Care, and Pediatrics
3. Clinical Support Services and Continuing Care Services

C. INTERDISCIPLINARY PRACTICE

1. There is an interdisciplinary practice committee for establishing policies and procedures where:
    a. Registered nurses perform functions requiring standardized procedures; and
    b. Licensed professionals, not members of the medical staff, are granted privileges.
2. Committees will develop written policies and procedures addressing:
    a. Provisions for securing recommendations from members of the medical staff and appropriate non-medical categories who practice in the clinical area under review;
    b. Methods for approving standardized procedures.
    c. Providing for clear lines of responsibility of the nursing service for nursing care and medical staff for medical services.
    d. Intended lines of approval for each recommendation of the committee.
3. Standardized procedures will:
    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; and

c. State any specific requirements, which are to be followed by the registered nurse in performing particular standardized procedures.

D. CODE OF CONDUCT AND STANDARDS OF PERFORMANCE

SVMC ensures the fair and decent treatment of patients by operating according to its Code of Conduct and our 10 Standards of Performance. SVMC conducts its business, including its marketing, admission, transfer, discharge and patient billing, in an honest and proper manner in accordance with these standards.

E. CORPORATE COMPLIANCE

To ensure that best efforts are taken by SVMC to comply with all applicable laws and regulatory requirements, a Corporate Compliance Program has been developed. In addition to program development and monitoring of compliance, this Program includes an educational component for all individuals who act on the behalf of SVMC.

PATIENT SERVICES

A. COORDINATION OF PATIENT SERVICES

Providing patient services and the delivery of patient care requires specialized knowledge, judgment and skill derived from the principles of biological, physical, behavioral, psychosocial, nursing and medical sciences. As such, patient services will be planned, coordinated, provided, delegated and supervised by the medical staff and professional health care providers who recognize the unique physical, emotional and spiritual needs of each person. Patient care encompasses the recognition of disease and health, patient teaching, patient advocacy, spirituality and culture.

Under the auspices of the SVMC medical staff, registered nurses and allied healthcare professionals function collaboratively as a part of an interdisciplinary team to achieve positive patient outcomes.

1. ***Medical Staff Services***

The Medical Staff of SVMC is organized to coordinate, direct, and provide medical staff services to the hospital. The medical staff has established bylaws and rules and regulations to govern their activities, management of patient care, quality improvement, peer review, appointment, reappointment and determination of clinical privileges.

2. ***Support Services***

Other hospital services are provided to ensure that direct patient care and services are maintained in an uninterrupted and continuous manner by coordination of identified organizational functions such as: leadership and management, information management, human resources, environment of care, infection control and organizational performance improvement. These services support the comfort and safety of the patient and the efficiency of services available. These services are integrated with the patient services of the hospital.

3. ***Contract Services***

Contact Services are obtained to provide services not offered directly by SVMC. Whenever possible, the contracted service shall be accredited through The Joint Commission. If the service is not accredited, they will be evaluated against appropriate clinical standards. Medical staff participation is sought through designated mechanisms in the selection of contracted clinical services.

4. ***Volunteer Services***

Volunteer Services assists the hospital in the delivery of services by obtaining and retaining an adequate number of volunteers. Volunteers serve as an adjunct to hospital personnel for the services they render. Volunteers perform work under the direction of the ~~Director of~~ Human Resources Leader. Volunteer services are organized and operated under the same standards that govern other hospital personnel.

B. PATIENT CARE DEPARTMENTS

Patient Care Departments and services are those inpatient and outpatient departments and services that provide patient services and/or patient care according to the previously stated definition, and where services and/or care are rendered by the types of staff described above.

PATIENT CARE UNITS	SURGICAL SERVICES	CLINICAL & SUPPORT
Critical Care	Flex Care Unit	Cardiology Services *
Medical/Surgical/Pediatrics	Operating Room	Clinical Nutrition Services*
Telemetry	PACU	Laboratory Services
	Interventional Radiology (IR)	Pharmacy*
Labor & Delivery	Cardiac Catheterization Lab	Radiology and Imaging
Post-Partum Unit	**AMBULATORY SERVICES**	Rehabilitation Services

Nursery/Neonatal Intensive Care Level IIA DP/SNF and Sub-Acute	Emergency Department ~~Ambulatory Surgery Department~~ —Endoscopy Unit Wound Healing Department Urology Department Rural Health Clinic Academic Health Center Obstetrics/Gynecology Clinic Surgery Clinic	Acute Dialysis* Respiratory Therapy* Social Services * Speech Therapy* Pastoral Care* Case Management* Social Services* ~~Community Wellness Center~~ Care Experience

*Indicates that professional services are typically provided in a patient care area not in the department.

INTERPROFESSIONAL PATIENT CARE STAFF AND THE MULTIDISCIPLINARY TEAM

The full scope of patient care is provided only by those professionals who are authorized to perform patient assessments and plan patient care based on findings from the assessment. Patient services and patient care are provided primarily by licensed staff.

ROLES & FUNCTIONS OF PATIENT CARE STAFF

Role	Patient Rights	Assessment*	Care, Treatments & Meds	Continuing Care/ Discharge Planning	Patient/ Family Teaching	Performance Improvement
Admitting Personnel	X	X				X
Chaplain	X	X				X
Case Management	X	X		X	X	X
Certified Hemodialysis Technologists	X	X	X (except Meds)	X	X	X
Licensed Vocational Nurses	X	Documents data collection	X	X	X	X
Pharmacists	X	X	X	X	X	X
Nursing Assistant	X	Documents data collection				X
Medical Assistant	X	documents data collection	X			X

		and reason for visit				
Physicians	X	X	X	X	X	X
Registered Nurses	X	X	X	X	X	X
Registered Dieticians	X	X		X	X	X
Respiratory Care Practitioner	X	X	X	X	X	X
Social Workers	X	X		X	X	X
Technologists • Medical • Imaging	 X X	 X	 X	 	 X	 X X
Therapists • Physical • Speech	 X X	 X X	 X X	 X X	 X X	 X X

*Assessment includes specific criteria: Physical, Safety, Emotional, Cultural, Spiritual, Functional, Educational, Nutritional and Social

STANDARDS OF PATIENT CARE

Standards of Patient Care are by definition patient-focused. The standards outline the fundamental elements for the effective delivery of patient care. The standards provide a guide for patient care. These standards of patient care are as follows:

- ***Each patient's health status is assessed.***

  This collection of data is systematic and continuous, serving as a basis for determining the health care needs and the delivery of care.

- ***Each patient has a plan of care.***

  An interdisciplinary approach is utilized, as appropriate; to promote continuity of care and optimal achievement of identified goals.

- ***Physical needs of the patient are attended to.***

  This is accomplished through interventions to achieve an optimal health outcome.

- ***Each patient is provided an environment which promotes psychosocial well-being.***

- ***Each patient and/or significant other is assisted to continuously adapt to the patient's health status.***

Patient education and discharge planning are provided.

Patient care goals are expected outcomes for each standard of care. The patient care goals define the expected care to be received by each patient at SVMC. The patient care goals at SVMC include, but are not limited to:

- Early recognition of patient condition and changes in condition to promote identification of patient care needs.
- Patient care interventions that complement the patient's plan of care.
- The patient is provided with a safe, comfortable environment.
- The patient's physical needs are met through appropriate patient care interventions.
- The patient's psychological stress is minimized and coping abilities enhanced.
- The patient and/or support system are provided with information and/or resources to provide on-going care to the best of their ability.
- The patient's rights are respected and ensured, including the right to confidentiality.
- The patient and/or support system will be satisfied with the care provided.
- The patient receives effective understandable and respectful care that is provided in a manner comfortable with their cultural health beliefs and practices and preferred language.

INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

Organizational structures at SVMC support an integrated approach to the delivery of patient care, treatment and services. Clinical services and departments are aligned under the direction of the VP of Finance, VP of Professional Services, VP Quality and Regulatory Services, VP of Patient Care Services, and patient care directors. Departments and/or services are integrated into the overall functioning of the hospital. The VP Patient Care Services/Chief Nurse Executive has oversight and authority, as a matrix reporting structure, to all staff that provide direct and indirect patient care.

The leaders of the hospital are responsible to coordinate and integrate services with other services, and to continuously improve these services. Additionally, the organization embraces a continuous quality improvement philosophy in which interdisciplinary cross-functional teams are chartered for the purpose of performance improvement.

The importance of a collaborative interdisciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves

as a foundation for integration. The interdisciplinary commitment of all departments in the provision of patient care, treatment and services is demonstrated through collaborative policy and procedure development, open communication, and participation in performance improvement teams.

Examples of such collaborative activities include, but are not limited to:

- Informing physicians of changes in patient condition, patient questions, needs, or concerns and wishes regarding care.
- Clarifying orders of a confusing nature or those which do not correlate with the patient's clinical condition.
- Involving patients and family members in care, including but not limited to, decisions regarding goals of care, services offered, providing information necessary to make effective decisions, and patient and family teaching.
- Initiating appropriate referrals.
- The discharge planning process likely includes various disciplines such as Nursing, Medical Staff, Pharmacy, Dietary, Physical Therapy, Speech Therapy, Respiratory Therapy, Case Management, and Social Services.
- Coordination between the patient care areas and the Admitting Department for appropriate patient placement.
- Fall Risk Program.
- Committees, Task Forces, ~~P.I.T. Teams and~~ Ad Hoc Teams for departmental or interdisciplinary performance improvement.
- Requisitioning and controlling equipment and supplies necessary for optimal patient care through Materials Management and Central Processing.
- Notification and referral to Biomedical Engineering regarding potentially unsafe equipment.
- Maintaining an interdisciplinary medical record.
- Pharmacy consultation regarding medical orders, effects, usage and food/drug interactions.
- Food and Nutrition consultation regarding nutritional assessment and interventions.

- Rehabilitative Medicine consultation regarding patient mobility and use of appropriate body mechanics by clinical personnel.

- Statistical tracking, trending, and analysis by Finance, Health Information Management Department, Performance Improvement, Financial Planning and Utilization Review.

Departments establish and maintain productive and professional working relationships with all of the hospital services and departments. Effective communication is the key to establishing these relationships. Employees from departments providing patient care and support services maintain open communication channels and forums with one another to ensure continuity of patient care, maintenance of the patient's environment and positive patient outcomes. To facilitate effective interdepartmental relationships, problem solving is encouraged at the lowest levels possible within the organization. The staff is open to addressing one another's issues and concerns and seeking mutually acceptable solutions. Leaders ~~Directors~~ have the authority to mutually solve problems and seek solutions within the scope of their responsibility. To support integrated patient care, an environment that stresses cooperation and communication is essential. Methods used that ensure effective communication throughout the hospital include, but are not limited to:

1. Town Hall Meetings
2. Employee Forums
3. Bulletin Board Postings
4. Memos
5. Hospital-Wide Policies and Procedures
6. Safety Update
7. Departmental Staff Meetings
8. Management Meetings
9. Nursing Management Council Mtgs.
10. Staff nurse committee meetings
11. Written Communication:
    a. Routine Directives

b. Emergency Directives

c. Newsletters

d. Bulletin Boards

12. Computer Applications

a. Hospital Intranet

13. Telephone System

a. Voice Mail

b. Unit Mobile Devices~~Pagers~~

c. Approved Cell Phones

14. Verbal Communications

a. Senior Management Meetings

Department Leader~~Director~~ Meetings

STAFFING PLANS

Staffing plans for patient care services are developed based on the level and scope of care or service required by the patient population, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately provide the type of care needed. SVMC maintains a system to ensure that appropriate levels of staffing are maintained to provide optimal patient care. Staffing levels are developed with consideration of the following:

- Regulatory mandates;
- National Specialty Standards;
- Internal experience;
- Overtime usage;
- Patient population;

- Patient needs;
- Staff Competency; and
- Work locations.

These levels are reviewed regularly and adjusted for changes based on above considerations.

PATIENT CLASSIFICATION SYSTEM

SVMC provides nursing care based on patient classification. The Patient Classification System is an objective mechanism of grouping patients according to significant care needs that relate to workload and staffing needs.

A. SHORT TERM USE

The Patient Classification System (OptiLink) is part of the Department of Nursing's staffing system designed to determine patient care needs on a short term basis, identify work load intensity, plan unit staffing numbers and skill mix and enable Nursing Leadership and Administrative House Supervisors to make appropriate decisions related to staffing adjustments. The acuity staffing coupled with management judgment is utilized in planning for staffing needs.

B. LONG TERM USE

The Patient Classification System provides a retrospective review of patient care needs and staffing requirements over a fiscal period to allow Nursing Leadership to more accurately forecast staffing needs on all units and adjust budgetary requirements for staffing during budget preparation.

C. VALIDITY / RELIABILITY

1. The Patient Classification System was developed by the Department lradersDirectors with outside assistance utilizing national specialty standards and state mandated nurse-to-patient ratios and historical data to determine the number of staff and skill mix required.

2. The system is evaluated periodically for reliability by the Department leaderDirector or designee. The leaderDirector or designee uses the same classification system as the staff on any given day to determine the acuity of the patients. It is expected that the two (2) sets of numbers for patient acuity will have an Inter-rater Reliability of 95% or greater.

3. Face validity of the classification system will be determined every year, or more frequently, if necessary, by Nursing Leadership with input from the caregivers to validate that it is current and accurate in reflecting patient needs, and number of staff and skill

mix required. Adjustments in the pre-calculated weighted values and equations can be made to accommodate variables such as new or changing state mandated nurse-to-patient ratios, national specialty standards, patient populations, skill of available caregivers, number and mix of patients, changes in lengths of stay, new medical and nursing technologies or changes in services offered.

4. Final approval of patient classification changes will be authorized by the Vice President of Patient Care Services / Chief Nurse Executive

STAFFING VARIANCES

- Staffing patterns that are designed with minimum staffing nurse-to-patient ratios, national specialty standards, average acuity levels and usual patient types are in place for each department. These provide guidelines from which staffing decisions can be made on a daily and per shift basis.

- Variances from staffing patterns are expected given the nature of patient needs. Reasons for variances can include higher acuity, lower acuity, and unavailability of skilled level as called for by acuity and higher or lower than usual volume. Each department/service has identified how they adjust staffing variances.

- During high acuity or volume, every attempt is made to provide appropriate staffing. Methods include but are not limited to: utilization of extra shifts from all categories of staff, utilization of overtime and double time, floating of cross-trained staff from other units and utilizing alternative staffing patterns with approval of the Nurse Executive. Outside agency staffing is the last method utilized to meet increased staffing needs and must have Administrative approval.

- To adjust for low acuity or volume, staff schedules are flexed to include shortened shifts, days off with pay and floating of cross-trained staff to units with staffing needs.

STAFF EDUCATION AND COMPETENCY PLAN

SVMC values each individual in the organization; therefore, education and training is a key component of employment. The organization provides continuing education, in-service education, and on-the-job-training in all departments. Staff education is also supported through an Education Assistance Program for selected categories of staff. Education programs are provided to maintain staff competency and enrich staff knowledge for enhanced patient care quality. The planning for the development of educational programs is based on the organization's mission, the case mix of patients served, the technology utilized, the identified learning needs of the staff (on an individual, departmental, and organizational basis), the required competency needs of the staff, and lastly the identified issues that influence the staff to continue their employment.

Ongoing training and continuing of education needs in all departments are met with the departmental in-services, departmental meetings, vendor-sponsored in-services, arranging for outside instructors to

provide classes, self-learning modules, workshops, annual updates and ongoing competency validation of critical skills and knowledge specific to the job and department. The competency validation process is reviewed and updated annually to ensure that the knowledge and skills necessary for the provision of services are addressed.

RECRUITMENT AND RETENTION

Recruitment efforts to address current openings are handled in collaboration with the Human Resources Department. Recruitment activities include, but are not limited to:

- Direct mail campaign
- Newspaper and magazine advertising
- Attendance at job fairs and career days
- Open houses in conjunction with educational conferences
- On-site visits to student classrooms
- Graduate Nurse Luncheons
- Professional Recruitment Firms
- Professional Websites

An environment conducive to hiring is maintained in a purposeful manner by such strategies as the ready availability by the leaders~~Director~~ or designee for interviewing, receptivity to students utilizing the hospital for clinical rotations, and active recruitment of supplemental staff into permanent positions. A positive work environment, competitive wages and benefits and the provision of opportunities for professional achievement and recognition is maintained. Retention factors include, but are not limited to:

- Free educational offerings
- Active staff committee participation
- Tuition reimbursement
- In-house promotions
- 403B Retirement Plan

- Retirement benefits
- Flexible Benefits plan with multiple options
- Paid Time Off Plan
- Service date recognition
- Employee social activities
- Celebration of professional recognition days
- Employee recognition
- Employee of Month and Year
- Formal Retention Plan
- Employee Assistance Plan (EAP)

PATIENT CARE AND ORGANIZATION PERFORMANCE IMPROVEMENT

The Organizational Performance Improvement Plan has been designed in collaboration with the leaders of the organization to improve patient care, patient safety and services offered at Sierra View Medical Center. The Plan supports the organization's mission and vision and provides mechanisms for evaluating care and services. Performance Improvement activities are prioritized yearly giving high priority to high-volume, high-risk, or problem-prone processes. Organizational activities are carried out in accordance with State, Federal and Joint Commission regulatory requirements. The Performance Improvement Program provides for a comprehensive and objective assessment of aspects of care with respect to cultural sensitivity and diversity, and ensures that the delivery of care is supported by evidence-based medical and healthcare research.

CONSULTATION AND REFERRALS FOR PATIENT SERVICES

To ensure that patient care services are available in a timely manner to meet the needs of our patients, all services essential in providing quality patient care are provided to our patients either directly by SVMC or through the referral, consultation and/or contract arrangements with providers that are qualified and can supply these services. Consultations are requested and provided according to the Medical Staff Bylaws, Rules and Regulations.

Essential services provided on a regular basis, which are performed outside the organization or by another source, are approved by the medical staff and the organization has written agreements that the source meets applicable accreditation standards.

Contracted services for onsite provision of patient care include, but are not limited to:

- ~~Central Valley Lithocare, Mobile~~ Lithotripsy Services
- ~~NES~~ – Emergency Physicians Services
- Sweet Dreams Anesthesia~~Comfort Anesthesia Associates, Inc.~~ Anesthesia Services
- ~~T. MacLennan, Inc~~. – Professional Radiology Services
- ~~In Compass~~ – Adult Hospitalist Services
- ~~Valley Children's Medical Center~~ – Pediatric Hospitalist Services
- ~~Oak Grove Critical Care Medical Group~~ – Intensivist Services
- ~~Premier Pathology Laboratories, Inc.~~ – Professional Pathology Services

CONTRACTUAL RELATIONSHIP FOR PATIENT CARE WITH EXTERNAL ORGANIZATION

Contracted clinical services agreements with external organizations include, but are not limited to:

- Imperial Ambulance – Ambulance Services
- Kaweah Health – Transfer Agreement
- Bakersfield Heart Hospital – Transfer Agreement
- Community Regional Medical Center – Transfer Agreement
- Valley Children's Hospital – Transfer Agreement
- San Joaquin Medical Center – Transfer Agreement
- HCA Regional Hospital – San Jose
- St. Agnes Medical Center – Transfer Agreement

DEPARTMENT SCOPES OF SERVICE

Each department has a defined scope of service, which support the operation of the organization.

CLINICAL DEPARTMENTS:

A. **CRITICAL CARE SERVICES**
(Critical Care Unit and Telemetry Unit)

1. ***DEFINITIONS-*** An intensive care service is a nursing unit in which there are specially trained nursing and supportive personnel and diagnostic, monitoring and therapeutic equipment necessary to provide specialized medical and nursing care to critically ill patients.

2. ***SCOPE OF SERVICE –***

   a. ***The Critical Care Unit*** is a 10-bed unit, with an average daily census of approximately ~~4.7 patients~~5 patients. The unit is staffed by specially trained Registered Nurses and Monitor Technicians and ready for emergent critical care services, 24-hours a day, 7-days a week.

   b. ***The Telemetry Unit*** is a 20-bed unit, including one negative air-flow room, with an average daily census of -16~~6~~ patients. The unit is staffed by Registered Nurses, Certified Nurse Aides, and Monitor Technicians and is ready for those patients requiring cardiac monitoring 24-hours a day, 7-days a week.

3. ***PATIENT POPULATIONS:***

   a. ***The Critical Care Unit*** provides nursing care to adolescent (ages 12 and above), adult and geriatric patients meeting the admission criteria to the unit. Types of patients generally seen include trauma cases, cardiac, post-operative and acute exacerbation of chronic medical conditions affecting one or more body systems.

   Patient care includes patients requiring life support measures, equipment and/or interventions for a life-threatening condition. Patients may be hemodynamically unstable, requiring continuous monitoring and frequent nursing interventions. The hospital provides for critical care consultation, referral or transfer process when the need for a higher level of specialty services is identified.

   b. ***The Telemetry Unit*** provides nursing care to adolescent (ages 12 and above), adult and geriatric patients meeting the admission criteria to the unit. Types of

patients generally seen include those patients requiring less than critical care services, but still require close cardiac monitoring and nursing interventions.

4. ***GOALS:***

a. ***Critical Care:***

- To provide ongoing systematic process for monitoring and evaluating the quality of services provided;
- To provide optimum 24-hour/day nursing care to our patients with an emphasis on the preservation of life, prevention of complications, and the restoration of maximum functional capacity based on the nursing process;
- To provide multi-disciplinary assessment and intervention for the stabilization of the critically ill patient;
- To preserve patient's rights to accept or refuse treatment, including the right to die;
- To maintain psychological, emotional, and social integrity of the critically ill patient;
- To promote interaction of the critically ill patient's family and/or significant other(s); and
- To provide patient/family education.

5. ***CORE STAFFING AND AUGMENTATION***

The Critical Care Unit -- core staffing for 1-2 patients is with 2 RNs, a Monitor Technician (MT)/Clerk 24-hours/day, 7 days a week, 24/7. ~~With a census of 2 or less patients, the MT will be flexed off.~~ Augmentation occurs when the acuity of the patients are such that an additional RN is needed, ~~or with the fifth patient that is admitted to the unit.~~ Staffing guidelines are available in the unit in more detail for staffing purposes.

The Telemetry Unit – core staffing for 16 patients is with 4 RNs, 2 CNAs ~~on day shift and 1 CNA on night shift~~, a Monitor Technician 24/7 ~~and a day shift Unit Clerk~~ 7 days a week. Augmentation occurs when the acuity of the patients are such that additional staff are needed due to an increase in patient activity or a 17th patient is admitted to the unit.

B. **MATERNAL CHILD HEALTH**
(Mother-Baby, Nursery, Neonatal Intensive Care Unit Level IIA, and Labor & Delivery)

1. ***SCOPE OF SERVICE***

The Maternal Child Health Department does approximately 12~~8~~00 deliveries a year. Services are provided 24-hours a day, 7-days a week. The department employees include Registered Nurses who are specially trained to assist in all aspects of care for the Obstetrical patient and the neonate. The Labor and Delivery and Mother-Baby staff provides patient and family psychosocial support, education and discharge planning to assist in the transition of an infant and the post-partum mother into the family setting. The staff also provides care for Antepartum and Intrapartum patients through pre-term labor and other medical diagnoses while pregnant. The department also provides OB surgical care for cesarean sections and tubal ligations. Additionally, the department will provide pre- and post-operative care for Gynecological surgical patients.

The Neonatal Intensive Care staff provides care to the high risk neonate from 32 weeks gestation and above, emotional support to the parents during their infant's stay; as well as, education to the parents for the care of the neonate upon discharge.

2. ***PATIENT POPULATION:***

The Maternal Child Health Department provides nursing care to neonates, adolescent and adult patients. The department adheres to a mother-baby couplet care model but does provide services to newborns through a Level IIA Nursery as needed. Patients seen in the unit other than post-partum includes women from adolescent through adult, who are pregnant with a gestational age of 20 weeks or greater, in need of pregnancy-related hospitalization. The service is designed to provide routine obstetrical care to include the performance of Caesarean sections and post-partum tubal ligations in the department's Operating Room. There is a working referral process for perinatology and neonatology consultation, referral and/or transfer to neighboring tertiary centers as needed.
The department works on an intra-disciplinary basis with other members of the health care team to provide assessment care planning and educational needs of our patients. Association of Women's Health Obstetrics and Neonatal Nursing (AWHONN), American College of Gynecology (ACOG), The American Academy of Pediatrics

(AAP), National Association of Neonatal Nurses (NANN), and Association of Operating Room Nurses (AORN) guidelines are used in the care of the patients.

3. ***GOALS:***

a. To provide safe, effective, and appropriate nursing care using the ongoing nursing process.

b. To provide an environment that will be conducive to laboring or healing through detecting and coping with emergency situations and preventing complications associated with the various stages of labor or surgical interventions.

c. To provide high-level medical and nursing management with the focus on collaborative multi-disciplinary approach, minimizing negative physical and psychological effects through patient/family education, and restoring the patient/family to a high level of self-care.

4. ***CORE STAFFING AND AUGMENTATION:***

Department	***Staffing Guidelines***	***Guidelines***
Labor and Delivery Registered Nurse only	• Cesarean Section 1:1, additional RN for the baby catcher during procedure • Laboring patient 1:2 until mother tranistions from active labor to near delivery usually occurring between 7-9 cm, then 1:1 • Patient on MagSo4 or Diabetic 1:1 • Triage room - 1 Nurse	Staffing ~~is~~ considerations are based upon Acuity, ACOG, AWHONN guidelines and Title 22.
Department	***Staffing Guidelines***	***Guidelines***
Mother-Baby Registered Nurse only	• 1 Nurse to 4 Couplets (8 Patients)	Staffing ~~is~~ considerations are based upon ACOG, AWHONN guidelines and Title 22.
NICU Level IIA Registered Nurse only	• 1 Nurse to 3 Neonates • 1 Nurse to 2 Neonates • 1 Nurse to 1 Patient for critically ill patients needing to be transferred	Staffing considerations are ~~is~~ based upon ACOG, AWHONN, NANN guidelines and Title 22.

C. **PEDIATRICS**

1. ***SCOPE OF SERVICE:***

Pediatric patients are cared for in the designated area on the general Medical/Surgical Unit. Services are provided 24-hours a day, 7-days a week. The Pediatric employees include Registered Nurses that have received special training in the care of the pediatric patient~~., Certified Nurse Aides, and Unit Clerks.~~

The department works on an intra-disciplinary basis with other members of the health care team to provide assessment, care planning, and educational needs of the patients and their parents/guardians. The American Academy of Pediatric Guidelines are used in the care of the patients.

2. ***PATIENT POPULATION:***

The Pediatric Designated Care Area provides nursing care to those infants, children and adolescents (from 1~~2~~ days to 13 years of age) requiring nursing assessment and intervention to stabilize a medical condition or recover from respiratory, endocrine, or other medical/surgical condition. There are working referral processes for pediatrics to transfer to a tertiary hospital as needed. The department also cares for Medical/Surgical patients from the ages of 14 to geriatric.

3. ***GOALS:***

a. To provide optimum 24-hour, 7-days a week nursing care to the pediatric patient with an emphasis on the preservation of life, prevention of complications, and the restoration of maximum functional capacity based on the nursing process.

b. To provide continuous and comprehensive observation of all pediatric patients.

c. To provide individualized nursing care related to the child's level of growth and development, and to assist the parent/legal guardian in their cognitive understanding and emotional acceptance of their child's state, as the primary decision-maker for the child.

d. To ensure that the family actively participates in the process of planning and providing patient care.

e. To provide quality nursing care which is not influenced by race, color, religion, or socioeconomic status.

4. ***CORE STAFFING AND AUGMENTATION:***

Department	***Staffing Guidelines***	***Guidelines***

Pediatrics (1:4) Registered Nurse for Pediatric patients only **pediatric patients are combined on a mixed unit with adults.	• Day shift – -1 Nurse at all times, Unit Clerk when 5th pediatric patient is admitted a second pediatric competent nurse would be added. (adjustment based on acuity could be made with discretion of the Clinical Manager/Director. • Night shift – 1 Nurse at all times, and same situational guidelines as day shift	Staffing considerations are~~is~~ based upon AAP, Title 22 and Acuity.
Department	***Staffing Guidelines***	***Guidelines***
	• Overflow of Med/Surg patients – 1 Nurse and Unit Clerk to 5 adult patients, add second nurse when 6th adult patient admitted. ~~No Unit Clerk needed.~~ • If patient assignment consists of adult and pediatric patients, must follow Pediatric staffing of 2 RNs at all times.	

D. **MEDICAL/SURGICAL DEPARTMENT**
(3-North, 3-South, 3-East, 3-West)

1. ***SCOPE OF PRACTICE:***

The Medical/Surgical Department treats an average of 25 ~~45~~ patients per day. Services are provided 24-hours a day, 7 days a week. The Medical/Surgical Department employees include Registered Nurses., Certified nursing assistance, and unit clerks. ~~with specialized training in the care of the medical/surgical patient, Chemotherapy, Certified Nurse Aides, and Unit Clerks.~~ The Department is separated, e.g. 3-North and 3-South has 34-beds/rooms and is located in the 4-story tower. Directly across the hall in the 3-story tower building is 3-West and East which has 14~~11~~ semi-private rooms for a total bed capacity of 28~~22~~ and 4 private rooms for a total capacity of 32~~26~~ beds.

2. ***PATIENT POPULATION:***

The Medical/Surgical Department provides nursing care to adolescent, adult and geriatric patients requiring nursing assessment and interventions to stabilize a medical condition such as diabetes, pneumonia, renal failure, and post operative care.~~cancer~~.

3. ***GOALS:***

a. To provide optimum 24-hour/day nursing care to the adult patient with emphasis on the preservation of life, prevention of complications, and the restoration of maximum functional capacity based on application of the nursing process.

b. To provide continuous observation of all adult patients.

c. To provide nursing care that is not influenced by race, color, religion, or socioeconomic status.

4. ***CORE STAFFING AND AUGMENTATION***

Core staffing for an average daily census of 25~~45~~ patients will include RNs performing primary care for patients at a 5:1 ratio, assisted by CNAs and Unit Clerks. Staffing will be augmented with additional licensed staff and/or non-licensed staff based on patient acuity and/or increase in census.

E. **DISTINCT PART SKILLED NURSING FACILITY (DPSNF)**

1. ***SCOPE OF SERVICE:***

The DPSNF is a 35-bed unit and operates 24-hours per day, 7 days per week. The unit is staffed by Registered Nurses, Licensed Vocational Nurses, Certified Nurse Aides, Restorative Nurse Aides and Unit Clerk~~s~~ to care for the resident's immediate physical needs. Complementing the physical care, the following positions are present to address the resident's and family/surrogate decision-maker/significant other(s) psychosocial needs and meet state and federal regulatory requirements: Social Services Designee; an MDS Coordinator; an Activities Director and a Director of Staff Development.

2. ***PATIENT POPULATION:***

The DPSNF provides skilled long-term nursing care for residents aging from adult (21 years) through geriatric. The residents must be in stable condition with no acute care needs; can require ventilator care 50% of the time or greater; require therapies for wound debridement and healing and/or Gastric Tube feedings.

3. ***GOALS:***

a. Rehabilitate the resident to their maximum potential.

b. Improve their quality of life.

c. Provide quality care in a holistic manner during this transitional phase of their life.

d. Encourage family involvement with the resident's plan of care.

4. ***CORE STAFFING & AUGMENTATION***

For an average daily census of 33 residents, core nursing staff~~ing~~ will be consistent with title 22 regulations (monthly sub-acute staffing requirements) based on census needs. ~~consist of 1 RN, 5 LVNs, and 5 CNAs for direct care.~~ Additionally, the unit will be staffed with a Department Director (RN), 1 RN Clinical Manager, 1 MDS/DSD Coordinator, 1 Unit Clerk, 1 Medical Records Clerk, 1 Activities Coordinator~~Director~~, ~~1 Director of Staff Development,~~ and Social Services designee. This staffing will hold for up to 35 patients, which is the capacity of the department.

F. **SURGICAL SERVICES**
(Flexcare, PACU, Operating Room, Endoscopy, Cath Lab/IR)

1. ***SCOPE OF SERVICES:***
The Surgical Services Department operates 24 hours a day, 7 days a week. Elective procedures are scheduled from 0730 to 1500 with one room scheduled to 1700, Monday through Friday. After hours, weekends, and holidays are staffed with On-Call staff. The department is comprised of several separate units. ***Flexcare*** is an 8~~11~~-bed unit open Monday- Friday 0530-1400,which provides pre-operative care to AM Admission and Outpatients before their operative/invasive procedures, infusions procedures and ~~also~~ Extended Recovery Care to patients requiring extended observation/intervention after transfer/discharge from Phase I and Phase II levels of care. ***Pre-Liaison*** is staffed with one (1) RN from 0600-1430 ~~0830 to 1700~~. ***Post Anesthesia Care Unit (PACU)*** has 8-cubicles for the purpose of ~~immediate~~ postoperative recovery from anesthesia (Phase I) and Phase II level of recovery in preparation for discharge. It is staffed with four~~ive~~ (4~~5~~) RNs specially trained to handle the postoperative recovery period from the OR, Endoscopy Unit, ~~or~~ Radiology and Cath Lab. The ***Operating Room*** has 5~~4~~ separate operating rooms. They are staffed with specially trained RNs, RNFAs, and ORTs who assist the surgeons with their cases. ***Endoscopy Unit*** operates at the Ambulatory Surgery Department (ASD) and the main OR~~is an established area in the ASD in which all endoscopy procedures are completed.~~ It is staffed with specially trained RNs and endoscopy technicians to assist the physician with all procedures. Inpatients are completed in the operating room

The services provided are ENT, General Surgery, OB/GYN, Podiatry ~~Ophthalmology,~~ Orthopedics, ~~Plastic,~~ Urology, Vascular, and Gastroenterology. The list of procedures for each service performed are delineated and approved by the Medical Staff.

2. ***PATIENT POPULATION:***

The Surgical Services Department provides care for patients ranging from infant to geriatric who are undergoing either inpatient or outpatient surgical and/or invasive procedures.

3. ***GOALS:***

a. To provide the highest standard of care to our patient and families regardless of sex, race, creed, color, national origin, sexual orientation, or economic status.

b. To provide quality care in identifying and meeting the psychological, physiological, and sociological needs of each patient.

c. To provide knowledgeable customer-centered care in a safe environment to promote quality outcomes in a cost-effective manner.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing in ***Flexcare*** is dependent on the volume and type of patients being prepared for Surgery, Endoscopy and Interventional Radiology concurrently. Recommended patient/nurse ratio for rapid throughput into the procedural areas is 1:2~~2:1~~. After patients are prepared and ready for transfer to the procedural areas, the ratio drops to 1:~~4~~5~~:1~~. The unit is staffed with 3~~4~~ RNs and 2~~1~~ Unit Clerk ~~from 0500 until 0800, then 1 RN goes to the Pre-liaison role, and 1 RN goes to PACU.~~

Core Staffing in ***PACU*** is two (2) RNs, one of whom is an RN competent in **Phase I** post-anesthesia nursing~~., in the same room where the patient is receiving Phase I level of care.~~ General staffing ratio is a 1:2 nurse ratio; however, a ratio of 1:1 is required at time of admission until critical elements of report and status are met for patients with unstable airways and unconscious patients under the age of 8. **Phase II** requires two ~~competent personnel, one of whom is an~~ RN competent in Phase II nursing, ~~in the same room where the patient is receiving Phase II level of care.~~ **Extended recovery** requires two (2) ~~competent personnel, one of whom is an~~ RN's who possesses competence appropriate to the patient population, ~~in the same room/area where the patient is receiving extended level of care. Augmentation of the staff will be with RNs only. Immediate needs will be~~

~~filled with the Clinical Manager and additional RNs will be called in as the census warrants.~~

Core staffing for the ***Operating Room*** is one surgical team consisting of: 1 RN circulator, 1 OR Technician, and if needed for the procedure, an RN First Assistant (RNFA) for each OR case. Core staffing for ***Endoscopy*** is 1 RN and 1 Endoscopy Technician for each procedure. A second RN is needed if procedural sedation is being administered. If 2 endoscopic rooms are to be run simultaneously, a team of 1 RN (2 if procedural sedation is administered) and 1 Tech are required for each room. Staff are scheduled accordingly and called in as the case load increases.

G. AMBULATORY SURGERY DEPARTMENT (ASD)

1. *SCOPE OF SERVICES:*

The Ambulatory Services Department operates from 0630 to 1600 ~~0600 to 1630~~ Monday through Friday, excluding Holidays. The department is staffed to operate two procedure suites during that time. The department includes pre-operative, intra-operative and post-operative care areas under the direction of the Leader~~Director~~ of Surgical Services. Intra-operatively and post-operatively, the patient is continually monitored ~~reassessed~~ by a Registered Nurse. Modifications to the plan of care are based on reassessment of the patient. ~~In the immediate post-operative phase, the patient is under the direct supervision of the anesthesiologist/anesthetist who maintains responsibility for the needs of the patient until the patient has completed the recovery phase. The patient's disposition is a collaborative decision between the anesthesiologist and surgeon with information related to clinical data provided by the PACU Registered Nurse.~~

The services provided are GI/endoscopy. The list of appropriate procedures to be performed is delineated by the Medical Director/Medical Staff.

2. *PATIENT POPULATION:*

The ~~ASD~~ Endocopy Unit provides care for patients ranging from 14 year and above to the geriatric patient.

3. *GOALS:*

a. To provide the highest standards of care to our patients/families regardless of sex, race, creed, color, national origin or economic status.

b. To provide quality care in identifying and meeting the psychological, physiological and sociological needs of each patient.

c. To provide knowledgeable customer-centered care in a safe environment to promote quality outcomes in a cost-effective manner.

4. ***CORE STAFFING & AUGMENTATION:***

Staffing is based on the number of scheduled ~~cases and the complexity of the cases. The~~cases. The surgical team for a procedure is composed of a pre-operative RN, an RN Circulator with experience in and demonstrated competencies in endoscopy ~~operating room nursing,~~ a Endoscopy ~~Surgical~~ Technician with experience in and demonstrated competencies as an endoscopy technician ~~surgical scrub~~ and instrument processing technician, and one PACU RN competent in Phase I and Phase II post-anesthesia nursing. When patients are in Phase I of recovery, there must be a second RN immediately available in the area. Phase II requires two competent personnel, one of whom is an RN competent in Phase II level of care. Assistive personnel are Unit Clerks. ~~Registration Clerks/Schedulers and EVS/Orderlies.~~ The Disaster Manual call-in roster will be used to augment staff in the event of a disaster.

H. **Cardiac Cath Lab (CCL)/Interventional Radiology (IR)**

5. ***SCOPE OF SERVICES:***

The CCL/IR operates from 0630 to 1630 Monday through Friday, excluding Holidays. The CCL is staffed to support in- house STEMI's between the hours of 0700 – 1530 (normal hours of operation). The department is staffed to operate one CCL procedure suite and one IR procedure suite during that time. The department includes pre-operative, intra-operative and post-operative care areas under the direction of the Director of Surgical Services. Intra-operatively and post-operatively, the patient is continually monitored by a Registered Nurse. Modifications to the plan of care are based on reassessment of the patient.

The services provided include cardiovascular procedures and radiology procedure support. The list of appropriate procedures to be performed is delineated by the Medical Director/Medical Staff.

6. ***PATIENT POPULATION:***

The CCL provides care for adult patients. Radiology procedure support includes pediatric and adult populations.

7. ***GOALS:***

a. To provide the highest standards of care to our patients/families regardless of sex, race, creed, color, national origin or economic status.

b. To provide quality care in identifying and meeting the psychological, physiological and sociological needs of each patient.

c. To provide knowledgeable customer-centered care in a safe environment to promote quality outcomes in a cost-effective manner.

8. ***CORE STAFFING & AUGMENTATION:***

Staffing is based on the number of scheduled cases. The cardiac team for a procedure is composed of a RN Circulator with experience in and demonstrated competencies in cardiology, a Cardiovascular Technician with experience in and demonstrated competencies as a cardiovascular technician, an RN competent in procedural sedation and a CCL or CV Tech in the control room for documentation and communication. Radiology procedure support is composed of a RN Circulator with experience in and demonstrated competencies in CCL/IR, if procedural sedation is ordered, an RN with demonstrated competencies in procedural sedation and a radiology or CV technician. The holding area of the department is staffed with a minimum of 2 RNs competent in preoperative preparation of CCL/IR patients and Phase I and II of post-anesthesia nursing in CCL/IR patients. Assistive personnel are Unit Clerks.

~~H.~~I. **CANCER TREATMENT CENTER (CTC)**

1. ***SCOPE OF SERVICES:***

The Cancer Treatment Center is housed in a separate building from the hospital, but is on hospital grounds. The CTC offers not only Medical Oncology/Hematology services but also Radiation Therapy treatments Monday through Thursday~~Friday~~, 0800 to 1630 and Friday 0800-1200. The Medical Oncology section is staffed with RNs specially trained in the administration of various chemotherapeutic agents. The Radiation Oncology section is staffed with Radiation Therapists specially trained to provide radiation therapy and a Radiation Therapy Aide. CTC support staff includes a registration clerk, receptionist/scheduler, HIM clerk and an insurance authorization coordinator.

2. ***PATIENT POPULATION:***

The patients served at the CTC range from young adult (18 years of age) to geriatric. Services provided to the patients are administration of blood products; administration of chemotherapeutic agents ranging from 0 to 8 hours in duration; intravenous hydration; intravenous gamma globulin administration; subcutaneous / intramuscular injections or

supportive drug therapies, radiation therapy and medical procedures that include bone marrow aspiration and biopsy.

3. ***GOALS:***

a. To create a caring environment through education of patient and family, anticipatory guidance and emotional support with the intent of easing the burden of diagnosis of cancer and the treatment that follows.

b. To provide the highest quality of care in a compassionate manner to the satisfaction of the patient and family.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing for the Chemotherapy Treatment Room is 1 RN for 3 patients. Core staffing for the Radiation Therapy section is 1 Radiation Therapist. Additional staff (Radiation Therapist, Radiation Aide) will be assigned as required based on the number of treatments and complexity of set-ups.

~~I.~~J. **EMERGENCY DEPARTMENT**

1. ***SCOPE OF SERVICE:***

The Emergency Department (ED) is an 18-bed ~~Level IV~~ "Basic level" ED, that is a paramedic receiving and ~~a~~ designated Base Station with certified base hospital physicians. It is open 24-hours a day, 7 days a week. Care is provided by RNs and RN/MICNs who are specially trained to deal with emergency situations based on standards of care as referenced by the ENA, California Board of Nursing, EMTALA, the Joint Commission on Accreditation of Health Care Facilities and the California Department of Health. The RN staff is assisted by CNAs and Monitor Technicians/Unit Clerks.

2. ***PATIENT POPULATION:***

The Emergency Department provides assessment, evaluation, stabilization, and management of all life-threatening, emergent, urgent, and non-urgent conditions to all ages. Patients are triaged by a registered nurse competent in emergency nursing using the Evaluation Severity Index or ESI 5 Level Triage System. Patients triaged as ESI level I (Resuscitation) are taken directly to a treatment bed for immediate treatment. ESI Level II (Emergent) patients are placed in a bed within 10-15 minutes of arrival. ESI Level III (Urgent) patients are placed in a bed within 30 minutes of arrival. ESI Level IV/V (Less Urgent/Non-Urgent) patients will be treated in Extension Care during the hours of 9~~11~~ a.m. – 9:30~~11:00~~ p.m., 7 days a week. After initial triage assessment by an RN, Extension

Care is provided by a mid-level provider (PA) and ~~-~~a RN. During the hours that Extension Care is closed, ESI level IV/V patients will be treated in the acute area of the Emergency Department. Patients who are triaged when beds are full are placed in the waiting room or in a hallway bed if their triage category warrants closer observation until a room is available. A physician or mid-level provider (PA) will evaluate patients within 30-45 minutes of placement in a patient room based on the severity of their complaints and or the assigned ESI triage level.

3. ***GOALS:***

a. To provide competent, comprehensive, EMTALA compliant emergency care for all patients requesting service for themselves or others.

b. To provide emergency care, evaluation within the capability and capacity of our department and facilities.

c. To provide all patients presented to the ED with an initial triage, a Medical Screening Exam (MSE), appropriate treatment, appropriate follow-up care, and discharge instructions.

d. To provide treatment to patients within a reasonable amount of time contingent on the critical nature of the inquiry or illness, and ED saturation.

e. To utilize ancillary departments as needed.

f. To provide referral to specialty physician/areas as needed.

g. To provide ongoing continuous quality improvement monitoring.

h. To transfer patients to appropriate facilities based on the capability and capacity of our facility and based on the medical needs of the patient.

4. ***CORE STAFFING & AUGMENTATION:***

The department leadership consists of 1 department Leader~~director~~, ~~a clinical manager~~ and charge nurses that are assigned for each 12 hour shift. Core staffing for a 12 hour shift includes: 1 RN/MICN acting as charge nurse and responsible for EMS radio traffic, 6~~7~~ RNS with assigned rooms to maintain, a nurse to patient ratio of 1 nurse to 4 patients, 1 RN triage nurse, three (3) CNAs and 1~~2~~ Monitor Technician/Unit Clerks, in addition to the compliment of RN staff. As the need arises, the charge nurse and/or the department Leaders ~~director or clinical manager~~ will evaluate the staffing needs of the department. Staffing will be adjusted to accommodate the needs of individual patients (critical care),

surge capacity or any departmental or facility conditions that affect the ability of the ED to provide safe care.

~~J.~~K. RENAL SERVICES

1. ***SCOPE OF SERVICE:***

   Renal Services provides acute dialysis services.

2. ***PATIENT POPULATION:***

   Renal Services provides care to patients 18 years of age or older, for both~~both as~~ inpatients and Oberservation patients ~~and outpatients~~ with ~~for~~ the following conditions: acute renal failure; exogenous intoxication; drug pharmaceutical overdoses; end-stage renal failure ~~(inpatients and outpatients)~~; and other conditions deemed eligible by the nephrologist.

3. ***GOALS:***

   a. To create a caring environment for patients and family members by providing compassionate care and emotional support with the intent of easing the burden of the diagnosis of end stage kidney disease.

   b. To assist patients and family members in dealing with their chronic condition through education.

   c. Renal Services staff will work with the Nephrologists to provide the highest quality hemodialysis in a comfortable setting, striving to maintain and restore renal function.

4. ***CORE STAFFING& AUGMENTATION:***

   Core staffing for renal services is as follows:

   ~~a. The Outpatient Dialysis Center is open from 5:00 a.m. – 8:00 p.m., Mondays, Wednesdays and Fridays, and from 8:00 a.m. – 4:30 p.m. on Tuesdays and Thursdays.~~

   ~~b. The Outpatient Dialysis Center is staffed by the Department Director, the Clinical Manager, a Clerk/Receptionist, a Licensed Social Worker, a Dietitian, 7-8 Certified Hemodialysis Technicians and 4-5 Registered Nurses.~~

~~c.~~a. The acute setting is staffed by one Registered Nurse and one Certified Hemodialysis Technologist Monday- Saturday~~daily~~.

~~d.~~b. A Registered Nurse is on call for the acute care ~~setting daily~~ for emergent dialysis after closing of the unit for the shift and 24 hours on Sunday.

~~K.~~L. WOUND HEALING DEPARTMENT

1. **SCOPE OF SERVICE:**

Patients may be referred by a physician, other health care practitioner, or self-referred. A physician will complete a history and physical, order diagnostic tests, if indicated, and determine a plan of care following established clinical practice guidelines. Treatment will focus on the causation of the wound, co-existing conditions that impact wound healing, and topical wound management.

2. **PATIENT POPULATION:**

The patient population served by the Wound Healing Department is adults through geriatric age groups.

3. **GOALS:**

- To treat all patients with compassion and kindness;
- To systematically and continuously monitor the quality and appropriateness of care, treatment and services;
- To provide cost effective, safe quality care; and
- To coordinate the patient's plan of care with referring physicians, primary care physicians, home health agencies, and/or other health care providers.

4. **CORE STAFFING & AUGMENTATION:**

The clinic will have at all times a registered nurse and a clerical assistant. Additionally, a hyperbaric technician will be present when hyperbaric treatments are utilized. Additional staffing (RN or MA) will be added as volume and acuity of patients dictate.

~~L.~~ UROLOGY CLINIC

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1. ***SCOPE OF SERVICES:***

The urology clinic, while a department of the hospital, is located off campus. The clinic provides for the diagnosis and treatment of male and female urological and urological related conditions to include sub-specialties not limited to: endourology, infertility, and urologic oncology. Patients may be referred by a physician, other health care practitioner, or self-referred. The clinic has three exam rooms and one procedure room. The urological procedures performed at the clinic are minor in nature and do not involve sedation or anesthesia. The clinic functions are supported by a ~~nurse~~ manager, Charge Nurse, ~~a~~ ~~receptionist~~ Registration/Unit Clerk, ~~r~~Receptionist/~~s~~Scheduler, ~~a~~Authorization ~~c~~Coordinator and medical assistants. The clinic is open Monday through Friday, 0800 to 1630.

2. ***PATIENT POPULATION:***

The patient population is from adult ~~pediatric~~ to geriatric, male and female.

3. **GOALS:**

- To deliver patient centered quality care
- To provide well- coordinated, comprehensive access to urological specialty treatments
- To maintain a high level of quality care delivered in a safe and cost effective manner.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing will be 1 registered nurse, 1 registration/Unit Clerk~~ceptionist~~, and 1 Receptionist/scheduler, 1 authorization scheduler, medical assistant to 3 exam rooms .When the procedure room is in use, a second medical assistant may be utilized based on complexity.

~~M.~~L. RURAL HEALTH CLINIC

1. ***SCOPE OF SERVICES***

Primary care clinic setting located off the main campus in Terra Bella. The clinic provides family medicine for the entire age spectrum. The clinic has a primary provider of an advanced practice nurse and supervised by a Board Certified Family Medicine physician, who is also the medical director of the clinic. The clinic has variable hours and does welcome walk-ins.

2. ***PATIENT POPULATION:***

Family health that includes all age groups

3. ***GOALS:***

Bring primary care and population health to the community

4. ***CORE STAFFING & AUGMENTATION:***

Advanced Practice Provider (minimum 1)
Physician (supervising role)
Medical assistants to perform front and back office duties (minimum 2)

~~N.~~M. Academic Health Center (GME Internal Medicine & Continuity Clinic)

1. ***SCOPE OF SERVICES***

Provide internal medicine primary care in an outpatient clinic setting. The clinic will serve as a continuity-based clinic for follow-up for patients discharged from acute care who do not have a private physician and/or are unable to get into their private physician within 10-days of discharge from the acute care hospital setting. Additionally, the clinic is available for scheduled appointments. The clinic ~~in the inaugural opening in 2021 will be 5 half-days and beginning in July 2022, will~~ operates 5 days per week with full days~~.~~ when staff with a supervising physician. Times of clinic will be available through the scheduling/appointment process. Walk-ins will be accepted during the time the clinic is open.

2. ***PATIENT POPULATION***

Age 14 and older

3. ***GOALS:***

Provide primary care services to the community as part of an academic teaching program.

4. ***CORE STAFFING & AUGMENTATION:***

Supervising attending physician
Interns/Residents
RN reachable and available
Medical Assistants (front and back office) with core staffing of 2

ANCILLARY DEPARTMENTS:

A. **CASE MANAGEMENT/SOCIAL SERVICES**

Referrals for all Social Service/Discharge Planning Services are accepted from physicians, hospital personnel, patients, families, outside agencies and other healthcare professionals as appropriate. Referrals may be made in person, by telephone, computer referral, or written contact. Treatment modalities include crisis intervention, situational counseling, care conference, discharge planning, and referral to community service providers. Social Service works closely with the interdisciplinary team members to develop a holistic plan of care for the patient. The plan is successfully executed by all team members working together with the patient/family.

Case Management/Transfer Center is responsible and accountable for the act of coordinating both internal and external patient care needs by facilitating patient placement in the appropriate internal nursing unit or external hospital transfer utilizing pre-established criteria and consulting with members of the multidisciplinary team.~~Referrals for all Social Service/Discharge Planning Services are accepted from physicians, hospital personnel, patients, families, outside agencies and other healthcare professionals as appropriate. Referrals may be made in person, by telephone, computer referral or written contact. Treatment modalities include crisis intervention, situational counseling, care conference, discharge planning and referral to community service providers. Social Service works closely with the interdisciplinary team members to develop a holistic plan of care for the patient. The plan is successfully executed by all team members working together with the patient/family.~~

~~Case Management is responsible for promoting appropriate quality patient care and effective utilization of available health resources along the continuum of care from admission through post discharge.~~

~~Under the direction of the Utilization Review Committee, the LVN UR Nurses monitor the patient's placement into the hospital using benchmark criteria InterQual. They also collaborate with the insurance companies to provide patient updates regarding medical necessity for hospitalization, to minimize denials of reimbursement.~~

~~Case Management/Social Service is governed by the Utilization Review Committee with ongoing activities reported to the Performance Improvement Department~~

1. ***SCOPE OF SERVICE:***

~~Social Service provides discharge planning and clinical social work services to all inpatients ranging from newborn to geriatric age groups and to outpatients receiving renal dialysis, cancer treatment, physical rehabilitation and hospital emergency department care. The focus of all services is to remove barriers to recovery and wellness, and to~~

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~~facilitate access to health care resources both during and after a hospital stay. Regular business hours for the Social Services Department are from 8AM through 4:30 PM, Monday through Friday and on call for after hours and holidays.~~

~~Case Management provides services to ensure appropriateness and necessity of admission at the most efficient level of care, regardless of payment source. Services are provided to ensure that the level of continued care is appropriate to the patient need. Identification and analysis of patterns or trends which contribute to unnecessary or ineffective use of resources is performed.~~

~~The Utilization Review Committee analyzes reviews and evaluates clinical practices within the organization to promote and maintain quality patient care. Findings of the Committee are reported to the appropriate departments or the Directors of Case Management or Social Services, for their consideration and action.~~ Social Service provides discharge planning and clinical social work services to all inpatients ranging from newborn to geriatric age groups and to outpatients receiving renal dialysis, cancer treatment, physical rehabilitation and hospital emergency department care. The focus of all services is to remove barriers to recovery and wellness, and to facilitate access to health care resources both during and after a hospital stay. Regular business hours for the Social Services Department are from 8AM through 4:30 PM, Monday through Friday and on call for after hours and holidays.

Case Management/Transfer Center provides services to ensure interdisciplinary communication and collaboration to provide a dynamic environment for ongoing development of the internal and external movement and placement of patients. Services are provided to ensure that the level of continued care is appropriate to the patient's need. Identification and analysis of patterns or trends which contribute to unnecessary or ineffective use of resources is performed.

2. ***GOALS:***

a. To promote appropriate allocation of the hospital's resources in striving to provide high quality care to each patient in a cost-effective and timely manner.

b.

c. To optimize the delivery of quality patient care at the most appropriate level of care which facilitates maximum treatment and recovery through effective monitoring processes.

d.

e. To assist patients to make best use of personal and community resources in order to promote their well-being and that of the community.

f.

g. To facilitate continuity of care including discharge to appropriate setting.

~~a. To promote appropriate allocation of the hospital's resources in striving to provide high quality care to each patient in a cost-effective and timely manner.~~

~~b. To optimize the delivery of quality patient care at the most appropriate level of care which facilitates maximum treatment and recovery through effective monitoring processes.~~

~~c. To assist patients to make best use of personal and community resources in order to promote their well-being and that of the community.~~

~~d. To facilitate continuity of care including discharge to appropriate setting.~~

3. ***CORE STAFFING & AUGMENTATION:***

~~The CM/SS department will be staffed on a daily basis as follows:~~ The CM/Transfer Center and SS department will be staffed on a daily basis as follows:

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Position	***Monday – Friday***	***Weekends & Holidays***
Director of Care Continuum	0700- 1730 Monday-Thursday~~8:00 – 4:30 PM~~	***On call 24/7***
~~Manager of Care Continuum~~	~~8:00 – 4:30~~	~~***On Call 24/7***~~
Social Services (3~~2~~) MSW (2~~1~~) BSW	8:00 – 4:30 PM	***Weekends ~~Saturday~~ & Holidays 8:00 -4:30 PM (2~~1~~) ~~(Alternates with CM)~~***
Social Services Designee – DPSNF (1)	8:00 – 4:30 PM	***None***
Position	***Monday – Friday***	***Weekends & Holidays***
RN Case Manager (1~~3~~)	0700- 1930~~8:00 – 4:30~~ PM	***Weekends ~~Saturda~~y & Holidays 0700-1930~~8:00 -4:30~~ PM (1) ~~(Alternates with SS)~~***
ED Care Coordinator – ED (1~~2~~)	0700-1930~~Variable Hours~~ 7/days week	***Weekends and Holidays 0700-1930 (1)~~Holidays if scheduled day~~***
~~Denials Specialist RN (1)~~	~~8:00 – 4:30~~	~~***M-F***~~
~~LVN UR Nurses (1)~~	~~8:00 – 4:30 PM~~	~~***None***~~
Case Management Analyst (1)	0800~~7:00~~ – 1630~~3:30~~ PM	***None***

Augmentation of core staff will include the use of Per Diem staff as needed and the Directors working on the units to facilitate Case Management/Social Service/Discharge Planning of the patients.

B. **CLINICAL LABORATORY**

1. ***SCOPE OF SERVICE:***

   The Clinical Laboratory is open 24-hours a day, 7 days a week, 365 days per year to provide patients and their physicians with accurate and efficient laboratory testing. The lab is staffed with Clinical Lab Scientists who are specially trained for performing and analyzing the tests ordered, and phlebotomists who are trained to draw blood samples and perform simple processes. The following types of lab work offered are: hematology, coagulation, chemistries, blood bank, urinalysis, microbiology, TDMs, toxicology, serology and blood gases.

2. ***PATIENT POPULATION:***

   The patient population served by the clinical lab includes all ages, neonate through geriatric.

3. ***GOALS:***

   a. To obtain samples for testing in a timely and efficient manner with the least amount of discomfort to the patients.

   b. To provide accurate test results in a timely manner to enhance patient outcomes.

4. ***CORE STAFFING & AUGMENTATION***

Position	***Monday – Friday***	***Weekend***
Lab Director	9:00 AM – 6:00 PM (1)	On Call
Lab Manager	8:30 AM – 5:00 PM (1)	On Call
Lab Informatics Coordinator	8:30 AM – 5:00 PM (1)	On Call
Clinical Lab Scientist	5:30 AM – 4:00 PM (1) 6:00 AM – 4:30 PM (1) 7:30 AM – 6:00 (1) 8:00 AM – 4:30 PM (1) 4:00 PM – 2:30 AM (1) 6:00 PM – 6:30 AM (1)	5:30 AM – 1:00 PM (1) 6:00 AM – 4:30 PM (1) 8:30 AM – 7:00 PM (1) 4:30PM –5:00 AM (1) 6:00 PM – 6:30 AM (1)
Position	***Monday – Friday***	***Weekend***
Phlebotomist	4:00 AM – 2:30 PM (2) 6:30 AM – 3:00 PM (1) 8:00 AM – 5:00 PM (1) 11:30 AM – 9:00 PM (1) 2:30 PM – 11:00 PM (1)	4:00 AM – 2:30 PM (2) 8:00 AM – 12:00 PM **Sat. only** 11:30 AM – 9:00 PM (1) 2:30 PM – 11:00 PM (1)

	3:00 PM – 8:00 PM (1) 8:00 PM – 6:30 AM (1) 10:00 PM – 6:30 AM (1)	 8:00 PM – 6:30 AM (1) 12:00 AM – 8:30 AM (1)
Clerk	6:45 AM – 3:15 PM (1) 7:00 AM – 3:30 PM (1) 9:30 AM – 5:00 PM (1)	 8:00 AM – 12:00 PM **Sat. only**

Additional phlebotomists can be called in to assist with greater patient census to acquire the specimens for testing.

C. **FOOD & NUTRITION SERVICES**

1. ***SCOPE OF SERVICES:***

The Food and Nutrition Service Department is open daily from 0500 to 2100 and provides the following services: patient/resident meals (3 per day based on physician's orders); nourishments as ordered by the physician; patient snacks; coffee kiosk and cafe services for breakfast, lunch and dinner for staff and guests; and in-house catered meals for hospital staff meetings.

2. ***PATIENT POPULATION:***

The Food and Nutrition Service Department serves all patients and the general public who come to the hospital as visitors, or to attend special meetings or educational programs.

3. ***GOALS:***

a. To serve attractive, satisfying meals prepared with high sanitation and safety standards.

b. To plan appetizing, well-designed menus that meet the nutritional and therapeutic needs of patients/residents in accordance with physicians' orders.

c. To operate a department that meets and exceeds the standards as set forth by federal, state, and local regulatory agencies, as well as other bodies such as The Joint Commission.

d. To foster good interdepartmental relations that will enhance the overall quality of patient/resident care.

e. To provide continuing in-service education for all Food and Nutrition Service employees that will increase their understanding of required job tasks and improve overall skills and performance.

f. To provide optimum nutritional care and customer service while keeping within the prescribed fiscal budget.

g. In collaboration, the Food & Nutrition Service Director and Lead Dietitian will establish policies and training based on the Food Code standards of practice for food safety and food allergy awareness.

h. Collaborate with Infection Control Department and adhere to sanitary requirements of the Food and Drug Administration for employee health and personal hygiene.

i. Integrate Food & Nutrition Service in the hospital wide QAPI (Quality Assessment and Performance Improvement) and Infection Control Programs.

4. ***CORE STAFFING & AUGMENTATION:***

Position	***Monday – Friday***	***Weekend***
Food & Nutrition Service Director	8:00 AM – 4:30 PM	On Call
Lead Dietitian	8:00 AM – 4:30 PM	On Call
Clinical Dietitian	7:30 AM – 4:00 PM	
Clinical Dietitian	8:00 AM – 4:30 PM	8:00 AM – 4:30 PM/ On Call
Clinical Dietitian	8:30 AM – 5:00 PM	
Lead Cook #1	6:00 AM – 4:30 PM	On Call
Food Service Lead- #20	11:00 AM – 9:30 PM	11:00 AM – 9:30 PM
Cook #3	5:00 AM – 1:30 PM	5:00 AM – 1:30 PM
Cook #4	11:00 AM – 7:30 PM	11:00 AM – 7:30 PM
Diet Aide # 7	5:00 AM – 1:30 PM	5:00 AM – 1:30 PM
Diet Aide # 9	12:30 PM – 9:00 PM	12:30 PM – 9:00 PM
Cafe Cashier # 11	5:30 AM – 2:00 PM	5:30 AM – 2:00 PM
Cafe Cashier # 12	6:00 AM – 2:30 PM	
Caterer #13	5:30 AM – 2:00 PM	
Cafe Cashier # 14	12:30 PM – 9:00 PM	12:30 PM – 9:00 PM
Cafe Coffee Corner #33	6:30-11:30 AM/6:30-8:30 PM	
Food Service Worker #6	6:30 AM – 3:00 PM	6:30 AM – 3:00 PM
Food Service Worker # 8	5:30 AM – 2:00 PM	5:30 AM – 2:00 PM
Food Service Worker #16	6:30 AM – 3:00 PM	6:30 AM – 3:00 PM
Food Service Worker #17	6:30 AM – 3:00 PM	6:30 AM – 3:00 PM
Food Service Worker #18	12:30 PM – 9:00 PM	12:30 PM – 9:00 PM

Food Service Worker #19	5:00 PM – 9:00 PM	5:00 PM – 9:00 PM
Inventory Clerk #21	7:00 AM –3:30 PM	

The daily census report will be used to adjust staffing levels as needed. A low patient census may require staffing pattern adjustments. Staffing pattern adjustments will be issued in 30 minute increments. When adjusting the staffing pattern, the FNS Director will ask for staff members who want to volunteer to leave early. If further adjustments are necessary, it will be in a fair and consistent manner.

D. IMAGING SERVICES

1. *SCOPE OF SERVICE:*

Imaging services are provided to both inpatients and outpatients 24 hours/day, 7 days per week for inpatients and the Emergency Department. Services are offered 11-hours a day, Monday through Friday to all outpatients, with the exception of observed holidays. Services provided include CT Scanning, Nuclear Medicine Diagnostic Ultrasound, Mammography, Magnetic Resonance Imaging (MRI), and X-ray procedures. Range of treatment comprises diagnostic procedures, invasive/intra-operative and non-invasive techniques with or without the use of contrast media. Echocardiography is performed Monday – Friday, 8:00 AM – 4:30 PM for in-patients and out-patients.

2. *PATIENT POPULATION:*

The Imaging Services are provided to both inpatients and outpatients of all ages.

3. *GOALS:*

To effectively provide complete Imaging Services for detection, diagnosis, treatment of human illnesses and injuries with appropriate staff, equipment and supplies in a timely manner.

4. *CORE STAFFING & AUGMENTATION:*

Core staffing for the imaging services will have a minimum of one (1) Certified Radiologic Technologist on-site at all times, (1) Certified Radiologic Technologist on-site for CT Scan at all times, On Call personnel for Ultrasound, and Radiological services are available with a defined 30 minute response time from the first call.

Position	***Monday – Friday***	***Weekends***
Imaging Services Administrative Director	0800 – 1630 (1)	
Imaging Services Director~~Manager~~	~~0630 – 1500~~0800- 1630 (1)	
Lead Radiologic Technologist	0800 – 1630 (1)	

Radiologic Technologist	24-hour coverage ~~0630 – 2230 (6)~~	24-hour coverage ~~0700 – 1200 (5)~~ ~~1700 – 0630 On Call (1)~~ ~~Monday thru Friday~~ ~~0700 – 0700 On Call~~ ~~Saturday & Sunday~~
CT Lead CT Technologist's ~~CT Technologist~~ ~~CT Technologist~~ ~~CT Technologist~~	0630 – 1500 (1) 24 hour coverage ~~1000 – 2030 (1)~~ ~~1900 – 0700 (1)~~ ~~Thurs, Fri., Sat.~~ ~~0700 – 1900 (1)~~ ~~Fri., Sat., Sun.~~ ~~1930 – 0630 (1)~~ ~~Sun., Mon., Tues., Wed.~~	~~No On Call Coverage~~ 24 hour coverage
MRI Technologist	0630 – 1900 (1)	Saturday 0630- 1900 (1) No Coverage Sunday ~~No On Call Coverage~~ ~~0730 – 1530 (1)~~
Nuclear Medicine Technologist	0800- 1630 ~~0700 – 1630~~ (1) ~~Wed., Thurs., Fri.~~	No ~~on call~~ coverage
Ultrasound Technologist	24 hour coverage ~~0600 – 2300~~ (4) ~~On Call 2300 – 0630~~	24 hour coverage ~~0730 – 1930 (1)~~ ~~On Call 1930 – 0730 (1)~~
~~RN's Angio, CT, Specialties~~	~~7:30 – 17:30 (2)~~	~~No On Call coverage~~

Staffing as available in augmented based upon projected census and volume as scheduled procedures, including outpatient procedures.

E. **INFECTION PREVENTION**

1. ***SCOPE OF SERVICE:***

Infection Prevention Services are provided 24-hours a day, 7 days a week. The Infection Prevention leader~~Director~~ is in the hospital facility or one of the outpatient units M-F 8:00 a.m. – 4:30 p.m. The Infection Prevention leader~~Director~~ is on-call 24 hours a day, weekends and holidays. The Infection Prevention leader~~Director~~ has the overall responsibility for department performance, improvement plans and follow-up for the quality of care/service provided to all customers of the department. The Infection Prevention leader~~Director~~ will be responsible for coordinating data collection and the evaluation of data for the department. Duties include but are not limited to: (1) investigation of positive cultures, clusters of pathogens, personnel and/or medical staff involved; (2) evaluation of confirmed infectious cases to ensure correct implementation of appropriate barriers; (3) partners employee health related issues, in-service education

related to infection control practices; (4) review of medical waste management and disposal; and (5) interaction with regulatory agencies.

2. ***PATIENT POPULATION:***

Infection Prevention services are available to all inpatients, pediatric to geriatric as well as all ancillary and support departments and hospital personnel. Internal and External customers to include: patient care services department; ancillary services departments; administrative departments; medical staff; Department of Health and community groups.

3. ***GOALS:***

a. To provide a systemic coordinated and continuous approach to improving performance, focusing on surveillance, prevention, and control of infections throughout the organization.

b. To ensure a functioning, coordinated process to reduce the risk of transmitting infections to patients, staff, volunteers, students and visitors.

c. To provide education to all personnel regarding infection control.

d. To increase community education regarding communicable diseases.

e. To ensure SVMC~~DH~~'s compliance with all regulatory agencies and requirements.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing for the department is 1 Leader~~Manager~~ who is well-versed in infection prevention with a working knowledge of microbiology, epidemiology, infectious diseases, aseptic techniques and current practices, 1 RN who provides education, collects data, conducts surveillance, and reports findings to various hospital groups and units, and an analyst who provides clerical and analytical services. It is preferred the Leader~~Director~~ is a member of the Association of Professionals in Infection Control and Epidemiology (APIC) and is certified in Infection Prevention. If a situation presents that requires augmentation, depending upon the nature of the event, the Tulare County Health & Human Services Department will be notified for assistance.

F. **PHARMACEUTICAL SERVICES**

1. ***SCOPE OF SERVICE:***

The Department of Pharmacy Services is available to the patients 24-hours/day, 7 days per week, 365 days per year. Physical SVMC Pharmacy hours of operation are: 0700 – 2100 Monday through Friday and 0700 – 1900 weekends and holidays. Remote Pharmacy Service hours are 2100 – 0700 Monday through Friday and 1900 – 0700 weekends and holidays. There will always be a physical SVMC~~DH~~ Pharmacist on-call from: 2100 – 0700 Monday through Friday and 1900 – 0700 weekends and holidays. The Pharmacy is staffed with Clinical Pharmacists and Pharmacy Technicians. Services include clinical pharmacist presence on all floors, medication procurement, storage, preparation, distribution, administration, provision of medication-related information to patients and other health professionals, and therapeutic, preventive, and diagnostic use of pharmaceuticals and related devices.

2. ***PATIENT POPULATION:***

The Department of Pharmacy Services serves the following types of patients: General Acute Care: Medical/Surgical including Pediatrics, OB/GYN including newborns; Critical Care and Telemetry; Perioperative and Post-Anesthesia Recovery; Special Procedures (Endoscopy, Prostate Biopsy, Radiological Interventions); Emergency Medicine; Ambulatory Outpatients (Physical Therapy, Nuclear Medicine); outpatient Chemotherapy and Sub-acute Unit. The ages of patients served range from prenatal through geriatric.

3. ***GOALS:***

a. To ensure the optimal use of medications to achieve a specific outcome that improves a patient's quality of life.

b. To ensure individual patient care, optimal use of medications, quality of life and positive outcomes.

c. To foster a close working relationship between the Pharmacist and patient, healthcare providers and to collaborate with all parties involved in the care of the patient.

4. ***CORE STAFFING & AUGMENTATION:***

The Department of Pharmacy Services shall be staffed on a daily basis as follows: *(see Table below)*

Position	***Monday – Friday***	***Weekends***
Director of Pharmacy	0800 – 1630 (1)	
Clinical Coordinator	0900 – 1730 (1)	

Clinical Pharmacist	0800 – 1730 (1) 1030 – 1730 (1)	
Staff Pharmacist	0700 – 0800 (1) 0700 – 1030 (1) 1030 – 2100 (1)	0700 – 1730 (1) 0830 – 1900 (1)
Pharmacy Technician Supervisor	0900 – 1730 (1)	
Pharmacy Buyer	0900 – 1730 (1)	
Pharmacy Technicians	0700 – 1530 (1) 0700 – 1530 (1) (M,W,F) 0800 – 1630 (1) 1030 – 1900 (1) 1230 – 2100 (1)	0700 – 1530 (1) 0700 – 1530 (1) 1030 – 1900 (1)

G. **PHYSICAL THERAPY**

1. ***SCOPE OF SERVICE:***

Physical Therapy is available for Acute Care patients as well as patients in the Distinct Part Skilled Nursing Facility (DPSNF). PT Services are provided 7-days a week, 52 weeks per year. Weekend as well as holiday coverage is available for evaluations and treatments for the inpatients on the acute side. Staffing is provided by California licensed Physical Therapists and Physical Therapy Assistants.

2. ***PATIENT POPULATION:***

Physical Therapy services are provided to inpatients on both the acute and DPSNF side of the hospital. The ages of patients served range from pediatric to geriatric for all types of orthopedic conditions and soft tissue injury, neurological conditions, wound care for pressure ulcers, and medical conditions if the condition impacts the patient's ADL's.

3. ***GOALS:***

a. To provide effective and efficient patient care;

b. To increase professional and lay awareness and encourage on-going education and research in the field of physical therapy;

c. To educate at many levels, recruit personnel and maintain standards of practice for the welfare of patients and its own member.

4. ***CORE STAFFING & AUGMENTATION:***

The Physical Therapy Department will be staffed on a daily basis as follows:

Position	***Monday – Friday***	***Weekends & Holidays***
Department Administrative Director	8:00 AM –4:30PM (1)	
Physical Therapists	0800-1700 ~~10:00 AM – 6:30 PM~~ (2)	~~Contract or On Call therapist on an "as needed" basis.~~ Per Diem Staff 0900-1400
Physical Therapy Assist.	8:00 AM – 4:30 PM (1) Tuesday and Thursday ~~Wed. to Fri.~~	No PTA coverage~~8:00 AM – 4:30 PM (1)~~
Physical Therapy Aide	8:00 AM – 4.30 PM (1) as needed	

~~Staffing is augmented by calling in additional staff that are on a Per diem or contract employment basis.~~

H. **RESPIRATORY THERAPY**

1. ***SCOPE OF SERVICES:***

Respiratory Therapy (RT) ~~Services is open 24 hours per day, 7 days per week, 365 days per year. The department is staffed with licensed Respiratory Care Practitioners on all shifts. Services are provided for both inpatients and ambulatory outpatients to include but not be limited to the following: ABG's, EKGs, EEGs, pulmonary function testing, peak flow, and breathing treatments, nebulizers, Bi-PAP, and CPAP, ventilator care as well as basic and advanced cardiopulmonary resuscitative measures. Additionally, the RT Department provides neurological testing Monday through Thursday, 6:00 AM – 5:00 PM as ordered by members of the hospital Medical Staff. Patient education on disease entities is provided via educational handouts with verbal explanation, as well as scheduled instructions and follow-up.~~ are available 24 hours a day, 7 days a week, 365 days a year. The department is staffed on all shifts by licensed Respiratory Care Practitioners. Services are provided to both inpatient and ambulatory outpatient populations and include, but are not limited to: arterial blood gases (ABGs), EKGs, EEGs, pulmonary function testing (PFTs), peak flow measurements, pulmonary hygiene, breathing treatments, BiPAP and CPAP therapy, mechanical ventilation, and both basic and advanced cardiopulmonary resuscitative care. In addition, the RT Department offers ambulatory outpatient neurological testing, EKGs, and PFTs Monday through Friday from 7:00 a.m. to 5:00 p.m., as ordered by members of the hospital's medical staff. Patient education related to disease processes is provided through written educational materials, verbal instruction, and scheduled follow-up sessions.

2. ***PATIENT POPULATION:***

Respiratory Therapy Services ~~to include neurological testing are available for pediatric, adolescent, adult, and geriatric patients requiring cardiac, respiratory care services, treatment or testing to maintain optimum physiological maintenance of cardiac and respiratory systems. Neurological testing is available for the adult population.~~ Respiratory Therapy Services, including neurological testing, are available to pediatric, adolescent, adult, and geriatric patients requiring cardiac and respiratory care, treatment, or diagnostic testing to support optimal physiological function of the cardiac and respiratory systems. Neurological testing is available for the adult population.

3. ***GOALS:***

a. To provide optimum cardiac and respiratory services to the patient population;

b. To provide those services in such a manner as to improve the patients cardiac and respiratory functioning;

c. To ensure high-quality respiratory care across the continuum of care to our patients and their families.

~~c.~~d. ~~provide quality respiratory care across the continuum of care to our patients and their families.~~

4. ***CORE STAFFING & AUGMENTATION:***

Respiratory Therapy Services will be staffed on a daily basis as follows:

Position	***Monday – Friday***	***Weekends & Holidays***
Leader~~Director~~ of RT	8:00 AM – 4:30 PM (1)	
Licensed Respiratory Care Practitioners	5:30AM – 6:00 PM (5) 5:30 PM – 6:00 AM (5)	5:30AM – 6:00 PM (5) 5:30 PM – 6:00 AM (5)
EEG, EKG, PFT Technician	6:00 AM - 4:30 PM (1) Monday thru Friday~~Saturday~~	

Staffing will be augmented by calling in off-duty staff and or asking for overtime on current shift.

I. **SPEECH THERAPY**

1. ***SCOPE OF SERVICE:***

Speech Therapy provides services for the acute inpatient or in the Distinct Part Skilled Nursing Facility. Speech Therapy Services is staffed with a Licensed Speech and Language Pathologist who provides services to the communication-disordered patient, as well as those with swallowing problems, in the most effective, efficient, and economical manner compatible with exceptional patient care. Services include, but are not limited to:

evaluation and assessment prior to the provision of services; cognitive perceptual retraining; swallow evaluations, which may be bedside or in conjunction with Radiology during a Modified Barium Swallow, and communication education.

2. ***PATIENT POPULATION:***

The Speech Therapy services are provided to those patients who are neurologically impaired, have cognitive problems, aphasia (which is a language disorder due to CVA or head trauma), and dysphasia, which is a swallowing disorder. The age of patients services range from pediatric to geriatric.

3. ***GOALS:***

a. To preserve the dignity of the patient;

b. To lessen patient frustration;

c. To assist the patient and family in understanding the communication problems or the need for changes in diet consistency.

4. ***CORE STAFFING & AUGMENTATION:***

Speech Therapy services are provided from 0800 to 1630 Monday through Friday and 0700-1100 on Saturday and Sunday. Telespeech services may be used when therapist unavailable. When Speech Therapy services are ~~is~~ not available ~~due to weekends, holidays, vacation or illness,~~ the nursing staff will complete the initial assessment for swallowing difficulties and work with the patient's physician until the Speech Therapist is available.

SUPPORT SERVICES:

A. **CENTRAL PROCESSING**

1. ***SCOPE OF SERVICES:***

Central Processing is responsible for the sterile processing and decontamination of equipment and instrumentation hospital-wide to include assisting the Surgical Services Department in the processing of surgical instrumentation. The department is open Monday – Friday 0615-2015 and on weekends and holidays from 0830-1700.

2. ***PATIENT POPULATION:***

Central Processing services all departments within the hospital to include both inpatients and outpatients.

3. ***GOALS:***

a. To provide all necessary supplies, equipment, instrumentation, and lines in a timely and efficient manner to all patient care areas;

b. To strive for uniformity and simplicity in the trays, sets, and supplies that Central Processing maintains for the care of our patients;

c. To promote quality of care by providing prompt, courteous, and accurate services to our patient care staff;

d. To provide all services within the Central Processing Department in a cost efficient manner.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing for the Central Processing Department is as follows:

Position	***Monday – Friday***	***Weekends & Holidays***
C.P. Supervisor	6:45 AM- 3:15 PM (1)	
C.P. Tech I	6:45 AM- 3:15 PM (1) 10:45 AM – 7:15 PM (1) 11:45 AM – 8:15 PM (1)	8:00 AM – 4:30 PM (1)
C.P. Tech II	6:15 AM – 2:45 PM (1) 8:30 AM – 5:00 PM (2)	

Augmentation for increased caseloads will include adding extra hours to complete the necessary jobs as required.

B. **CHAPLAINCY SERVICES DEPARTMENT**

1. ***SCOPE OF SERVICES:***

The Chaplaincy Department provides spiritual and emotional support to all patients of the District and their families, as well as to District employees. The Department may also provide non-denominational worship opportunities on occasion, or memorial services in the event of the death of District staff.

2. ***PATIENT POPULATION:***

Chaplaincy (Pastoral Care) services are available to all inpatients and outpatients as well as patients' families and hospital staff who desire this service. Chaplaincy (Pastoral Care) services are available to all, without discrimination as to religion, ethnicity, cultural background or any other characteristic.

3. ***GOALS:***

The goal of Chaplaincy services is to provide spiritual and emotional support to patients, families and hospital staff through various means, including bedside visitation, prayer, religious ritual and worship, emotional support at the end of life, and bereavement counseling. All of these are seen as a means of enhancing the wellbeing and peace of our patients and staff, as they confront illness and/or death.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing for the Chaplaincy Department consists of a part-time and on-call Chaplain. Additional unpaid assistance is provided by local clergy who serve in an on-call capacity a night and on weekends. The Chaplain is on site Monday through Friday from 0800 AM – 1630 PM. The Coordinators are scheduled so as to augment the availability of services to all patients, including the sacramental needs of Catholic patients. The Coordinators also arrange for community clergy to visit any of their own members who desire this service.

C. **ENVIRONMENT OF CARE**
(PHYSICAL PLANT OPERATIONS & MAINTENANCE)

1. ***SCOPE OF SERVICE:***

The Division of Physical Plant Operations encompasses the departments of Engineering, Security, Grounds and Bio-Medical Engineering. These services are provided 24 hours per day, seven days per week, 365 days a year. This Division provides operations support for care to all patients, including services which affect facility staff, physicians, visitors, vendors and the general public in compliance with State, Federal and Local regulatory agency requirements, licensing and accreditation standards.

2. ***PATIENT POPULATION:***

The patient population served is all patients including geriatric, adult, adolescent, pediatric, and newborn. This also includes services which affect facility staff, physicians, visitors, vendors and the general public.

3. ***GOALS:***

   a. To assist with compliance for State, Federal, and Local regulatory agency requirements, licensing and accreditation standards.

   b. To uphold and enforce all standards as set forth in the following Plans: Safety Management, Security Management, Life Safety Management, Emergency Management, Equipment Management, Hazardous Materials & Waste Management and Utilities Management.

4. ***CORE STAFFING & AUGMENTATION:***

   The General Plant Operations & Maintenance Division is staffed as follows:

Position	***Monday – Friday***	***Weekends & Holidays***
Administrative Director of General Services	8:00 AM – 4:30 PM (1) *on-call 24/7 unless otherwise noted	
Facilities Manager	7:00 AM – 4:00 PM (1) *on-call 24/7 unless otherwise noted	
Chief Engineer (Central Plant)	7:00 AM – 3:30 PM (1) *on-call 24/7 unless otherwise noted	
Facilities Project Coordinator	8:00 AM – 4:30 PM (1)	
Facilities Project Manager	8:00 AM – 4:30 PM (1) *on-call 24/7 unless otherwise noted	
Facilities Coordinator	8:00 AM – 4:30 PM (1)	
EOC Manager	8:00 AM – 4:30 PM (1)	
Engineers	7:00 AM – 3:30 PM Mondays & Fridays (6) Tuesday – Thursday (8) 3:00 PM – 11:30 PM (2) 11:00 PM – 7:30 AM (2)	7:00 AM – 3:30 PM (2) 3:00 PM – 11:30 PM (1) 11:00 PM – 7:30 AM (1)
Groundskeeper	5:00 AM – 1:30 PM Mondays & Fridays (2) Tuesday – Thursday (3)	5:00 AM – 1:30 PM (1)

Augmentation of staff includes calling in off-duty staff, or contracting out special projects that requires more manpower and expertise than the staff are able to accommodate.

D. **ENVIRONMENTAL SERVICES**

1. ***SCOPE OF SERVICE:***

The Environmental Services Department is an essential part of the Sierra View Medical Center healthcare team. The department works to provide a sanitary and attractive environment. By providing a consistent level of service, the Environmental Services Department contributes to the safety, health and well-being of all residents, patients, visitors and staff.

2. ***PATIENT POPULATION:***

The EVS Department serves all residents, patients, visitors and staff that access the hospital.

3. ***GOALS:***

The Environmental Services Department is committed to exceeding the expectations of their customers through continuous quality improvement, customer satisfaction, and financial responsibility.

4. ***CORE STAFFING & AUGMENTATION:***

Staffing needs are based on the square footage of the hospital to be cleaned, the cleaning system utilized for specified areas, and total patient census. The core staffing includes:

Position	***Monday – Friday***	***Weekends & Holidays***
Environmental Services Leader~~Director~~	0800 - 1630 (1) or PRN	On call ~~PRN~~
~~Environmental Services Supervisor~~	~~1300 – 2130 (1) or PRN~~	~~PRN~~
Environmental Services Team Leads~~ers~~	0630-1400~~0800 – 1630~~ (1) 1400 – 2230 (1)	0703~~0~~ – 1530~~1600~~ (1)
Environmental Services Team	0630-15 (13)~~0800 – 1630 (13)~~ 1430-2300~~1300 – 2130~~ (9~~1~~) ~~1500 – 2330 (9)~~ ~~2300 – 0730 (3)~~	0630-1500~~0800 – 1630~~ (7~~11~~) 1430-2300~~1500~~ – 2330 (34) Mid shift 10-1930 (1) Graveyard shift 2230-0700 (2)2300 – 0730 (3)
Environmental Services Floor Care Team	PRN (4)	PRN
Laundry & Linen Department	06~~5~~30 – 15400 (2~~1~~) ~~0630 – 1500 (1)~~	0630 – 1500 (1)

E. **HEALTH INFORMATION MANAGEMENT**

1. ***SCOPE OF SERVICE:***

The Health Information Management (HIM) Department is responsible for the timely processing, completeness, integrity, and, when necessary, retrieval of all patient medical records. HIM services are provided to all areas of the facility in accordance with operational needs and applicable security and confidentiality requirements.
The department ensures the creation and maintenance of an accurate, complete patient medical record, with primary functions including record processing; abstracting, analysis, and coding; transcription of medical dictation; correspondence management; record retrieval, filing, and storage; and birth certificate completion.
The HIM Department is staffed by HIM Documentation Imaging Specialists, HIM Coding Specialist, Correspondence Clerks/Receptionists, a Transcription Coordinator, Birth Certificate Clerks, an Revenue Cycle Systems Lead, Charge Master Analyst, Charge Capture Analyst and RAC Coordinator.
Services to the public are available Monday through Friday from 8:00 a.m. to 4:30 p.m.
Services to internal departments are available Monday through Friday from 7:00 a.m. to 4:30 p.m.
~~The Health Information Management (HIM) Department is responsible for overseeing the timely processing, completeness, and when necessary, the retrieval of all patient medical records. The services are provided to all areas of the facility as appropriate to need and security levels. Services include provision of an accurate patient record with emphasis on the following: record processing; record abstracting, analysis, and coding; transcription of dictation for the medical record; correspondence; record retrieval, filing and storage and birth certificate completion. The department is staffed with HIM Specialists, Technicians, Correspondence Clerk/Receptionists, Transcription Coordinator, Birth Certificate Clerks, Informatics Coordinator and Coding Specialists. Services are available to the public Monday through Friday 8:00 AM to 5:00 PM and are available to internal departments Monday – Friday 7:00 AM to 6:30 PM.~~

2. ***PATIENT POPULATION:***

The HIM Department serves both inpatients and outpatients ranging from neonate to geriatric.

3. ***GOALS:***

a. To ensure that an adequate medical record is maintained for every patient in our hospital;

b. To ensure that the medical record includes all significant clinical information pertaining to the patient;

c. To ensure that the medical record contains sufficient information to identify the patient, to justify the diagnosis, to delineate the plan of treatment, and to document the results accurately;

d. To ensure that the medical record is appropriately documented to meet the standards of licensing and surveying agencies, as well as hospital policies and procedures and Medical Staff Bylaws and Rules & Regulations;

e. To ensure that the medical records are held confidential and information only released in accordance with the law.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing for the HIM Department shall consist of:

Position	***Monday – Friday***	***Weekends & Holidays***
Director of HIM	8:00 AM – 4:30 PM	
Manager of HIM	8:00 AM – 4:30 PM	
HIM Specialist Lead	8:00 AM – 4:30 PM	
HIM Clerk	7:00 AM – 3:30 PM 9:00 AM – 6:30 PM	
HIM Inpatient Coding Specialist	6:00 AM – 4:30 PM (3)	
HIM Outpatient Coding Specialist	6:00 AM – 4:30 PM (4)	
HIM Document Imaging Specialist	6:00 AM – 4:30 PM (3)	
HIM Transcription Coordinator	7:00 AM – 3:30 PM	
HIM Birth Certificate Clerk	8:00 AM – 4:30 PM	6:00 AM – 2:30 PM
HIM Informatics Coordinator	8:00 AM – 4:30 PM	
HIM Correspondence Clerk/ Receptionist	8:00 AM – 5:00 PM	

F. **INFORMATION TECHNOLOGY**

1. ***SCOPE OF SERVICES:***

The Information Technology (IT) Department has the responsibility and accountability for introducing and maintaining all IT functions. The IT Department is open from 0700~~6:30~~ AM to 5:30PM Monday through Friday. The IT HELP Desk is available at that

time as well. The Technician ~~Senior Network Administrator, Network Administrator, PC Specialists, IT System Engineer and IT Support~~ Specialist take turns and are available in an On-Call status for all after-hours, weekends and holidays needs that should arise. Types of services provided include but are not limited to: hardware and software support house-wide, development of Decision Support solutions for data analysis; web development for Internet and Intranet access; maintaining security on all major applications house-wide; address and implement HIPAA security issues; recommendations on new technology as well as improvements with existing technology; maintain integrity of computer network; maintain integrity of telecommunication systems and equipment; and coordinate house-wide IT education for hospital.

2. ***PATIENT POPULATION:***

The IT Department serves both the inpatient and outpatient population indirectly by maintaining the computer systems that make it possible for the timely processing of information.

3. ***GOALS:***

a. Improve the HELP Desk response to all clients

b. Improve hardware reliability to improve efficiency and efficacy of information/data handling;

c. Overall resolution time on problem requests.

4. ***CORE STAFFING & AUGMENTATION:***

Position	***Monday – Friday***	***Weekends & Holidays***
IT Director	8:00AM – 5:00 PM (1)	
~~Programmer Analyst~~	~~8:00AM – 5:00 PM (1)~~	~~Programmer Analyst~~
IT Educator	8:00AM – 5:00 PM (1)	
Nursing Informatics	8:00AM – 5:00 PM (1)	
Applications Specialist	8:00AM – 5:00 PM (2)	
Telecommunications Specialist	7:00 AM – 3:30 PM (1)	
Sr. Network Engineer~~Administrator~~	8:00 AM – 5:00 PM (1)	
Network Administrator	8:00 AM – 4:30~~5:00~~ PM (2~~1~~)	On call for after – hours, weekends, and holidays is rotated on a weekly basis.
Techician~~PC~~ Specialists	7:0~~3~~0 AM – 3~~4~~:3~~0~~0 PM (2~~1~~) 8:00 AM – 4:30 PM (1) 8:30 AM – 5:00 PM (2~~1~~)	
IT Support Specialist	8~~7~~:30 AM – 5~~4~~:00 PM (1)	

IT Systems Engineer	08007~~:30~~ AM – 4:30~~00~~ PM (2~~+~~)	

G. **MARKETING, COMMUNITY RELATIONS**

1. ***SCOPE OF SERVICE:***

Marketing and Community Relations is responsible for the coordination of public relations, marketing activities, marketing materials, and for providing necessary support to the Department Managers/Supervisors and/or staff members in carrying out public relations and/or marketing activities. The Marketing Department is open Monday – Friday from 8:00 AM to 5:00 PM. Any staff member of the District who is contacted by a member of the media for information or comment will, prior to releasing any information, obtain approval for such release from either the CEO or the Director of Community Relations. Requests for information regarding the District as a whole shall be directed to the CEO and/or his/her designee. After hours inquiries will be directed to the Director of Marketing, Community Relations and Foundation via the media cell phone (559) 788-8249 (See *Release of Information to the Media or General Public* policy for more information).

2. ***PATIENT POPULATION:***
Marketing services all departments and patients within the hospital to include both inpatients and outpatients.

3. ***GOALS:***

a. To provide all necessary marketing and advertising materials to all departments as well as facilitate all facility media inquiries.

b. To promote patient privacy by providing prompt and appropriate response to the press and/or media following the facility's Release of Patient Information to the Media and General Public policy guidelines.

c. To promote a positive image of Sierra View Medical Center to the communities we serve and in all interactions on the facility's behalf.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing for the Marketing Department is as follows:

Position	***Monday – Friday***	***Weekends & Holidays***

Director, Marketing, Community Relations and Foundation	8:00 AM – 5:00 PM (1)	On Call (559) 788-8249
Public Relations Coordinator	8:00 AM – 4:30 PM (1)	

H. **MATERIALS MANAGEMENT ADMINISTRATION AND PURCHASING**

1. ***SCOPE OF SERVICE:***

~~The Materials Management (MM) Department is responsible for ensuring that all purchases of materials and equipment are centrally controlled and obtained at prices that are most beneficial to the facility. MM also ensures proper distribution and customer satisfaction for all materials operations. Medical supplies are secured based on specified par stock levels for the Storeroom and throughout the facility. Purchasing has the responsibility to validate the quality, quantity and rationale for materials requested in order to ensure the most efficient and cost effective purchase possible. Purchased items are standardized as much as possible throughout the institution. Materials Management Administration The department consists of a buyer, the materials manager and the Director of Materials Management who has oversight for Purchasing, Receiving, Distribution and the Mailroom.~~

The Materials Management (MM) Department is responsible for ensuring that all purchases of materials and equipment are centrally controlled and obtained at prices that are most beneficial to the facility. MM also ensures proper distribution and customer satisfaction for all materials operations. Medical supplies are secured based on specified par stock levels for the Storeroom and throughout the facility. Purchasing has the responsibility to validate the quality, quantity and rationale for materials requested in order to ensure the most efficient and cost effective purchase possible. Purchased items are standardized as much as possible throughout the institution. The Materials Management department consists of a Director, Supply Chain Analyst, Buyer, Surgical Inventory Control Specialist, and Distribution Clerks. All who have oversight for Purchasing, Receiving, Distribution and the Mailroom.

2. ***PATIENT POPULATION:***

Through the distribution of supplies and equipment, the department provides services to patients from neonate to geriatric in all areas of the hospital

3. ***GOALS:***

a. To cultivate a passionate attitude for service to every person we come in contact with;

b. To assist in the efficient and effective delivery of care through making readily available those supplies and equipment that are required.

~~b.~~c. c. To Continuously improve customer service by treating every department as a valued internal customer, responding timely to their needs, and fostering collaborative relationships.

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4. ***CORE STAFFING & AUGMENTATION:***

Core staffing for Materials Management Administration and Purchasing is as follows:

Position	***Monday – Friday***	***Weekends & Holidays***
Leader~~Director~~ of Materials Management	0700-1530~~8:00 AM – 4:30 PM~~ (1)	
Supply chain Analyst~~Materials Manager~~	0730-1530 ~~8:00 AM – 4:30 PM~~ (1)	
Buyer	0630-1500~~7:00 AM – 3:30 PM~~ (1)	
Surgical Inventory control Specialist	0800-1600 (1)	

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I. **MATERIALS MANAGEMENT DISTRIBUTION**

1. ***SCOPE OF SERVICES***

Materials Management Distribution is responsible for managing the supply chain which includes management of stock and non-stock supplies and distribution of patient chargeable and non-patient chargeable medical supplies with the exception of pharmaceuticals and enteral feeding products. This includes stocking fixed stock areas throughout the facility according to designated par levels. The department is open from 0800 to 1630 Monday through Friday. After hours, weekends and holidays, the House Supervisor has the authority to access the Storeroom for supplies.

2. ***PATIENT POPULATION:***

Materials Management Distribution supplies on all patient care areas on an as-needed basis based on pre-established par levels.

3. ***GOALS:***

a. To cultivate a passionate attitude for service to every person we come in contact with;

b. To focus our attitudes on those who do care for patients;
c. To provide our clinicians with quality products and service on a consistent basis.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing consists of the following:

Position	***Monday – Friday***	***Weekends & Holidays***
~~Materials Management Distribution Supervisor~~	~~8:00 AM – 4:30 PM (1)~~	
~~Materials Management Distribution Clerks (5)~~	~~6:00 AM – 2:30 PM (1)~~ ~~6:30 AM – 3:00 PM (1)~~ ~~7:00 AM – 3:30 PM (1)~~ ~~9:00 AM – 5:30 PM (2)~~	
Position	***Monday – Friday***	***Weekends & Holidays***
~~Shipping / Receiving Clerk (2)~~	~~6:00 AM – 2:30 PM (1)~~ ~~8:00 AM – 4:30 PM (1)~~	
~~Surgical Inventory Control Spec.~~	~~6:00 AM – 6:30 PM (1)~~	
Lead Distribution Clerk (1)	8:00 AM – 4:30 PM (1)	
Materials Management Distribution Clerks (5)	6:30 AM – 3:00 PM (3) 8:30 AM –4:30 PM (2)	

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Coverage for holidays and weekends is not available except for a disaster. If this should occur, all personnel will be expected to work.

J. **PATIENT REGISTRATION**

1. ***SCOPE OF SERVICE:***

Patient Registration is responsible for the registration of all outpatients, outpatient surgical patients, emergency department (ED) patients, and inpatients. Services include explaining the registration process to patients, their families, and/or designated representatives.
The department ensures that all registrations are complete and accurate by obtaining required authorizations, verifying insurance benefits, and securing all necessary demographic and insurance information, including applicable signatures.
In addition, Patient Registration provides patients with information regarding consent forms, Advance Directives, patient rights, and other registration-related materials, in accordance with regulatory and hospital requirements.
The Main Registration Office is open Monday through Friday from 6:30 a.m. to 5:00 p.m. Emergency Department Registration operates 24 hours a day, 365 days per year, and is responsible for all ED registrations, obstetrical (OB) registrations, and inpatient admissions when the Main Registration Office is closed.

~~Patient Registration is responsible for the registration of outpatients; outpatient surgery, ER patients, and inpatients. Services include explaining the registration procedure/process to the patient, the patient's family and/or designated representative. The service further ensures that all registrations are complete by obtaining appropriate authorizations and verification of benefits and that the record contains all necessary demographic and insurance information with applicable signatures. Additionally, patient registration is to explain consent forms, Advance Directives, patient rights and other information related to the patient. The main registration is open Monday through Friday from 6:30 AM to 5:00 PM. Emergency Department registration is open 24 hours a day, 365 days per year for all ED registration, OB registrations and inpatient admissions when the main registration office is closed.~~

2. ***PATIENT POPULATION:***

The Patient Registration Department serves all outpatients and inpatients from ages of neonate to geriatric.

3. ***GOALS:***

a. To provide an accurate and timely registration / admission process for all patients;
b. To obtain all consents and signatures as appropriate.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing for Patient Registration shall include:

Position	***Monday – Friday***	***Weekends & Holidays***
Director of Patient Registration and PBX	8:30 AM – 5:00 PM (1)	
Supervisor of Patient Registration	8:00 AM - 4:30 PM (1)	
Main Registration Radiology Out Patient Services Women Services (OB)	6:30 AM – 5:00 PM (2)	7:30 AM – 1:00 PM (1) For pre-scheduled Radiology patients only
Authorization Clerk – Main Hospital	7:00 AM – 4:30 PM (2)	
Position	***Monday – Friday***	***Weekends & Holidays***
Informatics Coordinator	7:30 AM – 4:30 PM (1)	
Lead	8:00 AM – 4:30 PM (1) 3:00 PM – 11:30 PM (1)	Variable weekends

	On Call 24/7	
Surgery Pre-Registration	8:15 AM – 4:45 PM (1)	
SVDH Laboratory	8:00 AM – 5:00 PM (1-2)	8:00 AM – 12:00 NOON (1) Saturdays only
Out Patient Laboratory (Medical Office Building) MOB	6:30 AM – 5:15 PM (5)	
Cancer Treatment Center	7:00 AM – 4:30 PM (1)	
ER Registration	7:30 AM – 3:30 PM (2-3) 11:00 AM – 7:30 PM (1) 3:00 PM – 11:30 PM (3-4) 11:00 PM – 7:30 AM (2)	7:30 AM – 3:30 PM (2-3) 11:00 AM – 7:30 PM (1) 3:00 PM – 11:30 PM (3-4) 11:00 PM – 7:30 AM (2)

K. **PBX**

1. ***SCOPE OF SERVICE:***

PBX Operators are responsible for receiving, screening, and appropriately routing all internal and external telephone calls. Services are provided 24 hours a day, 365 days per year. PBX Operators are trained in the operation and monitoring of the hospital telephone switchboard and central paging systems.

The department ensures that established procedures for hospital code alerts and overhead announcements are followed, including paging individuals through the central paging system in accordance with hospital policy. Responsibilities include maintaining current and accurate contact information for administrative staff, department directors, medical staff, and hospital departments.

In addition, PBX Operators provide general information and directions to callers as needed.

Information Desk responsibilities include providing visitors with directions and general information, and interacting with a wide variety of individuals—including administration, department directors, medical staff, employees, vendors, and visitors—in a tactful, courteous, and professional manner.

~~PBX Operators are responsible for receiving and screening all external and internal telephone calls.~~

~~Services are provided 24 hours a day, 365 days per year. PBX Operators are trained to understand and monitor telephone switchboard and central paging systems. Services ensure the proper processes for Hospital codes alerts and overhead announcements are followed, including paging of individuals over the central paging system as requested and~~

~~according to Hospital policy. Services include, but are not limited to, keeping a current list of all administrative staff, department directors, medical staff and areas of work.~~

~~Additionally, PBX Operators provide information and directions as needed.~~

~~Information Desk responsibilities include, but are not limited to, providing visitors with proper directions and information, interacting with a broad variety of people, including administration, department directors, medical staff, employees, vendors, and visitors in a tactful, sensitive and diplomatic manner~~.

2. ***PATIENT POPULATION:***

The PBX Department serves all outpatients and inpatients from ages of neonate to geriatric

3. ***GOALS:***

a. To provide the highest standard of customer service to patients and visitors.

b. To ensure widespread notification during emergencies, including house wide drills, disasters, codes, information system downtime and medical emergencies.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing for PBX shall include:

Position	***Monday – Friday***	***Weekends & Holidays***
Director of Patient Registration and PBX	8:30 AM – 5:00 PM (1)	
PBX Operator	7:00 AM – 3:30 PM (2) 3:00 PM – 11:30 PM (2) 11:00 PM – 7:30 AM (2)	7:00 AM – 3:30 PM (2) 3:00 PM – 11:30 PM (2) 11:00 PM – 7:30 AM (2)
Clerk- Information Desk Main Hospital	6:00 AM – 2:30 PM (1) 2:30 PM – 9:00 PM (1)	Saturdays 7:30 AM – 9:00 PM (1-2) Sundays 9:00 AM – 9:00 PM (1-2)
Clerk-Information Desk Medical Office Building (MOB)	6:30 AM – 12:30 PM (1) 12:30 PM – 5:15 PM (1)	

L. **SECURITY**

1. ***SCOPE OF SERVICE:***

Security Services are provided through a contract service agreement. Services are provided 24-hours per day, 365 days per year with specially trained officers who monitor the entire hospital, accompanying buildings and grounds. ~~A minimum of 5 officers will be on duty at all times.~~ A minimum of 5-day shift officers, 5 PM shift Officers and 4 NOC shift Officers (these numbers include the Security Supervisor and Leads) will be on duty at all times.

2. ***PATIENT POPULATION:***

Security Services is available to all ages from neonate through geriatric, inpatient and outpatient as well as families, visitors and staff.

3. ***GOALS:***

a. To promote "total" patient care and awareness within the healthcare facility;

b. To recognize that the principle responsibilities are security service to the hospital patients, visitors, staff and personnel;

c. To protect life and property and reduce crime through the implementation of recognized crime prevention and investigative techniques;

d. To respect the moral and constitutional rights of all persons;

e. To perform duties in accordance with the highest moral principles, observing the precepts of truth, accuracy, and prudence without allowing personal feelings, prejudices, animosities or friendships influence judgments;

f. To maintain a professional posture with other security professionals recognized law enforcement agencies and other professionals with whom business is conducted.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing for Security is as follows:

Position	***Monday – Friday***	***Weekends & Holidays***
Security Supervisor	8:00 AM – 4:00 PM (1)	
Security Lead	6:00 AM – 2:00 PM (1) 2:00 PM – 10:00 PM (1) 10:00 PM – 6:00 AM (1)~~6:00 AM – 2:00 PM (1)~~	6:00 AM – 2:00 PM (1) 2:00 PM – 10:00 PM (1) 10:00 PM – 6:00 AM (1)~~10:00 PM – 6:00 AM (1)~~
Security Officers	6:00 AM – 2:00 PM (34) 2:00 PM – 10:00 PM (4) 10:00 PM – 6:00 AM (34)	Coverage throughout weekend and holidays (5 officers per day shift, 5 per PM shift and 4 per NOC shift to include lead on each shift).~~shift).~~

Additional Security Guards can be obtained with sufficient notice to the company, however in extreme emergencies; the local Police Department can be called for additional assistance.

M. **ADULT ~~LEAGUE OF~~ VOLUNTEERS**

1. ***SCOPE OF SERVICE:***

Adult Volunteers provide non-clinical support services to patients and hospital staff across multiple departments and volunteer stations. Volunteers may assist with patient escorting, patient transfers, routine deliveries to departments and patient care areas, and general patient support activities such as providing pillows, blankets, and water. Additional responsibilities include monitoring for expired items, assembling admission packets, cleaning and wiping down equipment, collecting and organizing wheelchairs, and assisting with approved special projects, filing, and organizational tasks.

The Volunteer Desk shall be staffed by one (1) Dispatcher and one (1) Runner. The Surgery and Radiology desks shall each be staffed by one (1) Greeter per station. Volunteers may also be assigned to float to inpatient units or other departments as needed to provide support within their approved scope of service.

~~The League of Volunteers provide assistance to all patient types as well as staff and manage various volunteer stations, to include the gift shop, throughout the hospital. Services provided include escorting patients, assistance with patient transfers, routine deliveries to various departments and patients. The Volunteers are available Monday through Friday only; whereas the Gift Shop operates Monday through Saturday. The Volunteer Desk is staffed with 1 Dispatcher and 3 runners while the Surgery Desk, Information Desk, and Gift Shop have 1 volunteer per station.~~

2. ***PATIENT POPULATION:***

The Adult ~~League of~~ Volunteers provides services to all ages of inpatients from pediatric to geriatric.

3. ***GOALS:***

a. To augment staff by providing assistance to patients, visitors, and employees;

b. To provide excellent customer service;

c. To assist staff in providing a positive hospital experience without regard for race, color, religion, or socio-economic status.

4. ***CORE STAFFING & AUGMENTATION:***

Core staffing for the League of Volunteers is as follows:

Position	***Monday – Friday***	***Weekends & Holidays***
Surgery Desk	7:00 AM – 4:00 PM (1)	Closed
Volunteer Desk • Dispatcher • Runners	 9:00 AM – 4:00 PM (1) 9:00 AM – 4:00 PM (3)	Closed
Radiology ~~Information~~ Desk	9:00 AM – 4:00 PM (1)	Closed
~~Gift Shop~~	~~10:00 AM – 4:00 PM (1)~~	~~10:00 AM – 4:00 PM (1) – Saturday Only~~

N. **UTILIZATION REVIEW**

5. ***SCOPE OF SERVICE:***

The Utilization Review (UR) Department is responsible for reviewing the medical necessity, appropriateness, and level of care of services provided to patients in accordance with regulatory, payer, and hospital requirements. UR supports accurate patient status determination, appropriate length of stay, and efficient use of hospital resources through timely clinical review and collaboration with physicians, nursing, and interdisciplinary teams. Services are provided to support compliance, authorization requirements, and optimal patient care.

6. ***PATIENT POPULATION:***

The UR provides services to all ages of inpatients from pediatric to geriatric.

7. ***GOALS:***

- Accurate patient status (level of care) by utilizing MCG criteria
- Timely faxing of clinicals to the payer for appropriate authorization
- Timely communication with physicians in identifying status changes and/or delays in service.

8. ***CORE STAFFING & AUGMENTATION:***

The UR Department is staffed by a UR Coordinator, Clinic Denials Specialist, 2 LVN-UR Nurse, 1 RN Nurse. The UR department is staffed Sunday 7:00 am to 3:30 pm and Monday through Friday, 7:00 am to 4:30 pm.~~Core staffing for the UR as follows~~

~~***Position***~~	~~***Monday – Friday***~~	~~***Weekends & Holidays***~~

N. Obstetrics/Gynecology Clinic

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1. SCOPE OF SERVICES

Provide women's health services including Obstetrics and gynecology care in an outpatient clinic setting. The clinic is available for scheduled appointments. The clinic will provide general and specialty women's services, care and treatment to include but not limited to:

1. Care for pregnant women
2. Family Planning/ contraceptive
3. Diagnostic screening
4. Gynecological concerns/needs

2. PATIENT POPULATION

Female patients within reproductive age

3. GOALS:

- Provide routine well women's care
- Support and optimize maternal and fetal outcomes
- Comprehensive gynecology, obstetrics, and post-partum care

4. CORE STAFFING & AUGMENTATION:

Position	***Monday – Friday***	***Weekends & Holidays***
Leader of OB/GYN Clinic (1)	8:00 – 4:30 PM	***On call 24/7***
CPSP Coordinator (1)	8:00 – 4:30	***Closed***
Front Office Assistant (1)	8:00 – 4:30 PM	***Closed***
Back Office Assistant (1)	8:00 – 4:30 PM	***Closed***
MA (3)	8:00 – 4:30 PM	***Closed***
Authorization Coordinator (1)	8:00- 4:30 PM	***Closed***

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- California Office of Administrative Law. (n.d.). *California Code of Regulations, Title 22: Social Security*. Retrieved January 8, 2026, from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=IE55EDC305B6011EC9451000D3A7C4BC3&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default) ~~Code of Regulations (2019). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.~~

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SUBJECT:	SECTION:
UROLOGY CLINIC- URINE SPECIMEN COLLECTION AND TESTING (STANDARDIZED PROCEDURE)	**Page 1 of 2**

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

PURPOSE:

To define and clarify procedures and tests that may be performed by a qualified medical assistant or nurse presenting to the Urology Clinic.

POLICY:

To proactively direct clinic staff in the timely collection and accurate processing of patient urine specimens during the operation of the Urology Clinic.

AFFECTED PERSONNEL/AREAS: *UROLOGY CLINIC MEDICAL ASSISTANTS AND/OR NURSE*

EQUIPMENT:

- Clinitek Status Connect Urine Analyzer

PROCEDURE:

A. Clinic Nursing and/or Medical Assistants, will complete training and documentation of demonstrated competency to perform Clinical Laboratory Improvement Amendments (CLIA) Urinalysis Tests (Dipstick Method).

B. The Medical Staff authorizes trained and competent Medical Assistants and nurses to instruct all patients presenting for care to provide a clean catch urine specimen for testing in the Clinics prior to the patient being placed in the examination room and examined/treated by the physician and/or physician assistant.

C. The following patient specimens will be tested upon collection as a standardized procedure:

   a. Patient history of hematuria

   b. Patient history of chronic UTI

   c. Patient with any of the following symptoms:

      i. pain on urination,

      ii. cloudy/odorous urine,

      iii. difficulty in urination,

      iv. frequent urination,

      v. pain in back located near kidney region

d. Patients scheduled for cystoscopy, prostate biopsy, urodynamics

e. Or as directed by physician/provider.

D. All urine specimens collected will be processed using the designated point-of-care testing equipment, with results being recorded in the Electronic Health Record.

E. Specimen will be tested and results posted prior to the patient being seen by the physician/physician assistant.

F. Specimens not meeting the above-noted criteria will be retained, pending physician examination of the patient. Based upon physician examination of the patient, a subsequent order to test the specimen and record the results in the patient's electronic health record may be issued.

G. Unless directed to send the specimen to the laboratory for further testing, all specimens collected in the clinic will be disposed of at the end of the clinic day.

H. Urinalysis testing is a useful assessment and is required to identify primary and secondary health issues and to monitor some health conditions.

REFERENCES:

- California Hospital Association. CHA Guidelines for Standing Orders, Standardized Procedures and Other Delegation Tools. Retrieved on July 23, 2015 from calhospital.org.

CROSS REFERENCES:

- Waived and Point of Care Testing- Competency and Quality

SUBJECT:	SECTION:
UTILITY SYSTEM OPERATIONAL PLANS AND FAILURE PROCEDURES	***Utilities Management***

PURPOSE:

Utility system operational plans are written to help ensure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

Written Operational Plans

- *Management of failure*
- *User and operator training*

As part of utility system operational plans, planned or preventive maintenance is a key factor in assuring the ongoing performance and reliability of utility systems whereby each system is properly identified, operated, and maintained. A system is no more reliable than the individual pieces of equipment, or components, within it. Each component within a system must be evaluated to determine the content and frequency of testing procedures, inspections, calibrations, and the servicing and replacement of parts. In the development of preventive maintenance programs, a review is made from various sources of information, such as manufacturer's recommendations, codes, standards, and federal, state, and local laws and regulations. The basic sources of information are invaluable as start-up aids; however, over time it is essential that local operating experience be factored in to modify the program. Through this process, initial levels of risk are maintained or reduced.

The preventive maintenance program consists of training of operating and maintenance personnel to familiarize them with the program and to train them to acquire data useful for analyzing the performance of utility systems. Management of the utility systems must identify key indicators of equipment and personnel performance.

Job training is provided by individuals with appropriate technical and/or educational backgrounds in the organization, along with outside training seminars and educational programs. The training is designed to customize basic technical skills to the medical center's needs. Training is central to maintaining system reliability and to protecting the health and safety of all those affected by the systems

- The Administrative Director of General Services is responsible for the proper and safe functioning of all equipment within the facility and the condition of the facility generally. It is therefore the responsibility of the Engineering Manager to maintain awareness of the activities within the facility.

- Engineering Services requires that written procedures shall be developed that specify the action to be taken during the failure of essential equipment and major utility services. The written procedures shall include a call system for summoning essential personnel and outside assistance when required. The following essential equipment and services shall be included: Major air conditioning equipment, air handling systems (ventilation, filtration, quantitative exchanges, and humidity), boilers, electrical power services, fire alarm and extinguishing systems, water supply, all waste disposal systems, and medical gas and vacuum systems. Qualified engineering consultative advice should be available as needed.

- The Administrative Director of General Services should be notified first when a disruption of service occurs, but in the event of his absence, this system gives Administration and other department heads a greater idea of who is best qualified to handle the situation.

- In the event that the in-house personnel cannot correct the problem and restore the operation of the equipment, then Administration, the Administrative Director of General Services, or their designated representative shall have full authorization to call in an outside resource to correct the situation.

UTILITY FAILURE DEFINITIONS:

Equipment/Utilities Failures Reports should be completed for the following Utilities Failures:

Loss of Electrical Power

- One breaker in a distribution panel which would shutdown a whole area.

Failure of Emergency Generator and/or Emergency Power Distribution System

- Any contamination of fuel source, switch gear malfunction, or power interruption lasting 10 seconds or more. Any failure or shutdown during weekly testing or actual use.

Failure of Fire Alarm System

- Loss or unscheduled shutdown of a zone.

Failure of Fire Protection System

- Loss or unscheduled shutdown of a zone.

Elevator Failure

- When more than two out of four elevators are inoperable for more than eight hours.

Failure of Vertical Lifts

- When a dumbwaiter is inoperable for more than 72 hours.

Failure of Communication System

- PBX and Paging System: Any area loss of overhead paging.
- Telephone System: Failure of any one switch on the telephone system or loss of any card.

Failure of Nurse Call System

- Any zone failure of more than eight rooms.

Failure of Blood, Bone, and Tissue Storage Systems

- Any loss of temperature above 6 degrees C for longer than two hours.

Failure of HVAC System

- Any unscheduled total shutdown of chillers or a major air handling unit.

Failure of Medical Air System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Medical Vacuum System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Medical Gas Oxygen System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Medical Gas Nitrous Oxide System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Natural Gas System

- Any unscheduled shutdown of the system.

Failure of Boiler System

- When water temperature falls 15 degrees below steeping or when alarm goes off.

Failure of Water Distribution System

- Contamination of the potable water supply or an unscheduled shutdown of the main riser for more than one hour.

Failure of Plumbing System

- Unscheduled shutdown of the main riser for more than one hour.

SUBJECT: OUTSIDE VENDOR ASSISTANCE

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

OUTSIDE VENDOR ASSISTANCE:

Outside vendor assistance may be used should an emergency occur beyond the scope of the Engineering Department or if assistance is required due to a utility system failure.

PROCEDURE:

During normal working hours (8:00 A.M. - 5:00 P.M.) (Monday through Friday) notify the Administrative Director of General Services and obtain permission to use outside vendor.

If Administrative Director of General Services is unavailable or does not respond within 15 minutes, notify the Administrator On Call and obtain permission to use outside vendor.

SUBJECT: LOSS OF ELECTRICAL POWER

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The normal/emergency/critical systems for the medical center are supplied by Southern California Edison (SCE) through substations which provide the normal (primary) power source and the alternate (secondary) power source. The emergency distribution is supplied by two (2) sources, normal SCE power and emergency generator power.

Warning signs or indicators of loss of power and failure of emergency power include:

- Total loss of power and lights in all areas
- Warning signs or indicators of loss of external power only include:
    - Loss of most lighting and power in all areas

Reasons for loss of electrical power:

- Disruption in all or part of internal electrical distribution system
- Disruption of external power (utility company equipment)

PROCEDURE: (For loss of power to primary and secondary power sources)

Containment:

- A failure of the normal power source will result in the emergency generators automatically starting and emergency loads automatically transferring to the emergency generators. The generator is managed through an automatic paralleling system and all are diesel powered.
- The Engineer on duty will ensure generator is running properly.
- Notify the Administrative Director of General Services and the Administrator On Call.
- Check to ensure that the generator is running and supplying power to essential areas.
- Monitor generator for any load-shedding requirements.

Resolution:

Determine whether loss of power is due to internal or external disruption.

- Check main electrical distribution panel
- Call utility company

If power loss is due to disruption in the external power source, the Administrative Director of General Services or his designee will contact Southern California Edison to determine and estimate how long outage will last.

Administrative Director of General Services or his designee will notify the following:

- Administrator On Call
- Nursing House Supervisor (after normal business hours)

If power loss is due to disruption in the internal electrical distribution system, identify the problem.

- If emergency generator is on line, identify the distribution panel(s) serving the affected area(s).
- Trace and correct the problem.
- If the problem cannot be resolved immediately, notify the following: Administrative Director of General Services Administrator On Call, Nursing House Supervisor, Engineering Manager, and the affected areas.
- If repairs are beyond the scope of the Engineering Department, request assistance from the licensed electrical contractor on the call list.

- Request other outside assistance as necessary.
- Distribute emergency extension cords so power can be supplied from one area to another if there is a critical need (determined by Administrative Director of General Services, Nursing House Supervisor, Administrator On Call).
- When normal utility power has been restored, restart and reset all affected equipment in the power plant, mechanical rooms and other parts of the hospital affected by the power outage.

Evaluation:

- Record incident on Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the loss of electrical power include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF EMERGENCY GENERATOR AND/OR EMERGENCY POWER DISTRIBUTION SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

A failure of the normal power source will result in the emergency generator automatically starting and emergency loads automatically transferring to the emergency generator.

PROCEDURE:

In the event of failure of the emergency generator, or if emergency power is not supplied to the essential emergency power system during an electrical power outage, the following procedures as outlined below are to be followed:

Containment:

- Call for assistance and notify key personnel.
- Call generator repair service/request immediate dispatch of service tech
- Notify Administrative Director of General Services
- Notify Nursing Supervisor
- Notify Administrator On Call

Determine reason for generator failure:

- If engine failure, attempt to manually start generator.
- If engine does not start, check starter system.
- Check fuel system for fuel in day tank; refuel from main supply if necessary.
- If generator can be started, check transfer switch for tripping.
- If transfer switch is not tripped, check control panel for fault indicators.
- If no fault indicators, attempt to manually throw transfer switch.
- If transfer switch cannot be manually thrown or a fault is indicated on control panel, call an electrician.
- If transfer switch can be thrown, notify Nursing Supervisor and Administration that the medical center is on emergency power.
- If no malfunction of generator or transfer switch, check for fuel contamination.
- If fuel contaminated, call for immediate dispatch of mobile fuel tanker.

Resolution:

- If directed, call generator supplier for portable generator(s), cables and lugs.
- Notify Nursing Supervisor and Administration for estimated length of power outage.
- Assist service technician to resolve and repair problem.

Evaluation:

- Record incident on Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the failure of the Emergency Generators or the Emergency Power Distribution System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF FIRE ALARM SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

The fire alarm system provides fire detection services to all parts of all areas of the medical center. Warning signs or indicators of failure include:

- Audible alarms
- Visual observance

Reasons for fire alarm systems failure:

- Neglect
- Vandalism
- Computer malfunction
- Failure in electrical system

PROCEDURE:

Containment:

In the event of fire alarm systems failure, notify all affected areas including:

- Fire Department
- Administrative Director of General Services or his designee
- Alarm service company
- Alarm monitoring company
- If repairs are beyond scope of service of Engineering Service's staff, call the alarm company and request immediate dispatch of service technician.

Resolution:

- Administrative Director of General Services will post fire watch.
- A log of all fire watch activities will be maintained by Engineering Services.
- Notify Administration and all affected departments of estimated time fire alarm system will be out of service.
- Notify Fire Department, Alarm Monitoring Company, Administration, and all affected departments when repairs have been completed.
- Check with alarm monitoring company to ensure alarm signal is being received.
- Discontinue fire watch.
- File fire log watch activities in Engineering Services.

Evaluation:

- Record incident on Utility Disruption Form.
- Determine cause of failure and immediate steps taken to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the failure of the Fire Alarm System include:

- Maintenance Engineers on all shifts

SUBJECT: ELEVATOR FAILURE/PASSENGER EVACUATION

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

Employees of the medical center who become aware of individuals detained in an elevator, due to an elevator failure, should respond immediately by reporting the incident to maintenance and the Nursing House Supervisor. Maintenance staff will respond to meet the needs of the situation caused by the elevator failure.

ELEVATOR FAILURE:

Elevators serve vertical transportation in all areas throughout the medical center. Warning signs of an elevator failure include:

- Audible alarm
- Sounds of passenger(s) yelling or banging on elevator doors
- Elevator not responding to call buttons

Reasons for elevator failure:

- Power failure
- Failure of relay switches to reset

PROCEDURE:

Containment:

In the event of elevator failure with passenger(s) on board, notify the following:

- Maintenance and Administrative Director of General Services
- Maintenance staff will respond immediately to site of elevator failure.
- If no alarms or signals have been received from the disabled elevator(s), determine if passengers are on board by yelling at the approximate level elevator has stopped.

- Assure passengers that help is on the way.
- If patients are in elevator, communicate with escorting staff to determine if patient must be immediately evacuated.

Resolution:

EMERGENCY EVACUATION:

- If unclear to urgency of evacuation, contact Emergency Room Physician on duty. If the patient must be evacuated immediately, refer to the Emergency Evacuation Plan.
- When it is determined that a patient must be evacuated immediately, contact the elevator service company and request immediate dispatch of a service technician. Stress the urgency of the situation. Call the fire department and notify them that an emergency elevator evacuation is needed.
- Instruct passengers on board (if any) to remain calm and inform them not to attempt to restart elevators with reset button.
- Inform passengers that the Elevator Service Company and Fire Department have been notified and that help is on the way.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure and/or Passenger Evacuation of Elevator(s) include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF COMMUNICATION SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and

train users and operators of the systems.

POLICY:

The communication system provides telephone and paging services to all parts of all areas of the medical center. Warning signs or indicators of failure include:

- No dial tones
- Poor transmission quality

Reasons for communication systems or paging system failure:

- Equipment malfunction
- Broken transmission lines
- Switch malfunction
- Failure in electrical system

PROCEDURE:

In the event of a malfunction and/or failure of the communications system (telephone and/or paging system), the following procedure will be followed:

Containment:

In the event of communication systems failure, notify all affected areas including:

- Information Technology (IT)
- Maintenance
- Telephone company
- Notify Administrative Director of General Services, who will determine amount of down time and inform Administration, Nursing Services, and all affected departments.
- IT staff with the assistance of maintenance staff will try to identify and correct the problem.

Resolution:

- If repairs are beyond scope of service of IT and Maintenance Service's staff, the Administrative Director of General Services will call the telephone company or the paging system service company and request immediate dispatch of service technician.

- Administrative Director of General Services will assign priority departments with 2 way radios for communication.
- Notify affected departments on estimated repair time.
- Notify affected departments when service has been restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Communication System or the Paging System include:

- Information Technology staff
- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF NURSE CALL SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The nurse call system provides audible communication between patients and nursing staff for assistance in routine or emergency situations. Warning signs or indicators of failure include:

- Lack of audible communication

- Call lights not illuminated
- Lack of system response
- Inability to cancel audible or visual alarms

Reasons for nurse call system failure:

- Equipment malfunction
- Individual component failure
- Power supply failure in call system control panel
- Circuit breaker trip

PROCEDURE:

In the event of a malfunction and/or failure of the nurse call system, the following procedure will be followed:

Containment:

In the event of nurse call system failure, notify all affected areas.

- When notified by nursing of a failure in the nurse call system, instruct staff members to set up an alternative method of communication.
- Identify the cause of the failure and attempt to repair.

Resolution:

- If the nurse call system has been disabled and the problem is not remedied immediately, notify nurse call system vendor to dispatch immediate emergency service technician.
- Notify House Supervisor.
- Notify affected departments on estimated repair time.
- Notify affected departments when service has been restored.

Evaluation:

- Record incident on the Utility Disruption Form.

- Determine cause of failure and immediate steps taken to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Nurse Call System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF BLOOD, BONE, AND TISSUE STORAGE SYSTEMS

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The electrical and alarm system provides utilities and detection services to refrigerators used in the storage of blood, bone, and tissue. The Blood Bank refrigerator should maintain a temperature of 2-6 degrees C. When the temperature rises above 6 degrees C, the alarm at the Blood Bank will sound. Warning signs or indicators of failure include:

- Audible alarms
- Visual observance

Reasons for systems failure:

- Mechanical malfunction
- Failure in electrical system

PROCEDURE:

Containment:

In the event of systems failure, notify all affected areas including:

- Laboratory Director

- Administrative Director of General Services or his designee
- Notify maintenance that there is a utility or equipment failure.
- Notify the Nursing Supervisor on duty.
- Identify the cause of failure and attempt to repair.

Resolution:

- If repairs cannot be completed by Biomed and Engineering Services Staff, call equipment repair Service Company.
- If repairs cannot be completed in a timely manner, the Laboratory Director will make arrangements for an alternate location for refrigerated storage.
- Notify Laboratory Director and Nursing Supervisor of estimated time system will be out of service.
- Notify affected departments when service has been restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Blood, Bone and Tissue Storage Systems include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF THE HVAC SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The HVAC system provides control of the desired temperature, humidity and air purity for the health, safety and comfort of patients and employees. Warning signs or indicators of failure include:

- Sudden drop or rise of temperatures in any area of the facility
- Audible alarms
- Inability to control humidity
- Loss of air balance (positive and negative airflow)

Reasons for HVAC system failure:

- Mechanical malfunction
- Failure in electrical system
- Extreme temperatures

PROCEDURE:

Containment:

In the event of systems failure, notify all affected areas including:

- Administrative Director of General Services
- Engineering Manager
- If repairs are beyond scope of the Engineering Services staff, call the appropriate vendor to request immediate dispatch of a service technician.

Resolution:

- The Engineering staff will determine the cause of the failure.
- The time for repair will be estimated and departments will be notified of period that the system will be out of service.
- In the event of a prolonged failure, the Engineering Department will coordinate with affected units to mitigate temperature extremes.

- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the HVAC system include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL AIR SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical air system provides medical air to patient care areas on nursing units, surgery, recovery, labor and delivery, special procedure rooms and the emergency department. Warning signs or indicators of failure include:

- Audible alarm
- Drop in pressure
- Call from user staff

Reasons for medical air system failure:

- Equipment malfunction
- Rupture of air lines

- Contamination of system
- Electrical failure

PROCEDURE:

In the event of medical air system failure, notify all affected areas.

Containment:

- Check compressors to ensure they are functioning properly.
- If one compressor has failed, switch valves and isolate the defective unit.
- Check filter to ensure they are not plugged.
- If the main supply line has ruptured, attempt to repair or request outside emergency assistance from our certified medical gas testing and repair vendor.
- If a total loss of medical air has occurred, notify the Respiratory Therapy Department, House Supervisor, and Administrative Director of General Services.
- The Director of Respiratory Services shall be responsible for ordering additional medical air supplies until the failure has been corrected and purity tests have been completed if necessary.

Resolution:

- If service cannot be restored by Maintenance Staff, call for assistance from our certified medical gas testing and repair vendor.
- Notify affected departments of estimated time system will be out of service.
- Nursing will monitor and support patients during the interim period. Assist with the relocation of patients if necessary.
- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.

- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Medical Air System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL VACUUM SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical vacuum system provides medical vacuum to patient care areas on nursing units, surgery, recovery, labor and delivery, special procedure rooms and the emergency department. Warning signs or indicators of failure include:

- Audible alarm
- Drop in suction
- Call from user staff

Reasons for medical vacuum system failure:

- Equipment malfunction
- Rupture of vacuum lines
- Contamination of system
- Electrical failure

PROCEDURE:

In the event of medical vacuum system failure, notify all affected areas.

Containment:

- Check pumps to ensure they are functioning properly.

- If one pump has failed, switch valves and isolate the defective unit.
- If the main supply line has ruptured, attempt to repair or request outside emergency assistance from our certified medical gas testing and repair vendor.
- If a pump failure occurs to the vacuum system, notify the Administrative Director of General Services or designee and Administrator on Call.
- Deliver portable vacuum pumps to Special Care Units, Surgery and Medical/Surgical floors as needed.

Resolution:

- Notify affected departments as to the length of time required to make repairs for their planning purposes. If repairs are beyond the scope of the Maintenance Department, call for outside assistance from SVMC's certified medical gas testing and repair vendor.
- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Medical Vacuum System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL GAS OXYGEN SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical gas piping systems provides oxygen to all parts of all inpatient and nursing units, labor and delivery, surgery and recovery, emergency area, radiology, and other clinical areas of the medical center. Warning signs or indicators of failure include:

- Audible alarm
- Drop in pressure
- Call from user staff

Reasons for medical gas oxygen system failure:

- Equipment malfunction
- Depletion of oxygen
- Rupture of oxygen line
- Shut-off of zone valve

PROCEDURE:

In the event of medical gas oxygen systems failure, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee.
- Identify the cause of the failure. Use extreme caution as the risks of combustion are much greater in an environment of pure oxygen. Avoid skin contact with liquid oxygen due to its extremely low temperature. No smoking.
- If both the oxygen supply and the reserve have been disabled and the problem is not remedied immediately, notify Respiratory Therapy Department to deliver portable cylinders to the critical care areas immediately.
- Ensure that the reserve supply is on line.
- Notify Nursing Services and request that it alert all affected areas.
- Call and request immediate emergency delivery of oxygen as needed.

Resolution:

- Make minor repairs and request outside assistance from SVMC's certified medical gas testing and repair vendor as required.

- If tests of the medical gas oxygen system are necessary, coordinate them with the Respiratory Therapy Department.
- Notify affected departments, House Supervisor, and Respiratory Therapy when medical gas oxygen system is back online.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the failure of the medical gas oxygen system include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL GAS NITROUS OXIDE SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical gas piping systems provides nitrous oxide to Labor and Delivery and Surgery. Warning signs or indicators of failure include:

- Audible alarm
- Drop in pressure
- Call from user staff

Reasons for medical gas nitrous oxide system failure:

- Equipment malfunction

- Depletion of nitrous oxide
- Rupture of nitrous oxide line
- Shut-off of zone valve

PROCEDURE:

In the event of medical gas nitrous oxide systems failure, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee.
- Identify the cause of the failure. Check the nitrous oxide bulk supply tank to be sure that the manifold valve and regulator are properly aligned and correct as necessary.
- Replace empty tanks as necessary.
- If the tanks are not empty and the alignment is correct, check for point of disruption in the system.
- If Engineering Services staff are unable to correct the problem, request outside assistance from our certified medical gas testing and repair vendor.
- If the problem cannot be corrected immediately, notify the affected departments.

Resolution:

- Notify the House Supervisor.
- Call and request immediate emergency delivery of nitrous oxide.
- If tests of the medical gas nitrous oxide system are necessary, coordinate them with the Surgery Department.
- Notify affected departments, House Supervisor, and Surgery when medical gas nitrous oxide system is back on-line.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.

- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Medical Gas Nitrous Oxide System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF NATURAL GAS SUPPLY SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The natural gas supply system provides natural gas to the central plant and the kitchen areas. Warning signs or indicators of failure include:

- Drop in pressure
- Call from user staff

Reasons for natural gas supply system failure:

- Equipment malfunction
- Rupture of gas line
- Shut-off of valve

PROCEDURE:

In the event of natural gas supply system failure, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee immediately.
- Identify the cause of the failure. Use extreme caution as the risks of combustion are much greater in an environment of natural gas.

- If the natural gas supply has been disabled and the problem is not remedied immediately, notify the gas company to dispatch immediate emergency service technician.

- Notify Dietary Services, House Supervisor, Laboratory, and Administration.

Resolution:

- Make minor repairs and request outside assistance as required.

- Notify affected departments, House Supervisor, Laboratory, Dietary and Administration when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.

- Determine cause of failure and taken immediate steps to eliminate.

- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.

- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Natural Gas Supply System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF BOILER SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The boiler equipment generates hot water and heating water. Warning signs or indicators of failure include:

- Loss of hot water

- Pressure gauge readings

- Call from user staff

Reasons for boiler steam system failure:

- Equipment malfunction
- Disruption of supply lines (water or fuel)

PROCEDURE:

In the event of boiler system failure of all boilers at the same time, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee immediately.
- Check operation of fuel supply valves.
- Check boiler control panel.
- Check boiler water level.
- If boiler is functioning properly but water is not being supplied to end user, check circulating loop distribution system or valve closure for restriction and end user's equipment.
- If boiler system is estimated to be out of service during critical time frame of departmental activities, notify Administration, Surgery, Nursing, Housekeeping and Dietary Services.

Resolution:

- Attempt to repair or request outside emergency assistance from boiler service contractor.
- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Boiler Steam System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF WATER DISTRIBUTION SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The water distribution system serves all areas of the medical center. Warning signs or indicators of failure include:

- Decreased water pressure or flow at the delivery points
- Pressure gauge readings
- Call from user staff
- Change of color, odor, taste, and texture

Reasons for water distribution system failure:

- Disruption or breakage of main water line into medical center
- Contamination of outside water supply

PROCEDURE:

In the event of water distribution system failure, notify all affected areas.

Containment:

If breakage or disruption of main water line into medical center:

- Begin distribution of reserve water supplies
- Notify Administration that the reserve water supply is in use and that water rationing must be placed into effect
- Get estimate of length of time medical center will be without water from water company

- Secure boilers and follow procedures under "Failure of Boiler System"

If the breakage or disruption of water line is inside the building:

- Isolate and locate the point of breakage or disruption
- Notify all affected areas of disruption and estimated time of disruption
- Make necessary repairs or call for emergency assistance from outside plumbing contractor
- Notify affected areas upon restoration of service

If the water supply has been contaminated:

- Turn off the main domestic entry water valve
- Instruct all personnel and visitors through the Communications Department public address system not to drink the water or flush toilets
- Contact Administration or the House Supervisor to notify the Department of Health immediately about the water supply contamination

Resolution:

- Request delivery of additional potable water in accordance with the outside vendor's agreement
- Under guidance of Department of Health and Water Company, sanitize water lines
- Notify all affected areas upon completion of sanitizing and approval from Department of Health
- Notify the City of Porterville Public Works (559) 782-7518.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving

the Failure of the Water Distribution System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF PLUMBING SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The plumbing system serves all areas of the medical center. Warning signs or indicators of failure include:

- Overflowing of toilets
- Slow drainage in sinks
- Call from user staff
- Back-up in sinks and floor drains

Reasons for water distribution system failure:

- Blockage of the main sewer line
- Blockage of internal waste lines and mains
- Failure of sewage ejectors or sump pumps
- Breakage of internal sewer line

PROCEDURE:

In the event of plumbing system failure, notify all affected areas.

Containment:

In the event of failure of the external sewer main line:

- If failure is significant, notify Department of Public Health
- Limit available bathrooms for public and staff to compensate for flow of waste water in affected areas

- Post restriction signs or lock bathrooms as necessary
- Instruct Housekeeping Services to place red plastic liners in available bathrooms
- If failure results in flooding, Housekeeping Services will remove water with wet vacuums
- If major flooding caused by storm drain overflow, request emergency pumping by the City of Porterville

If the breakage or disruption of water line is inside the building:

- Notify affected areas by public address system or, if isolated area of failure, by telephone
- Isolate and locate the point of breakage or disruption
- Make necessary repairs or call for emergency assistance from outside plumbing contractor

Resolution:

- Limit available bathrooms for public and staff to compensate for flow of waste water in affected areas
- Post restriction signs or lock bathrooms as necessary
- Instruct Housekeeping Services to place red plastic liners in available bathrooms
- If failure results in flooding, Housekeeping Services will remove water with wet vacuums
- Notify affected areas upon restoration of service

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Plumbing System include:

- Maintenance Engineers on all shifts

AFFECTED PERSONNEL/AREAS:

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

REFERENCES:

- The Joint Commission (2026~~4~~). Hospital Accreditation Standards. PE.04.01.03~~EC.02.05.01. EP10~~. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **VOLUNTARY DISCLOSURE OF VIOLATIONS (REPORTABLE EVENTS)**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish a process and guidelines to address potential violations of law, and to report to appropriate governmental authorities reportable events requiring the return of overpayments.

POLICY:

Sierra View Medical Center (SVMC) will report to appropriate governmental authorities any reportable events or misconduct that violates criminal, civil or administrative law, including the return of overpayments or refunds to any governmental health care program. Reporting should be within a reasonable period, but not more than sixty (60) days after determining credible evidence of a violation. Prompt reporting demonstrates SVMC's good faith and willingness to work with governmental authorities to correct and remedy problems. A reportable event may be the result of an isolated event or a series of occurrences. For guidelines that address the correction of routine processing errors, refer to the Correction of Errors Related to Government Reimbursement Policy.

DEFINITIONS:

"Reportable Events" shall mean anything that involves: (1) a substantial overpayment relating to any government health care program, or (2) a matter that any reasonable person would consider a potential violation of criminal, civil or administrative laws applicable to any governmental health care program.

"Governmental Authority" shall mean any federal, state, or local governmental authority, including but not limited to the Office of the Inspector General of the U.S. Department of Health and Human Services; the Office for Civil Rights of the U.S. Department of Health and Human Services; the U.S. Department of Justice, including the U.S. Attorney's Office; the Federal Bureau of Investigation; the Centers for Medicare and Medicaid Services; any Medicare or Medi-Cal carrier or fiscal intermediary; the California Attorney General's Office; and a State Medicaid Fraud Control Unit.

"**Governmental Health Care Program**" shall mean any health care program funded or sponsored by a governmental authority, including the Medicare program and the Medi-Cal program.

"**Law**" shall mean any statute or other law, rule, regulation, or interpretation of any governmental authority.

"**Overpayment"** shall mean the amount of money received by SVMC in excess of the proper amount due and payable under the provisions of the applicable governmental health care program.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

1. Anyone with knowledge of a potential violation of any law or requirement of a governmental health care program shall immediately report the potential violation to the Compliance Office. Such report shall include as much detail as possible, including:

   a. A description of the relevant facts, including the time, place, and persons involved; the health care program implicated, and the dollar amount, if any, involved;

   b. A description of actions taken in identifying the potential violation and any actions taken or planned to correct the potential violation.

2. The Compliance Office or designee shall be responsible for making an initial assessment of such reports. If the initial assessment of the Compliance Office indicates that there is a credible basis that the conduct or event reported may constitute a violation of law or a requirement of a governmental health care program, or may adversely affect any governmental health care program, the Compliance Officer (CO) or designee shall promptly:

   a. Inform the Chief Financial Officer (CFO), the Chief Executive Officer (CEO) and/or Board of Directors, and

   b. Coordinate an investigation of the matter, using such internal and/or external resources as the CO or designee and/or the CFO, the CEO or Board of Directors deem necessary. Such resources may include management designated by the CO and/or legal counsel or other health care experts.

3. The CO or designee and/or legal counsel will determine whether a violation occurred and, if so, whether the information relating to the violation appears to be within the scope of an on-going investigation by a governmental authority.

4. If it is determined that the violation falls within the scope of an on-going investigation, the CO or designee and /or legal counsel shall present to the investigating governmental authority relevant information pertaining to the violation. Such information shall be provided to the governmental authority without payment of any amount due as a result of the violation in anticipation that any payment due will be included in negotiations regarding the resolution of the investigation.

5. If the CO or designee and/or legal counsel determine that a violation occurred that does not appear to be within the scope of an ongoing investigation, the CO or designee shall report such violation to the appropriate governmental authority and pay the governmental authority any amount due as a result of the violation.

6. If it is determined that SVMC has received an overpayment from a governmental health care program and/or SVMC may have violated a law or requirement of a governmental health care

program, then SVMC shall promptly take all necessary steps to correct the problem to prevent recurrence.

The CFO, the CEO or Administrator, and the CO are responsible for the implementation of this policy.

REFERENCES:

- Federal Register / Vol. 63, No. 35 / Friday, October 30, 1998, https://www.govinfo.gov/content/pkg/FR-1998-02-23/pdf/98-4399.pdf
- Office of Inspector General (OIG) Health Care Fraud Self-Disclosure Protocol 2021. **https://oig.hhs.gov/documents/self-disclosure-info/1006/Self-Disclosure-Protocol-2021.pdf**

CROSS REFERENCES:

- CORRECTION OF ERRORS RELATED TO GOVERNMENT REIMBURSEMENT

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SUBJECT:	SECTION:
WASTE DISPOSAL	***Hazardous Materials & Waste Mgt***

PURPOSE:

To outline the methods used at Sierra View Medical Center (SVMC) to comply with federal, state, county and city regulations.

ENGINEERING DEPARTMENT WASTE DISPOSAL:

- Light Bulbs, Fluorescent Tubes, Ballasts, Sharps, Metal Filing:
  - Metal Halide and High Pressure sodium vapor lamps will be recycled per Environmental Protection Agency (EPA) requirements.
  - All others will be disposed of in the trash compactor.
  - With the exception of metal halide and high pressure sodium vapor lamps, fluorescent tubes may only be disposed of in the trash compactor in groups of less than 24 at any one time due to the potential of mercury contamination within the public land fill.
- Sawdust, Paper, Trash:
  - Collected separately in designated nonflammable basket and disposed of in the trash compactor.
- Used Paint Thinner and Cleaning Solvents:
  - Stored in a nonflammable container, which is stored in designated flammables cabinets. When the container is full, it is disposed of using an outside pick-up service. A manifest for each pick-up is required and must be kept on file.

DIETARY DEPARTMENT WASTE DISPOSAL:

- To provide a safe and effective means of disposing food waste and other waste associated with the Dietary Department.
- Rubber gloves are provided and used when handling food and other waste.
- Food waste is removed from the Dietary Department through the city sewage system. Garbage disposal is located at the pot sink and dish washer areas.
- Trash receptacles are located throughout the department. They are emptied 3 - 4 times daily. These receptacles are UL approved, and lined with impervious liners. If the trash receptacle is not in continuous use, it is covered by a lid. Trash receptacles are transported in closed containers to the trash compactor located at the loading dock area on the South side of the facility.
- Used grease will be stored in a non-flammable barrel with a lid and will be picked up by an approved rendering company. Manifests documenting the pickup and disposal of the grease waste will be kept on file in the Director of Food and Nutrition's office.

- The facilities grease trap will be pumped at minimum twice per year by Thrifty Best pumping service. Enzymes will be added to the trap after pumping to aid the breakdown of grease waste. Manifests documenting the pickup and disposal of the grease waste will be kept on file in the General Services office.

ENVIRONMENTAL SERVICES WASTE DISPOSAL:

- All regular trash will be bagged and transported in containers to the trash compactor on the south side of the facility for disposal. The trash compactor will be picked up by the City of Porterville at least weekly and taken to an approved landfill for emptying. The trash compactor will be steam cleaned at least quarterly to minimize odors and pest infestation.

- All biohazardous waste or contaminated materials will be red-bagged. Biohazardous waste will not be mixed with regular trash and will be kept separate from other wastes until pick up by an approved hazardous waste hauler.

- The Environmental Services department will pick up the contaminated materials or biohazardous waste and take it to the storage area outside the hospital for proper disposal. All biohazardous waste containers will have tight-fitting lids. Biohazardous waste is stored in the labeled locked cage on the west side of the facility. The cage must be locked at all times. Biohazardous waste is picked up by the Steris Company. Manifests documenting the removal of all Bio Hazardous waste must be kept on file in the Facilities Coordinator's office. All staff will practice good hand washing techniques when handling biohazardous waste, including the use of personal protective equipment such as gloves.

- Under no circumstances will contaminated materials or waste be mixed in with regular trash or linen.

- All containers for contaminated waste will be routinely and thoroughly washed and disinfected.

- Pharmaceutical and Chemotherapy wastes will be placed in their respective appropriately labeled containers and transported in bins with tight fitting lids to the identified storage area for pickup and removal by the contracted waste disposal vendor. The waste storage area must be secured and locked at all times to prevent unauthorized access.

AFFECTED PERSONNEL/AREAS:

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

REFERENCES:

- The Joint Commission (2026~~0~~) Hospital accreditation standards. PE. 02.01.01 Joint Commission Resources. Oak Brook, IL.

- Association for the Healthcare Environment (2012). Practice Guidance for Healthcare Environmental Cleaning (2nd Edition) 2012.

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

SIERRA VIEW MEDICAL CENTER

HR Report 2026 QTR 1
January – March 2026

Dashboard

Measurement	Q1	YTD	Annualized	Goal	Variance
EE Referral Rate	14%	14%	14%	—	—
Geofencing Rate	0%	0%	0%	—	—
Turnover	2.9%	3%	11%	10%	🔴 -1.2%
RN Turnover	3.7%	4%	15%	10%	🔴 -4.9%
Retention >5 Years	45%	45%	45%	50%	🔴 -5.0%

Turnover by Dept

CY 2026 YTD through QTR 1

Department	Employees	Terms	Turnover Rate	Department	Employees	Terms	Turnover Rate
SVMC All	804	23	3%				
ACADEMIC HEALTH CLINIC	2	-	0%	MARKETING	4	-	0%
ACCOUNTING	7	-	0%	MATERIALS MANAGEMENT	10	-	0%
ACS	6	-	0%	MATERNAL CHILD HEALTH	44	-	0%
ADMINISTRATION	8	1	13%	MED SURG	55	3	5%
CARE INTEGRATION	11	-	0%	NURSING ADMIN	6	-	0%
CATH LAB/INTERV ANGIO	10	-	0%	OB-GYN CLINIC	8	-	0%
CHAPLAINCY	1	-	0%	PATIENT ACCESS	24	2	8%
COMMUNICATIONS	8	1	13%	PFS/CC	25	-	0%
CTC	19	-	0%	PHARMACY	18	-	0%
DIETARY	26	-	0%	PHYSICAL THERAPY/SPEECH	9	-	0%
DPSNF	48	1	2%	PLANT OP/MAINTENANCE	12	-	0%
EDUCATION	4	-	0%	QUALITY	9	-	0%
ER	43	3	7%	RADIOLOGY	40	1	3%
EVS/LAUNDRY	33	1	3%	RECOVERY/ENDO	20	-	0%
FACILITY/GROUNDS	7	1	15%	RENAL DIALYSIS	4	-	0%
FINANCIAL PLANNING	4	-	0%	RESPIRATORY	21	-	0%
FLOAT POOL	19	2	11%	RURAL HEALTH CLINIC	6	-	0%
GME	42	-	0%	SURGERY/CENTRAL SUPPLY	31	2	7%
HIM	26	1	4%	SURGERY CLINIC	6	-	0%
HUMAN RESOURCES	8	-	0%	UROLOGY	5	1	21%
ICU/TELE	50	1	2%	UTILIZATION MANAGEMENT	5	-	0%
IT	14	-	0%	WOUND CARE	5	-	0%
LAB	31	2	6%	*OTHER	13	-	0%

*Other includes: Compliance, Infection Control, Contracts, Medical Staff, Projects, Security


SVMC RECRUITMENT

Recruitment Update – Q1

84

Full Time Positions Filled

*Includes all positions

22

Per Diem Positions Filled

*Includes 9 internal transfers for all positions

41

RN Positions Filled

*Includes 13 internal transfers to a different/new RN role incldiuing New Grad/Interim Permittee

106

Total positions filled **including transfers**

Candidate Activity Metrics

Recruitment Metrics

131
New Jobs Created
*44 still open

106
Total Accepted Offers

1918
Total Applications Screened

160
Scheduled Interviews

13
Declined Offers

Quarter 1

Recruitment Events/Projects

- 3/2/26 – Unitek Cohort 1 New Grad Interviews
- 3/4/26 – Fresno State Career Fair
- 3/9/26 – College of Sequoias RN Students Luncheon
- 3/19/26 – Growing Healthcare Leaders Conference

Upcoming Quarter 2 (2026)

Recruitment Events/Projects

- 4/10/26 – Lemoore College Nursing Career Fair
- 4/13/26 – Tulare Adult School Interview Event
- 4/14/26 – Visalia Adult School Career Fair
- 4/21/26 – Porterville College Career Fair
- 4/30/26 – SVMC Career Fair, Admin Hallway
- 5/13/26 – Tulare County WIB Healthcare Career Fair


ONBOARDING UPDATE

Onboarding Stats

58

Total # of New Hires Onboarded

7

Total # of SPD / Travelers Onboarded

3

% of rescheduled onboarding appointments

6

# of cancelled employment – withdrew interest in job

0

# of cancelled employment – inability to pass EH Screening

0

# of cancelled employment – failed to clear background

EMPLOYEE RELATIONS

Employee Relations Activity

Human Resources

Performance Management Activities

INVESTIGATIONS CONDUCTED

32

PACPs SUPPORTED

2

EXIT INTERVIEWS CONDUCTED

8

GRIEVANCES MANAGED

3

Progressive Disciplinary Action

30
Attendance NOCAs

8
Performance NOCAs

55
Terminations Processed

1
Suspension Letters Pending Investigation

Employee Relations

Unemployment Insurance Activity

9	Submitted UI Claims/Additional Claims
6/3	Initial Claims Unfavorable/Pending
$0	Savings
1	Appeal Hearing Attended
0	Hearings Won
0	Hearings Pending

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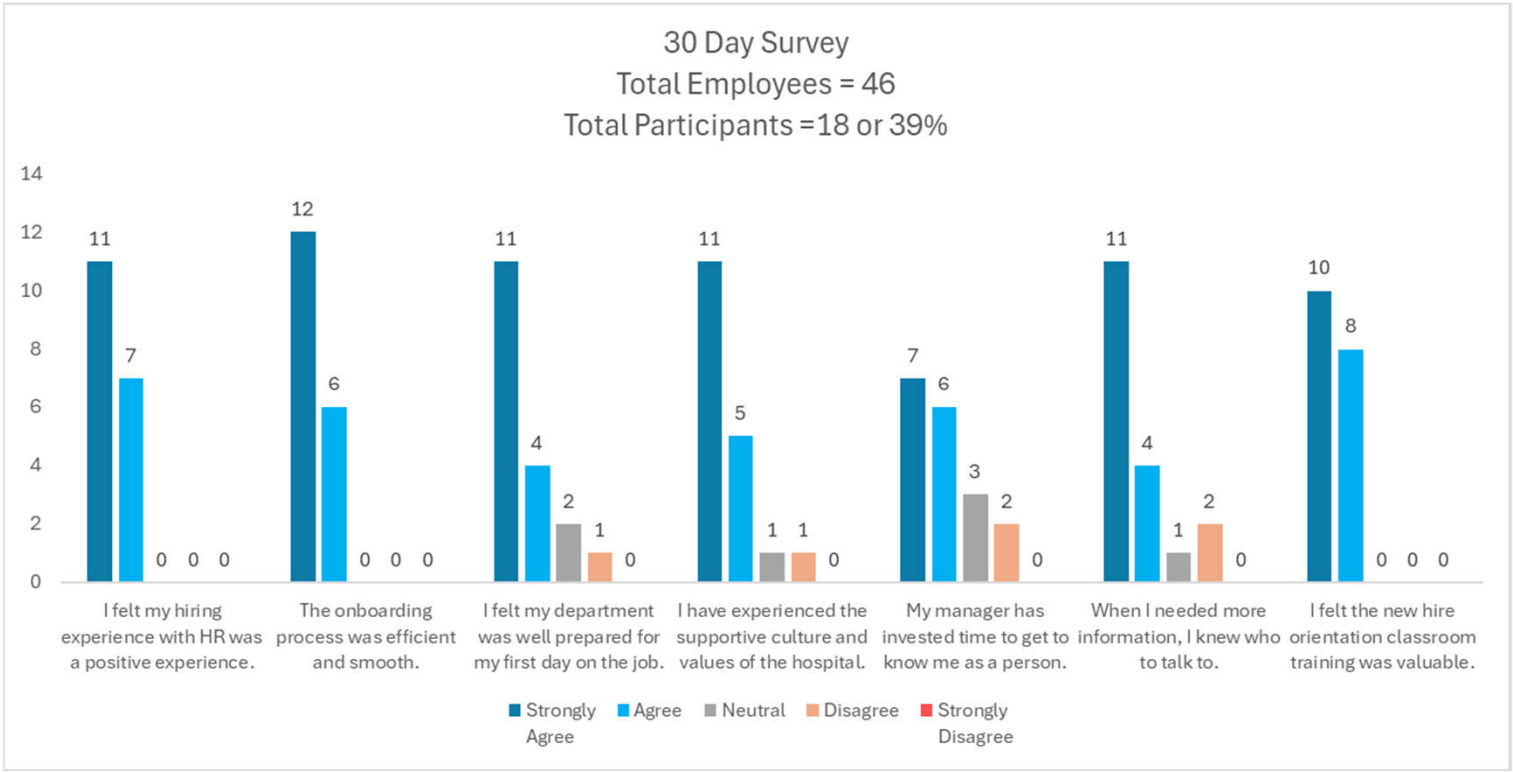
MEDICAL CENTER

Training & Development

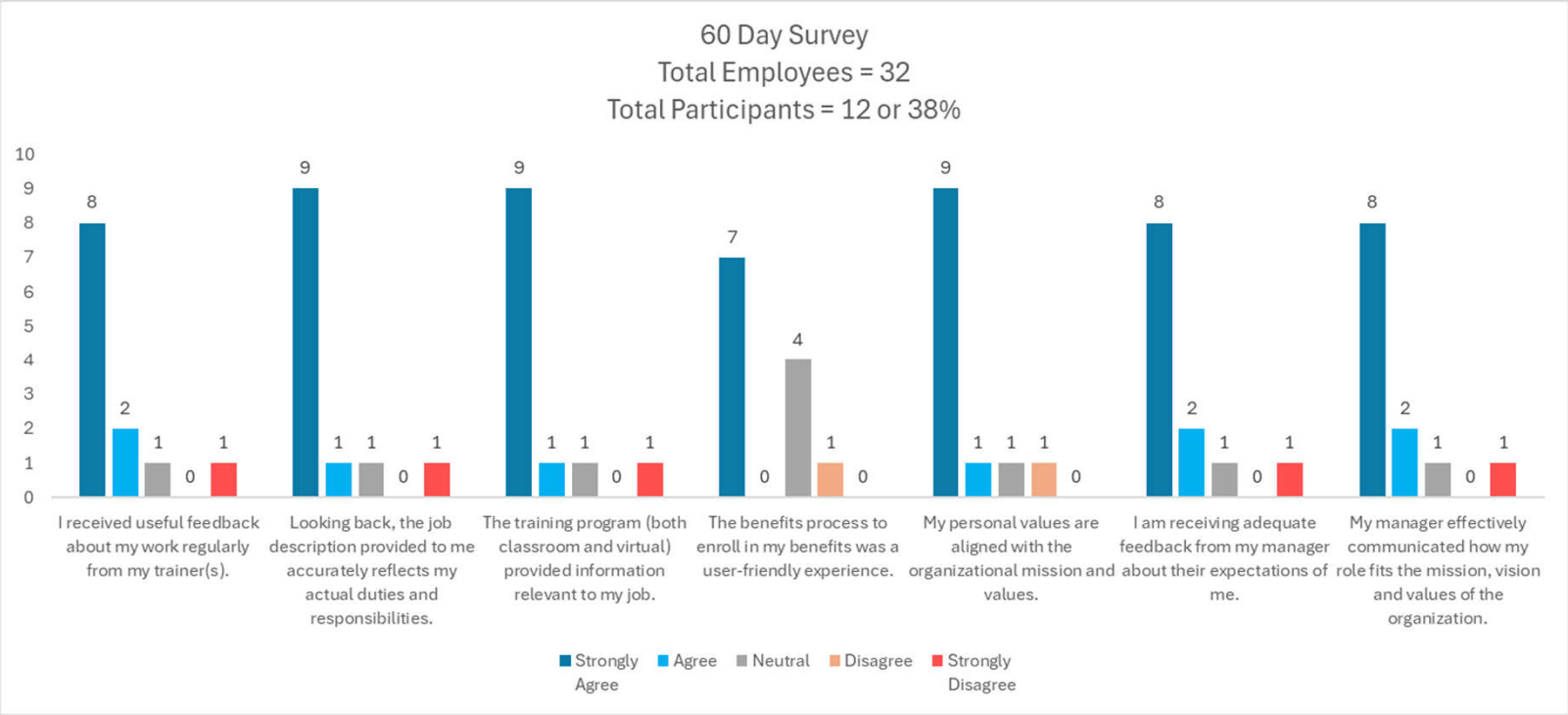
- ✓3 NHO Sessions Facilitated
- ✓40 New Hires Trained


EMPLOYEE ENGAGEMENT

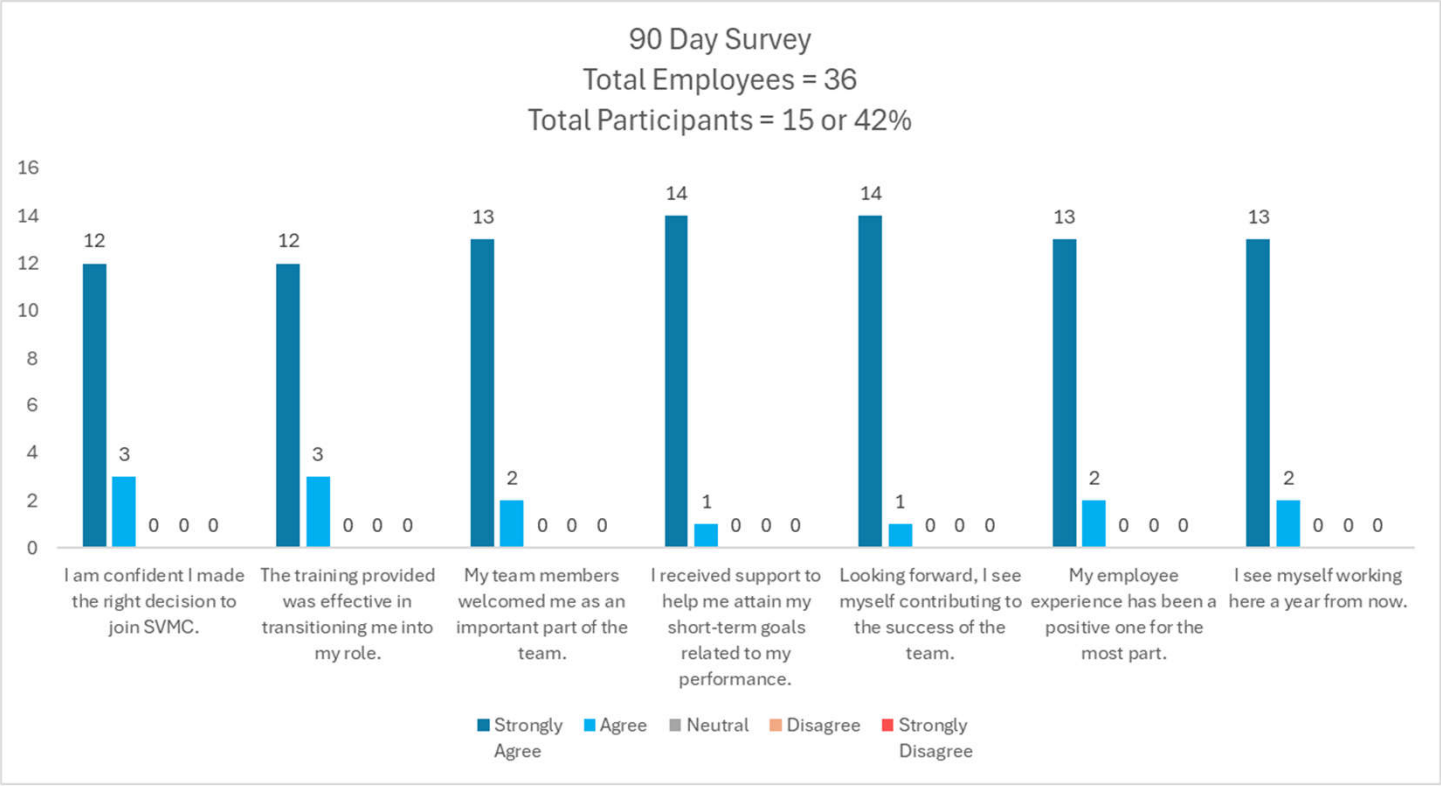
New Hire Survey



New Hire Survey

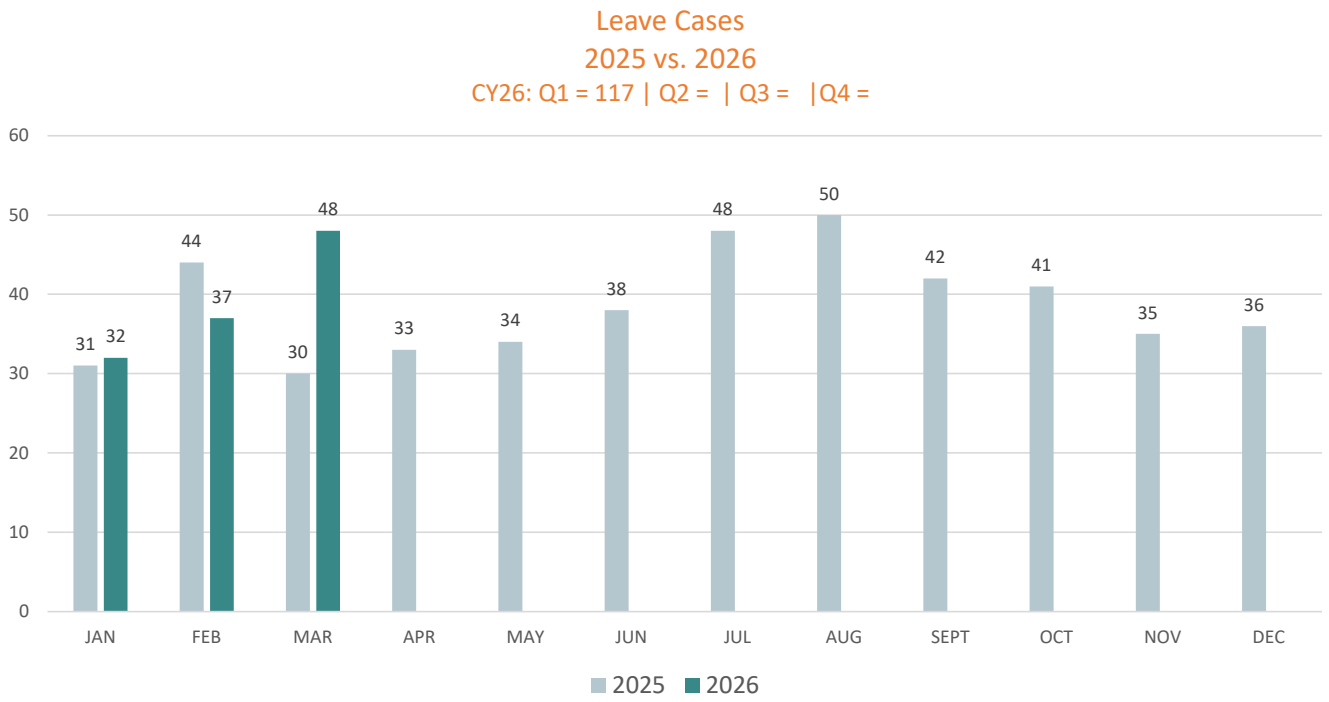


New Hire Survey

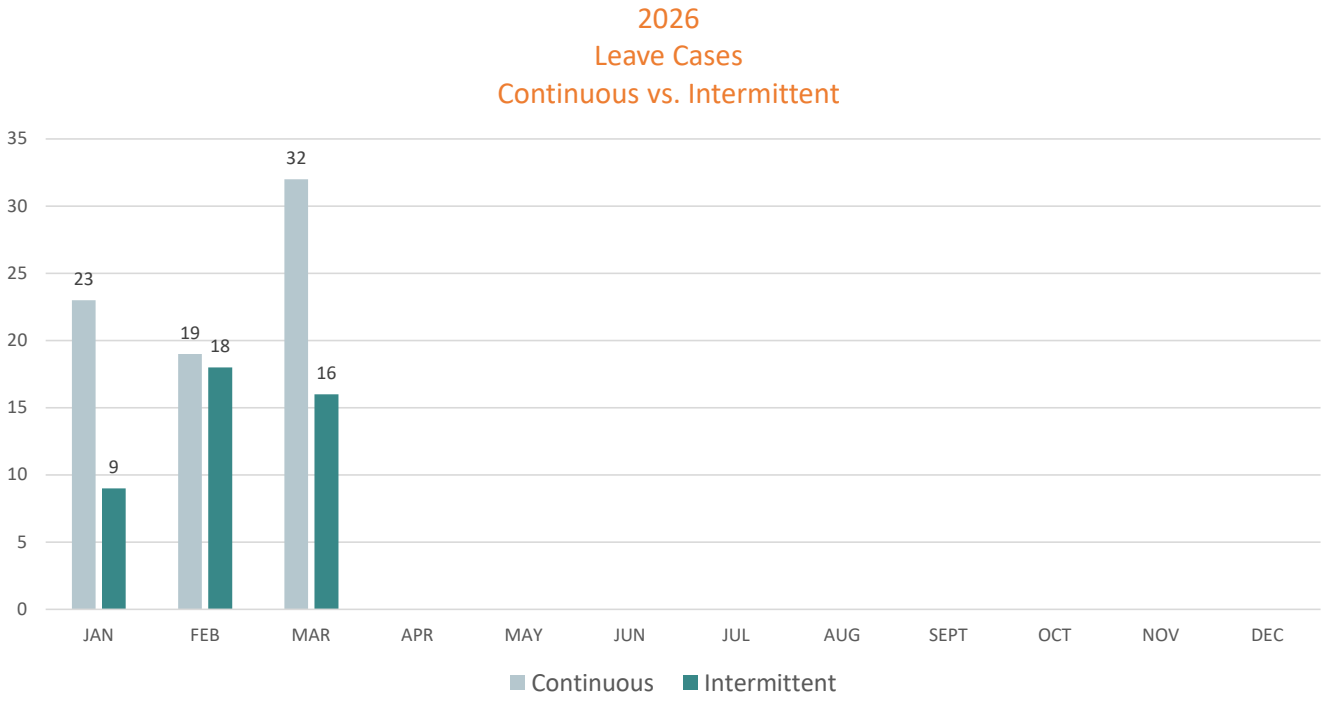



LEAVE OF ABSENCE
UPDATE

Leave of Absence Update



Leave of Absence Update



Leave of Absence & Accommodations

Leave Designation & Totals

- FMLA- 52
- FMLA Intermittent- 43
- ADA Accommodation- 18
- Administrative- 4
  - Licensure/Certification
    - Did not obtain certification by due date- 1
    - Expired licensure/certification- 2
    - Expired I-9 documentation- 1

- Workers Compensation- 7
- Extensions- 30
- Return to Work- 67
- Total of ALL Leaves- 117

Accommodations Requests

- Light Duty/Modified Duty- 5

Consultations with Benefits/Leave Coordinator

Q1 Total= 494

109

Benefits

310

Leave of Absence & Accommodations

23

Policy

52

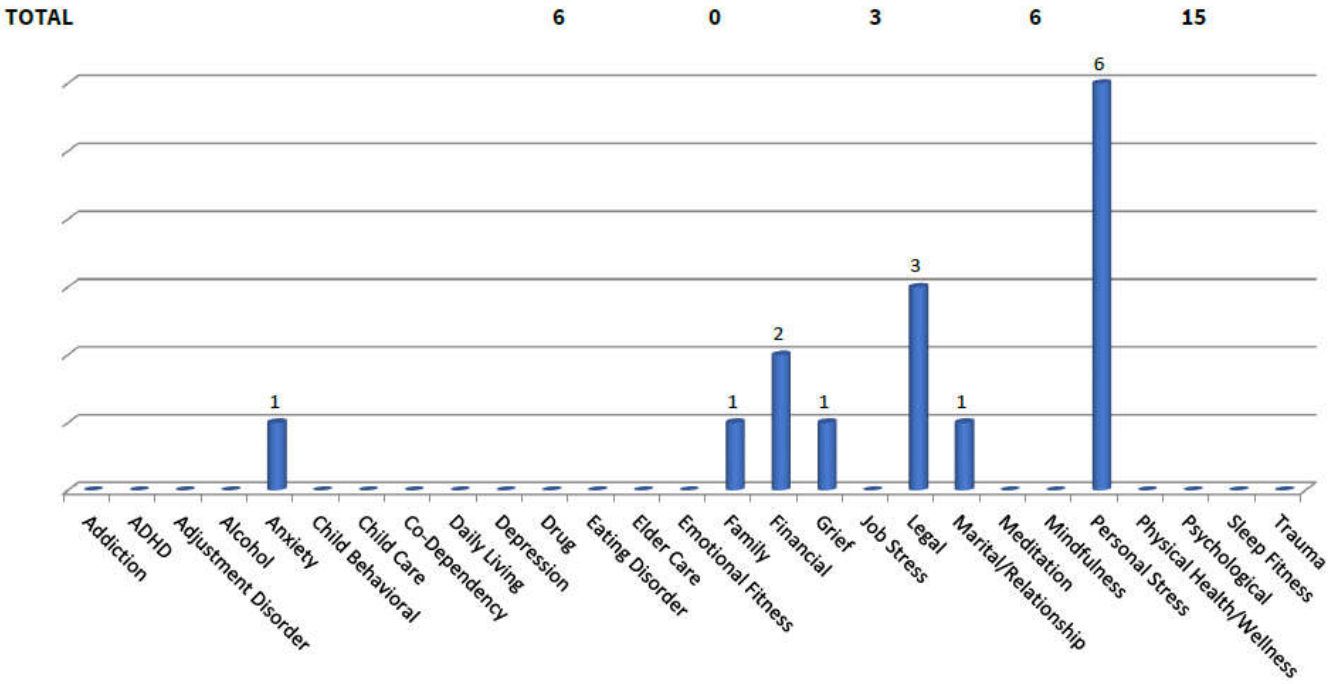
Miscellaneous

Ex: UKG, Access, VOE, Lic/Cert

BENEFITS UPDATES

* Always a QTR behind

Simple Therapy- EAP



Benefits Conversational Report

* Always a QTR behind

HR POLICY REVIEW

HR Policies

JANUARY BOARD APPROVALS

- None

FEBRUARY BOARD APPROVALS

- None

MARCH BOARD APPROVALS

- Employment Status
- Reasonable Accommodation
- Transitional Return to work
- Reimbursement for relocation
- Staff recruitment and employment and retention

REGULATORY COMPLIANCE AUDIT UPDATES

Regulatory Audits/Internal Audits

Below is a glimpse into our department's participation in regulatory surveys along with Internal Audits to ensure data is accurate.

QUARTERLY INTERNAL CONTROL AUDITS

- ✓ Employee Demographic
- ✓ HR Personnel User Changes
- ✓ Rate Variance from Pay Grade
- ✓ User Access and Security Roles

REGULATORY SURVEYS CONDUCTED

- CDPH – 3.23.26 Pt Complaint visit

Regulatory Compliance

262

License and Certification Renewals Processed

74

Employment Verifications

102

Employee Change Notices


HR PROJECT
UPDATES

HRIS Project Update

- **UKG Performance Review**
  - Completed the distribution of annual performance reviews in UKG
- **ACA Hours Integration**
  - In progress
- **Job Description Transition**
  - A new implementation timeline established, final JDs in place by 1/1/2027.
- **The Work Number – Employment and Income Verifications**
  - Setting up demo with The Work Number
- **Incorporate Just Culture Training into Annual Orientation**
  - Complete
- **Automate Personnel File Import into Papervision for Annual Reviews**
  - Complete
- **Salary Administration**
  - Completed analysis for FY 26/27 and approved by SLT

Report Requests

27

Total Report Requests

6

Total analyses

21

Total staff support reports

HR KEY ACCOMPLISHMENTS

- Continued to work to improve the new job description templates
- Updated Module for 2026 Volunteer Orientation
- Resolved Per Diem file issue going over to Empower Retirement
- Participated in the March Coffee and Coworkers
- Continued working on 2026 Regulatory updates needed
- CDPH complaint survey/HR had zero findings

Marketing Report

Quarter1

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MEDICAL CENTER

Social Media

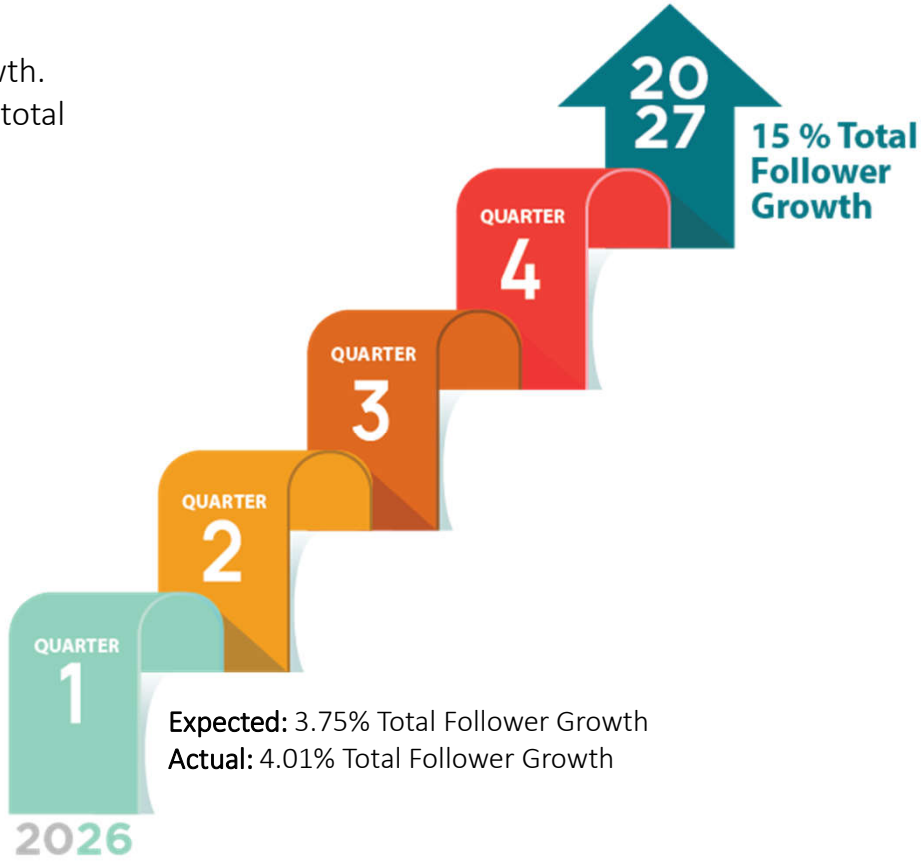
SIERRA VIEW
MEDICAL CENTER

Quarter 1

Social Media Growth

SVMC social media platforms continue to experience steady growth. Average growth for Q1 was 4.01% in overall audience net gain. A total of 437 new followers was gained across the three platforms.

Followers by Platform				
Platform	**2025 Q4**	2026 Q1	Followers Gained	Growth Percentage
Facebook	**5,779**	5,952	173	2.91%
Instagram	**2,354**	2,439	85	3.61%
LinkedIn	**2,760**	2,939	179	6.90%



Expected: 3.75% Total Follower Growth
Actual: 4.01% Total Follower Growth

SIERRA VIEW MEDICAL CENTER

Quarter 1

Social Media Analytics

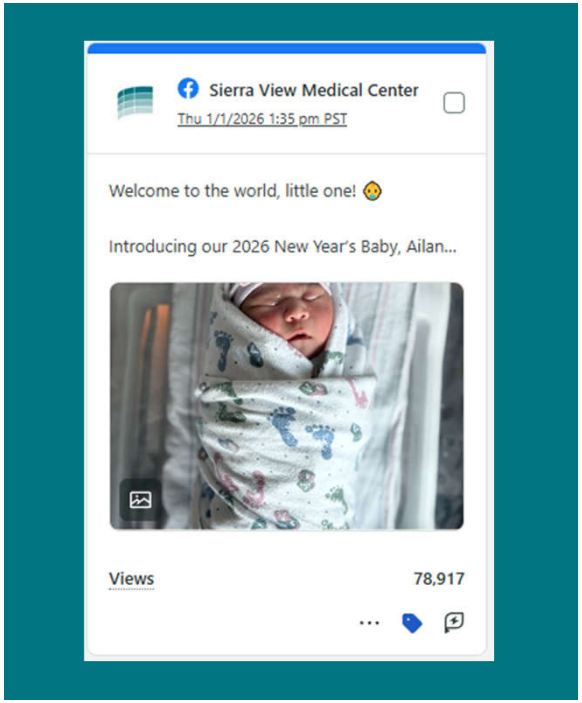
	Facebook	Instagram (Including Stories)	LinkedIn	Overall Total for Q4	Social Media Quarterly Goals
# of Posts	88	110	66	264 	250 per quarter
Impressions	1,207,342	314,032	33,054	1,554,428 	625,603
Engagements	120,304	4,213	6,728	131,245 	48,587
Engagement Rate	10%	1.3%	20.4%	8.4% 	8.4%

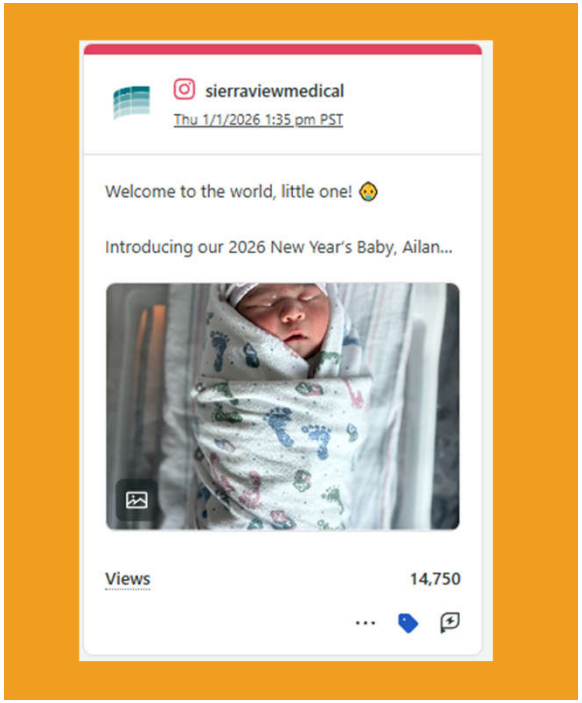
Social Media Quarterly Goals Explained:

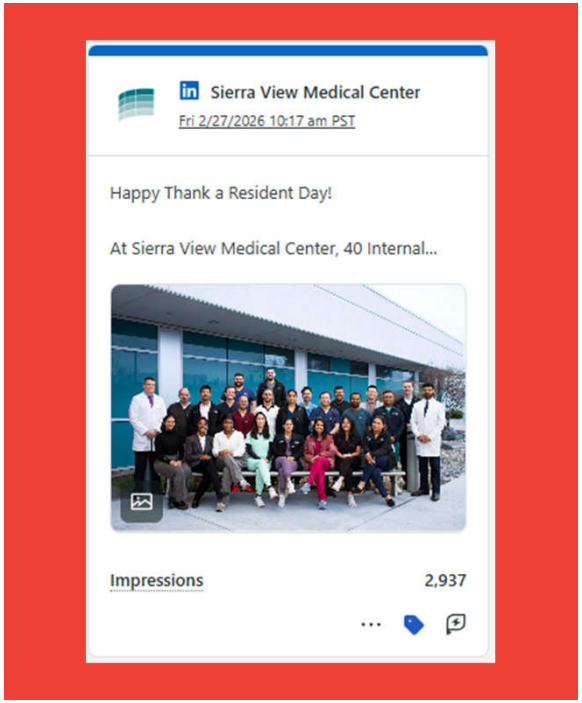
- **# of Posts (250 per quarter):** Realistic goal for SVMC that keeps up with industry standards
- **Impressions Goal (625,603 per quarter):** 10% growth from previous year-to-date
- **Engagements Goal (48,587 per quarter):** 10% growth from previous year-to-date
- **Engagement Rate Goal (8.4%):** 7.5%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

Quarter 1

Top Three Stories By Platform (Impressions)

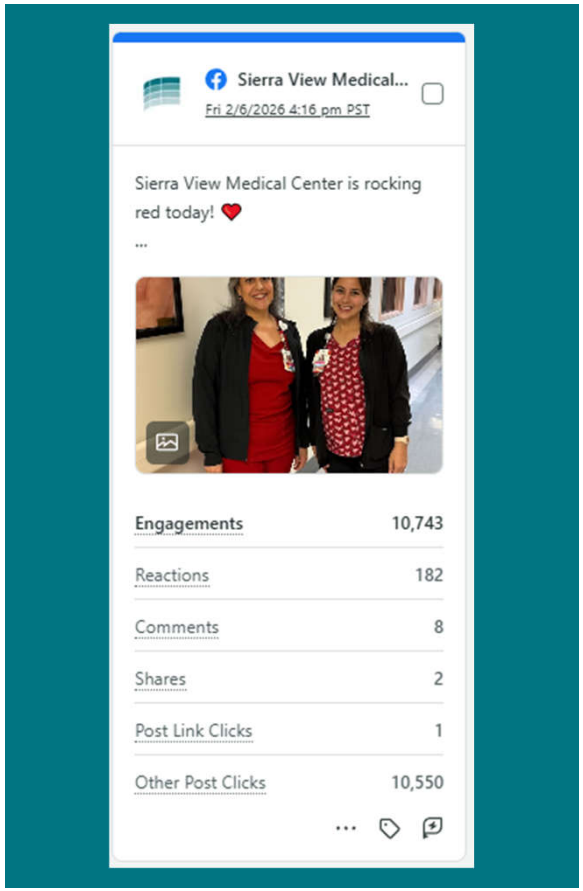


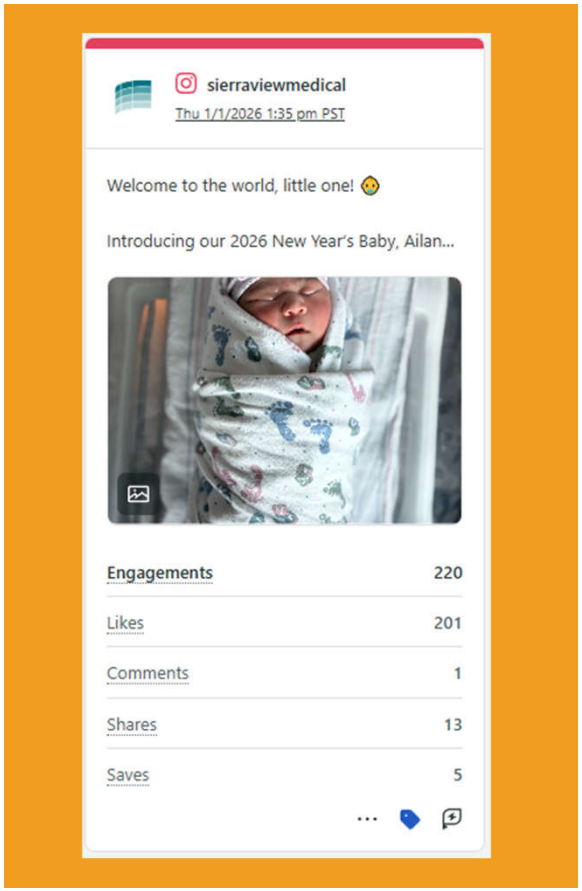


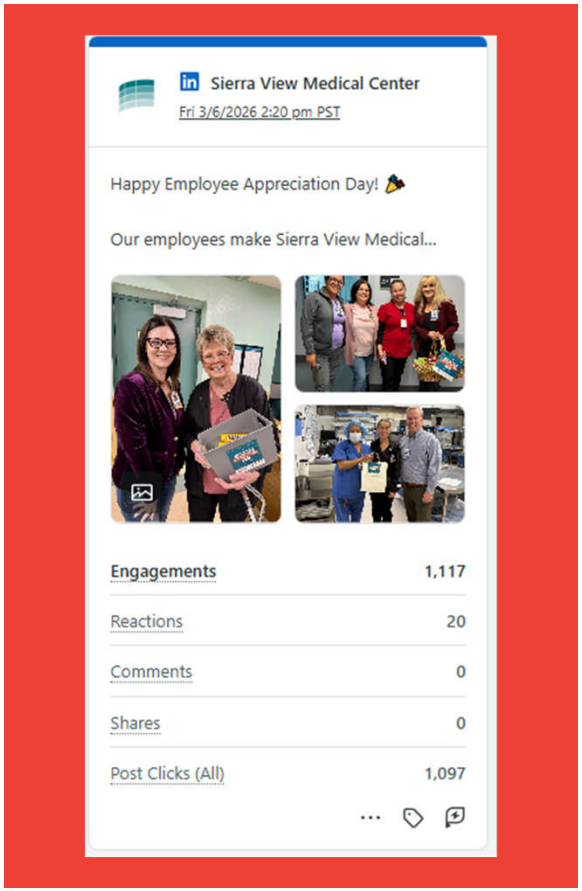


Quarter 1

Top Three Stories By Platform (Engagements)







Quarter 1

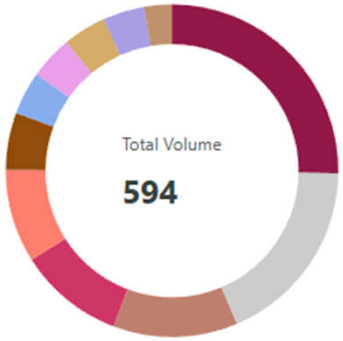
Top Paid Advertisement

Platform	Post	Date	Link Clicks	Views
Facebook	Inspired by Care	Starting January 16 for 90 days (Ends April 16)	1,527	128,000

Quarter 1

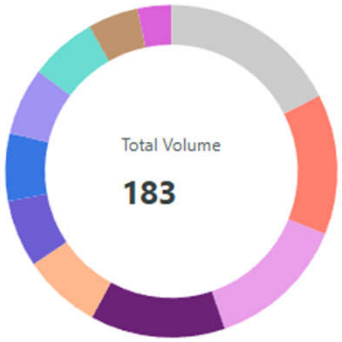
Category Breakdown for Social Media Posts

All Tags



Employees	25.3%
Senior Team	12.1%
Awards	10.3%
Holiday & Observances	9.1%
events	5.6%
Nursing Services	4.2%
partnerships	4.2%
SV Foundation	4.2%
Maternal Child Health	4%
recruitment	2.7%
All Other Tags	18.4%

Service Lines Only



Nursing Services	13.7%
SV Foundation	13.7%
Maternal Child Health	13.1%
Terra Bella Rural Health Center	7.7%
ASD	6.6%
CTC	6.6%
Hip & Knee Center	6.6%
Physical Therapy	6.6%
Women's Services Clinic	4.9%
DP/SNF	3.3%
All Other Tags	17.5%

Quarter 1

Competitive Analysis

Facebook	Kaweah Health	Sierra View Medical Center
Followers Gained	+273	+173
Growth Rate Based on Audience Size	1.04% Growth	2.91% Growth
# of Posts	62	88
Public Engagements	6,518 (105.13 per post)	8,415 (95.63 per post)

Instagram	Kaweah Health	Sierra View Medical Center
Followers Gained	+152	+85
Growth Rate Based on Audience Size	1.91% Growth	3.61% Growth
# of Posts (Not including stories)	61	87
Public Engagements	6,064 (99.41 per post)	3,909 (44.93 per post)

Analytics Explained:

- **Followers Gained:** New followers added during the reporting period.
- **Growth Rate:** % increase relative to total audience. Enables fair comparison across different-sized accounts (Kaweah: ~26K FB / ~8K IG; Sierra View: ~6K FB / ~2.5K IG).
- **Posts:** Total content published during the reporting period.
- **Public Engagements:** Total interactions (likes, comments, shares, etc.).

Reputation Management

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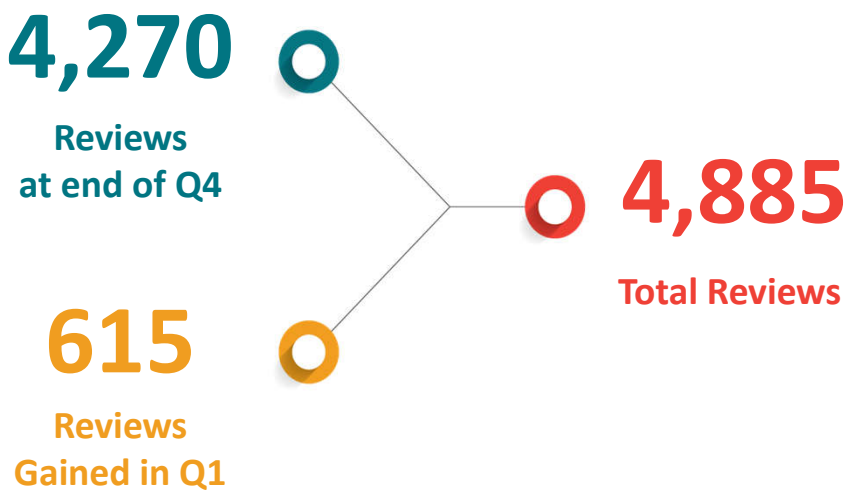
MEDICAL CENTER

Quarter 1

Reputation Management

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



Google Star Rating by Location	
Sierra View Medical Center	3.8 Stars
SVMC Urology Clinic	4.4 Stars
SVMC Medical Office Building	4.6 Stars
SVMC Physical Therapy	4.7 Stars
SVMC Roger S. Good Cancer Treatment Center	4.7 Stars
SVMC Women's Services Clinic	4.8 Stars
Sierra View Community Health Center – Terra Bella	4.8 Stars
Sierra View Hip & Knee Center	4.8 Stars
SVMC Wound Healing Center	4.8 Stars
SVMC Ambulatory Surgery Center	4.9 Stars

SIERRA VIEW MEDICAL CENTER

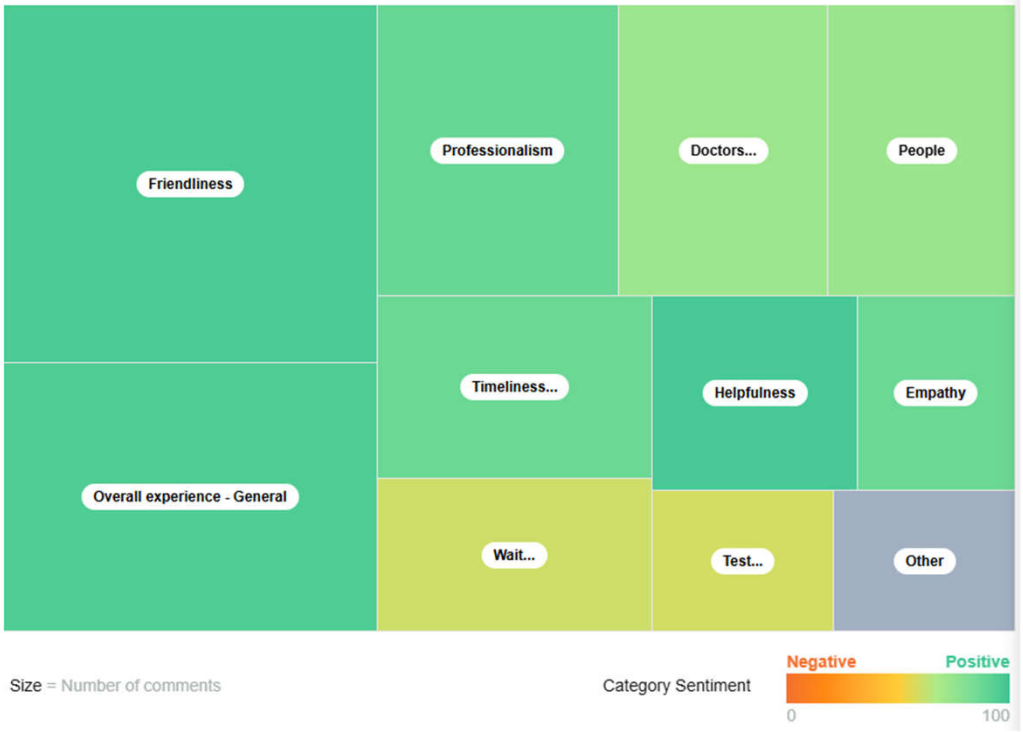
Quarter 1

What Our Patients Are Saying

Word Cloud

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

Sentiment Map



Quarter 1

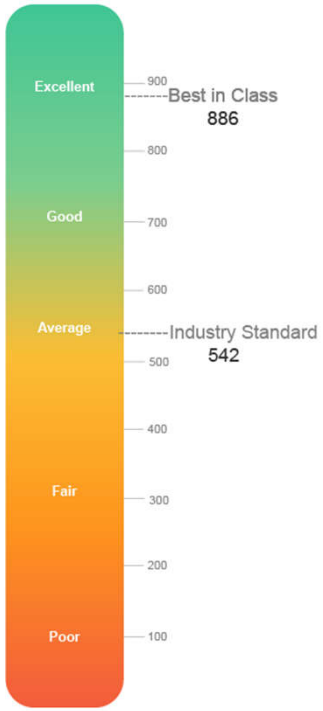
Reviews & Average Ratings

Location (10)	Total Reviews	Average Rating
Sierra View Medical Center (SVMC)	2,030 25% | 6% | 69%	3.8 /5
Sierra View Medical Center Urology Clinic in alliance with Keck Medicine of USC (SVMC_Urology_Clinic)	132 10% | 5% | 85%	4.4 /5
SVMC Medical Office Building (SVMC_MOB)	1,821 7% | 4% | 89%	4.6 /5
Sierra View Physical Therapy (SVMC_PT)	139 4% | 4% | 92%	4.7 /5
SVMC Roger S. Good Cancer Treatment Center (SVMC_CTC)	218 5% | 2% | 93%	4.7 /5
Sierra View Community Health Center – Terra Bella (SVMC_Terra_Bella_Clinic)	60 5% | 0% | 95%	4.8 /5
SVMC Women's Services Clinic	41 2% | 5% | 93%	4.8 /5
Sierra View Hip & Knee Center (SVMC_Hip_Knee)	155 3% | 2% | 95%	4.8 /5
SVMC Wound Healing Center (SVMC_Wound_Healing)	79 3% | 1% | 96%	4.8 /5
SVMC Ambulatory Surgery Center (SVMC_ASC)	216 0% | 1% | 99%	4.9 /5

SIERRA VIEW MEDICAL CENTER

Quarter 1

Reputation Scores



SIERRA VIEW MEDICAL CENTER

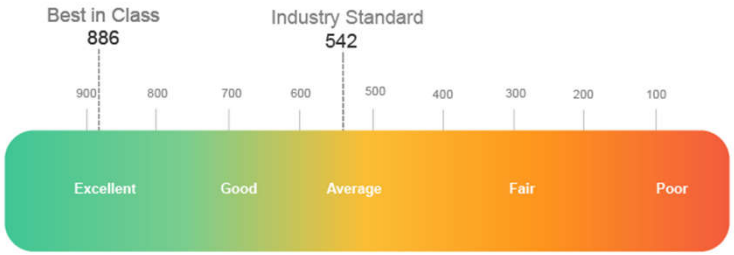
Location (10)	Reputation Score	Review Sentiment	Review Volume	Review Recency	Review Quality	Review Spread	Review Response	Search Impressions	Listing Completeness
Sierra View Medical Center Urology Clinic in alliance with Keck Medicine of USC (SVMC_Urology_Clinic)	595	49%	57%	100%	22%	57%	99%	31%	93%
Sierra View Medical Center (SVMC)	681	52%	57%	100%	68%	57%	100%	87%	93%
SVMC Medical Office Building (SVMC_MOB)	712	67%	57%	100%	61%	57%	100%	74%	81%
Sierra View Community Health Center – Terra Bella (SVMC_Terra_Bella_Clinic)	819	93%	57%	100%	11%	57%	100%	59%	93%
SVMC Wound Healing Center (SVMC_Wound_Healing)	833	93%	57%	96%	39%	57%	100%	74%	93%
SVMC Women's Services Clinic	849	95%	57%	86%	29%	57%	100%	90%	95%
SVMC Roger S. Good Cancer Treatment Center (SVMC_CTC)	851	95%	57%	100%	53%	57%	98%	74%	93%
Sierra View Physical Therapy (SVMC_PT)	859	98%	57%	100%	55%	57%	95%	74%	93%
SVMC Ambulatory Surgery Center (SVMC_ASC)	873	99%	57%	100%	64%	57%	100%	74%	93%
Sierra View Hip & Knee Center (SVMC_Hip_Knee)	882	98%	57%	100%	66%	57%	100%	91%	95%

SIERRA VIEW MEDICAL CENTER

Quarter 1

Competitive Analysis of Patient Reviews

Location (4)	Total Reviews	Average Rating	Reputation Score
Kaweah Health Medical Center	42 36% | 2% | 62%	3.5 /5	671
Sierra View Medical Center (SVMC)	266 16% | 4% | 80%	4.2 /5	679
Dignity Health - Memorial Hospital	248 10% | 4% | 86%	4.4 /5	801
Adventist Health Hanford	242 10% | 5% | 85%	4.5 /5	801



Website

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MEDICAL CENTER

Quarter 1

Session Durations

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111,929 Sessions

(Up 4,746)

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

1.5 Pages Per Session

(No Change)

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

2M 42S Average Engaged Duration

(Down 25S)

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

57S Average Session Duration

(Down 3S)

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

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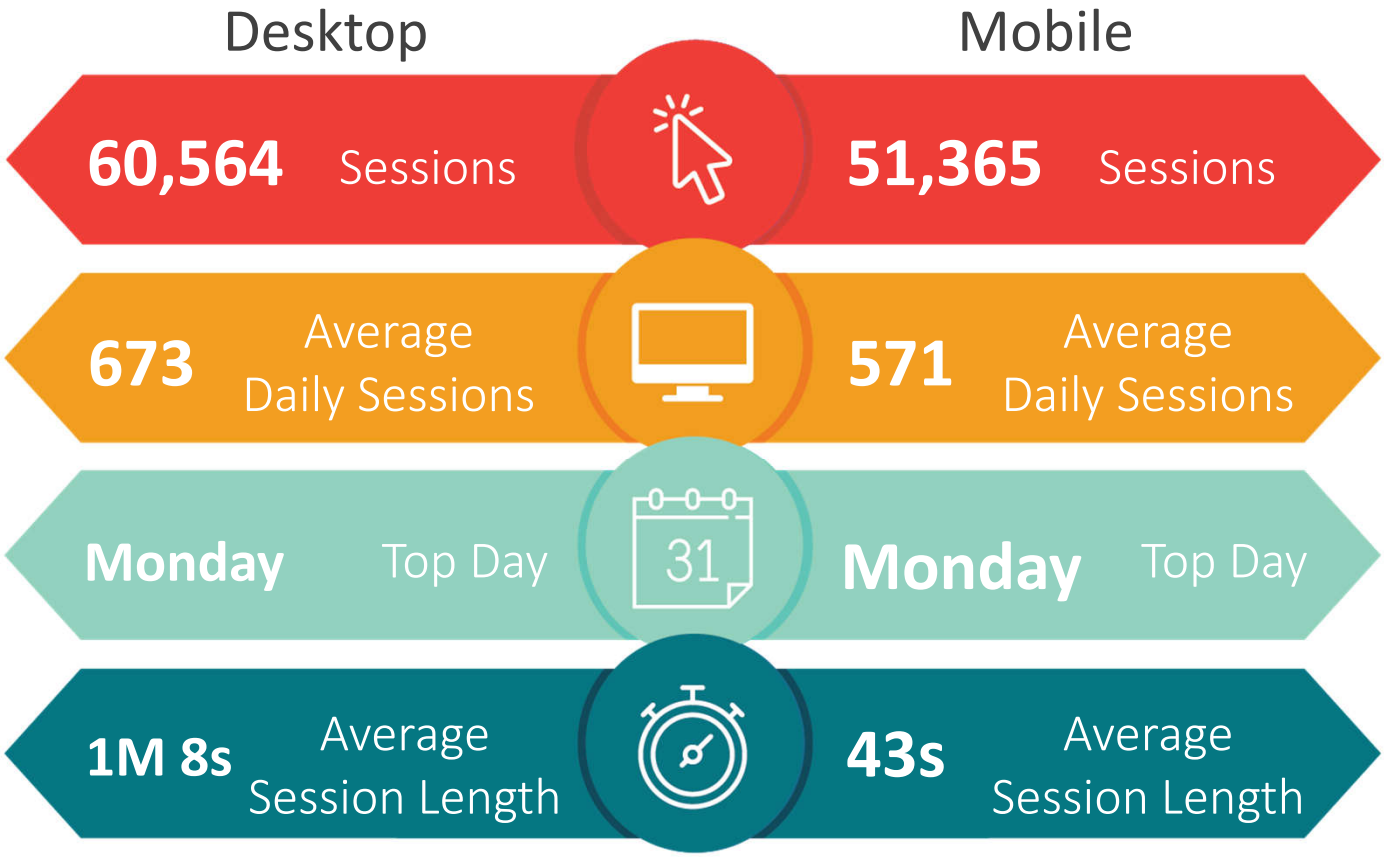
Quarter 1

A Snapshot of Our Users



SIERRA VIEW MEDICAL CENTER

Quarter 1

Top Pages

Page	Sessions	Bounce Rate
Home page	31,142	55.4%
Welcome	24,869	99.5%
Careers	18,741	22.8%
Patient Portal	6,345	8.9%
Locations: Sierra View Medical Center	5,677	18%
Remote Access	5,210	17.1%
Physician Directory	2,873	29.3%
Internal Medicine Residency	1,943	10.2%
Locations	1,864	24.9%
Meet the Residents	1,704	20.4%

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

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

Public & Media Relations

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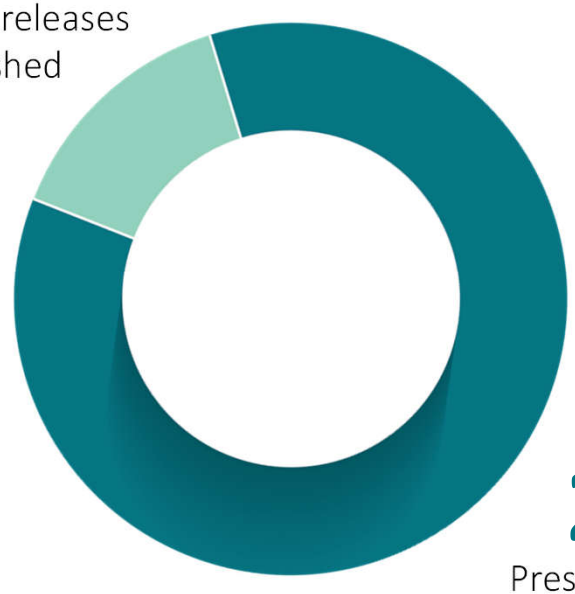
MEDICAL CENTER

Quarter 1

SVMC In the Headlines

5
Press releases published



21
Press mentions

Top Articles

1. New Year's Baby
2. Sierra View Earns CDPH Gold Antimicrobial Stewardship Designation
3. New CNO Announcement
4. SVF Golf Classic Promotion
5. GME Match Day
6. SVMC Announces CNO Retirement and new DAISY Nurse Leader Award
7. Behind the Scenes View of the Patient Portal

Quarter 1

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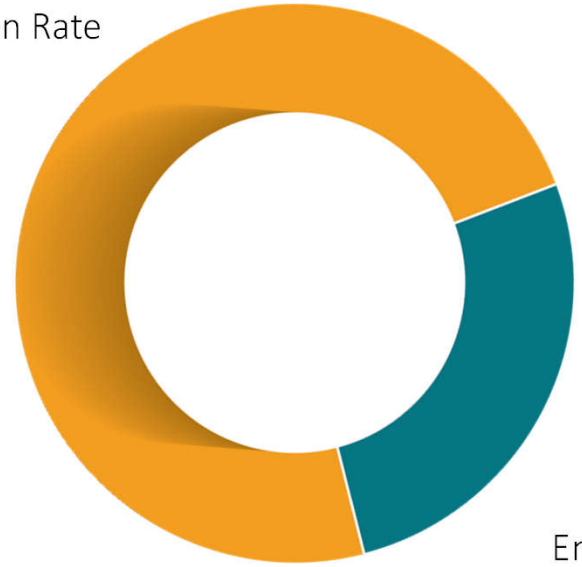
INSIDE View

SIERRA VIEW MEDICAL CENTER

58%
Open Rate



3
Emails Sent

Sierra View Medical Center delivered 3 installments of our digital newsletter, Inside View. This publication gives an Inside View of everything happening at and around our hospital such as news, events, career openings, and more.

Email Subscribers			
2025 Q4	2026 Q1	Subscribers Gained	Growth Percentage
536	704	168	31.3%

Community Relations, Events, & Fundraising

SIERRA VIEW
MEDICAL CENTER

Quarter 1

Community Events

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

January

- Lindsay Unified School District College & Career Fair

February

- Lindsay High School Health Science Academy Mentor Breakfast
- National Wear Red Day
- SVMC Community Blood Drive

March

- First Friday Coffee
- Porterville Chamber's Spring Festival
- Read Across America
- Doctor's Day Dinner Celebration
- Porterville Unified Golf Tournament
- Carl F. Smith Middle School Resource Round up in Terra Bella

Quarter 1

Community Relations Outreach

January

- ABC 30 Advisory Council Meeting
- MTA Pathway Advisory Board Meeting
- CHIP: TAME Bi Monthly Meeting
- Access To Care Meeting

February

- Access To Care Meeting (Tulare County)
- GAC Meeting
- MTA Pathway Advisory Board Meeting
- 2026 HEART Workshop hosted by BETA Healthcare Group

March

- Porterville Chamber's First Friday Coffee
- MTA Pathway Advisory Board Meeting
- Access To Care Meeting (Tulare County)
- GAC Meeting

Internal Communication Strategy

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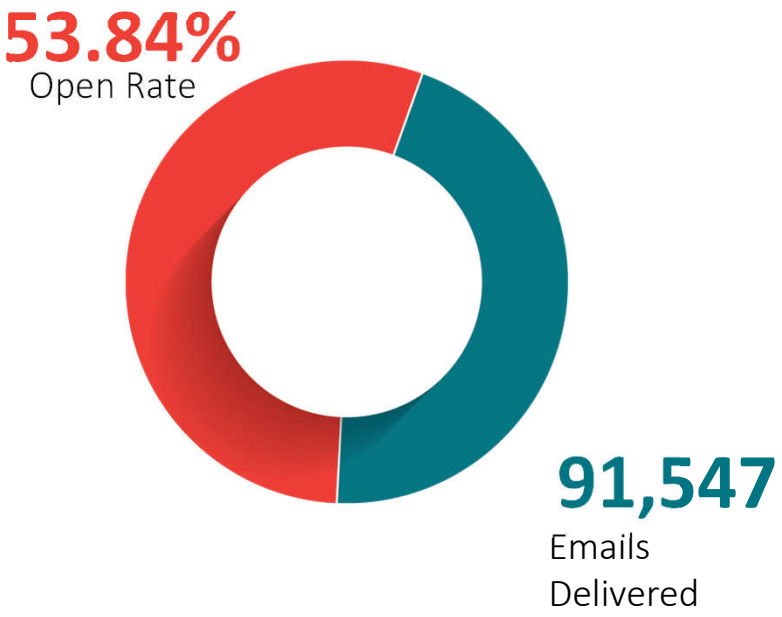
MEDICAL CENTER

Quarter 1

Internal Communications



Email	Open Rate
1/22 Bi-Weekly Leadership Email	97.96 % Open Rate
2/10 UKG Performance Review Session for Leadership	97.96% Open Rate

Types of Internal Communication:

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

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

Get In Touch With Marketing

Address

444 West Putnam Avenue

Porterville, CA 93257

General Email

Marketing@sierra-view.com

General Line

(559)791-3922

Thank You

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MEDICAL CENTER

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	04/01/2026
BOARD OF DIRECTORS APPROVAL	
	04/28/2026
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
April 28, 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. Policies:		**APPROVE**
• Abbreviations in the Medical Record	1-28	
• Annual Infection Prevention Plan	29-57	
• Medical Staff Dues	58	
• OR Charging Process	59-60	
• Registered Nurse First Assistant (RNFA)	61-63	
• Respiratory Protection Plan	64-84	
• Scabies	85-86	
• Tuberculosis Control Plan	87-114	

SUBJECT: **ABBREVIATIONS IN THE MEDICAL RECORD**	SECTION:

PURPOSE:

To define the standardized abbreviations and symbols acceptable for use in the medical record at Sierra View Medical Center.

POLICY:

There shall be an approved abbreviation list available for use throughout the Hospital. Only abbreviations from this list shall be used in the medical record.

Only those abbreviations from the medical staff list of approved abbreviations will be utilized for documentation.

Pre-printed forms shall not include any abbreviations identified on the "Do Not Use" list. All pre-printed forms include, but not limited to, physician orders forms, protocols, clinical practice guidelines and pathways.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL DEPARTMENTS*

PROCEDURE:

1. The HIM Director, Vice President of Patient Care Services and the Vice President of Quality and Regulatory Affairs shall have the authority to add, delete, and otherwise update the abbreviation list as the needs of the hospital shall dictate.

2. The abbreviation list shall be submitted to the Medical Executive Committee for review and approval.

3. The abbreviation list shall be an addendum to this policy and shall be available in all copies of the manual.

REFERENCE:

- The Joint Commission. (2025). Hospital accreditation standards. IM.02.02.01. Joint Commission Resources, Oakbrook Terrace, Illinois

CROSS REFERENCE:

- Health Information Management Policy: Subject: Medical Record – Unacceptable Abbreviations and Symbols.

SIERRA VIEW MEDICAL CENTER
~~APPROVED ABBREVIATION LIST~~
ATTACHMENT A

A

@	at
a	before
A1	aortic first sound
A2	aortic second sound
aa	of each
A	assistance
AAA	abdominal aortic aneurysm
AaDO2	alveolar-arterial oxygen difference
AAROM	active assisted range of motion
A&O	alert and oriented
A&P	auscultation and percussion
AB	abortion
ABD	abduction
abd	abdomen
abd pol	abductor pollicis
ABG	arterial blood gas
abn	abnormal
ABX	antibiotics
a.c.	before meals
AC	acromioclavicular
ACL	anterior cruciate ligament
ACLS	Advanced Cardiac Life Support
ACT	activated clotting time
ACTH	adrenocorticotrophic (hormone)
ACVD	arteriosclerotic cardiovascular disease
A.D.	right ear (auris dextra)
ADA	American Diabetic Association
Adapt.	Adaptive
ADC	average daily census
ADD	attention deficit disorder
ADH	antidiuretic hormone
ADL	activities of daily living
ad lib	as desired
add pol	adductor pollicis
ADM	administrative
adm	admission
adq	abductor digiti quinti (muscle)
AE	above elbow
AFB	acid fast bacilli
A-fib	atrial fibrillation

ag	antigravity
AgNO3	silver nitrate
A/G Ratio	albumin-globulin
AGA	appropriate for gestational age
AGE	acute gastroenteritis
AHD	acute hemodialysis
AI	aortic insufficiency
AIDS	autoimmune deficiency syndrome
AIN	allergic interstitial nephritis
AK	above knee
AKA	above knee amputation
alb	albumin
alk.p'tase	alkaline phosphatase
alk.	alkaline
ALOC	altered level of consciousness
ALS	amyotrophic lateralizing sclerosis
a.m.	morning
AMA	Against Medical Advice
amb	ambulatory
AMI	acute myocardial infarction
amp	ampule
amt	amount
anes	anesthesia
angio	angiogram
ANS	autonomic nervous system
ant	anterior
A/O	alert and oriented
AOCD	Anemia of chronic dsease
AODM	adult onset diabetes mellitus
AP	anterior-posterior
APAP	acetaminophen (not abbrev. brand name)
APB	abductor pollicis brevis
APL	abductor pollicis longus
A/P	auscultation and percussion
ap	apical pulse
approx	approximately
appt	appointment
appy	appendectomy
APS	Adult Protective Services
ARDS	adult respiratory distress syndrome
ARF	acute renal failure
AROM	artificial rupture of membranes
ART	Accredited Record Technician
art.	arterial
art.line	arterial line
artic	articulation

A.S.	left ear (auris sinistra)
AS	arteriosclerosis
ASA	acetylsalicylic acid (aspirin)
ASAP	as soon as possible
ASCVD	atherosclerotic cardiovascular disease
ASD	atrial septal defect
ASHD	arteriosclerotic heart disease
ASIS	anterosuperior iliac spine
ASO	antistreptolysin titre O
Assoc.	association
asst	assistance
as tol	as tolerated
ASVD	arteriosclerotic vascular disease
asym	asymmetrical
A.T.C.	around the clock
A.U.	both ears
auth	authorize(d)
A-V	arteriovenous
AV	arterioventricular
AVB	atrioventricular block
AWMI	anterior wall myocardial infarction
ax	axilla

B

B+C	board and care
Bab.	Babinski
Bact	bacterium(a)
bal	balance
Baso	basophils
BBB	bundle branch block
BBS	bilateral breath sounds
BC	blood culture
BG	blood glucose
BIB	brought in by
b.i.d.	twice daily
bilat; bil	bilateral
BILI	bilirubin
bio	biological
BE	barium enema
BF	breast feeding
BK	below the knee
BKA	below knee amputation
bld	blood
BLE	bilateral lower extremities
BLS	basic life support

BM	bowel movement
BMEVT	bilateral middle ear ventilation tubes
BMR	basal metabolism rate
BMT	bilateral myringotomy/tube placement
BOA	born out of asepsis
BOM	bilateral otitis media
BOME	bilateral otitis media with effusion
BOOP	bilateral organizing obstructive pnemonia
BOW	bag of waters
BP	blood pressure
BPH	benign prostatic hypertrophy
BPPN	benign paroxysmal postural nystagmus
BPPV	benign paroxysmal positional vertigo
BR	bedrest
BRB	bright red blood
B.R.P.	bathroom privileges
Bs; B/S	blood sugar
bs	breath sounds
BS	bowel sounds
BSA	body surface area
BSC	bedside commode
BSGT	bedside glucose tolerance
BSO	bilateral salpingo-oohorectomy
BST	breast stimulation test
BSW	Bachelor of Social Work
BTL	bilateral tubal ligation
BUE	bilateral upper extremities
BUN	blood urea nitrogen
BUR	back up rate
BUS	Bartholin, urethral and Skenes glands
BTL	bilateral tubal ligation
btl.	bottle
bx	biopsy

C

C/O	complaints of
c	with
C	centigrade (celsius)
C&S	culture and sensitivity
Ca	cancer/carcinoma
Ca++	calcium
CABG	coronary artery bypass graft
CAD	coronary artery disease
cal	calorie
Cap.	Capsule

CAPD	continuous ambulatory peritoneal dialysis
CAT	CAT Scan
Cat	cataract
cath	catheter/catheterization
Cauc	caucasian
CAVH	continuous arteriovenous hemoperfusion
CAVHD	continuous ateriovenous hemodialysis
CBC	complete blood count
CBOME	chronic bilateral otitis media with effusion
CBS	chronic brain syndrome
cc	cubic centimeter
CC	chief complaint
CCPD	Continuous Cycling Peritoneal Dialysis
CCS	California Children's Services
C.C.S.	Certified Coding Specialitst
CCU	coronary care unit
CDB	cough & deep breathe
CDC	Centers for Disease Control and prevention
CEA	carcinoembryonic antigen
CEO	Chief Exective Officer
ceph.floc.	cephalin flocculation test
cert.	Certification
cerv.	Cervical
CFO	Chief Financial Officer
CGA	Contact Guard Assist
CHAL	central hyperalimentation dialysis
CHD	coronary heart disease
CHF	congestive heart failure
chg	charge
CHO	carbohydrate
chol	cholesterol
Chole	cholecystectomy
CHT	Certified Hand Therapist
CI	cardiac index
CIE	counter immunoelectrophoresis
CIN	cervical intraepithelial neoplasia
circ	circumcision
CIS	carcinoma in situ
Cl	chloride
Cllig	clear liquid
cm	centimeter
CMCJ	carpometacarpal joint
CMV	cytomegalovirus
CNA	Certified Nurse Assistant
CNM	Certified Nurse Midwife
CNS	central nervous system

CO	cardiac output
c/o	complaint(s) of
CO2	carbon dioxide
Cocci	coccidioicomycosis
Cog	cognitive
COG	center of gravity
comp	compliance
conc.	Concentration
cong.	Congestion/congested
conj.	Conjunctiva(l)
cont.	continuous
contr.	Contractions
COO	Chief Operating Officer
COPD	chronic obstructive pulmonary disease
COS	Chief of Staff
COTA	Certified Occupational Therapy Assistant
C/P	cardiopulmonary
CP	cerebral palsy
cp	cold pack
CPAP	continuous positive airway pressure
CPD	cephalopelvic disproportion
CPK	creatinine phosphokinase
CPM	continuous passive motion
CPR	cardiopulmonary resuscitation
CPS	Child Protective Services
C/R	cardiorespiratory
CRC	Cypress Rehabilitation Center
CRF	chronic renal failure
CRNA	Certified Registered Nurse Anesthetist
Cr nn 2-12	cranial nerves two through 12
CRS	community re-entry skills
CRT	Certified Radiology Technician
C/S	cesarean section
CSF	cerebrospinal fluid
CSM	circulation, sensation, motion
CSOM	chronic suppurative otitis media
C-spine	cervical spine
CST	Certified Scrub Technician
CT	computerized axial tomography
CTR	carpal tunnel release
CTS	carpal tunnel syndrome
ctx	contraction
cu	cubic
cu.in.	cubic inch
C/V	cardiovascular
CVA	cerebrovascular accident

CVD	cardiovascular disease
CVP	central venous pressure
cx	cervix
CXR	chest x-ray

D

D&C	dilation and curettage
D&I	dry and intact
DAT	diet as tolerated
DB	diaphragmatic breathing
DBW	desired body weight
dc	discontinue
dep	dependent
DC	discontinue
dc'd	discontinued
D5W	IV Dextrose, 5% in water
DDS	Doctor of Dental Surgery
DDSc	Doctor of Dental Science
decub	decubitus
demo	demonstrate
Dept	department
diam	diameter
diff	differential
dig.	Digoxin,Lanoxin
dil	dilute(d)
DIPJ	distal interphalangeal joint
disch	discharge
dist	distilled
DJD	degenerative joint disease
DM	diabetes mellitus
DMV	Department of Motor Vehicles
DNR	Do Not Resuscitate
DOA	dead on arrival
DOB	date of birth
DON	Director of Nursing
DPM	Doctor of Podiatric Medicine
DPT	diphtheria, pertussis, tetanus
Dr.	doctor
dr.	dram
drng	drainage
dsg	dressing
DT	diphtheria/tetanus
D.T.'s	delirium tremens
DTRs	deep tendon reflexes
dtr.	daughter

dur.	duration
DVT	deep vein thrombosis
Dx	diagnosis

E

E coli	escherichia coli
e.g.	for example
ea	each
EBL	estimated blood loss
EBV	Epstien-Barr virus
ECF	extended care facility
ECG;EKG	electrocardiogram
ECHO	echocardiogram
Ed	education
ED	emergency department
EDC	estimated date of confinement
EDD	estimated date of delivery
EDW	estimated dry weight
EEG	electroencephalogram
EENT	eye, ear, nose and throat
EFM	external fetal monitor
EGD	esophagogastroduodenostomy
EJ	external jugular
ELF	elective low forceps
elix	elixir
emerg	emergency
EMG	electromyo(myelo)gram
EMS	Electric muscle stimulation
EMT	Emergency Medical Technician
ENG	electroneptagmogram
ENT	ear, nose and throat
EOA	esophagogastric oral airway
EOB	edge of bed
EOM	extraocular movements
eos	eosinophils
EPB	extensor pollicis brevis
EPC	electronic pain control
Epi	epinephrine
epi	epidural
EPL	extensor pollicis longus
Equip	equipment
equiv	equivalent
er	external rotation
ERD	emergency room
ERCP	endoscopic retrograde cholangiopancreatography

ERS	extension rotation sidebend
ES	electrical stimulation
ESR	erythrocyte sedimentation rate
ESRD	end stage renal disease
est	estimated
ESWL	extracorporeal shockwave lithotripsy
et	and
etal	and others
ET	endotracheal
ETA	estimated time of arrival
Etc.	et cetera (and so forth)
ETCO2	end tidal carbon dioxide
ETIOL	etiology
ETOH	ethyl alcohol
ev	eversion
eval	evaluate(ion)
ex	exercise
exam	examination
exp	expiratory
exs	exercises
ext	external
exte	extension
extr	extraction

F

F	fundus
F/B	followed up
FB	foreign body
FBS	fasting blood sugar
F.C.	FlexCare
FCE	functional capacity evaluation
FCH	Fresno Community Hospital
FCU	flexor carpi ulnaris
FDP	flexor digitorum profundus
FDS	flexor digitorum superficialis
fe	female
Fe	iron (ferrum)
FESS	functional endoscopic sinus surgery

Fetal positions and presentations:

LFA(RFA)	left frontoanterior (right)
FP(RFP)	left frontoposterior (right)
LFT(RFT)	left frontotransverse)right)
LMA(RMA)	left mentoanterior (right)

LMP(RMP)	left mentoposterior (right)
LMT(RMT)	left mentotransverse (right)
LOA	left occiput anterior
LOP	left occiput posterior
LOT	left occiput transverse
LSA(RSA)	left sacrum anterior (right)
LSP(RSP)	left sacrum posterior (right)
LST(RST)	left sacrum transverse
ROA	right occiput anterior
ROP	right occiput posterior
ROT	right occiput transverse
FEV	timed forced expiratory volume
FFC	fixed flexion contracture
FFP	fresh frozen plasma
FH	family history
FHM	fetal heart monitor
FHR	fetal heart rate
FHT	fetal heart tones
FI	fiscal intermediary
fib	fibrillation
FIL	fetal intolerance tolabor
Flliq	full liquid
FIM	Functional Independent Measure
Fi02	fraction of inspired oxygen
fl	fluid
fl oz	fluid ounces
flex	flexion
FLM	fetal lung maturity
FMS	fine motor skills
FNP	Family Nurse Practitioner
FOP	foot of bed
FPB	flexor pollicis brevis
FPL	flexor pollicis longus
FR	fluid restriction
Fr.	French
FRC	Functional Residual Capacity
freq	frequency
Fri	Friday
FROM	full range of motion
FRS	flexion rotation sidebend
FS	frozen section
FSH	follicle stimulating hormone
FT	fullterm
ft.	foot(feet)
FTA	fluorescent treponema antibody

F/U	followup
FUO	fever unknown origin
FVC	forced vital capacity
FVD	fluid volume deficit
FVE	fluid volume excess
FWB	full weight bearing
FWW	front wheeled walker
fx	fracture

G

G	gravid
GA	gestational age
GB	gallbladder
GBS	Guillian-Barre' Syndrome
GC	gonorrhea
GCS	Glasgow Coma Scale
gd	good
gen	general (appearance, anesthetic, etc)
GERD	gastroesophageal reflux disease
GH	glenohumeral
GI	gastrointestinal
gm	gram
GMC	gross motor control
gr	grain
GSW	gunshot wound
GT	gastrostomy tube
GTT	glucose tolerance test
gtt	drop
gtts	drops
GU	genitourinary
Gyn	gynecology(ist)

H

(H)	hypodermic into subcutaneous tissue
h	hour
H/H	hemoglobin/hematocrit
H&H	hemoglobin and hematocrit
HA	headache
hams	hamstrings
HB	heart block
HBP	high blood pressure
HCL	hydrochloric acid
HCO3	bicarbonate
Hct	hematocrit

HCVD	hypertensive cardiovascular disease
Hct	hematocrit
HD	hemodialysis
HEENT	head,eyes,ears,nose and throat
HEP	Home Exercise Program
Hep	hepatitis
Hg	mercury
Hgb	hemoglobin
hgm	hemogram
HHA	Home Health Agency
CHHA	Certified Home Health Aide
HHN	Hand Held Nebulizer
HHRN	Home Health Registered Nurse
HHVN	Home Health Vocational Nurse
hi cal	high caloric
hi chd	high carbohydrate
hi pro	high protein
hi vit	high vitamin
HIE	hypoxic encephalopathy
HIV	human immunosuppressive virus
HL	heparin lock
HLP	hyperlipoproteinemia
HM	Human milk
HNP	herniated nucleus pulposus
H/O	history of
HOB	head of bed
HOH	hard of hearing
HONK	Hyperosmolar nonketosis
hosp	hospital
H&P	history and physical examination
HP	hot packs
HPF	high power field (microscopic field)
HPI	history of present illness
HPPE	hyperpermeability pulmonary edema
HR	heartrate
hr	hour
h.s.	at bedtime
ht	height
HTL VIII	lab test for AIDS virus
HTN	hypertension
H2O	water
H2O2	hydrogen peroxide
HVD	hypertensive vascular disease
Hx	history
H20	water

I

I	independent
I131	radioactive iodine
IABP	intra-aortic balloon pump
IAC	ineffective airway clearance
IBCLC	International Board Certified Lactation Consultant
ibid	in the same place (ibidem)
IBW	ideal body weight
IC	iliac crest
ICN	Infection Control Nurse
ICP	intracranial pressure
ICS	intraclavicular space
ICT	intermittent cervical traction
ICU	Intensive Care Unit
ID	identification
I&D	incision and drainage
IDDM	insulin dependent diabetes mellitus
i.e.	that is (id est)
IGE	impaired gas exchange
IHSS	idiopathic hypertrophic subaortic stenosis
ILS	independent living skills
IM	intramuscular
IMI	brand name abbreviation for a radiant
Imp.	impression
IMV	intermittnet mandatory ventilation
in.	inch
inc.	increase
inf	inferior
inf mono	infectious mononucleosis
init	initial
inj	injection
insp	inspiration(ory)
int	internal
INTF	interferential
I&O	intake and output
IOL	intraocular lens
IPD	Intermittant Peritoneal Dialysis
IPJ	interphalangeal joint
IPPB	intermittent positive pressure breathing
I.Q.	intelligence quotient
IR	internal rotation
irrig	irrigate
I/S	incentive spirometry
ISE	internal scalp electrode

IUD	intrauterine contraceptive device
IUP	intra uterine pregnancy
IUPC	intrauterine pressure catheter
IV	intravenous
IVAB	intravenous antibiotics
IVC	inspiratory vital capacity
IVF	IV fluids
IVP	intravenous pyelogram(phy)
IV push	intravenous push
IVPB	intravenous piggyback
IVSS	intravenous soluset

J

J.P.	Jackson Pratt (hemovac/bulb)
JRA	juvenile rheumatoid arthritis
JV	jugular venous
JVD	jugular venous distention
JVP	jugular venous pressure or pulse
jt.	joint

K

K	potassium
KCI	potassium chloride
KDDH	Kaweah Delta District Hospital
kg	kilogram
K&K	Kline and Kohlmer (test for syphilis)
KUB	kidneys, ureters, bladder (x-ray)
KVO	keep vein open

L

L	liter
LAB	laboratory
LAD	lactic acid dehydrogenase
Lap	laporoatomy
LAO	left anterior oblique
LAQ	long arc quads
lat	lateral
LBBB	left bundle branch block
LBQC	large base quad cane
lb	pound
LC	Lactation consultant
LCL	lateral collateral ligament
LCSW	Licensed Clinical Social Worker

LD	left deltoid
LDH	Lindsay District Hospital
LE	lupus erythematosus
LF	left forearm
LFT	lower function test
Lg	large
LGA	large for gestational age
Litho	lithotripsy
LLE	left lower extremity
LLH	left lateral heelstick
LLL	left lower lobe
LLQ	left lower quadrant
LMH	left medial heelstick
LMP	last menstrual period
LOB	loss of balance
LOC	loss of consciousness
LOS	length of stay
LP	lumbar puncture
LR	lactated ringers
LS	lumbosacral
L-spine	lumbar spine
LSC	left subclavian
LSD	lysergic acid diethylamide
Lt	left
LTV	long term variability
LUE	left upper extremity
LUL	left upper lobe
LUQ	left upper quadrant
LVF	left ventricular failure
LVH	left ventricular hypertrophy
LVN	Licensed Vocational Nurse
L&W	living and well
LWBS	left without being seen
lymph	lymphocyte
lytes	electrolytes

M

M	male
m	minim
M1	mitral first sound
M2	mitral second sound
MA	milliamperes
MAC	monitored anesthesia care
macro	macrocytic(scopic)
MAE	moves all extremities

man.	manual(ly)
MAR	medication administration record
MAT	multifocal atrial tachycardia
max.	maximum
MAX A	maximum assistance
MCA	motorcycle accident
mcg	microgram
MCH	mean corpuscular hemoglobin
MCL	mid clavicular line
MCV	mean corpuscular volume
MD	Doctor of Medicine
mec	meconium
MED/SURG	medical/surgical unit
meds.	medications
MEF	maximal expiratory flow
mEq	milliequivalent
mg	milligram
Mg.	Magnesium
mgmt.	Management
mgr.	Manager
MI	myocardial infarction
micro	microscopic(cytic)
mid.	middle
MIN A	minimal assistance
min.	minute
ml	milliliter
Mlat	mediolateral
mm	millimeter
MMT	manual muscle test
mn	midnight
mo.	month
mob.	mobility
mod.	moderate(ly)
MOD A	moderate assistance
MOM	milk of magnesia
Mon.	Monday
monos	monocytes
MR	mitral regurgitation
MRI	Magnetic Resonance imaging
MRSA	methicillin resistant staphylococcus aureus
MS	morphine sulfate
M/S	multiple sclerosis
MSG	massage
MSS	medical social services
MSW	Medical Social Worker
MT	Medical Technologist

MTT	manual therapy
M+T	myringotomy and tubes
multip	multiparous
MVA	motor vehicle accident
MVP	mitral valve prolapse
MVV	maximum voluntary ventilation

N

N	nitrogen
N/A	not applicable
Na	sodium
N.A.	nursing assistant
NaCl	sodium chloride
NAD	no acute distress
NaHCO3	sodium bicarb
NB	newborn
NBN	newborn nursery
N/C	no charge
neg	negative
neuro	neurology(ist)(ical)
NG	nasogastric
NGT	nasogastric tube
NH3	ammonia
NICU	Neonatal Intensive Care Unit
NIDDM	noninsulin dependent diabetes
NKA	no known allergies
NKDA	no known drug allergies
NKDC	nonketotic diabetic coma
NKHHC	nonketotic hyperglycemic-hyperosmolar coma
nl	normal
NMES	Neuromuscular Electrical Stimulation
NN	nerves
No.	number
noc	at night (nocturia)
norm.	normal
NP	non-productive
NPO	nothing by mouth
NS	normal saline
N/S	no show
NSA	no significant abnormality
NSAID	nonsteroidal anti-inflammatory drugs
nsg.	nursing
NSR	normal sinus rhythm
NST	non-stress test
NSY	nursery

NT	non-tender
N/T	not tested
N&T	nose and throat
NTG	nitroglycerine
nullip	nulliparous
N&V	nausea and vomiting
NWB	nonweight bearing

O

O2	oxygen
OA	occiput anterior
OB	obstetrics
obl	oblique
OBS	organic brain syndrome
occ	occasional
OCG	oral cholecystogram
OCT	oxytocin challenge test
O.D.	right eye
od	overdose
OK	okay
OM	otitis media
OME	otitis media with effusion
OOB	out of bed
OPD	outpatient department
ophth	opthalmology
OPS	outpatient surgery
OR	operating room
ORIF	open reduction internal fixation
ortho	orthopedics
O.S.	left eye
os	mouth
O.T.	occupational therapy
O.U.	both eyes
oz	ounce

P

p	after
P	pulse
pa	pulmonary artery
PA	Physician Assistant
P&A	percussion and auscultation
PA-C	Physician Assistant-Certified
PAC	premature atrial contractions
PACO2	partial pressure carbon dioxide (arterial)

PACU	post anesthesia care unit
PAEDP	pulmonary artery end diastolic pressure
PAF	paroxysmal atrial fibrillation
PAFIB	paroxysmal atrial fibrillation
PA&L	poseterior, anterior and lateral chest x-ray
palp	palpate(ion)
PAP	Papanicolaou smear(test)
PAR	post anesthesia room
Para	parous(number of viable children)
PAT	paroxysmal atrial tachycardia
pap	papanicolaou, smear test
para	parity
path	pathology
PAWP	pulmonary artery wedge pressure
PBI	protein bound iodine
p.c.	after meals
PCA	patient controlled analgesia
PCE	physical capacity evaluation
PCL	posterior cruciate ligament
PCN	penicillin
pCO2	partial pressure CO2
PCV	packed cell volume
PCWP	pulmonary capillary wedge pressure
PDA	posterior descending artery
PDR	Physician's Desk Reference
PE	physical examination
PE tubes	pressure equalizaer tubes
ped.	pediatric
PEG	percutaneous endoscopic gastrostomy
PEEP	positive end expiratory pressure
per	by or through
peri	perineal
PERRLA	pupils equal, regular, react to light and accommodation
pf	plantar flexion
PF	peak flow
PFT	pulmonary function test
pg.	page
pH	hydrogen iron concentration
PH	past history
phal	phalanx
PI	present illness
PID	pelvic inflammatory disease
PIP	proximal interphalangeal joint
Pit	pitocin
PJC	premature junctional contractions
PKU	phenylketonuria

P.M.	afternoon
PMD	private medical doctor
PMH	past medical history
PMI	point of maximum impulse
PMR	polymyalgia rheumatura
PMS	premenstrual syndrome
PN	parenteral nutrition
PNC	premature nodal contraction
PND	paroxysmal nocturnal dyspnea
pneumo	pneumoencelphalogram
PNG	peripheral nerve glides
P.O.	phone order
p.o.	per mouth
pO2	partial pressure of oxygen
pO4	phosphate
POC	position of comfort
POD	postoperative day
Polys	polymorphonuclear leukocytes
POS	positive
post	posterior
postop	postoperative
POT	plan of treatment
POV	private vehicle
PP	postpartum
P&PD	percussion and postural drainage
PPD	purified protein derivative (tuberculin)
PRBC	packed red blood cells
PRBOW	prolonged ruptured bag of waters
pre	before
preg.	pregnancy
preop	preoperative
prep	preparation
prev.	previous
primip	primiparous (first birth)
prn	as necessary; when indicated
PROM	premature rupture of membranes
iPROM	prolonged ruptre of membranes
prog	progress
pro time	pro-thrombin time
prox.	Proximal
PSIS	posterior superior iliac spine
P.T.	physical therapy(ist)
PT/PTT	pro-thrombin/partial thromboplastin (time)
pt	patient
PTA	Physical Therapy Assistant
P.T.A.	prior to admission

PTC	prior to consult
PUD	peptic ulcer disease
PUW	pick-up walker
PVC	premature ventricular contractions
PWB	partial weight bearing
PXR	portable chest xray

Q

q	every
qam	every morning
qh	every hour
qhs	every bedtime
qid	four times a day
qns	quantity not sufficient
qs	to make sufficient quantity
qt	quart
QUAD	quadrant
quads	quadriceps

R

R	right
(R)	rectal thermometer
RA	rheumatoid arthritis
Rad	radiology
RB	read back
RBBB	right bundle branch block
RBC	red blood cell
RBOW	ruptured bag of water
RBS	random blood sugar
RCNA	restorative certified nursing assistant
R.D.	Registered Dietitian
RDS	respiratory distress syndrome
recert.	recertification
reg.	regular
rehab	rehabilitation
reps	repetitions
resp.	respiration(ory)
resist.	resistance
Rh	Rhesus factor
RHD	rheumatic heart disease
RHIT	Registered Health Information Technician
RL	ringers lactate
RLE	right lower extremity
RLH	right lateral heel

RLL	right lower lobe
RLQ	right lower quadrant
RMH	right medial heel
RML	right middle lobe
RN	Registered Nurse
RNA	ribonucleic acid
RNFA	Registered Nurse First Assistant
RNIP	Registered Nurse Interim Permittee
R/O	rule out
RO	routine orders
ROA	right occiput anterior
ROM	range of motion
ROP	right occiput posterior
ROS	review of systems
ROT	right occiput transverse
rot	rotation
RP	renal panel
RPR	rapid plasma regain test (for syphilis)
RR	respiratory rate
rrot	right rotator cuff
RSV	respiratory syncytial virus
R/T	released to
RTW	return to work
RTC	return to clinic
RUE	right upper extremity
RUL	right upper lobe
RUQ	right upper quadrant
RV	right ventricle
Rx	prescription

S

s	without
SAB	spontaneous abortion
sang.	Sanguineous
SAQ	short arc quads
Sat	Saturday
sat	saturated
SBA	stand by assist
SBO	small bowel obstruction
SCH	supra condylar humerus
Schiz	shizophrenia
SCI	spinal cord injury
SCM	sternocleidomastoid (joint)
sec	second(s)(ary)
sed.rate	erythrocyte sedimentation rate (blood)

segs	segmented neutrophils
serol.	serology
serosang.	Serosanguineous
SF	side flexion
SFB	superficial femoral artery
S/G	Swan-Ganz
SGA	small for gestational age
SGOT	serum glutamic oxaloacetic transaminase
SGPT	serum glutamic pyruvic transaminase
SH	social history
Shldr	Shoulder
SI	sacroiliac joint
SIADH	syndrome of inappropriate antidiuretic hormone secretion
SL	sublingual
SLE	systemic lupus erythematosus
SLR	straight leg raising
SNF	skilled nursing facility
SOAP	subjective/objective/assessment/plan
SOB	shortness of breath
sol	solution
SOM	serous otitis media
S/P	status post
spec	specimen
SPgr	specific gravity
SR	sinus rhythm
SROM	spontaneous rupture of membranes
ss	one half
SS	soapsuds
SSE	soapsuds enema
SS#	social security number
S/S	signs and symptoms
stab	band cell
staph	staphylococcus
stat	at once
strep	streptococcus
STSG	split thickness skin graft
STV	short term variability
St WP	sterile whirlpool
Sub-L	sublingual
Sub-Q	subcutaneous
Sun.	Sunday
sup	superior
surg	surg(ical)ery
SVD	spontaneous vaginal delivery
SVDH	Sierra View District Hospital
SVT	supraventricular tachycardia

Sx	symptom
sym	symmetrical

T

T	thermoscan (thermometer)
T&A	tonsillectomy and adenoidectomy
tab	tablet
TAB	therapeutic abortion
T&C	type and crossmatch
TAH	total abdominal hysterectomy
TAR	treatment authorization request (MediCal)
TAT	tetanus antitoxin
T.B.	tuberculosis
TBA	to be admitted
T.C.	traffic collision
Tbsp	tablespoon
TCDB	turn, cough, deep breathe
TCDHS	Tulare County Department of Health Services
TCU	Transitional Care Unit
TEA	thromboendarterectomy
tech	technician(ologist)
TED	antithromboembolic stockings
temp	temperature
TENS	transcutaneous electrical nerve stimulator
TFT	Thyroid Function Test
THEX	therapeutic exercise
THR	total hip replacement
thru	through
Thur.	Thursday
TIA	transient ischemic attack
TIC	transitional inpatient care
tid	three times a day
tinct	tincture
TJR	total joint replacement
TKO	to keep open
TKR	total knee replacement
TLC	triple lumen catheter
TM	tympanic membrane
TMJ	temporomandibular joint
TMJD	temporomandibular joint dysfunction
TMs	tympanic membranes
TNS	transcutaneous nerve stimulation
TO	telephone order
tol.	tolerate(d)
TOLAC	trial of labor after cesarean

tomo	tomogram
TORB	telephone order read back
TORCH	toxoplasmosis, syphilis, rubella, cytomegaloviras, herpes
TPA	tissue plasminogen activator
TPN	total parenteral nutrition
TPR	temperature, pulse, respiration
TR	transfer
trach	tracheostomy
tsp	teaspoon
T-spine	thoracic spine
Tues.	Tuesday
T.U.R.	transurethral resection
TURBT	transurethral resection of bladder tumor
TURP	transurethral resection of prostate
TVH	total vaginal hysterectomy
TV	tidal volume
Tx	treatment

U

U	uranium
Ua	urinalysis
UAC	umbilical artery catheter
U/C, UC	uterine contraction
UBW	usual body weight
U.C.	unit clerk
UCG	urine chorionic gonadotropin
UGI	upper gastrointestinal
UE	upper extremity
UF	ultrafiltration
UKE	unknown etiology
UMC	University Medical Center
UO	undetermined origin
Upper GI	upper gastrointestinal
URI	upper respiratory infection
Uro	urology(ist)
U.S.	both eyes
US	ultrasound
USP	United States Pharmacopoeia
UTI	urinary tract infection
UV	ultraviolet

V

VA	visual acuity
Vag	vaginal

VBAC	vaginal birth after cesarean section
VC	vital capacity
VCH	Valley Children's Hospital
VD	venereal disease
VDRL	Venereal Disease Research Laboratory
VE	vaginal exam
Vent	mechanical ventilator
VFD	visual field deficit
V-fib	ventricular fibrillation
via	by way of
Vit	vitamin
VO	verbal order
vol	volume
VORB	verbal order read back
VPB	ventricular premature beat
Vre	Vancomycin Resistant Enterococci
VS	vital signs
v, vs	versus
VSD	ventriculoseptal defect

W

w/a	while awake
WB	weight bearing
WBAT	weight bearing is tolerated
WBC	white blood count(cells)
W/C	wheelchair
WDWN	well developed, well nourished
W &	white female
W %	white male
Wed.	Wednesday
WFL	within functional limits
WIC	Women, Infants & Children (assistance program)
wk	week
wlkr	walker
wnd	wound
WNL	within normal limits
w/o	without
WP	whirlpool
wt	weight

X

x	times
XRT	radiation therapy

Y

yd.	yard
yrs	years

SUBJECT: **ANNUAL INFECTION PREVENTION PLAN**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 1 of 29**

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

PURPOSE:

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

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

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

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

DEFINITIONS:

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

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

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

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

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

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

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

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

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

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

OVERVIEW:

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

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

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

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

POLICY:

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

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

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

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

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

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

   a. Surgical Site Infections (SSIs): Prevention of surgical site infections is a high priority. CDC (2025) reports SSI is the most costly HAI type with estimated annual cost of $3.3 billion and extend length of stay by approximately 9.7 days, with cost of hospitalization increased by more than $20,000 per admission. Methods to reduce surgical site infections are well documented in medical literature by medical associations/organizations (e.g., AORN, APIC, ASA). SSIs are monitored, reported, and analyzed on an ongoing basis.

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

   c. Central Venous Catheter-Associated Blood Stream Infections (CLABSI): Nationally, bloodstream infections associated with central venous catheters are often preventable and have a high mortality rate. It is a high priority to reduce risk factors leading to these infections. (https://www.cdc.gov/clabsi/about/?CDC_AAref_Val=https://www.cdc.gov/HAI/bsi/CLABSI-resources.html). At SVMC, CLABSIs are monitored house-wide and reported on an ongoing basis to P&T/& IP Committee and to the appropriate clinical units.

   d. Catheter-Associated Urinary Tract Infections (CAUTI): Catheter-associated urinary tract infection (CAUTI) is one of the most common hospital-acquired infections. The use of urinary catheters is associated with several complications and increased mortality and morbidity. Complications associated with CAUTIs cause discomfort to the patient, prolonged hospital stays, and increased costs and mortality. It has been estimated that each year, more than 13,000 deaths are associated with UTIs. (https://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf). At SVMC, house-wide monitoring for CAUTIs in all units will be continued and reported upon.

8. Surveillance Documentation of All Infections

   a. Infection Prevention has created databases for documenting targeted and non-targeted HAIs as a method to track and identify trends. The surveillance fulfills internal requirements for SVMC, California Department of Public Health Services (CDPH), and The Joint Commission (TJC) standard of IP that requires a review for any HAI sentinel event(s) that cause death. (IC.02.02.01).

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

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

9. Infection Control Reports

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

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

10. Surveillance Strategies

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

b. Surgical Site Infection Components:

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

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

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

2. Surgical Wound class

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

4. If multiple procedures were performed through the same incision

c. Surgical Surveillance:

i. Objectives:

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

ii. Methodology:

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

iii. Data Sources:

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

iv. Defining Indicators for Infections:

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

v. Follow-up:

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

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

d. Ventilator Associated Pneumonia (VAP)

i. Objectives:

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

ii. Methodology:

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

iii. Data Sources:

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

iv. Defining Indicators for Infections:

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

v. Follow-up

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

e. Central Line Associated Blood Stream Infections (CLABSI)

i. Objectives:

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

ii. Methodology:

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

iii. Data Sources:

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

iv. Defining Indicators for Infection:

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

v. Follow-up:

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

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

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

i. Objectives:

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

ii. Methodology:

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

iii. Data Sources:

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

iv. Defining indicators for infection:

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

v. Follow-up:

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

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

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

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

i. Objectives:

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

ii. Methodology:

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

iii. Data Sources:

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

iv. Defining Indicators for Infection:

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

v. Follow-up:

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

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

i. Objectives:

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

ii. Methodology:

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

iii. Follow-up:

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

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

12. Requirements for Surveillance of All Infections:

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

13. Precautions:

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

14. Hand Hygiene Compliance:

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

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

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

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

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

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

iii. There was an 85% vaccination rate in the 2024-2025 influenza season with 15% of all staff declining vaccination (see Table below) as indicated by the signed letter of declination. There was an 86% vaccination rate in the 2025-2026 influenza season with 14% of all staff declining vaccination.

Respiratory Disease Season	Vaccinated (%)	Declined (%)
2023 – 2024	85%	15%
2024 - 2025	85%	15%
2025 - 2026	86%	14%

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

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

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

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

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

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

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

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

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

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

16. Additional Infection Prevention Activities

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

a. Healthcare Personnel and Public Education: Government regulations, bioterrorism, and unusual microorganisms such as H5N1 Influenza, Ebola, Coronavirus (SARS-CoV-2), etc., have greatly increased the need for education and training. Infection Prevention will continue to update and present information when necessary to keep healthcare personnel, volunteers, and the public informed. Annual requirements for healthcare personnel education is maintained in Human Resources.

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

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

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

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

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

g. Environmental Cleanliness: Working with environmental services, Infection Prevention, clinical departments, and hospital leadership, the Environmental of Care (EOC) was established to better serve the hospital and to meet CMS standards.

17. Unscheduled Reports

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

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

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

a. Geographic Location and Community Environment

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

County Community Health Assessment (CHA), https://tchhsa.org/eng/community/community-health-assessment-cha-community-health-improvement-plan-chip/)

b. Characteristics of the Population Served

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

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

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

d. Care, Treatment and Services Provided

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

e. Employee Health

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

f. Emergency Preparedness

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

Table of Goals for 2025

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

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Result**
Improve Hand Hygiene Compliance	Achieve 90% hand hygiene compliance through 2026. Achieve 90% compliance for proper hand hygiene technique	Education Surveillance to monitor compliance On-the-spot reminder when needed	Monitor hand hygiene of staff with data upload to reporting software (Huron) to generate weekly reports	Unit Directors, Managers, IPs, HCW and Medical Staff.	Increase Department Hand Hygiene participation and compliance to 90% Obtain a realistic report for "no hand

		Provide regular compliance reports and feedback to leadership and staff Regular reminders for staff, visitors and other HCWs	Generate quarterly reports for distribution at committee meetings and hospital physician leadership		hygiene displayed"

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

Infection Prevention Goal	**Measurable Objective**	**Strategies**	**Evaluation**	**Responsibility**	**Expected Results**
Implement evidence-based practices to reduce spread of MDROs throughout the hospital (HAIs)	Reduce the incidence of HAI MDROs below1% through 2026	Identify patient on admit or transfer – take appropriate specimen, for laboratory evaluation. Educate staff, patients and families as appropriate to prevent spread. Remind HCW of hand hygiene, standard precautions and contact precautions.	Document and Report on education of staff and patients Monitor hand hygiene and report data for further hand hygiene compliance analysis. IP and Dept. leadership will supervise surveillance to monitor isolation precautions compliance. Report any	IPs, department directors and managers, staff, medical staff services director.	Observe evaluation and testing of qualified patients within the 72-hour time window. Observe a reduction of HAIs overall, but specifically MRSA

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

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

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

		tool; compare to currently recommended surveillance tools, if necessary, update and implement.	Strive for 100% compliance rate.		
Reduce catheter-associated urinary tract infections (CAUTIs) in patients	Maintain incident of CAUTIs at zero	Conduct regular surveillance of catheters; provide annual education of staff to keep catheter usage at a minimum	Monitor CAUTIs. Report to P&T IP committee, IP and clinical unit directors and managers	Clinical departments that utilize catheters, physicians, IPs	Maintain incidence of CAUTIs at zero through the end of the fiscal year
Reduce surgical site infections (SSIs)	Maintain incidence of SSIs below 1% (see Expected Result)	Education of staff involved in surgical procedures upon hire, conduct annual competency reviews, and whenever surgical procedures are added to an individual's job responsibilities. Educate patients and/or patient family about infection prevention after a surgical procedure.	Monitor and report education sign in sheets to support completion of required education. Review nursing care plans for patient education.	Surgical staff, IPs, surgical nursing department, nursing staff and performance improvement.	Maintain incidence of SSIs below 1% through the end of the 2026 fiscal year

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

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

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Cross Reference:

- Influx Of Infectious Patients Contingency Plan
- Surge Capacity Plan

Risk Assessment for the Infection Prevention and Control (IP&C) Program
Annual Infection Control Risk Assessment 2025
Year: 2025_
Organization Name: ____Sierra View Medical Center____
Date of Report: ___Dec. 30, 2025_____

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

SUBJECT: **ANNUAL INFECTION PREVENTION PLAN**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 25 of 29**

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

SUBJECT: **ANNUAL INFECTION PREVENTION PLAN**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 26 of 29**

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

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

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

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

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

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

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SUBJECT: **MEDICAL STAFF DUES**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish guidelines relative to collection and use of the Medical Staff dues.

POLICY:

The Medical Staff shall adhere to the following guidelines in the collection and use of Medical Staff dues that are deposited into the Medical Staff funds account.

AFFECTED AREAS/PERSONNEL: *MEDICAL STAFF*

PROCEDURE:

1. Current Medical Staff dues by staff category: Active/Provisional Staff: $200; Courtesy and Consulting Staff: $150; Allied Health Practitioners: $150. No dues are required for Ambulatory Staff.

2. Medical Staff funds may be used for Physician Lounge expenses, gifts and donations, medical staff publications, consulting fees or education. Stipends to the department chairs, Credentials Committee members and Bylaws Committee members are paid from Medical Staff funds. Any expenditures over $2,500.00, other than to department chairs or committee members, must be approved by the Medical Executive Committee.

3. Failure to pay dues without good cause as determined by the Medical Executive Committee shall be grounds for automatic suspension of a member's Medical Staff membership and clinical privileges. The member shall be deemed to have voluntarily resigned if dues remain unpaid six (6) months after written warning of the delinquency.

4. The Medical Executive Committee, via the Secretary Treasurer of the Medical Staff, shall monitor the funds in the Medical Staff funds account.

REFERENCE:

- Medical Staff Bylaws, Article 13.3.

SUBJECT: **OR CHARGING PROCESS**	SECTION: **Page 1 of 2**

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

PURPOSE:

Provide guidelines for consistent charging processes for surgical procedures.

POLICY:

SVMC staff will follow the guidelines for completion charges. Surgical charges will be documented and entered into the computer system with accuracy and timeliness by the Surgical Staff to assure appropriate, effective patient billing.

AFFECTED AREAS/ PERSONNEL: *REGISTERED NURSE (RN) CIRCULATOR, REGISTERED NURSE FIRST ASSISTANT (RNFA), OPERATING ROOM (OR) TECH, ANESTHESIOLOGIST, LEAD TECHNICIAN/MATERIALS MANAGEMENT, MATERIALS MANAGEMENT*

PROCEDURE:

A. Surgery:

1. The charges will be entered into the EMR by the following process:
   a. Confirm selection of the correct patient and procedure.
   b. In the EMR, proceed to ITEMS, bring in the Preference Card
   c. Adjust the number of items opened or wasted
   d. Add items by reference number that are not on the Preference Card
   e. Add implants by reference number
   f. Place a sticker on the back of the printed Preference Card for reference
2. Place printed Preference Card for scheduler review
3. Schedulers will review charges and submit requests for items needing a CDM number
4. Schedules will close the record within 5 business days to drop the charges

B. Recovery (Post-Anesthesia Care Unit (PACU)):

1. Phase 1 recovery refers to any patient who received general/spinal/regional anesthesia. Patients requiring increased intervention post procedure due to severely diminished level of consciousness also qualify for this charge. Phase I recoveries are billed in minutes of time.

2. Phase II recovery refers to any patient who received procedural conscious sedation or has met criteria Aldrete for Phase II, and is alert enough to maintain an airway independently. Phase II patients are billed as a one hour minimum and then in 30 minute increments.

C. Surgical Treatment Charge refers to procedures performed in the Flex Care unit; i.e., blood or medicine transfusions. The charge for the treatment is a flat rate.

D. Observation Charge refers to the patient who is waiting for an inpatient bed or has not met discharge criteria. This could be a patient who is alert or drowsy, one with nausea, uncontrollable pain, or is unable to void. Observation Charge is billed by the hour.

E. Intubated patients who are transported directly to the Intensive Care Unit (ICU) from surgery are NOT charged a recovery fee.

EXAMPLES:

- A patient who received procedural sedation for a lung biopsy and stays in the hospital for 6 hours would receive a charge of Phase II for the first hour, then 30 minute increments x 10.
- An EGD patient who received procedural sedation and is alert but drowsy, stays 45 minutes before meeting discharge criteria. The charge is one hour of Phase II.
- An outpatient receiving a blood transfusion is charged surgical treatment at a flat rate. In the Flex Care Unit, these charges are recorded on the charge card. The other Nursing Units will continue to use the form for OP Observation.

SUBJECT: **REGISTERED NURSE FIRST ASSISTANT (RNFA)**	SECTION:

PURPOSE:

To define the standardized procedure under which a Registered Nurse First Assistant (RNFA) may function in the perioperative setting in compliance with the California Board of Registered Nursing (BRN), to ensure safe, effective, and consistent patient care before, during, and after surgical procedures.

DEFINITIONS:

1. **Registered Nurse First Assistant (RNFA):**
   A Registered Nurse who has completed additional education and clinical training to provide first assistant services during surgical procedures under the supervision of a licensed physician and surgeon.
2. **Supervising Surgeon:**
   A licensed physician and surgeon who provides medical direction, supervision, and responsibility for surgical care in which the RNFA participates.

POLICY:

A. The RNFA may perform designated perioperative functions under this standardized procedure when credentialed, privileged, and supervised by a licensed physician and surgeon.

1. The RNFA shall practice within the scope of education, training, competency validation, and current licensure as required by the California Board of Registered Nursing.
2. The RNFA shall function in collaboration with the surgeon and perioperative team to promote patient safety and optimal surgical outcomes.
3. This standardized procedure shall be reviewed, approved, and signed by nursing leadership, medical staff leadership, and administration per facility policy.

AFFECTED PERSONNEL/AREAS:

1. Registered Nurse First Assistants (RNFAs)
2. Surgeons and Surgical Residents/Fellows
3. Anesthesia Providers
4. Perioperative Nursing Staff
5. Surgical Services Department
6. Operating Rooms

EQUIPMENT:

1. Standard surgical instruments and supplies appropriate to the procedure

2. Sutures, stapling devices, and wound closure materials
3. Electrosurgical and hemostatic devices
4. Personal protective equipment (PPE)

PROCEDURE:

PROCEDURE:

A. **Preoperative Phase**

1. Perform a focused preoperative assessment as appropriate, including review of the patient's history, diagnostics, and surgical plan.
2. Verify informed consent, surgical site marking, and compliance with safety protocols (e.g., Universal Protocol, Time Out).
3. Communicate pertinent patient information to the surgical team.

B. **Intraoperative Phase**

1. Perform first assistant activities as directed by the supervising surgeon, which may include:
    a. Positioning and prepping the patient
    b. Maintaining aseptic technique
    c. Exposure of the operative field
    d. Tissue handling and retraction
    e. Hemostasis using approved techniques
    f. Suctioning and irrigation
    g. Suturing, stapling, and wound closure
    h. Application of dressings
2. Continuously assess patient status and communicate concerns to the surgeon and anesthesia provider.
3. Adhere to all facility policies, safety standards, and regulatory requirements.

C. **Postoperative Phase**

1. Assist with patient stabilization and transfer as needed.
2. Participate in postoperative assessments and documentation per facility policy.
3. Provide postoperative instructions and education within RN scope of practice.

D. **Competency and Supervision**

1. The RNFA must maintain:
    a. Current California RN license
    b. CNOR certification and completion of an approved RNFA program
    c. Ongoing competency validation and continuing education

2. The supervising surgeon retains responsibility for surgical decision-making and patient outcomes.

REFERENCES:
REFERENCES:

California Board of Registered Nursing. (2023). *Standardized procedures and guidelines.* https://www.rn.ca.gov

Association of periOperative Registered Nurses. (2024). *AORN guidelines for perioperative practice.* Denver, CO: AORN.

California Code of Regulations, Title 16, Section 1474. (2023). *Nurse practice act regulations.*

Centers for Medicare & Medicaid Services. (2024). *Conditions of participation for hospitals.*

SUBJECT: **RESPIRATORY PROTECTION PLAN**	SECTION: **Page 1 of 21**

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

PURPOSE:

To ensure that all employees that are required to wear respiratory protection as a condition of their employment are protected from respiratory hazards through the proper use of respirators. To meet the Occupational Safety and Health Administration (OSHA) Respiratory Protection Standard, 29 CFR 1910.134.

DEFINITIONS:

1. **Aerosol-generating procedures (AGP)** - Procedures that may increase potential exposure to aerosol transmissible disease pathogens due to the reasonably anticipated aerosolization of pathogens. Aerosol-generating procedures may also be known as high hazard or cough inducing procedures.

2. **Airborne infection isolation room (AIIR)** - A single-occupancy patient-care room designed to isolate persons with suspected or confirmed airborne infectious diseases. Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that can be spread from person-to-person by the airborne route. AIIRs should maintain negative pressure relative to adjacent rooms and halls), an air flow rate of 6–12 air changes per hour, and direct exhaust of air from the room to the outside of the building or recirculation of air through a HEPA filter.

3. **Airborne Precautions** - A category of Transmission-Based Precautions that Centers for Disease Control and Prevention (CDC) and Healthcare Infection Control Practices Advisory Committee (HICPAC*) may recommend when Standard Precautions alone are not sufficient to prevent the transmission of disease. When Airborne Precautions are required, patients should be placed in airborne infection isolation rooms and healthcare personnel sharing patients' airspaces should wear respirators.

4. **Air-purifying respirator (APR) -** A respirator with an air-purifying filter, cartridge, or canister that removes specific air contaminants by passing ambient air through an air-purifying element.

5. **Aerosol transmissible disease (ATD) or aerosol transmissible disease pathogen** - Any disease or pathogen requiring Airborne Precautions and/ or Droplet Precautions.

6. **Droplet Precautions** - A category of Transmission-Based Precautions that CDC and HICPAC may recommend when Standard Precautions alone are not sufficient to prevent the transmission of disease. When Droplet Precautions are required, patients should be spatially separated, preferably in separate rooms with closed doors. Healthcare personnel should wear surgical masks for close contact and, if substantial spraying of body fluids is anticipated, gloves and gown as well as goggles (or face shield in place of goggles). Patients should be masked during transport.

7. **Employee Exposure** - Exposure to a concentration of an airborne contaminant that would occur if the employee were not using respiratory protection.

8. **Facemask** - A loose-fitting, disposable device that creates a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment. Facemasks may be labeled as surgical, laser, isolation, dental, or medical procedure masks and are cleared by the

FDA for marketing. They may come with or without a face shield. Facemasks do not seal tightly to the wearer's face, do not provide the wearer with a reliable level of protection from inhaling smaller airborne particles, and are not considered respiratory protection.

9. **Filter**- A component used in respirators to remove solid or liquid aerosols from the inspired air.

10. **Fit Test** - A protocol to quantitatively or qualitatively evaluate the fit of a tightfitting respirator on an individual.

11. **Food and Drug Administration (FDA)** - An agency within the U.S. Department of Health and Human Services. The FDA is responsible for, among other things, protecting the public health by assuring drugs, vaccines, and other biological products and medical devices intended for human use are safe and effective.

12. **Healthcare Infection Control Practices Advisory Committee (HICPAC) -** A federal advisory committee assembled to provide advice and guidance to the CDC and the U.S. Department of Health and Human Services regarding the practice of infection control and strategies for surveillance, prevention, and control of healthcare-associated infections and antimicrobial resistance in United States healthcare settings. CDC and HICPAC authored the 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, which describes Standard and Transmission-Based Precautions used for infection control. (At the time of this revision, HICPAC has been dismantled by Trump Administration)

13. **Healthcare personnel (HCP) -** Paid and unpaid persons who provide patient care in a healthcare setting or support the delivery of healthcare by providing clerical, dietary, housekeeping, engineering, security, or maintenance services.

14. **High-efficiency particulate air (HEPA) filter** - The NIOSH classification for a filter that is at least 99.97% efficient in removing particles and is used in powered air-purifying respirators (PAPRs). When high-efficiency filters are required for non-powered respirators, N100, R100, or P100 filters may be used.

15. **N95 respirator** - A generally used term for a half mask air-purifying respirator with NIOSH approved N95 particulate filters or filter material (i.e., includes N95 filtering facepiece respirator or equivalent protection).

16. **Personal protective equipment (PPE) -** Specialized clothing or equipment worn by an employee to protect the respiratory tract, mucous membranes, skin, and clothing from infectious agents or other hazards. Examples of PPE include gloves, respirators, goggles, facemasks, surgical masks, face shields, footwear, and gowns.

17. **Powered air-purifying respirator (PAPR) -** An air-purifying respirator (APR) that uses a blower to force air through filters or cartridges and into the breathing zone of the wearer. This creates a positive pressure inside the facepiece or hood, providing more protection than a non-powered or negative-pressure half mask APR.

18. **Respirator program administrator (RPA)** - Individual designated to oversee a facility's respiratory protection program (RPP).

19. **Respiratory protection program (RPP)** - Program required by OSHA under the Respiratory Protection standard that includes development and implementation of detailed policies and worksite-specific procedures for respirator use for control of respiratory hazards.

20. **Surgical mask** - A loose-fitting, disposable type of facemask that creates a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment. Surgical masks are fluid resistant and provide protection from splashes, sprays, and splatter. Surgical masks do not seal tightly to the wearer's face, do not provide the wearer with a reliable level of protection from inhaling smaller airborne particles, and are not considered respiratory protection.

POLICY:

Sierra View Medical Center (SVMC) Respiratory Protection Program (RPP) is designed to minimize or eliminate occupational exposure of heath care workers to infectious airborne transmissible diseases (ATDs) through the provision and use of appropriate respiratory protective devices. This program was developed in accordance with the Centers for Disease Control and Prevention (CDC) and California OSHA ATD control enforcement guidelines. The RPP program includes:

1. A plan for annual risk assessment.
2. The methods by which employees are educated concerning the risks associated with airborne transmissible diseases in the healthcare setting.
3. The high-risk procedures for ATD transmission
4. Engineering, work practice controls, and personal protective equipment, to minimize employee exposures to ATDs.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES WHO COULD POTENTIALLY BE EXPOSED TO AIRBORNE RESPIRATORY ILLNESSES DURING NORMAL WORK OPERATIONS, AND DURING NON-ROUTINE OR EMERGENCY SITUATIONS*

EQUIPMENT:

- Powered Air-Purifying Respirator (PAPR)
- N-95
- N95 fit testing equipment

PROCEDURE:

I. Respiratory Protection Program responsibilities:

A. PROGRAM ADMINISTRATORS: The Infection Prevention Department and Employee Health are responsible for administering the Plan:

1. Infection Prevention Department will provide the knowledge of infection control principles and practices and oversight of Employee Health as they apply to SVMC, and be responsible for:

    a. Conducting an annual evaluation of the respiratory protection program. Any new hazards or changes in policy that would require respirator use are presented to and acted upon by the Infection Control and Prevention Committee.
    b. Responding to any Aerosol Transmissible Disease (ATD) Alerts sent by public health departments and/or the Center for Disease Control (CDC).

2. Employee Health (EHS) will have oversight of implementing the RPP with employees and providing employee education; due to knowledge of healthcare worker exposure protocols, testing, and the potential need for employee follow-up. EHS will be responsible for:

    a. Identifying work areas, processes, or tasks that require respiratory protection
    b. Monitoring OSHA policy and standards for changes and making changes to SVMC's policy
    c. Coordinating selection of respirator protection products, in conjunction with the Infection Prevention and Control Coordinator, Respiratory Therapy and Materials Management
    d. Monitoring respirator use to ensure that respirators are used in accordance with their certification
    e. Distributing and evaluating medical questionnaire
    f. Arranging for and/or conducting training and fit testing in conjunction with Respiratory Therapy
    g. Ensuring proper storage and maintenance of respirator protection equipment in conjunction with Respiratory Therapy
    h. Providing data regarding any suspected or known employee exposure to ATDs
    i. Conducting any necessary testing to confirm exposure to ATDs
    j. Conducting any necessary follow-up with any employee with confirmed ATD exposure.

B. PURCHASING AGENT – Materials Management Supervisor is responsible for the RPP equipment storage and inventory:

1. Purchasing respiratory protection equipment

2. Assuring that all respiratory protection equipment purchased has been approved by the National Institute of Occupational Safety and Health (NIOSH)

C. STORAGE AND MAINTENANCE OF CAPRs/PAPRs – The manager of the Emergency Department (ED), and the Intensive Care Unit(ICU), will be responsible for:

1. Maintaining Carts - ED Cart and ICU Cart

   a. Clean/free of clutter
   b. Stocked
   c. Locked when not monitored

2. Daily inspection of helmets and reusable equipment PAPR Sets (ED-1 through ED-6 helmets and ICU-1 through ICU-6 helmets, battery, and charger). If any set is signed out, inspect set when logged back in:

   a. No tear or breaks of helmets and accessories
   b. No contamination from blood or other bodily fluids
   c. No damage or distortion of filter
   d. No physical damage or tampering of Lithium Ion Batteries (LIB)
   e. No compromise between the filter and filter cover seal
   f. LED light working properly (if yellow or red light on, see manual instruction for further instruction or contact IP)

3. Storing of PAPRs in designated cart

4. Checking and maintaining supplies:

   a. Check on par levels of disposable items daily
   b. Perform the LIB Check Procedure every 3-6 months (see Monthly Inspection Log)

5. Checking battery charge status daily

6. Logging of the sign-in/sign-out sheet for the PAPRs daily

7. Documentation of ***Sign In/Sign Out Log, Daily Inspection Log, and Monthly Log*** will be kept in binder on or near the designated carts

D. DIRECTORS and MANAGERS are responsible for:

1. Knowing which hazards within their areas require respiratory protection
2. Knowing the types of respirators that need to be used
3. Enforcing the use of respiratory protection in areas where it is required

4. Ensuring that employees are knowledgeable about the respiratory equipment for the areas in which they work.

E. EMPLOYEES are responsible for:

1. Participating in all training
2. Wearing respirator when indicated
3. Maintaining equipment:
   a. Logging PAPR in and out with witness initials in Log Binder
   b. Cleaning of helmet and reusable accessories after each use and prior to returning PAPR to designated cart
      i. Inspect the system and perform any assembly/dis-assembly instructions necessary for disposable items and for all components that have become worn or damaged
      ii. Apply a suitable wipe with a decontamination agent over all outside reachable surfaces, and then over all inside surfaces
      iii. Let air dry and re-assemble or place in storage
   c. Properly dispose of all disposable items
4. Reporting equipment malfunctions or concerns to their manager

II. Respiratory Protection Program Elements

A. Medical evaluations for respirator users

1. A medical evaluation will be conducted to determine each individual's fitness to wear a respirator (see Appendix C). These evaluations consist of administering a medical questionnaire and/or providing a physical examination that elicits the same information as the questionnaire.

2. All new hires and current employees involved in patient care shall be required to complete a Medical Evaluation form. Each employee involved in patient care shall receive a medical clearance by a licensed HCP stating they are able to wear a PAPR prior to performing any of the designated activities that require respiratory protection.

3. Follow-up medical examinations will be provided to employees as required by Employee Health:

   a. If an individual gives a positive response to any question among questions 1-8 in Section 2, Part A of Appendix C of the OSHA Respiratory Standard (20 CFR 1910.134) (attached to policy) (NOT DONE ON MD)
   b. If the initial medical examination demonstrates the need for a follow-up medical examination.

c. These follow-up exams must include any medical tests, consultations, or diagnostic procedures that Employee Health deems necessary to make a final decision.

4. All employees will be granted the opportunity to speak with Employee Health about their medical evaluation, if they so request.

5. After an employee has received clearance and has begun to wear a respirator, a medical re-evaluation will occur under the following circumstances:

   a. Employee reports physical symptoms that are related to the ability to use a respirator (e.g. wheezing, dizziness, shortness of breath, chest pain).
   b. It is identified that an employee is having a medical problem during respirator use.
   c. Employee Health or the employee's Supervisor/Director determines that the employee needs to be reevaluated and the frequency of the evaluation.
   d. If a change occurs in workplace conditions (e.g. physical work effort, protective clothing, and temperature) that may result in substantial increase in physiological burden placed upon respirator users.

B. Documentation and Record Keeping

1. All examinations, evaluation and questionnaires are to remain confidential between the employee and Employee Health.
2. All employee medical records will be maintained by Employee Health. Relevant medical information will be maintained for the duration of the employment of the individual plus thirty years.
3. E-Learning will keep a record of HCWs completing the Annual Competency module on *"PAPR Use"*.
4. Department Leaders will keep a record of all staff within their department completing PAPR training.

C. Respirator Training

1. Employees will be trained prior to the use of a respirator and thereafter when deemed necessary by knowledgeable department designee.

2. Training will include:

   a. Identification of hazards, potential exposure to these hazards and health effects after exposure to hazards.
   b. Respirator fit, improper fit, usage, limitations and capabilities for maintenance, usage, cleaning and storage.
   c. Emergency use, if applicable.
   d. Inspecting, donning, doffing, seal check and trouble shooting.

e. Explaining the respirator program policies and procedures.
f. The following will be done annually:
   1. Departments required to wear a PAPR will take the E-Learning module on *PAPR Use*.
   2. Departments required to use the PAPR will perform the donning and doffing steps in **Departmental Competencies** and add to initial department checklist.

D. Respirator Use

1. No employee shall wear any type of respirator until they have been trained and medically cleared to wear the respirator.
2. Employees will use their respirators under conditions specified by this program and accordance with the training they receive on the use of each particular model. In addition, the respirator shall not be used in a manner for which it was not certified by NIOSH or by its manufacturer.
3. Employees who detect problems, with, or experience failure of, the respirator shall leave the hazardous environment immediately and notify their supervisor.
4. No employee shall be assigned to tasks requiring the use of a respirator if Employee Health determines that the individual will be unable to function normally while wearing a respirator.
5. EHS will provide documentation of individuals unable to wear a PAPR by notifying the employee's manager.

E. Emergency Fit Testing – The Infection Prevention and Control Committee will activate emergency fit testing for use of an N95 Mask.

1. N95 fit testing will be required for employees who are anticipated to have direct patient care contact with a known ATD.

2. A PAPR may be available to be used by employees unable to be fitted with a N95 respirator.

3. Fit testing will be conducted prior to an employee being allowed to wear an N95 respirator.

4. Employee Health will conduct fit tests following the protocol found in Appendix B of the 29 CFR 1910.134 OSHA Respiratory Protection Standard.

F. Cleaning and Disinfecting Respirators

1. PAPRs should be cleaned according to manufacturer's recommendations, after every use by HCW:

   a. All outer and inner surfaces of the assembled system may be wiped down with approved cleaning solution/wipes between uses
   b. Replace the front headband comfort strip.

c. The rear closed cell foam comfort strip may be cleaned for reuse by cleaning with approved cleaning solution/wipes.
d. Allow hood to air dry

G. Inspecting, Maintenance and Repairs of the PAPR is to be done by HCW before and after every use:

1. Examine the helmet for physical damage; if parts are damaged, contact BioMed.

2. Check for airflow prior to use.

3. Follow manufacturer's recommendations on maintenance, including battery recharging.

4. The battery will hold a charge for one year. As with all rechargeable batteries, the amount of charge will decline slowly when not in use or during storage. The Manager of the unit where the carts are kept will check charge status every 6 months or more often if needed.

III. Risks for Occupational Exposure to ATDs (e.g. Mycobacterium tuberculosis, Severe Acute Respiratory Syndrome (SARS), measles, smallpox, and/or COVID-19)

A. All employee job classifications that include direct patient care are at risk of exposure to ATDs.

B. Risk from exposure to high-hazard medical procedures in patients with an ATD include, but are not limited to:

1. Respiratory care procedures such as tracheotomy, endotracheal tube care or sputum induction.

2. Diagnostic medical procedures such as fiber optic endoscopic evaluation of swallow (FEES), laryngoscopy, bronchoscopy and pulmonary function testing.

3. Any medical procedure performed on a "suspect" or "confirmed" infectious TB case which can aerosolize body fluids or tissue likely to be infected with TB bacteria.

4. Resuscitative procedures performed by any personnel.
5. Invasive procedures such as tracheotomy, thoracentesis, insertion of chest tube, or lung biopsy.

C. All employees entering the room or assisting with a high hazard procedure on a patient with an ATD will use respiratory protection in accordance with OSHA regulations, such as a PAPR as designated by OSHA and CDC, and follow contact precautions to use Personal Protective Equipment (PPE) - gloves and gown.

D. Employees attending a patient who has been determined to have or may have an ATD are at risk of exposure to ATDs and are required to use Personal Protective Equipment (PPE) and respiratory protection.

IV. Control Measures and Early Detection of ATD

A. Engineering controls: Patients with potential ATD will be placed in a negative air pressure room or private room with a HEPA filter.

B. Work Practice Controls: To prevent or minimize employee exposure to airborne, droplet, and contact transmission of aerosol transmissible pathogens (ATP), precautions are in accordance with the CDC Guidelines.

1. Hand hygiene
2. (PPE): Gloving, gowning, mask, face shield/goggles
3. Cleaning and disinfecting contaminated surfaces, articles and linens.

C. Available personal protective equipment (PPE) includes, but is not limited to:

1. A NIOSH-approved PAPR or NIOSH-approved N-95 respirator
2. Eye Protection
3. Gown
4. Gloves

D. Source Control Measures

1. At the first point of contact with a potentially infected person, standard precautions are implemented, which include respiratory hygiene and cough etiquette.

2. Persons identified to have or are suspected of having an airborne transmissible disease will be masked with a surgical mask for source control.

3. Visual alerts to instruct patients and visitors to practice respiratory hygiene and cough etiquette will be posted until the infected person is transferred.

4. Employees and visitors are made aware of placement of disposable tissues and hand hygiene dispensers.

5. Infected persons are placed in an area where contact with others not wearing respiratory protection is eliminated or minimized until transfer to another facility with an airborne isolation room.

6. Respiratory hygiene and cough etiquette measures include:

a. Cover nose and mouth when coughing or sneezing.
b. Use tissues to contain respiratory secretions and dispose of them immediately after use in the nearest waste receptacle.
c. Wash hands with soap and water or alcohol-based hand rub after contact with respiratory secretions, contaminated objects or materials.

7. Health care workers will wear a PAPR or approved N-95 when examining a patient in airborne isolation precautions.

ATTACHMENTS:

- Appendix A: Respiratory Assignments by Task or Location
- Appendix B: Information for Voluntary Users
- Appendix C: OSHA Respirator Medical Evaluation Questionnaire
- Appendix D: Max Air CAPR Sign In and Out Log
- Appendix E: Max Air CAPR Respirator Monthly Inspection Log
- Appendix F: PAPR Cart Daily Log
- Appendix G: Competency Assessment Tool

REFERENCES:

- *Healthcare Workers: Healthcare Respiratory Protection* (2025, Jan 15, accessed May 2025). Retrieved from Centers for Disease Control and Prevention: Chttps://www.cdc.gov/niosh/healthcare/respiratory-protection/?CDC_AAref_Val=https://www.cdc.gov/niosh/npptl/hospresptoolkit/policies.html
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- Occupational Safety and Health Administration. Appendix B of the 29 CFR 1910.134 OSHA Respiratory Protection Standard. (2020). Accessed May 2025 from https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134.
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RPP Appendix A: Respirator Assignments by Task or Location

Task or Location	Potential Exposure	Respiratory Protection	Employees Included
Performing aerosol-generating procedures on patients suspected or confirmed with a disease requiring Airborne Precautions or present when such procedures are performed **[see HICPAC 2007 or other public health guidance for lists of diseases], including**: • Sputum induction • Bronchoscopy • Aerosolized administration of medications • Pulmonary function testing • Manual Ventilation • Open suctioning of air ways • Endotracheal Intubation and Extubation • Cardiopulmonary resuscitation • Non-invasive ventilation (BiPAP, CPAP)	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR) ***[Note: PAPR use for aerosol-generating procedures on patients with a disease requiring Airborne Precautions is High Priority]***	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Performing aerosol-generating procedures on patients suspected or confirmed with influenza cases or present during such procedures.	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Entry into airborne infection isolation room or other area occupied by patients suspected or confirmed with a disease requiring Airborne Precautions.	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Performing, or present during, routine patient care and support operations on a patient suspected or confirmed with a disease requiring Airborne Precautions	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• RN • RT • Lab techs • IR techs • OR techs • Radiology techs • CNA
Cleaning/decontaminating an area occupied by a patient suspected or confirmed with a disease requiring Airborne Precautions, or cleaning/decontaminating such an area after a patient has left but before the space has been adequately ventilated.	Infectious aerosols	N95 respirator or a more protective respirator (such as a PAPR)	• EVS • RT • Lab techs • IR techs • OR techs • Radiology techs
Laboratory operations involving aerosol transmissible disease pathogens **[see HICPAC, CDC, OSHA]** for which requires respiratory protection	Infectious aerosols	As specified in biosafety plan	• Lab techs • Lab personnel

NOTE ** Priority PAPR use for staff who **failed** the N-95 *"Fit Test"* and staff providing AGPs **
In order to maintain Sierra View's high standard of patient and Healthcare Worker safety, clinical students and contingent staff working in patient care areas are required to pass a respiratory fit test and be able to wear an N95 respirator mask when required.
Those unable to pass will be unable to complete their school rotation or work assignments.

RPP Appendix B: Information for Voluntary Users

Information Taken From OSHA Appendix D to Sec. 1910.134: (Mandatory) Information for Employees Using Respirators When Not Required Under the Standard

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard.

You should do the following:

1) Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirator's limitations.

2) Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.

3) Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designated to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors or very small solid particles of fumes or smoke.

4) Keep track of your respirator so that you do not mistakenly use someone else's respirator.

APPENDIX C: OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

SIERRA VIEW MEDICAL CENTER

OSHA Respirator Medical Evaluation Questionnaire

The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Today's date: _____ Your age (to nearest year):_____

Your name:_____ Dept: _____

Job title:_____ Sex : Male/Female

Height: _____ft. _____ in. Your weight: _____ lbs.

Type of respirator you will use: NIOSH approved, disposable, R- rated filter mask, non- cartridge type.

Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):_____

If you answer "YES" to any of the following questions, you will be contacted by a Licensed Health Care Professional for further clarification. You may call EHS at the hospital to obtain the name and contact information of the health professional who will be reviewing the questionnaires.

Please provide a phone number where you can be reached by the health care professional who will review this questionnaire (include the Area Code): _____

The best time to phone you at this number: _____

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month:

○ Yes ○ No

2. Have you ever had:	YES	NO
Seizures		
Diabetes		
Allergic reaction that interferes with breathing		
Claustrophobia(fear of closed places)		
Trouble smelling odors		
3. Have you ever had any of the following pulmonary or lung problems:	**YES**	**NO**
Asbestosis		
Asthma		
Chronic Bronchitis		
Emphysema		
Pneumonia		
Tuberculosis		
Silicosis		
Pneumothorax		
Lung Cancer		
Broken Ribs		
Any chest injury or surgery		
Any other lung problem you have been told about		
4. Do you currently have any of the following symptoms of pulmonary or lung illness?	**YES**	**NO**
Shortness of breath		
Shortness of breath when walking fast on level ground or walking up a slight hill or incline:		
Shortness of breath when walking with other people at an ordinary pace on level ground:		
Have to stop for breath when walking at your own pace on level ground:		
Shortness of breath when washing or dressing yourself		

ADDENDUM (A)

Employee Name:_____ Dept:_____

The following questions below must be answered by every employee who has been selected to use either a full-face piece respiratory or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

1. Have you ever lost vision in either eye (temporarily or permanently): ☐ Yes ☐ No
2. Do you currently have any of the following vision problems:
   a. Wear contact lenses: ☐ Yes ☐ No
   b. Wear glasses: ☐ Yes ☐ No
   c. Color blind: ☐ Yes ☐ No
   d. Any other eye or vision problems: ☐ Yes ☐ No

		YES	NO
1.	Have you ever had an injury to your ears, including a broken ear drum		
	Do you currently have any of the following hearing problems?		
	a. Difficulty hearing ☐ Yes ☐ No		
	b. Wear a hearing aid ☐ Yes ☐ No		
	c. Any other hearing or ear problems ☐ Yes ☐ No		
2.	Have you ever had a back injury:	YES	NO
3.	Do you currently have any of the following musculoskeletal problems?		
	a. Weakness in any of your arms, hands, legs, or feet: ☐ Yes ☐ No		
	b. Back pain ☐ Yes ☐ No		
	c. Difficulty fully moving your arms and legs: ☐ Yes ☐ No		
	d. Pain & stiffness when you lean forward or backward at the waist: ☐ Yes ☐ No		
	e. Difficulty fully moving your head up or down: ☐ Yes ☐ No		
	f. Difficulty fully moving your head side to side: ☐ Yes ☐ No		
	g. Difficulty bending at your knees: ☐ Yes ☐ No		
	h. Difficulty squatting to the ground: ☐ Yes ☐ No		
	i. Climbing a flight of stairs or a ladder carrying more Than 25 lbs: ☐ Yes ☐ No		
	j. Any other muscle or skeletal problem that interferes With using a respiratory: ☐ Yes ☐ No		

Do not write below this line

Date: Physician/Licensed Healthcare Professional Signature:

Fit to test? YES NO

If no, why?

ehs → EHS FORMS → Current EHS forms Revised 2009 → New Hire forms → NEW – Initial Fit to test medical evaluation

APPENDIX D: MAX AIR CAPR SIGN IN AND OUT LOG

Max Air: CAPR RESPIRATOR DAILY SIGN IN/OUT LOG

Prior to each use, if any of the following issues are discovered for any system component(s), replace the particular item(s) by following the assembly/dis-assembly procedures for the particular item(s).

CAPR SET: (Please circle) **ED** **ICU**

____/____ (Month / Year)

Employee name	CAPR SET	Date	Print corresponding number: • Helmet (1) • Battery (2) • Charger (3) • Belt (4)	No contamination	No damage to filter cartridge, batteries or threat to proper function	No yellow or red indicator lights	No compromise between the filter cartridge and helmet seal	Return Date and Time	User initials	Witness Initials	Comments

APPENDIX E: MAX AIR CAPR RESPIRATOR MONTHLY INSPECTION LOG

SIERRA VIEW MEDICAL CENTER
Infection Prevention

Max Air: CAPR RESPIRATOR MONTHLY INSPECTION LOG												
Log begin date: **Log end date:**	**CART: ED 1-6 (sets) ICU 1-6 (sets)** Circle appropriate Cart											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Monthly respirator cleaning record	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X	☑ X
Helmet: Intact, clean, without breaks or visible damage												
Helmet Power Cord: Intact, clean, and securely connected to helmet												
Filter: Clean, without tears or breaks; proper seal between Filter and helmet (Visual inspection **ONLY**; Do **NOT** remove Filter Cover)												
Filter Cover (FC): FC is secured and helmet mounting is stable; no tears or breaks												
Battery: • Lithium Ion Battery (LIB) connected to charger. If charger LED light is green, disconnect LID from charger • LIB is free from visible damage • Perform the LIB Check Procedure every 3-6 months (See back of page)												
Daily Log: Daily Log is up-to-date												
Note: If any boxes above are marked X address item and/or contact IP: Ext: 3795 or 3781												
IP contact on date:												
Supervisor monthly review (initial):												

Notes: Which item needs to be addressed (e.g., ER-1 helmet; ICU-3 Battery), discrepancy, and any needed descriptive information need to clarify the issue:

_____

_____

_____

SIERRA VIEW MEDICAL CENTER
Infection Prevention

LIB Check Procedure - MAXAIR LIB Test for Diminishing Battery Capacity

CAUTION: If the LIB performs in one of the "Suspect LIB" categories below, discontinue using it and replace that LIB as soon as possible.

Case 1: The LIB has been connected to a charger and the charger green LED is on.

- **Procedure:** Unplug the LIB from the charger and plug the helmet power cord to the LIB. Allow the helmet to settle for about 10 seconds.
  - **A. Good LIB:** The helmet runs with 3 or 2 green indicator lights on.
  - **B. Suspect LIB:** The helmet runs with only 1 green indicator light on.
  - **C. Suspect LIB:** The helmet runs with the red indicator light on.
  - **D. Suspect LIB:** The helmet doesn't run.

Case 2: The LIB has been in storage.

- **Procedure:** Plug the helmet power cord to the LIB to be tested. Allow the helmet to settle for about 10 seconds.
  - **A. Good LIB:** The helmet runs with 3, 2 or 1 green indicator light on.
  - **B. Suspect LIB:** The helmet runs with the red indicator light on.
  - **C. Suspect LIB:** The helmet doesn't run.

Case 3: The LIB is connected to the MAXAIR Charger.

- **A. Good LIB:** the LIB is felt to be about room temperature.
- **B. Suspect LIB:** the LIB is warm or hot to touch.

Y:\Administrative Assistant\Policy & Procedure Committee\3-19-2020 Max Air Monthly Check List.docx

APPENDIX F: PAPR CART DAILY LOG

SIERRA VIEW MEDICAL CENTER
Infection Prevention

Month: _____ **Year**_____

PAPR Cart Daily Log							
DATE:	PAPRS	Batteries	Chargers	Belts	Cart stock with DLC and Helmet Liner	Signature	Comments
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
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27							
28							
29							
30							
31							

C:\Users\hernm10\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\Y2W2ARK3\8-25-20 PAPR Cart Daily Log v2.docx

APPENDIX G: COMPETENCY ASSESSMENT TOOL

SIERRA VIEW MEDICAL CENTER
Infection Prevention

MAX AIR: CAPR SYSTEM
Competency Assessment Tool

Name: _____ Unit: _____

Skills Validation Method of Evaluation: DO-Direct Observation VR- Verbal Response WE-Written Exam OT-Other				
MAX AIR: CAPR SYSTEM		Method of Evaluation	Initials	Comments
Assemble the Cuff to the Helmet				
1	Attach Lens to Helmet			
2	Remove Lens Protective Cover from Lens			
Donning				
1	Connect Power Cord to Battery			
2	Loosen Headband Ratchet Knob prior to Donning helmet			
3	Don Helmet per Manufacture Instructions			
Doffing the Helmet				
1	Reverse Donning steps			
2	Connect Battery to Charger, leaving Cord attached to helmet			
4	Wipe down all reusable item surfaces with approved cleaning solution			
5	Dispose of Lens at end of patient care (shift)			

Name of Person Validating the Skills:_____

Signature of Skills Validator:_____ Date:_____

Employee Signature:_____ Date:_____

References

Max Air Systems User's Instructions. (n.d.). Retrieved from Max Air Systems: http://maxair-systems.net/ManualsUIMIFU/78SP_Rev_F.pdf

SUBJECT: **SCABIES**	SECTION: **Page 1 of 2**

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

PURPOSE:

To determine if an employee has had an exposure to or has become infested with scabies. To provide guidelines for the appropriate treatment for an exposure that results in a confirmed infestation of scabies.

POLICY:

Employees will receive appropriate evaluation and treatment for suspected and/or confirmed scabies infestation.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

GENERAL INFORMATION:

Scabies is a disease of the skin caused by the mite *Sarcoptes scabiei var. hominis*. Transmission occurs primarily through prolonged skin-to-skin contact with an infested person. Transmission through casual or brief contact with objects such as bedding or clothing has been reported to be infrequent. However, healthcare workers will require treatment if they have an exposure that is followed by signs of infestation.

The initial lesion is a burrow ½ to 2 cm in length. A burrow is a minute, slightly raised tunnel in the epidermis that may end in a vesicle. Skin lesions often include small papules, pustules and/or excoriation.

The most common symptoms after infestation are intense itching and rash. The itching is often worse at night. Lesions commonly occur on the hands, webs of fingers, wrists, the extensor surfaces of elbows and knees, the outer surfaces of feet, armpits, buttocks and waist.

INCUBATION PERIOD:

Symptoms begin to show about 3-6 weeks after the initial infestation period. If previously infested, symptoms may begin to show up as soon as 1-4 days after re-exposure due to sensitization.

PERIOD OF TRANSMISSIBILITY:

Even without symptoms, scabies is considered to be transmissible until mites and eggs are completely destroyed by treatment. A single treatment is usually effective in eradicating the mite infestation. However, a second treatment one week later may be indicated for some individuals.

PROCEDURE:

1. Infection Prevention should be notified when a patient is diagnosed with scabies either by a physician or by confirmation via a skin scraping. Departments that have had contact with the patient will be notified of the event by Infection Control. The Director (or the Director's designee) will identify individual employees that must be notified of the exposure and give instructions for follow up.

2. Employees who have had prolonged skin-to-skin contact with the patient or who develop symptoms of scabies will report to Employee Health Services (EHS) for assessment and sent for physician evaluation.

3. The EHS Nurse will review and document history and allergies.

4. EHS Nurse will assess skin appearance, location of rash and type of exposure. If an employee develops a rash with a differential diagnosis of scabies, the employee will be sent for physician evaluation and treatment if necessary.

5. Employees with a positive diagnosis of scabies are not to work for a minimum of 24 hours after the completed treatment.

   a. Instructions to the employee should include the following:

      - Wash all clothing, towels, bedding and other linen using the hot cycles of the washer and the dryer. Clean upholstered furniture.
      - All household members and intimate contacts should be treated by their personal physician.
      - Pruritus may persist for as long as 2 weeks after treatment.
      - Notify EHS for continued symptoms.

REFERENCES:

- Centers for Disease Control and Prevention (Sep 9, 2024). For Everyone: About Scabies. Signs and Symptoms; How it Spreads; Preventing: Treatment. Retrieved March 6, 2026. From: https://www.cdc.gov/scabies/about/index.html
- Centers for Disease Control and Prevention (Dec. 18, 2023). Health Care Providers. Clinical Care of Scabies; Clinical Overview of Crusted Scabies. Retrieved March 6, 2026. From: https://www.cdc.gov/scabies/hcp/clinical-care/index.html
- Centers for Disease Control and Prevention (Dec. 18, 2025). Scabies Outbreaks in Institutional Settings; Public Health Strategies for Crusted Scabies Outbreaks in Institutional Settings. Retrieved March 6, 2026. From: https://www.cdc.gov/scabies/php/public-health-strategy/index.html.

PURPOSE:

The Tuberculosis Control Plan (TCP) integrates Centers for Disease Control and Prevention (CDC) evidence-based research and guidelines across all entities and provides Sierra View Medical Center (SVMC) staff a comprehensive plan for the early detection, management, isolation and treatment of persons with active tuberculosis (TB). Adherence to the policies and procedures addressed in this TB Control Plan will assist in reducing the risk of exposure to patients, visitors and staff within the Sierra View Medical Center (SVMC) environment. This Tuberculosis Control Plan includes:

TB CONTROL PLAN – TABLE OF CONTENTS

POLICY:

Sierra View Medical Center (SVMC) is committed to providing a safe and healthful work environment for our staff, caregivers, and patients. In pursuit of this endeavor, the following TCP is provided to minimize or eliminate occupational exposure to TB in accordance with the corrected and updated 2005 CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities. It is the intent of SVMC to comply with California Code of Regulations Title 8, Section 5144, Subchapter 7 concerning respiratory protective equipment and OSHA Standard 29 CFR 1910.134 concerning respiratory protection for Mycobacterium tuberculosis (MTB).

DEFINITIONS/VOCABULARY

Acid-fast bacilli (AFB) - Bacteria that retain certain dyes after being washed in an acid solution. Most acid-fast organisms are mycobacteria. When AFB are seen on a stained smear of sputum or other clinical specimen, a diagnosis of TB should be suspected; however, the diagnosis of TB is not confirmed until a culture is grown and identified as M. tuberculosis.

Active TB - TB bacteria are dividing and multiplying within an affected individual's body, causing tissue and organ damage. A person with active TB is likely to be or soon become symptomatic.

Aerosol - The droplet nuclei that are expelled by an infectious person (e.g., by coughing or sneezing); these droplet nuclei can remain suspended in the air and can transmit M. tuberculosis to other persons.

Anergy - The inability of an individual to react to skin-test antigens (even if the person is infected with the organisms tested) because of immunosuppression.

Bacille Calmette-Guérin (BCG) – The only vaccine currently used to prevent tuberculosis. It was developed by the French scientists Albert Calmette and Camille Guérin at the Institute Pasteur, Lille, between 1907 and 1921. It is a living, attenuated (weakened) variant of the bovine tubercle bacillus.

Bronchoscopy - Examination of the airways by means of a flexible or rigid tube. Modern instruments are fiber-optic and highly flexible and they enable specimens to be obtained from the lung by aspiration, washing, brushing and biopsy.

Cavity, pulmonary – It is defined as a gas filled space within the zone of pulmonary consolidation or within a mass or nodule. Cavities are present in many processes, such as TB, lung cancer, and other infections.

Cluster - Two or more PPD skin-test conversions occurring within a 3-month period among HCWs in a specific area or occupational group, and epidemiologic evidence suggests occupational (hospital acquired) transmission.

Culture - The process whereby bacteriological specimens are grown in an incubator. In the case of tuberculosis, this can take weeks.

Droplet nuclei - Microscopic particles (i.e., 1-5 mm in diameter) produced when a person coughs, sneezes, shouts, or sings. The droplets produced by an infectious TB patient can carry tubercle bacilli and can remain suspended in the air for prolonged periods of time and be carried on normal air currents in the room.

Ethambutol - One of the first-line anti-tuberculosis drugs, given during the first 2 months of therapy. Care is required in its use as it can cause visual disturbance (blurred and red/green color disturbance) and irreversible eye damage. Patients should be told that if they experience any visual disturbance they should stop taking the drug and seek medical advice.

Ethionamide - An antibiotic (second-line) used to treat cases of drug resistant tuberculosis.

Exposure -- The condition of being subjected to something (e.g. infectious agents) that could have a harmful effect. A person exposed to M. tuberculosis does not necessarily become infected.

First line drugs - Active, drug-sensitive TB disease is treated with a standard six-month course of four antimicrobial drugs: Isoniazid, Rifampicin, Pyrazinamide and Ethambutol. These are referred to as first line drugs for treating TB.

Fluoroquinolones - A class of antibiotics used to treat drug-resistant tuberculosis and some diseases caused by environmental mycobacteria. An example includes moxafloxacin.

***Haemoptysis* (or Hemoptysis) -** Expectoration (coughing up) of blood or of blood-stained spit from the bronchi, larynx, trachea, or lungs.

Health Disparity - a higher burden of illness, injury, disability, or mortality experienced by one group relative to another.

Healthcare Worker (HWC) - Those working for the agency that care directly for patients/clients.

Immunosuppressed - A condition in which the immune system is not functioning normally (e.g., severe cellular immunosuppression resulting from HIV infection or immunosuppressive therapy). Immunosuppressed persons are at greatly increased risk for developing active TB after they have been infected with M. tuberculosis. No data are available regarding whether these persons are also at increased risk for infection with M. tuberculosis after they have been exposed to the organism.

Incubation period - The interval between infection and the development of clinically evident disease.

Isoniazid – An antibiotic and one of the first line anti-tuberculosis drugs. It is particularly effective against actively replicating bacilli in the lung cavities. It is also used for preventive therapy in those with latent tuberculosis.

Latent tuberculosis - A term applied to the status of those infected with the tubercle bacillus but remaining healthy. It is assumed that the tubercle bacilli are in some dormant or resting 'persister' state.

Miliary tuberculosis - Is a form of disseminated tuberculosis, usually occurring in immunocompromised individuals. The lesions are millet-seed sized granulomas (Latin: milium – a millet seed) that are easily seen on chest radiographs. Miliary lesions differ from those of cryptogenic disseminated tuberculosis.

Multidrug-resistant TB (MDR TB) – TB disease caused by bacteria resistant to two of the most important medicines: INH and RIF.

Mycobacterium - The genus of bacteria which includes the tubercle and leprosy bacilli and the environmental mycobacteria. The name means 'fungus bacteria', in allusion to the mould-like pellicles they form on liquid culture media.

M. tuberculosis complex -- A group of closely related mycobacterial species that can cause active TB (e.g. M. tuberculosis, M. bovis, and M. africanum); most TB in the United States is caused by M. tuberculosis.

Negative Pressure - An isolation room used for infectious patients from which the air is constantly being extracted to result in slight negative pressure in the room compared with the outside corridor. Any bacteria coughed by the patient will then be extracted through a filter system rather than blowing into the corridor.

Percutaneous - The route of administration through or via the skin.

Prevalence - Prevalence is a measurement of all individuals affected by the disease at a particular time. This is distinct from incidence, which is a measurement of the number of new individuals who contract a disease during a particular period of time.

Positive PPD reaction - A reaction to the purified protein derivative (PPD) - tuberculin skin test that suggests the person tested is infected with M. tuberculosis. The person interpreting the skin-test reaction determines whether it is positive on the basis of the size of the induration and the medical history and risk factors of the person being tested.

Pulmonary tuberculosis - Tuberculosis of the lung. It is the most common form of tuberculosis. TB in the larynx and in open abscesses can be infectious.

Purified protein derivative (PPD) - tuberculin - A purified tuberculin preparation that was developed in the 1930s and that was derived from old tuberculin. The standard Mantoux test uses 0.1 ml of PPD standardized to 5 tuberculin units.

Rifampicin (Rifampin in the USA) - A member of a class of antibiotics termed the rifamycins, it is the most powerful of the first-line anti-tuberculosis drugs. It has the unique property of killing very slowly, replicating bacilli that persist in lesions.

Smear positive/smear negative - Smear positive means that bacteria can be seen when a sample of sputum is specially stained and examined under a microscope. It usually indicates an infectious patient. Smear negative means that the bacteria could not be seen in a specimen. It may mean that disease is absent or that bacteria are too few to be seen.

Sputum – Phlegm coughed up from deep inside the lungs. Sputum is examined for TB bacteria using a smear; part of the sputum can also be used to do a culture.

TB blood test – A test that uses a blood sample to find out if you are infected with TB bacteria. The test measures the response to TB proteins when they are mixed with a small amount of blood. Examples of these TB blood tests include QuantiFERON®-TB Gold In-tube (QFT-GIT).

Tuberculosis - A chronic infectious disease caused by the closely related species *Mycobacterium tuberculosis*, *M. bovis*, and *M. africanum*.

AFFECTED AREAS/PERSONNEL: *ALL HEALTHCARE WORKERS*

SECTION I - RESPONSIBILITY FOR THE TB INFECTION PREVENTION PROGRAM

A. The fundamentals of a TB Control Plan should consist of administrative controls, environmental controls, and a respiratory protection program.

1. Administrative Controls: These are management measures that are intended to reduce the risk of exposure to persons with infectious TB and include:

- Assigning someone the responsibility for TB infection control in the health care setting;
- Conducting a TB risk assessment of the setting;
- Developing and implementing a written TB infection-control plan;
- Ensuring the availability of recommended laboratory processing, testing, and reporting of results;
- Implementing effective work practices for managing patients who may have TB disease;
- Ensuring proper cleaning, sterilization, or disinfection of equipment that might be contaminated (e.g., endoscopes);
- Educating, training, and counseling health care personnel, patients, and visitors about TB infection and TB disease;
- Screening, testing, and evaluating personnel who are at risk for exposure to TB disease. Early identification, isolation, and treatment of persons with TB, (e.g., provide and practice early patient screening in the Emergency Department, to identify potentially infectious patients, and prevent employee exposures).
- Using posters and signs to remind patients and staff of proper cough etiquette (covering mouth when coughing) respiratory hygiene; and
- Coordinating efforts between local or state health departments and high risk healthcare and congregate settings.

2. Environmental Controls: The use of environmental controls to reduce the concentration and prevent the spread of infectious droplet nuclei.

- Primary environmental controls consist of controlling the source of infection by using local exhaust ventilation (e.g., hoods, tents, or booths) diluting and removing contaminated air by using general ventilation.
- Secondary environmental controls consist of controlling airflow to prevent contamination of air in areas adjacent to the source airborne infection isolation (AIIR) rooms; and cleaning the air by correctly using high efficiency particulate air (HEPA) filtration.

3. Respiratory-Protection Controls: Consists of the use of personal protective equipment in situations that pose a high risk of exposure to TB disease.

    - Implementing a respiratory protection program;
    - Training healthcare personnel on respiratory protection; and
    - Educating patients on respiratory hygiene and the importance of cough etiquette procedures.

B. The Tuberculosis Control Plan was developed and approved by the Administrative staff and the Board of Directors, who have ultimate responsibility for the development of programs that create a safe work environment for the employees.

The Infection Prevention and Control Committee has the authority for implementation and ongoing evaluation of the TB Control Plan. Leadership is responsible for monitoring compliance with the plan. All employees are expected to follow the policies and procedures contained in the TB Plan.

SECTION II – RISK ASSESSMENT

Risk assessment includes:

A. Analysis of the number of infectious TB patients admitted to the facility and each area in the facility
B. Analysis of Healthcare Worker (HCW) Tuberculin Skin Test (TST) conversion and possible patient-to-patient TB transmission.
C. Analysis of the management of infectious TB patients in the hospital, drug susceptibility patterns, and adequacy of treatment of TB patients.
D. Analysis of relevant current epidemiological information for the geographic area (locally, statewide and nationally)

SECTION III - PROTOCOL FOR EARLY DETECTION

In order to protect healthcare workers, patients and visitors from exposure to tuberculosis, patients (across all SVMC entities) with known or suspected infectious tuberculosis will be promptly screened and identified. Control measures will be employed in accordance with this policy and local, state, and federal regulations. *See other SVMC entity-specific policies as appropriate.*

Characteristics of TB:

Symptoms of TB disease depend on where in the body the TB bacteria are growing. TB bacteria usually grow in the lungs (pulmonary TB). TB disease in the lungs may cause symptoms such as:

A. Signs and symptoms of active TB:
    1. Productive, persistent cough of 3 weeks (or longer) duration (unclear etiology)
    2. Purulent bloody sputum/phlegm from deep inside the lungs (hemoptysis)
    3. Night sweats
    4. Pleuritic chest pain

5. Unexplained weight loss
6. Loss of appetite (anorexia)
7. Easy fatigability
8. Fever of unknown origin

Symptoms of TB disease in other parts of the body depend on the area affected.

B. Certain groups experience disease and infection rates in excess of the general population. These groups include:

1. Persons with certain comorbid medical conditions: diabetes, cancer, and HIV infection alter the immune system's ability to fight TB

2. Babies and young children with weak immune systems

3. Geographic disparities:

    a. Foreign-born persons from high prevalence countries (see listed reference)
    b. Medically underserved low-income populations, including high risk minority, African American, Hispanics, Native Americans and Southeast Asians
    c. Certain other populations that have been identified locally as having an increased prevalence of TB, such as homelessness, refugees and migrants, etc.

4. Close contacts with known infectious TB cases

5. Persons with alcohol use disorder and intravenous drug users

6. Residents of high-risk congregated settings:

    a. Long-term care facilities (e.g., correctional facilities, skilled nursing)
    b. Individuals experiencing homelessness

C. Medical Risk Factors:

1. Persons with HIV infection
2. Silicosis
3. Abnormal chest radiograph showing fibrotic lesions
4. Prolonged corticosteroid therapy
5. Organ transplants
6. Immuno-suppressive therapy
7. Hematologic and reticuloendothelial diseases
8. End-stage renal disease
9. Intestinal by-pass
10. Post-gastrectomy
11. Chronic malabsorption syndromes
12. Carcinomas of the oropharynx and upper GI tract

13. Ten percent (10%) or more below ideal bodyweight

SECTION IV - SCREENING AND DIAGNOSIS

Diagnostic measures/assessment should be initiated on any person with suspected TB. The nursing staff shall notify the primary physician/hospitalist of any symptoms suggestive of TB upon initial patient assessment.

A. Diagnostic measures may include:

1. History and physical examination
2. Tuberculin Skin Test (TST)
3. Blood Assay for Mycobacterium tuberculosis (BAMT); Interferon Gama Release Assay (IGRA) or QuantiFERON-TB Gold test
4. Chest X-Ray
5. AFB sputum smear and culture
6. Others as prescribed

B. Tuberculin Skin test (TST): *See TST – ADMINISTRATION AND INTERPRETATION OF TB SKIN TEST POLICY*

1. PPD skin test results should be read by designated, trained personnel between 48-72 hours after injection. The skin test is to be read by the presence or absence of induration at the injection site. Redness or erythema are not to be measured. The transverse diameter of induration should be recorded in millimeters.
2. Test may be given to employees, healthcare providers, and patients. Patient results will be entered into the medical record.

3. Two-step TST Testing is used for new employees through Employee Health.

C. Notification of the Nursing Unit and Infection Prevention Department

1. In addition to notifying the nursing unit, the Infection Prevention Department shall be notified (ext. 3781 or 6121; Fax at 791-3819) by any person on the healthcare team in a timely manner of any suspect or confirmed TB diagnosis.

2. Notification can be accomplish by:

   a. The **nursing units** should notify Infection Prevention **ASAP** when placing a patient in Airborne Precautions
   b. **Physicians** can notify the nursing units/IP Department

c. The interpreting **radiologist** (or Imaging designee) shall be responsible for immediately notifying attending imaging staff, who will inform the nurse and Infection Prevention of any abnormal radiological findings suggestive of TB
d. The **laboratory** will notify the nursing unit, physician and Infection Prevention of any **positive** results of in-patient AFB smears, cultures or TST as soon as possible.
e. **Pharmacy** should notify the Infection Prevention Department when a patient has been placed on a new regimen of TB medications.

SECTION V - MANAGEMENT AND ISOLATION OF PATIENTS WITH POSSIBLE TUBERCULOSIS

A. Decision to place in Airborne Precautions (See Figure 1)

1. Signs and symptoms suggestive of TB may include:

   a. Productive, persistent cough 3 weeks duration (unclear etiology)
   b. Purulent or bloody sputum (hemoptysis)
   c. Night sweats
   d. Pleuritic chest pain
   e. Unexplained weight loss
   f. Loss of appetite (anorexia)
   g. Easy fatigability
   h. Fever of unknown origin
   i. Abnormalities (i.e., cavitation) in the chest X-Ray including apical and posterior segments of the upper lobe, in the superior segments of the lower lobe or diffuse nodular infiltrates

2. Any patient with signs and symptoms suggestive of TB, **and** any of the following circumstances will be considered suspect for TB and placed into Airborne Precautions as soon as possible:

   a. There is an order for sputum for AFB's
   b. The physician writes "R/O suspect or confirmed TB"

3. The physician, infectious disease physicians, nurse, nursing supervisor or infection preventionist shall have the authority to implement Airborne Isolation Precautions when

signs and symptoms are suggestive of TB (suspected or confirmed). The physician and Infection Prevention Team should be consulted as part of the decision making process.

B. Airborne Precautions (Airborne Infection Isolation Room (AIIR)

When a patient is placed in Airborne Precautions, the following should take place:

1. Assure the room is negative pressure or has a HEPA filter at bedside.
2. An Airborne Precautions sign (caddy as needed) shall be placed on the door to the patient's room.
3. The door will remain closed, except when entering or leaving the room
4. A National Institute for Occupational Safety and Health (NIOSH) approved **N-95 or Powered Air Purifying Respirator (PAPR)** should be donned by **all** staff (i.e., nursing, physicians, EVS, Lab, RT, Imaging, etc.) upon entering the room.

C. Airborne Infection Isolation Room (AIIR) Location

Designated Airborne Infection Isolation Rooms (AIIR) appropriate for the placement of patients with known or suspected TB are located in the following areas:

1. **Main Hospital:**
    a. Telemetry Department - Room 260
    b. Medical Surgical Department – Room 360
2. If a room is not a designated AIIR, it may be able to be adapted with an appropriately placed HEPA filter.

D. Inpatients with known or suspected TB:

1. Patient must be placed in Airborne Infection Isolation room (AIIR) or have a HEPA filter unit placed at bedside.
2. Patients on treatment for infectious TB who are re-admitted to SVMC shall be placed in the above designated room until infectiousness is ruled out.
3. Notify the Infection Prevention Department as soon as possible (Infection Prevention Department 3781).
4. Within 24 hours of diagnosis or strong suspicion of an active TB case, notification of the Tulare County TB Office must be done. The IP Team will initiate this process.
5. Adherence to Airborne Precautions/etiquette compliance by the staff and patient is mandatory.

6. Any incident of noncompliance with Airborne Precautions protocol shall be reported to the area Clinical Director/Manager.
7. The physician shall be notified if the patient will not comply with Airborne Precaution protocols.
8. The physician and/or nurse will provide the following education to the patient in respiratory precautions:
    a. Transmission of TB
    b. Reasons for respiratory precautions and importance of compliance
    c. Precautions, such as covering the mouth and nose with tissues when coughing or sneezing
    d. Importance of staying inside the patient's room
    e. Specific instructions for transportation to areas outside the patient's room

SECTION VI - OTHER CIRCUMSTANCES

A. Patient Movement to other locations:

1. A patient in Airborne Precautions shall not be routinely transported to other locations for a procedure/test unless it is deemed medically essential (and cannot be done in the patient's room).
2. If a patient in Airborne Precautions must be transported outside the patient's room for a medically essential procedure, the patient shall wear a surgical mask during the transfer and procedure. The mask should be changed if it is no longer effective (i.e., wet or soiled). If use of a mask is not possible during the procedure, the receiving department should use Airborne Precautions. Patient should be placed in a single room with a HEPA-filter. Staff should don an N-95 respirator or (PAPR) and follow other Standard Precautions (gown, face shield/goggles, gloves) if further exposure to body fluids is anticipated. Room should be exhausted for one hour (door closed) after the procedure with the HEPA-filter on.
3. If the patient requires mechanical ventilation, a HEPA-filter must be used on the expiratory side of the resuscitation bag or ventilator circuit. Portable ventilators are ***not*** equipped with closed circuit capability, therefore, a HEPA-filter ***must*** be placed prior to transporting active TB ventilated patients.
4. The minimum respirator is a fitting face-piece respirator and must be selected from those approved by CDC/National Institute for Occupational Safety and Health (NIOSH) under Title 42 CFR, Part 84. It must meet one of the following specifications:
    - Non-powered air-purifying respirators (N-95)
    - Powered air-purifying respirators (PAPRs) with high-efficiency filters; or
5. Outside the patient room, during transport within the hospital or clinics, the employee does not need respiratory protection because the patient is wearing a surgical mask.

6. Staff should make **all** attempts to schedule the procedure at a time when it can be performed rapidly, when the patient is in a single room, and when waiting areas are less crowded (i.e., end of day).

B. Outpatients with known or suspected TB

1. Facility staff should be notified by physician's office staff in **advance** regarding a possible TB patient arrival.
2. Patient should be instructed to wear a surgical mask upon entering the facility and practice appropriate respiratory etiquette (i.e., use tissues while coughing, proper disposal, etc.).
3. Place patient in a room with a HEPA filter. If not readily available, patient is to wear a mask until placed in an appropriate room.
4. When appropriate, schedule suspect TB patients at times to avoid contact with immunocompromised patients

C. Aerosol-generating (high hazard, cough-inducing) procedures (i.e., bronchoscopy, airway surgeries, intubation/extubation, non-invasive positive pressure ventilation (e.g., CPAP, BIPAP, open Suctioning of tracheostomy or endotracheal tube)

1. Minimize such procedures when possible.
2. Use the HEPA units for aerosol-generating procedures.
3. HCWs should utilize Airborne Precautions during the procedure (i.e., N-95 respirator mask/PAPR, goggles/face shield, gloves and gown).
4. Following the procedure, confine the patient to the room or enclosure until coughing subsides or until patient is discharged. Have patient use tissues to contain any secretions.
5. Allow at least 1 hour following the procedure before placing another patient in the procedure room.
6. Document precautions taken on the patient record, including area of recovery.

D. During Emergency Department Care

1. The patient shall wear a surgical mask when being transported via emergency medical services (EMS) if TB is suspected or confirmed. Staff should be alerted to a possible TB patient.
2. The suspect patient should be provided supplies for respiratory etiquette (mask, tissues and hand sanitizer) and instructed on respiratory hygiene. This process should begin in the waiting room. The patient should be separated from other patients as soon as possible.
3. The patient should be placed in a private room with HEPA filtration. Airborne Precautions should be implemented.

4. A mask should be worn at all times by the patient, until sufficient arrangements are made. The mask should be changed as necessary (i.e., when wet or soiled).
5. The patient should be processed as quickly as possible through the Emergency Department.

E. Operating Room (OR):

1. Elective operative procedures shall be deferred, if possible, until TB is no longer infectious.
2. OR procedures that must be done shall be completed with the door closed and traffic minimized.
3. If possible, procedures shall be performed at the end of the day.
4. A bacterial filter shall be placed on the endotracheal tube and/or expiratory side of the anesthesia breathing circuit.
5. OR personnel shall wear an N-95 respirator mask instead of a surgical mask during the procedure.
6. HEPA filtration should **not** be used during the operative procedure due to disruptions of normal air flow.
7. HEPA filtration will be required for air scrubbing the environment post-operation after the patient has been removed from the OR suite. Note: The HEPA unit must be disinfected prior to entry into the operating room.
8. Allow the HEPA-filter unit to run for at least 60 minutes after the patient has vacated the room.
9. Recovery shall be in an individual room meeting ventilation requirements.

F. PPD Positive Obstetric Patients

1. Obstetric patients and their newborns will be provided quality effective care that meets the requirements for effective management of TB.
2. Positive PPD skin test obstetric patients should have a documented chest radiograph in their medical records to verify disease status.
3. Asymptomatic PPD positive obstetrics patients **with** a documented x-ray within the last year do not require any additional precautions related to TB upon admission
4. Asymptomatic PPD positive obstetrics patients **without** a documented chest x-ray within the last year will require a chest x-ray as soon as possible after delivery. They (as well as the infants) will not require any additional precautions related to TB upon admission until the status of the x-ray is determined.

5. **Symptomatic positive PPD** patients will require Airborne Precautions:
    a. Separation may be necessary:

1) Mothers who are too ill to care for their infants or who need higher levels of care.
2) Neonates at higher risk for severe illness (e.g., preterm infants, infants with underlying medical conditions, infants needing higher levels of care).

b. If the neonate remains in the mother's room, measures that can be taken to minimize the risk of transmission from a mother with symptomatic TB to her neonate include:
   1) Mothers should wear a mask and practice hand hygiene during all contact with their neonates. **Note**: Plastic infant face shields are not recommended and masks should **not** be placed on neonates or children younger than 2 years of age.

6. If an obstetric patient is undergoing active treatment for TB, place the patient under airborne precautions. The staff will contact the Infection Prevention Department. The Infection Prevention Department will communicate with the Tulare County TB Office. A determination will be made regarding the patient's current infectious status. The Birth Center will notify the Infection Prevention Department when the patient is discharged. The Infection Prevention Department will notify Tulare County of the discharge.

SECTION VII - ENGINEERING CONTROLS

A. Negative Pressure Rooms (AIIR)

1. Monitoring
   a. Negative airflow pressure rooms are kept at a constant "negative pressure". An alarm will notify HCW if negative pressure is disrupted. HCW may notify the Engineering Department for assistance.

B. Ventilation
1. Local exhaust ventilation
   a. Air from ventilation in the patient room is directly exhausted to the outside of the building, away from air intake vents.
   b. Precaution rooms and rooms used for treatment have a minimum of twelve (12) air exchanges per hour. Air is exhausted to the outside and not recirculated.

C. HEPA Filtration

A HEPA air filtration unit is a portable device used to "clean" the air of a non-negative pressure patient room or area by creating high efficiency particulate air filtration (removal of respirable particles).

1. Installation of Unit

    a. Call Engineering when a HEPA unit is needed in a patient room.
    b. Engineering staff will install the unit in required area as per nursing staff and use appropriate particulate respirator and other protective equipment, as required due to patient condition.

2. Monitoring

    Checked by staff. Staff will confirm HEPA unit is in place and is in working condition. Staff will call Engineering Department for assistance.

3. Unit Removal

    Upon notification from nursing that the unit is no longer necessary:

    a. Engineering will be called to remove the HEPA unit.
    b. HEPA unit will remain "ON" in the patient's room (to scrub the air) for at least one (1) hour, prior to being removed by Engineering (necessary only if patient had infectious TB).
    c. Unit will be cleaned by Environmental Services staff (must adhere to airborne precautions)
    d. Pre-filter will be changed every 1-3 months on average. If the MAP unit is utilized in the treatment of a patient with confirmed infectious disease, the Pre-filter should be replaced immediately after use by Bio-med every 3 months.
    e. HEPA filter should be replaced every 12 months on average when the MAP is used in continuous service. If the MAP unit is utilized in the treatment of a patient with confirmed infectious disease the Pre-filter should be replaced immediately after use by Bio-med every 3 months.
    f. Unit will be stored by Engineering.

4. Maintenance Procedure

    a. HEPA filters are to be properly installed, tested, and maintained per manufacturer's instructions. HCW will maintain documentation in the patient's record indicating the time that the unit was used.
    b. Filters are to be installed to prevent leakage between filter segments and between the filter bed and its frame.
    c. A pressure sensing device in the filter system will determine the need for filter replacement. Changes will take place per manufacturer's recommendations by Engineering.
    d. Installation should allow for maintenance without contaminating the delivery system or area served.
    e. Engineering personnel are adequately trained on the installation and maintenance procedures. Respiratory protection is worn during maintenance and testing.

SECTION VIII - DISCHARGE PLANNING

A. Discontinuance of Airborne Precautions:

1. The following persons are authorized to discontinue isolation:
    a. Attending physician
    b. Infection Preventionist
2. Isolation may be discontinued if the patient is:
    a. 3 consecutive sputum smears (at least 8 hours apart and one taken in the morning before brushing teeth, eating or drinking) for AFB are negative
    b. 2 negative NAAT
    c. With permission of Tulare County Health Department
    d. When patients are found not to have infectious TB

B. TB Inpatient Notification/Discharge Planning:

Every health care provider who provides treatment for a patient with active tuberculosis must promptly report to the local health officer each diagnosis or suspected diagnosis of active TB. Also reportable are instances when the patient discontinues treatment for active TB.

A healthcare facility cannot discharge a person who is known or reasonably suspected to have active TB until after the discharge plan for the patient is approved by a Tulare County Public Health Official.

To comply with the above regulations, the Infection Prevention Department will be the overall coordinator for the reporting process. Problems or concerns should be directed to the Infection Prevention Department. However, a team approach should be used to facilitate the initial reporting mechanism and discharge planning process between the facility and the Tulare County Health and Human Services Agency (TCHHSA) TB Office. Nursing, the patient's physician, Case Management and the Infection Prevention RN will collaborate to expedite the communication of information necessary to report TB cases and to obtain approval for the patient's discharge plan.

1. Within **24 hours** of diagnosis or strong suspicion of an active TB case (i.e. patient with symptoms suggestive of TB, positive chest radiograph with positive PPD or AFB smear), notification of the Tulare County TB Office must be done. Nursing staff or the patient's physician shall notify the IP Nurse to initiate this process.

2. When the Infection Preventionist receives notice of the patient actual or suspected diagnosis, the completed TB Suspect Case Report will be faxed or input in CalREDIE by the IP.

3. The Infection Preventionist and staff will communicate with Tulare County TB Office as necessary, to facilitate patient treatment/progress. Documentation of any communication shall be recorded in the patient's medical record.

4. As soon as a projected discharge date is known and at **least one day prior to discharge,** the Tuberculosis Discharge Treatment Plan will be completed and faxed to the Tulare County TB Officer or his/her designee. By phone: Monday through Friday (559)623-0690. By fax: (559)749-9780.

5. Notification of approval of the discharge plan will be sent from the Tulare County TB Office within approximately 24 to 48 hours after the plan was submitted as above. **The patient may not be discharged, transferred or released prior to receiving approval from the Tulare County Public Health Officer.** If the patient refuses to wait for the facility to receive the approved discharge plan form from the Health Department, the patient must sign out AMA and the TCHHSA TB Office must be informed immediately by hospital staff.

6. For medically necessary transfers to other acute care hospitals or correctional institutions, notification of the Tulare County TB Health Officer should be done ASAP. Document in the patient's medical record that the transfer was reported and to whom it was reported. The TB discharge plan will need to be completed.

SECTION IX - RESPIRATORY PROTECTION OF EMPLOYEES/FIT-TESTING

7. All employees are required to be fit-tested by Employee Health Services (EHS) for a NIOSH-approved N-95 respirator mask.

8. The mask must seal the mask around the nose and mouth.

9. The mask must be "seal checked" for an effective seal each time before entry into an Airborne Precautions room. To do so, blow forcefully into the mask as it expands. The wearer should not feel air escaping around the edges of the mask.

10. As with any disposable mask, N-95 respirator shall be removed and disposed of immediately after a single use or when visibly soiled

11. If the employee fails the N-95 fit test, they must wear a Powered Air Purifying Respirator (PAPR).

SECTION X - EVALUATION OF CONVERSIONS/TRANSMISSION

A. Exposure to TB in a HCW (See APPENDIX D: Employee Health Policy *Tuberculosis screening Program* and Employee Screening Form)

1. A contact investigation among other HCWs, patients, and visitors after a confirmed exposure to active TB will be initiated by Infection Prevention and Employee Health.
2. The Infectious Disease Department Chair will also be consulted.
3. Employee Health and Infection Prevention will follow current CDC recommended guidelines for exposure of employees (i.e., baseline TST and follow up at 8 - 10 weeks).
4. An employee exposure line list will be developed. Any employee converting to positive will be managed by Employee Health. Appropriate measures will be implemented based on each individual case.
5. Previous positive TST employees will be evaluated for symptoms and will be recommended for a chest x-ray.
6. The Tulare County Office will be notified for community contact investigation and consultation as required.
7. Investigation will be performed to determine the cause of transmission.
8. An evaluation of the TB exposure/TB Control Plan and processes will be conducted, with possible opportunities for improvement to be developed and recommendations implemented.
9. Summary of findings and recommendations will be presented to the Infection Prevention Committee.

B. Patient-to-Patient/Visitor TB Transmission

1. Surveillance will be conducted by Infection Prevention to determine any additional cases of TB transmission related to other patients and visitors.

2. Potential patient/visitor (as possible) exposures will be identified and the primary physician will be notified for recommended follow-up.
3. Tulare County TB Office will be notified as necessary.

C. Exposure Follow-up for Unrecognized TB at Time of Hospitalization

1. Investigation will be conducted to determine areas and persons potentially exposed.
2. All persons exposed shall be handled as above in A and B.

APPENDIX A

Fit Testing Procedure

1. Assignment of Responsibility- Employee Health Services.

2. Identify those HCWs to be fit-tested.

3. Select respirator- NIOSH-approved (minimum N- 95).

4. Instruct each HCW to abstain from eating, drinking, and chewing gum for a minimum of 15 minutes prior to being fit-tested.

5. HCW to fill out questionnaire/medical evaluation entitled, "Mandatory Information for those Employees Selected to use a Respirator" to determine the employee ability to use a respirator (see attachment). Evaluate the employee potential health problems that might limit the employee's ability to wear a respirator during performance of normal job duties. (Using a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used and the medical status of the employee.)

6. Fit-tester to review and determine HCW's ability to be fit-tested and wear N-95 in the clinical setting. If questionnaire results indicate health concerns and inability to wear respirator safely, do not continue with fit-testing. (Refer if needed, as designated by EHS.)

7. Describe to the employee the limitation of the respirator and the consequences for not wearing it correctly.

A. Limitations:

i) Respirator face-seal: leakage is not necessarily 100%.
ii) Lack of fit-checking each time used may increase risk of leakage.
iii) Qualitative tests rely on the subjective response of the HCW being fit-tested.
iv) Considerations of hygiene, damage, and breathing resistance all are factors in its use.

B. Consequences:

i) Risk of exposure to *M. tuberculosis*.

8. Train the healthcare worker on:

A. How the N-95 respirator is to be applied to the face and how to adjust it.
B. How to inspect the integrity (physical damage or soil) of the N-95 respirator.
C. How to fit-check with each use.
D. How to maintain the N-95 respirator (protect from elements.)
E. How to store the N-95 respirator (clean, convenient, sanitary area, if it is to be reused due to shortage.)

When to dispose of the N-95 respirator (damaged or noticeable breathing resistance.)

F. How to dispose of the N-95 respirator (regular trash.)
G. How to obtain additional respirators.
H. To return for fit-testing if the employee has facial changes (through weight loss/gain, medical conditions, facial surgery, etc.) or if there are any questions. Training can recur annually or as needed.
I. Fit-testing and N-95 respirators are at no cost to the employee.

9. Inform the HCW of the ingredients of the fit-test solution and that they will be exposed to a fine mist.

10. Qualitatively (saccharin) fit-test an appropriate size respirator to the HCW following the instructions of the manufacturer's fit-test kit.

11. Allow the healthcare worker to practice how it should be worn.

12. If the HCW cannot be fitted with the available respirators, assign HCW to use (PAPR).

13. Maintain documentation of fit-testing in personnel file.

APPENDIX B: FIT TESTING RECORD FOR RESPIRATOR USERS

SIERRA VIEW MEDICAL CENTER

Fit Testing Record for Respirator Users

Employee: _____ **Job Title:** _____

Department: _____ **Extension:**_____ **Date of Birth:** _____

Description of condition requiring RPE use:

_____

Since your last fit test, has a physician diagnosed you with any major conditions that would interfere with your ability to use a respirator?

Yes / No

Employee signature: _____

Fit Testing Record

☐ **PE Manufacturer:** 3M 1860 **R / S Model Number:** 1860 (N95)
NIOSH Approval #: TC-84A-0006
Face-piece Type and Size: Regular / Small

☐ **PE Manufacturer:** Alpha Pro Tech **Model Number:** 695 (N95)
NIOSH Approval #: TC-84A-0457
Face-piece Type and Size: Regular

☐ **PE Manufacturer:** _____ **Model Number:** _____ (N95)
NIOSH Approval #:_____
Face-piece Type and Size: Regular / _____

Medical Restriction Noted by Physician? Yes / No

Odor Detection Adequate? Yes / No

Date Fit Tested: _____ **Qualitative Analysis:** ____X____

Pass / Fail Comments: _____

_____
Signature of Fit Tester

APPENDIX C: TUBERCULOSIS SCREENING PROGRAM AND EMPLOYEE TB SCREENING FORM

1. General Information

   A. Participation in the MTB screening program is mandatory initially for all, and for HCWs annually thereafter.

   B. PPD skin tests are available to employees at no cost.

   C. Determination shall be made concerning any medical condition or treatment that leads to severely impaired cell-mediated immunity, thereby affecting the reading of a PPD skin test.

   D. An employee shall be counseled regarding the meaning of a PPD skin test result.

   E. PPD skin test results should be read by designated, trained personnel between 48-72 hours after injection. The skin test is to be read by the presence or absence of induration at the injection site. Redness or erythema are not to be measured. The transverse diameter of induration should be recorded in millimeters.

   F. PPD Positive Interpretation (definition):

      i) A reaction of ≥ 5 mm is classified as positive in:

         - Persons with HIV infection or risk factors for HIV infection with unknown HIV status.
         - Persons who have had recent contact with persons with active TB
         - Persons who have abnormal chest radiographs consistent with old healed TB

      ii) A reaction of ≥ 10 is classified as positive in all persons who do not meet any of the criteria above but who have other risk factors for TB including:

         - High-Risk Groups

            a) Intravenous drug users known to be HIV seronegative
            b) Persons with other medical conditions that have been reported to increase the risk of progressing from latent TB infection to active TB, including silicosis, gastrectomy, jejuno-ileal bypass surgery, being 10% or more below ideal body weight, chronic renal failure, diabetes mellitus, high dose corticosteroid and other immunosuppressive therapy, some hematologic disorder (e.g. leukemia and lymphomas), and other malignancies.

- High-Prevalence Groups

  a) Foreign-born persons from high prevalence countries in Asia, Africa and Latin America
  b) Persons from medically underserved low income populations
  c) Persons from high-risk populations in their communities, as determined by local public health authorities

iii) Induration of ≥ 15 mm increase within a 2-year period is classified as positive for persons who do not meet any of the above criteria.

iv) Recent converters are defined on the basis of both induration and age:
- ≥ 10 mm increase within a 2-year period is classified as positive for persons < 35 years of age
- ≥ 15 mm increase within a 2-year period is classified as positive for persons ≥ 35 years of age
- ≥ 5 mm increase under certain circumstance (see "i" above).

2. New Healthcare Workers and PPD Skin Testing:

A. Healthcare workers with no documented evidence of PPD skin testing or those with history of BCG vaccine or those new healthcare workers who have documentation of a PPD (-) status, yet the documentation is greater than 12 months:

i) New healthcare workers with undocumented history of PPD testing or (PPD- more than 12 months ago) or treatment with BCG shall be tested upon hire using the two-step tuberculin skin testing method. If the first tuberculin test is negative, a second 5-TU shall be administered 1-3 weeks later. A positive second result probably indicates boosting from a past infection or prior BCG vaccination. Persons having a boosted reaction should be classified as a reactor, not a converter. If the second result is negative, the person is probably uninfected and a positive reaction to subsequent tests indicates a true tuberculin skin-test conversion.

ii) Use intermediate strength PPD 5 TU/0.1cc intradermal in the forearm.

B. PPD Positive New Healthcare Workers

i) Known PPD (+) new healthcare workers with professionally documented previous positive reaction or TB infection/treatment, or both, are exempt from further PPD screening and shall be evaluated by symptom review and risk evaluation using the employee screening form. Obtain chest x-ray if indicated.

ii) New healthcare workers with a history of possible significant previous reaction which is undocumented should be: 1) strongly encouraged to obtain

documentation of previous (+) as many people are unclear on their medical history/testing, 2) probed to describe the "positive" test (i.e. where was it given, what did it look like, who told you it was positive, what was the follow-up?), 3) considered for skin testing if answers to questions in 2) clearly indicate that the HCW does not know their PPD history, 4) if unable to obtain documentation of skin test, then obtain chest x-ray at the hospital's provider of employee health services, 5) if the chest x-ray is clear, consider the employee cleared for patient care activities. If the chest x-ray is abnormal, employee health services provider will evaluate for further follow-up/clearance for work. All new healthcare workers who react or convert to PPD (+) will need to be evaluated by chest x-ray and should be medically evaluated for further treatment and clearance for work.

3. Annual Healthcare Worker Evaluation for Clinical Employees:

   All employees must have a PPD skin test annually (unless already documented positive). If the HCW converts their skin test to a (+), assess for symptoms of TB and refer to hospital's provider of employee health services for chest x-ray, further medical evaluation, treatment if indicated, and clearance for work:

4. TB Exposure Incident:

   A. Definition- An exposure incident is defined as any unprotected exposure to a patient/client with a (+) AFB smear, which results in identification as MTB, or if clinical diagnosis of MTB is confirmed by the health department.

   B. Follow-up- Administer PPD skin testing to non-reactors at time of exposure and at 8-10 weeks after the exposure.

      i) If the skin test is negative, the healthcare worker shall revert to annual skin testing schedule.
      ii) If the skin test is positive, refer to PPD converter section above and work with the health department for proper follow-up.

   C. Investigate the exposure incident for transmission risks, need for further education, procedural changes, and further employee contacts/exposures.

APPENDIX D: CLIENT/FAMILY EDUCATION MATERIAL

1. Healthcare workers from SVMC are practicing **Airborne Precautions** until deemed unnecessary. SVMC is dedicated to protecting the health and safety of its employees. The healthcare workers entering the patient's room will wear a N-95/PAPR at all times. The reason for these **Airborne Precautions is that the patient has been diagnosed with or has symptoms/diagnostic test results indicating suspicion of active tuberculosis:**

   ☐ The patient has been diagnosed by a physician as having clinical signs/symptoms of active tuberculosis.

- ☐ The health department has determined that the patient has or is suspicious for having active tuberculosis.
- ☐ One of the laboratory tests done by the hospital indicates that they may have active tuberculosis (+ AFB sputum test).

2. You may contact the Tulare County Department of Health Services if you have additional questions. They will be involved with following up on contacts and exposed individuals. You may also contact your primary care physician.

3. Active pulmonary/laryngeal TB is carried in airborne particles, or droplet nuclei, that can be generated when persons who have pulmonary or laryngeal TB sneeze, cough, speak, or sing. The particles are tiny, and normal air currents can keep them airborne for prolonged periods of time. Infection occurs when a susceptible person inhales droplet nuclei containing the TB bacteria.

4. It is important that you take your anti-TB medicines exactly as prescribed.

5. Visitors in the home- the Health Department will determine when it is safe for you to have visitors in the home.

6. Do not leave your home until deemed safe by the health department. If you must go to a doctor's appointment or the Health Department, wear a regular mask until you are no longer considered infectious.

7. While at home, always use tissues to cover your mouth and nose when coughing or sneezing. Take any other precautions that the Health Department has instructed you in.

APPENDIX E: TUBERCULOSIS DISCHARGE TREATMENT PLAN

Tulare County
Health & Human Services Agency
Public Health Branch
Public Health / Tuberculosis Program

TUBERCULOSIS DISCHARGE TREATMENT PLAN

☐ **In Patient** ☐ **Out Patient**

Prior to anticipated discharge…Complete this form in entirety and FAX to Tulare County TB Control Program: **559-713-3720**

Patient Name	Date of Birth	Facility

PART I: DISCHARGE INFORMATION

Anticipated Discharge Date:	Discharge to: ☐ Home ☐ Jail/Prison ☐ Skilled Nursing Facility ☐ Other (specify) ☐ Shelter			
Discharge Address: STREET	CITY	ZIP CODE	COUNTY	PHONE NUMBER

People In Household?	Children Under 4?	Any Immunocompromised Individuals?

Name Of Medical Provider After Discharge	Pager Number	Phone Number	Fax Number

Meds to last until appointment ☐ YES ☐ NO	Follow Up Appointment Date:	Time:	SPECIAL INSTRUCTIONS:

PART II: DISCHARGE MEDICATIONS/TREATMENT PLAN (Complete upon discharge)

CURRENT BACTERIOLOGY: Include all negative and positive				DISCHARGE MEDICATIONS		Weight:
DATE (Month/Day/Year)	SOURCE	SMEAR +/-	CULTURE +/-	Medication	Daily Doses in mgs	Start Date
				ISONIAZID		
				RIFAMPIN		
				PYRAZINAMIDE		
				ETHAMUTOL		
				B6		
				OTHER		
				OTHER		
				OTHER		

INCLUDE DATES OF UNSUCCESSFUL SPUTUM COLLECTION ATTEMPTS: ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )

Current CXR Report Date: Describe: ☐ Stable ☐ Improved ☐ Worse	D.O.T. Recommended? ☐ YES ☐ NO START DATE:
	DOT Legal Order Required? ☐ YES ☐ NO DOT To occur where? ☐ Clinic ☐ Home ☐ Worksite Other?

PHN Home Assessment Received? ☐ Yes ☐ No Reviewed? ☐ Yes ☐ No	COMPLETED BY:	PHONE #	FAX #	DATE

PART III: HEALTH DEPARTMENT REVIEW

Discharge Approved: ☐ Yes ☐ No Problems Identified: _____

Actions Required Prior to Discharge: _____

Authorized By: _____ Date: _____
NAME OF HEALTH OFFICER/DESIGNEE

TD Discharge Treatment Plan Attachment_(3-27-19)(Paula Phomey, PHN) Page 1 of 2

Tulare County
Health & Human Services Agency
Health Services Department
Public Health / Tuberculosis Program

TUBERCULOSIS DISCHARGE TREATMENT PLAN

Discharge of a Suspected or Confirmed Tuberculosis Patient

As of January 1, 1994, California State Health and Safety Codes mandate that patients suspected of or confirmed as having TB may not be discharged or transferred without prior Health Department approval. To facilitate timely and appropriate discharge, the provider should notify the Health Department 1-2 days prior to anticipated discharge to review the discharge criteria. (See Below)

Tuberculosis Control Program (TBC) Response Plan

For Weekday Discharge- Non Holiday: Monday – Thursday 8:am – 5:00pm. Upon a receipt of a completed discharge request form, TB staff will provide a response within 24 hours. To expedite your request, please include all laboratory and/or radiology reports.

TBC staff will review the request and notify the submitter of approval, or will inform the submitter if additional information or action is required prior to discharge approval. If a home evaluation is needed to determine if the environment is suitable for discharge, the TBC staff will make a home visit within (1) working day notification.

Holiday and Weekend Discharge

If you anticipate a discharge on a weekend or holiday please contact the TB Control Program immediately. For discharge planned Friday through Sunday, a completed form must be received no later than 5pm on Wednesday. For holiday discharge, a completed form must be received no later than 5pm on the second preceding business day.

Discharge Criteria

Approval of patient discharge is dependent upon compliance of the discharge treatment plan meeting the guidelines included below. Final approval for discharge is granted by the Health Officer after receipt and review of the discharge plan. Forms must be filled out in entirety to avoid delay in approval.

1. Home with no at risk individual(s) in the home:
   - ❖ Patient is on appropriate drug regimen
   - ❖ Patient is clinically stable
   - ❖ Patient deemed an acceptable candidate for home isolation
2. Home with high risk individual(s) in the home who have not been exposed:
   - ❖ Patient is on appropriate drug regimen >1 week
   - ❖ Patient is clinically stable
   - ❖ Patient deemed an acceptable candidate for home isolation
   - ❖ Contact(s) considered for or placed on prophylaxis
3. High Risk Setting:
   - ❖ Patient is on appropriate drug regimen >2 weeks
   - ❖ Patient clinically improving
   - ❖ Three consecutive negative AFB smears

In all instances, an accurately completed Discharge Treatment Plan must be submitted at least 24 hours prior to consideration for approval for discharge. If these criteria cannot be satisfied, discharge cannot be approved and the patient **MUST** be held until the next business day for appropriate arrangements to be made.

REFERENCES:

- California Tuberculosis Risk Assessment | Curry International Tuberculosis Center. Updated August 2024. Accessed 4 December 2025. https://www.currytbcenter.ucsf.edu/products/california-tuberculosis-risk-assessment.
- Clinical Testing Guidance for Tuberculosis: Health Care Personnel. 15 December 2023. Accessed 4 December 2025. https://www.cdc.gov/tb-healthcare-settings/hcp/screening-testing/index.html
- California Code of Regulations Title 8, Section 5144, Subchapter 7. Accessed 4 December 2025 at: https://www.dir.ca.gov/title8/5144.html
- Frequently Asked Questions about TB Protocols at Duke Hospital and Clinics Dec. 10 December 2024. https://www.safety.duke.edu/sites/default/files/FAQs_about_TB_Protocols.pdf.
- Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005. Center for Disease Control and Prevention. Accessed November 26, 2025 at https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e
- OSHA Standard 29 CFR 1910.134. Accessed 4 December 2025 at: https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134
- Tuberculosis. Mayo Clinic Staff. 4 April 2025, Accessed 4 December 2025 at: https://www.mayoclinic.org/diseases-conditions/tuberculosis/symptoms-causes/syc-20351250
- Tuberculosis Infection Control (Health Care Providers). Center for Disease Control and Prevention. Updated December 15, 2023. Accessed November 26, 2025 at https://www.cdc.gov/tb-healthcare-settings/hcp/infection-control/index.html

CROSS REFERENCES:

- TST- Administration and Interpretation of TB Skin Test

SIERRA VIEW
MEDICAL CENTER

MEETING MINUTES

MINUTES FROM PREVIOUS MEETING SUBMITTED FOR APPROVAL

MEETING MINUTES

BOARD OF DIRECTORS ANNUAL MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly March 24, 2026 at 5:00 P.M. in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Vice Chair Reddy called the meeting to order at 5:00 p.m.

Board Attendance:

- Bindusagar Reddy, Vice Chair - Present
- Areli Martinez, Secretary – Present
- Martha A. Flores, Director – Present
- Liberty Lomeli, Chair - Absent
- Hans Kashyap, Director – Absent

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, Terry Villareal, Clerk to the Board, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

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

FLORES	Yes
MARTINEZ	Yes
REDDY	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:

1. General Update

C. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation; Anticipated Litigation: Conference with Legal Counsel; (1 Item).

D. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter – One (1) Items. Estimated Date of Disclosure January 1, 2029, for materials that are not part of an individual's private personnel file.

Closed Session Items E, F & G 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: Vice Chair REDDY adjourned Closed Session at 5:32 p.m., reconvening in Open Session at 5:33 p.m.

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

A. Chief of Staff Report:

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
MARTINEZ	Yes
REDDY	Yes

B. Quality Division Update

1. Quality Division Report
   Following review and discussion, Director MARTINEZ 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
MARTINEZ	Yes
REDDY	Yes

C. Conference with Legal Counsil
   Information Only: No Action Taken

D. Discussion Regarding Confidential Personnel Matter
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
MARTINEZ Yes
REDDY Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director FLORES and seconded by Director MARTINEZ to approve the February 24, 2026, Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

FLORES Yes
MARTINEZ Yes
REDDY Yes

VII. Business Items

A. February 2026 Financials

Craig McDonald, CFO presented the Financials for February 2026.

Following review and discussion, it was moved by Director FLORES, seconded by Director MARTINEZ and carried to approve the February Financials as presented. The vote of the Board is as follows:

FLORES Yes
MARTINEZ Yes
REDDY Yes

B. 2024 Environment of Care Annual Evaluation
Following review and discussion, it was moved by Director FLORES and seconded by Director MARTINEZ to approve the Environment of Care Annual Evaluation as presented. The motion carried and the vote of the Board is as follows:

FLORES Yes
MARTINEZ Yes
REDDY Yes

C. Graduate Medical Education (GME) Match
Information Only; No Action Taken

VIII. SVLHCD Board Chair Report

Vice Chair Reddy expressed his appreciation to the Senior Team and staff for doing a good job and encouraged them to keep building on that momentum to make improvements where needed.

IX. CEO Report

- Congratulations to the Vizient Inc./American Association of Colleges of Nursing Nurse Residency Program Cohort #16 for an excellent job at presenting their final projects, focused on improving patient safety and the patient experience at Seirra View Medical Center.
- Thank you for Bank of the Sierra for their donation through the Sierra Grant program. These funds will help support he purchase of new echocardiography and ultrasound equipment, which will help care teams to diagnose and monitor patients.
- Our Senior Team had a great time delivering sweet treats to the team for Employee Appreciation Day.
- Daisy Award was presented to Jeffery Hudson-Covolo in recognition of his leadership and support to nursing teams across.
- Our latest employee of the month was Gabriela who helped to lead the implementation of a new process that improves how patients move through their infusion appointments. Great job Gabriela.
- Coffee and Cocoa with the CNO was a success. The give employees the opportunity to share ideas with nursing leadership in a relaxed setting.
- CEO, Donna Hefner, had the opportunity to read to a 3rd grade class at West Putnam School to celebrate Read Across America. The book used was entitled Dream Along Anesthesia, by Dr. Simon Kim who generously donated 100 copies to SVMC to help bring comfort to children during surgery.
- SVMC sponsored the March Porterville Chamber's First Friday Coffee, where Dr. Misra, Chair of the Department of Obstetrics & Gynecology highlighted our new Women's Services Clinic, which opened in 2025 at our Medical Office Building.

X. Announcements:
Regular Board of Directors Meeting – April 28, 2026, at 5:00 p.m.

XI. Closed Session: Board adjourned Open Session at 6:05 p.m., reconvening in Closed Session at 6:12 p.m. to discuss the following items:

E. 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.

F. 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.

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

XII. Open Session: Chairman REDDY adjourned Closed Session at 6:32 p.m., reconvening in Open Session at 6:33 p.m.

E. Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning
Information Only; No Action Taken

F. Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning
Information Only; No Action Taken

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

XIII. Adjournment

The meeting was adjourned at 6:35 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

SIERRA VIEW MEDICAL CENTER

FINANCIALS

FINANCIAL REPORTS FROM THE PREVIOUS MONTH

FINANCIAL PACKAGE
Mar-26

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
March 2026

Statistic	Mar-26 Actual	Mar-26 Budget	Mar-26 Over/ (Under)	Mar-26 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 25 YTD	Increase/ (Decrease) Mar-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	1,085	1,019	66	6.4%	9,264	9,278	(14)	-0.2%	8,830	434	4.9%
Medi-Cal	527	497	30	6.0%	4,307	4,629	(322)	-7.0%	4,406	(99)	-2.2%
Acute Patient Days	1,582	1,543	39	2.5%	14,464	14,888	(424)	-2.8%	14,963	(499)	-3.3%
Acute Discharges	459	409	50	12.2%	4,102	3,947	155	3.9%	3,956	146	3.7%
Medicare	190	196	(6)	-2.9%	1,551	1,598	(47)	-2.9%	1,602	(51)	-3.2%
Medi-Cal	206	170	36	21.0%	1,970	1,849	121	6.5%	1,853	117	6.3%
Contract	55	40	15	37.1%	542	475	67	14.1%	476	66	13.9%
Other	8	3	5	172.5%	39	25	14	56.4%	25	14	56.0%
Average Length of Stay	3.45	3.77	(0.33)	-8.6%	3.53	3.77	(0.25)	-6.5%	3.78	(0.26)	-6.8%
Newborn Patient Days											
Medi-Cal	148	120	28	23.5%	1,474	1,383	91	6.5%	1,369	105	7.7%
Other	21	23	(2)	-9.3%	359	280	79	28.4%	309	50	16.2%
Total	169	143	26	18.2%	1,833	1,663	170	10.2%	1,678	155	9.2%
Total Deliveries	99	84	15	17.9%	993	872	121	13.9%	877	116	13.2%
Medi-Cal %	84.85%	83.43%	1.42%	1.7%	79.62%	83.43%	-3.82%	-4.6%	82.23%	-2.62%	-3.2%
Case Mix Index											
Medicare	1.4677	1.6368	(0.1691)	-10.3%	1.5482	1.6368	(0.0886)	-5.4%	1.6095	(0.0613)	-3.8%
Medi-Cal	1.1013	1.1975	(0.0962)	-8.0%	1.1330	1.1975	(0.0645)	-5.4%	1.1913	(0.0583)	-4.9%
Overall	1.2649	1.3724	(0.1075)	-7.8%	1.2907	1.3724	(0.0817)	-6.0%	1.3677	(0.0770)	-5.6%
Ancillary Services											
Inpatient											
Surgery Minutes	5,123	8,105	(2,982)	-36.8%	62,505	70,280	(7,775)	-11.1%	67,685	(5,180)	-7.7%
Surgery Cases	65	99	(34)	-34.2%	746	824	(78)	-9.5%	803	(57)	-7.1%
Imaging Procedures	1,466	1,574	(108)	-6.9%	13,928	13,416	512	3.8%	13,605	323	2.4%
Outpatient											
Surgery Minutes	15,535	14,760	775	5.3%	134,027	125,780	8,247	6.6%	122,599	11,428	9.3%
Surgery Cases	203	205	(2)	-0.7%	1,721	1,743	(22)	-1.3%	1,675	46	2.7%
Endoscopy Procedures	154	195	(41)	-21.0%	1,562	1,662	(100)	-6.0%	1,622	(60)	-3.7%
Imaging Procedures	4,525	4,385	140	3.2%	37,686	37,366	320	0.9%	36,866	820	2.2%
MRI Procedures	340	318	22	7.1%	2,880	2,706	174	6.4%	2,716	164	6.0%
CT Procedures	1,357	1,319	38	2.9%	12,667	11,241	1,426	12.7%	11,047	1,620	14.7%
Ultrasound Procedures	1,610	1,421	189	13.3%	13,425	12,113	1,312	10.8%	11,755	1,670	14.2%
Lab Tests	35,866	33,776	2,090	6.2%	311,901	287,829	24,072	8.4%	285,941	25,960	9.1%
Dialysis	15	4	11	325.5%	68	30	38	126.4%	32	36	112.5%

Sierra View Medical Center
Financial Statistics Summary Report
March 2026

Statistic	Mar-26 Actual	Mar-26 Budget	Mar-26 Over/ (Under)	Mar-26 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 25 YTD	Increase/ (Decrease) Mar-25	% Change
Cancer Treatment Center											
Chemo Treatments	2,023	2,105	(82)	-3.9%	17,688	17,940	(252)	-1.4%	17,347	341	2.0%
Radiation Treatments	1,861	2,007	(146)	-7.3%	15,188	17,105	(1,917)	-11.2%	16,466	(1,278)	-7.8%
Cardiac Cath Lab											
Cath Lab IP Procedures	12	15	(3)	-18.0%	135	125	10	8.3%	115	20	17.4%
Cath Lab OP Procedures	43	35	8	23.5%	293	297	(4)	-1.2%	297	(4)	-1.3%
Total Cardiac Cath Lab	55	49	6	11.3%	428	421	7	1.6%	412	16	3.9%
Outpatient Visits											
Emergency	3,845	3,369	476	14.1%	31,846	30,992	854	2.8%	31,108	738	2.4%
Total Outpatient	16,102	14,964	1,138	7.6%	133,021	127,519	5,502	4.3%	126,181	6,840	5.4%
Staffing											
Paid FTE's	909.65	900.16	9.49	1.1%	878.25	900.16	(21.91)	-2.4%	875.37	2.88	0.3%
Productive FTE's	789.98	772.13	17.85	2.3%	758.00	772.13	(14.13)	-1.8%	748.70	9.30	1.2%
Paid FTE's/AOB	4.88	5.55	(0.67)	-12.1%	4.98	5.25	(0.27)	-5.2%	5.17	(0.20)	-3.8%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	10,969	12,092	(1,123)	-9.3%	11,276	11,252	24	0.2%	11,251.10	25	0.2%
Cost/Adj.Patient Day	2,752	3,037	(285)	-9.4%	2,850	2,923	(72)	-2.5%	2,812.86	37	1.3%
					-						
					-						
Revenue/Adj. Discharge	50,772	60,682	(9,910)	-16.3%	52,438	55,668	(3,229)	-5.8%	55,015	(2,576)	-4.7%
Cost/Adj. Discharge	12,737	15,241	(2,504)	-16.4%	13,255	14,459	(1,204)	-8.3%	13,754	(499)	-3.6%
Adj. Discharge	1,249	1,001	247	24.7%	10,397	9,493	904	9.5%	9,484	913	9.6%
Net Op. Gain/(Loss) %	14.06%	0.79%	13.27%	1673.5%	3.44%	0.79%	2.65%	333.6%	-2.37%	5.81%	-245.2%
Net Op. Gain/(Loss) $	2,602,509	121,989	2,480,520	2033.4%	4,907,603	(2,220,386)	7,127,989	-321.0%	(3,017,602)	7,925,205	-262.6%
Gross Days in Accts Rec.	102.37	95.03	7.34	7.7%	102.37	95.03	7.34	7.7%	84.10	18.27	21.7%
Net Days in Accts. Rec.	45.90	57.75	(11.85)	-20.5%	45.90	57.75	(11.85)	-20.5%	40.23	5.66	14.1%

Sierra View Local Health Care District
Balance Sheet

	Mar-26	Feb-26
Assets		
Current Assets:		
Cash & Cash Equivalents	5,283,173	5,566,878
Short-Term Investments	-	3,317,296
Assets Limited As To Use	4,252,091	3,766,320
Patient Accounts Receivable	206,680,032	210,973,526
Less Uncollectables	(13,102,195)	(14,733,646)
Contractual Allowances	(169,988,215)	(172,647,269)
Other Receivables	35,203,437	33,156,622
Inventories	4,454,079	4,423,241
Prepaid Expenses and Deposits	5,581,359	3,802,027
Less Receivable - Current	301,020	301,020
Total Current Assets	**78,664,781**	**77,926,015**
Assets Limited as to use, Less		
Current Requirements	32,839,063	32,760,859
Long-Term Investments	142,623,422	139,937,501
Property, Plant and Equipment, Net	69,479,405	69,843,598
Intangible Right of use Assets	177,597	187,920
SBITA Right of use Assets	2,096,272	2,220,883
Lease Receivable - LT	481,975	507,261
Other Investments	250,000	250,000
Prepaid Loss on Bonds	1,069,960	1,090,940
Total Assets	**327,682,474**	**324,724,976**
Liabilities and Funds Balances		
Current Liabilities		
Bond Interest Payable	304,412	202,942
Current Maturities of Bonds Payable	4,235,000	4,235,000
Current Maturities of Long Term Debt	171,662	257,361
Account Payable and Accrued Expenses	5,008,902	5,561,363
Accrued Payroll and Related Costs	7,588,796	7,318,854
Estimated Third-Party Payor Settlements	5,714,625	4,382,634
Lease Liability - Current	129,125	129,125
SBITA Liability - Current	1,472,212	1,472,212
Total Current Liabilities	**24,624,733**	**23,559,490**
Self-Insurance Reserves	2,041,096	2,073,153
Capital Lease Liab LT	0	0
Bonds Payable, Less Curr Reqt	29,040,000	29,040,000
Bonds Premium Liability - LT	1,668,896	1,714,416
Lease Liability - LT	68,647	79,546
SBITA Liability - LT	1,089,230	1,234,175
Other Non Current Liabilities	-	-
Deferred Inflow - Leases	725,557	750,054
Total Liabilities	**59,258,160**	**58,450,834**
Unresticted Fund	258,350,395	258,350,395
Profit or (Loss)	10,073,919	7,923,747
Total Liabilities and Fund Balance	**327,682,474**	**324,724,976**
	-	-

Sierra View Local Health Care District
Income Statement

For Period **Mar-26**

	ACTUAL	BUDGET	VARIANCE	% VARIANCE	ACTUAL YTD	BUDGET YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	5,371,462	5,171,382	200,080	4%	49,219,701	49,290,580	(70,879)	(0%)
Inpatient - Ancillary	17,932,781	19,647,513	(1,714,732)	(9%)	166,367,429	170,429,744	(4,062,315)	(2%)
Total Inpatient Revenue	**23,304,243**	**24,818,895**	**(1,514,652)**	(6%)	**215,587,130**	**219,720,324**	**(4,133,194)**	(2%)
Outpatient - Ancillary	40,088,797	35,945,629	4,143,168	12%	329,613,940	308,738,477	20,875,463	7%
Total Patient Revenue	**63,393,040**	**60,764,524**	**2,628,516**	4%	**545,201,070**	**528,458,801**	**16,742,269**	3%
Medicare	(20,658,438)	(20,174,684)	(483,754)	2%	(168,797,475)	(174,154,672)	5,357,197	(3%)
Medi-Cal	(19,488,809)	(18,588,876)	(899,933)	5%	(181,836,586)	(162,450,044)	(19,386,542)	12%
Other/Charity	(6,883,114)	(7,172,881)	289,767	(4%)	(53,040,908)	(61,965,688)	8,924,780	(14%)
Discounts & Allowances	(269,014)	(19,016)	(249,998)	1,315%	(1,528,494)	(165,382)	(1,363,112)	824%
Bad Debts	1,779,259	(243,058)	2,022,317	(832%)	(4,731,400)	(2,113,835)	(2,617,565)	124%
Total Deductions	**(45,520,116)**	**(46,198,515)**	**678,399**	(1%)	**(409,934,862)**	**(400,849,621)**	**(9,085,241)**	2%
Net Service Revenue	**17,872,923**	**14,566,009**	**3,306,914**	23%	**135,266,207**	**127,609,180**	**7,657,027**	6%
Other Operating Revenue	633,226	818,039	(184,813)	(23%)	7,454,810	7,433,926	20,884	0%
Total Operating Revenue	**18,506,150**	**15,384,048**	**3,122,102**	20%	**142,721,017**	**135,043,106**	**7,677,911**	6%
Salaries	6,401,152	5,977,881	(423,271)	(7%)	54,271,155	54,189,105	(82,050)	(0%)
S&W PTO	526,797	710,888	184,091	26%	5,971,340	6,424,695	453,355	7%
Employee Benefits	1,565,522	1,460,204	(105,318)	(7%)	13,550,440	13,141,836	(408,604)	(3%)
Professional Fees	2,096,196	1,869,154	(227,042)	(12%)	16,872,311	16,999,539	127,228	1%
Purchased Services	878,683	911,503	32,820	4%	8,057,015	8,168,379	111,364	1%
Supplies & Expenses	2,543,052	2,357,469	(185,583)	(8%)	21,636,468	20,552,513	(1,083,955)	(5%)
Maintenance & Repairs	284,383	303,754	19,371	6%	2,557,068	2,733,786	176,718	6%
Utilities	215,132	306,217	91,085	30%	2,594,623	2,755,953	161,330	6%
Rent/Lease	39,801	30,041	(9,760)	(32%)	345,861	270,369	(75,492)	(28%)
Insurance	120,877	122,727	1,850	2%	1,069,223	1,104,543	35,320	3%
Depreciation/Amortization	865,117	811,079	(54,038)	(7%)	7,401,832	7,299,711	(102,121)	(1%)
Other Expense	366,928	401,142	34,214	9%	3,486,078	3,623,063	136,985	4%
Impaired Costs	-	-	-	0%	-	-	-	0%
Total Operating Expense	**15,903,641**	**15,262,059**	**(641,582)**	(4%)	**137,813,415**	**137,263,492**	**(549,923)**	(0%)
Net Gain/(Loss) From Operations	**2,602,509**	**121,989**	**2,480,520**	**2,033%**	**4,907,602**	**(2,220,386)**	**7,127,988**	**(321%)**
District Taxes	138,477	138,477	-	0%	1,246,293	1,246,293	-	0%
Investment Income	178,130	488,226	(310,096)	(64%)	4,315,998	4,394,034	(78,036)	(2%)
Other Non - Operating Income	27,917	40,308	(12,391)	(31%)	260,225	362,772	(102,547)	(28%)
Interest Expense	(68,287)	(70,649)	2,362	3%	(640,059)	(635,841)	(4,218)	(1%)
Non-Operating Expense	(21,012)	(39,854)	18,842	47%	(315,975)	(358,680)	42,706	12%
Total Non-Operating Income	**255,225**	**556,508**	**(301,283)**	(54%)	**4,866,482**	**5,008,578**	**(142,096)**	(3%)
			-				-	
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	**2,857,734**	**678,497**	**2,179,237**	**321%**	**9,774,084**	**2,788,192**	**6,985,892**	**251%**
Net Incr/(Decr) in the Fair Value Invstmt	(707,562)	162,500	(870,062)	(535%)	299,835	1,462,500	(1,162,665)	(79%)
Net Gain/(Loss)	**2,150,172**	**840,997**	**1,309,175**	156%	**10,073,919**	**4,250,692**	**5,823,227**	137%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
March-26

	Current Month	YTD
Cash flows from operating activities:		
Operating Income/(Loss)	2,602,509	4,907,602
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation/Amortization	865,117	7,401,832
Provision for bad debts	(1,631,452)	(1,118,602)
		-
Change in assets and liabilities:		-
Patient accounts receivable, net	1,634,440	(3,074,678)
Other receivables	(2,046,815)	(14,934,982)
Inventories	(30,838)	38,831
Prepaid expenses and deposits	(1,779,331)	(2,961,441)
Advance refunding of bonds payable, net	20,980	188,816
Accounts payable and accrued expenses	(552,461)	(489,046)
Deferred inflows - leases	(24,497)	(220,473)
Accrued payroll and related costs	269,942	(1,606,639)
Estimated third-party payor settlements	1,331,991	1,305,912
Self-insurance reserves	(32,057)	(87,992)
Total adjustments	(1,974,982)	(15,558,461)
Net cash provided by (used in) operating activities	627,527	(10,650,859)
Cash flows from noncapital financing activities:		
District tax revenues	138,477	1,246,293
Noncapital grants and contributions, net of other expenses	(5,167)	(191,726)
Net cash provided by (used in) noncapital financing activities	133,310	1,054,567
Cash flows from capital and related financing activities:		
Purchase of capital assets	(490,601)	(5,332,252)
Proceeds from sale of assets	-	5,000
Proceeds from debt borrowings	-	-
Proceeds from lease receivable, net	25,286	224,660
Principal payments on debt borrowings	-	(4,235,000)
Interest payments	(264)	(1,307,875)
Issuance of bonds payable and bond premium liability	-	-
Net change in notes payable and lease liability	(116,933)	(759,371)
Net changes in assets limited as to use	(563,975)	686,969
Net cash provided by (used in) capital and related financing activities	(1,146,486)	(10,717,869)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(3,393,482)	(3,267,859)
Investment income	178,130	4,315,998
Net cash provided by (used in) investing activities	(3,215,352)	1,048,139
Net increase (decrease) in cash and cash equivalents:	(3,601,002)	(19,266,023)
Cash and cash equivalents at beginning of month/year	8,884,174	24,549,196
Cash and cash equivalents at end of month	5,283,173	5,283,173

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
March 2026

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
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
Feb-26	12,005,852	5,418,366	17,424,218
Mar-26	**16,266,557**	**2,876,805**	**19,143,362**

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

March 2026 Summary of Other Activity:

253,428	M-Care interim payments
2,029,458	M-Care Cost Report Tentative Settlement FY25
478,585	M-Cal OP AB915 FY25
115,334	Miscellaneous
2,876,805	03/26 Total Other Activity