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

AMENDED AGENDA
May 26, 2026

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

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

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

1. **Quality Division Update;**
2. **Compliance Quarterly Report**

C. Pursuant To Gov. Code Section 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).

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

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

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): **Public Employee Annual Performance Evaluation of Hospital CEO** – One (1) Item. Estimated Date of Disclosure May 27, 2026, 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

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

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

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

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

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

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

G. Public Employee Annual Performance Evaluation of Hospital CEO
Recommended Action: Approve/Disapprove Completion of CEO's Annual Performance Evaluation as Required by Employment Contract.

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. April 28, 2026, Minutes of the Regular Meeting of the Board of Directors

Recommended Action: Approve/Disapprove April 28, 2026, Minutes of the Regular Meeting of the Board of Directors

B. May 8, 2026, Minutes of the Special Meeting of the Board of Directors

Recommended Action: Approve/Disapprove May 8, 2026, Minutes of the Special Meeting of the Board of Directors

IX. Business Items

A. Baker Tilly Audit Report

Recommended Action: Information Only/No Action Taken

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

C. Resolution 05-26-26/01 Ordering Board of Directors Election; Consolidation of Elections; Specifications of the Election Order; and Specific Services Rendered to the District
Recommended Action: Approve/Disapprove Resolution 05-26-26/01

D. Resolution 05-26-26/02 Appointing CFO as Treasurer of the Board
Recommended Action: Approve/Disapprove Resolution 05-26-26/02 Appointing CFO as Board Treasurer

X. SVLHCD Board Chair Report

XI. SVMC CEO Report

XII. Announcements:

- Regular Board of Directors Meeting – June 23, 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	5/26/2026
Board of Director's Approval	
Liberty Lomeli, Chairman	5/26/2026

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
May 26, 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 ↓
• 014190 COA English 2-26	1-2	
• 014191 COA 2-26 Spanish	3-4	
• 021285 Request to Amend Protected Health Information	5-6	
• 021286 Request to Amend Protected Health Information - Spanish	7-8	
• 021620 6-23 Advance Beneficiary Notice Update	9-10	
Policies:		
• Compliance Officer	11-13	
• Managing Construction	14-15	
• Participant Input of the Retirement Policy	16-17	
• Paychecks and Paydays	18-20	
• Permits, Licenses, Manifests and SDS	21-23	
• Standardized Emergency Codes	24-27	
• Urology Clinic-Urine Specimen Collection and Testing	28-29	
• Voluntary Disclosure of Violations	30-32	
• Waste Disposal	33-35	
• Weapons Prevention: Searches and Metal Detectors	36-37	
Plan:		
• Surge Capacity Plan	38-41	
• System-Wide Plan for the Provision of Patient Care	42-116	
• Utility System operational Plans and Failure Procedures	117-148	

CONSENT TO MEDICAL AND SURGICAL PROCEDURES

I consent to the procedures that may be performed during this hospitalization or while I am an outpatient. These may include, but are not limited to, emergency treatment or services, telehealth services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment at this hospital.

PERSONAL BELONGINGS

As a patient, I am encouraged to leave personal items at home. The hospital maintains a fireproof safe for the safekeeping of money and valuables. The hospital is not liable for the loss or damage to any money, jewelry, documents, or other articles that are not placed in the safe. Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars ($500.00) unless I receive a written receipt for a greater amount from the hospital.

MATERNITY PATIENTS

If I deliver an infant(s) while a patient of this hospital, I agree that these same Conditions of Admission apply to the infant(s).

NURSING CARE

The hospital provides only general nursing care and care ordered by the physician(s). If I want a private duty nurse, I agree to make such arrangements. The hospital is not responsible for failure to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide this additional care.

TEACHING INSTITUTION

SVMC is a teaching institution. I understand that residents, interns, medical students, and other trainees may observe, examine, treat, and participate in my care at the request and under the supervision of the attending physician. Nursing students and allied health students (e.g., ultrasound, x-ray, respiratory, rehabilitation therapy, etc.), may also be involved in my care as part of the Medical Center's education programs and are supervised by hospital and non-hospital staff. I understand that I can decline care provided by a resident, intern, medical student, or other trainee or allied health student.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS

I understand that all physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, nurse midwife, physician assistant and others, are **NOT** employees or agents of this hospital. They have been granted the privilege of using the hospital for the care and treatment of their patients, but they are **NOT** employees or agents of this hospital.

Patient initials: _____

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

CONSENT TO PHOTOGRAPH

The taking of pictures/videotapes for medical or surgical process and the use for treatment documentation, scientific, education or research purposes is approved and will be part of my medical record.

CONSENT TO COPY PHOTO ID

In order to help prevent the possibilities of identify theft, Sierra View Medical Center will request and obtain identifying information during the registration process of patients. I give permission to Sierra View Medical Center to obtain a copy of my driver's license or identification card for purposes of proving and protecting my identity.

TEXT/EMAIL NOTIFICATIONS

By my initials and providing my mobile phone number and/or email to SVMC, I certified that I am the owner of the mobile phone number and/or email address and consent to receive communication, including billing information, automated emails, voice mails, written statements, text messages, autodialed calls and prerecorded messages from SVMC or its affiliated entities. I understand that while SVMC does not charge for these communications, some forms of communication could incur telecommunication carrier charges that I am responsible to pay. To opt out of text messages or unsubscribe to emails, please follow the instructions within the body of the text and/or email.

Patient Initials: _____

I certify that I have read the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or am otherwise duly authorized by the patient to sign the above and accept its terms on his/her behalf.

Date: _____ Time: _____ AM / PM Signature: _____
(patient/parent/conservator/guardian)

If signed by other than patient, indicate name and relationship: _____

Date: _____ Time: _____ AM / PM Witness: _____
(signature)

Name: _____
(print)

INTERPRETER'S STATEMENT

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

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

_____
Print Name

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

PATIENT'S LABEL

CONSENTIMIENTO PARA PROCEDIMIENTOS MÉDICOS Y QUIRÚRGICOS

Doy mi consentimiento a los procedimientos que puedan ser realizados durante esta hospitalización o mientras sea un paciente ambulatorio. Estos pueden incluir, pero sin limitarse a estos, tratamiento o servicios de emergencia, servicios de telesalud, procedimientos de laboratorio, exámenes radiológicos, tratamiento o procedimientos médicos o quirúrgicos, anestesia u servicios hospitalarios que me sean provistos bajo las instrucciones generales y especiales de mi médico o cirujano. Comprendo que el ejercicio de la medicina y la cirugía no es una ciencia exacta y que el diagnóstico y el tratamiento pueden involucrar riesgos de sufrir lesiones o incluso la muerte. Acepto que no me han dado garantía alguna con respecto al resultado de la examinación o del tratamiento en este hospital.

PERTENENCIAS PERSONALES

Como paciente, me recomiendan dejar los artículos personales en casa. El hospital mantiene una caja de seguridad a prueba de incendios para guardar dinero y objetos de valor. El hospital no se hace responsable por la pérdida o daño de dinero, joyas, documentos u otros artículos que no se colocan en la caja de seguridad. La responsabilidad del hospital por la pérdida de cualquier propiedad personal depositada en el hospital para su custodia está limitada por ley a quinientos dólares ($500.00), a menos que el hospital me entregue un recibo escrito por una cantidad mayor.

PACIENTES DE MATERNIDAD

Si doy a luz un bebé(s) mientras sea paciente de este hospital, acepto que se apliquen estas mismas Condiciones de Admisión al (a los) bebé(s).

CUIDADOS DE ENFERMERÍA

El hospital sólo proporciona cuidados generales de enfermería y cuidados indicados por el (los) médico(s). Si deseo recibir los servicios de una enfermera privada, yo acepto hacer los arreglos correspondientes. El hospital no es responsable por no proveer los servicios de una enfermera privada y por medio del presente queda eximido de cualquier y toda responsabilidad que pudiera surgir del hecho de que el hospital no proporcione esta atención adicional.

INSTITUCIÓN DE ENSEÑANZA

SVMC es una institución de enseñanza. Entiendo que los residentes, pasantes, estudiantes de medicina y otros aprendices pueden observar, examinar, tratar y participar en mi atención a solicitud y bajo la supervisión del médico tratante. Los estudiantes de enfermería y los estudiantes de salud afines (por ejemplo, ultrasonido, rayos x, respiratorio, terapia de rehabilitación, etc.) también pueden participar en mi atención como parte de los programas educativos del Centro Médico y son supervisados por personal hospitalario y no hospitalario. Entiendo que puedo rechazar la atención brindada por un residente, un pasante, un estudiante de medicina u otro aprendiz o estudiante de salud afín.

RELACIÓN LEGAL ENTRE EL HOSPITAL Y LOS MÉDICOS

Comprendo que todos los médicos y cirujanos que me proporcionan servicios, incluidos el radiólogo, patólogo, médico de emergencia, anestesiólogo, partera, asistente de médico y otros, **NO** son empleados ni agentes de este hospital. Se les ha dado el privilegio de usar el hospital para el cuidado y tratamiento de sus pacientes, pero ellos **NO** son empleados ni agentes de este hospital.

Iniciales del paciente: _____

Comprendo que estoy bajo el cuidado y la supervisión del médico que me atiende. El hospital y su personal de enfermería son responsables de seguir las instrucciones de mi médico. Mi médico o cirujano es responsable de obtener mi consentimiento informado, cuando sea necesario, para el tratamiento médico o quirúrgico, procedimientos terapéuticos o diagnósticos especiales; o servicios hospitalarios que me sean proporcionados bajo las instrucciones especiales y generales de mi médico.

CONSENTIMIENTO PARA FOTOGRAFIAR

La toma de fotos / cintas de vídeo para el proceso médico o quirúrgico y el uso para la documentación del tratamiento, con fines científicos, educativos o de investigación está aprobado y serán parte de mi registro médico.

CONSENTIMIENTO PARA COPIAR LA IDENTIFICACIÓN CON FOTO

Para ayudar a prevenir las posibilidades de robo de identidad, Sierra View Medical Center solicitará y obtendrá información de identificación durante el proceso de registro de los pacientes. Doy mi autorización a Sierra View Medical Center para obtener una copia de mi licencia de conducción o tarjeta de identificación para propósitos de comprobar y proteger mi identidad.

NOTIFICACIONES DE TEXTO/CORREO ELECTRÓNICO

Por medio de mis iniciales y proporcionando mi número de teléfono celular y/o correo electrónico a SVMC, certifico que soy el propietario del número de teléfono celular y/o dirección de correo electrónico y doy mi consentimiento para recibir comunicaciones, incluyendo la información de facturación, correos electrónicos automatizados, mensajes de voz, declaraciones por escrito, mensajes de texto, llamadas de marcación automática y mensajes pregrabados de SVMC o sus entidades afiliadas. Entiendo que, si bien SVMC no cobra por estas comunicaciones, algunas formas de comunicación podrían generar cargos por parte del operador de telecomunicaciones que yo soy responsable de pagar. Para no recibir mensajes de texto o cancelar la suscripción a correos electrónicos, siga las instrucciones dentro del cuerpo del texto y/o correo electrónico.

Iniciales del paciente: _____

Certifico que he leído lo anterior y he recibido una copia del mismo. Soy el paciente, el representante legal del paciente, o estoy debidamente autorizado por el paciente para firmar lo antedicho y acepto estos términos en su representación.

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

Si es firmado por una persona que no sea el paciente, indicar nombre y relación con el mismo:_____

Fecha:_____ Hora: _____ AM / PM Testigo: _____
(Firma)

Nombre: _____
(letra imprenta)

INTERPRETER'S STATEMENT

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

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

_____
Print Name

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

Form # 014191 REV. 2/26

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

PATIENT'S LABEL

SIERRA VIEW MEDICAL CENTER

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Information

Full Name: _____

Date of birth: _____ Medical Record Number (If Known): _____

Address: _____

City / State / ZIP: _____

Phone Number: _____ Email (Optional): _____

Requestor (if different from patient)

Name: _____

Relationship to Patient: _____

Address (If different): _____

Phone Number: _____ Email: _____

Amendment Request Details

1. What information do you want to amend? (Check all that apply)

❑ Physician's note ❑ Lab result ❑ Diagnosis / problem list

❑ Medication record ❑ Radioliology Report

❑ Other (describe): _____

2. Date(s) of the record(s) to be amended: _____

3. Account #: _____

4. Describe the amendment you are requesting: _____

_____

_____

_____

5. Reason for amendment: _____

_____

_____

_____

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Form # 021285 REV 10/25

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

PATIENT'S LABEL

6. Supporting Documentation (list if attaching): _____

_____

_____

Signature & Authorization

Signature: _____ Date: _____

If signed by a representative / power of attorney, print name: _____

Relationship / authority: _____

FOR SIERRA VIEW USE ONLY (INTERNAL USE)

Date Received: _____

Method Received: ❑ Mail ❑ FAX ❑ In-person ❑ Email

Reviewed By: _____

Decision: ❑ Accept Amendment ❑ Deny Amendment

If denied, reason: _____

_____

Notice Sent to Requestor on: _____

_____

PATIENT'S LABEL

SIERRA VIEW MEDICAL CENTER

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Información del Paciente

Nombre Completo: _____

Fecha de Nacimiento: _____ Numero de Registro Medico (si se sabe): _____

Dirección: _____

Ciudad / Estado / Código Postal: _____

Número de Teléfono: _____ Correo Electrónico: _____

Solicitante (si es diferente del paciente)

Nombre: _____

Relación al Paciente: _____

Dirección (si es diferente): _____

Número de Teléfono: _____ Correo Electrónico: _____

Detalles de la Solicitud de Enmienda

1. ¿Qué información desea modificar? (marque todo lo que corresponda)

❑ Nota Medica ❑ Resultado de Laboratorio ❑ Diagnostico/Lista de Problemas

❑ Registro de Medicación ❑ Informe de Radiología

❑ Otros (describa): _____

2. Fecha(s) del/de los registro(s) que se van a modificar: _____

3. # de Cuenta: _____

4. Describa la modificación que solicita: _____

_____

_____

_____

5. Razón de la enmienda: _____

_____

_____

_____

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Form # 021286 REV 04/26

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

PATIENT'S LABEL

6. Documentos de Respaldo (enumere si adjunta): _____

_____

_____

Firma y Autorización

Firma: _____ Fecha: _____

Si está firmada por un representante / Poder Notarial, nombre en letra de molde: _____

Relación / Vinculo: _____

SOLO PARA USO INTERNO DE SIERRA VIEW (USO INTERNO)

Date Received: _____

Method Received: ❑ Mail ❑ FAX ❑ In-person ❑ Email

Reviewed By: _____

Decision: ❑ Accept Amendment ❑ Deny Amendment

If denied, reason: _____

_____

Notice Sent to Requestor on: _____

_____

SIERRA VIEW MEDICAL CENTER

Advance Beneficiary Notice of Noncoverage (ABN)

Notifier: Sierra View Medical Center, 465 W Putnam Ave, Porterville, Ca. 93257, (559)784-1110

Patient First/Last Name: _____ **C. ID Number:** _____

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

Item, Test, Service or care	Reason Medicare May Not Pay:	Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the _____ listed above.

Choose one option below to let us know if you still want to get the item, test, service, or care.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1. I want the item, test, service or care listed above, and I want Medicare to be billed for an official decision on payment, which I'll get on a Medicare Summary Notice (MSN)**. You can ask to be paid now. I understand that if Medicare doesn't pay, I'm responsible to pay, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles

☐ **OPTION 2. I want the item, test, service or care listed above, but don't bill Medicare.** You can ask to be paid now and I'm responsible to pay. I understand that I can't appeal, since Medicare isn't billed.

☐ **OPTION 3. I don't want the item, test, service, or care listed above.** I understand I'm not responsible for payment and I can't appeal to see if Medicare would pay

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227).(**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You may ask to receive a copy.

Signature:	**Date:**

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint ifyou feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.The valid OMB control number for this information collection is 0938-0566. This information collection is for providers, suppliers, Hospice and Religious Non-medical HealthCare Institutes andHome Health Agencies to notify original Medicare beneficiaries of their potential financial liability under specific conditions. The time required to complete this information collection is estimated toaverage less than 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. Thisinformation collection is mandatory under Section 1879 of the Social Security Act, 42 CFR 411.404(b) and (c) and 411.408(d)(2) and (f). If you have comments concerning the accuracy of the timeestimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

Form CMS-R-131 (Exp. 03/31/2029) Form Approved OMB No. 0938-0566

SIERRA VIEW MEDICAL CENTER

Notificación previa de NO-cobertura al beneficiario (ABN)

A. Notificante: Sierra View Medical Center, 465 W Putnam Ave, Porterville, Ca. 93257, (559)784-1110

B. Nombre del paciente: _____ **C. Número de identificación:** _____

NOTA: Si Medicare no paga **D.** _____ a continuación, usted deberá pagar.
Medicare no paga todo, incluso ciertos servicios que, según usted o su médico, están justificados. Prevemos que Medicare no pagará **D.** _____ a continuación.

D.	E. Razón por la que no está cubierto por Medicare:	F. Costo estimado

Lo que usted necesita hacer ahora:

- Lea la presente notificación, de manera que pueda tomar una decisión fundamentada sobre la atención que recibe.
- Háganos toda pregunta que pueda tener después de que termine de leer.
- Escoja una opción a continuación sobre si desea recibir **D.** _____ mencionado anteriormente.
  Nota: Si escoge la opción 1 ó 2, podemos ayudarlo a usar cualquier otro seguro que tal vez tenga, pero Medicare no puede exigirnos que lo hagamos.

G. Opciones: Sírvase marcar un recuadro solamente. No podemos escoger un recuadro por usted.

☐ **Opción 1.** Quiero **D.** _____ mencionado anteriormente. Puede cobrarme ahora, pero también deseo que se cobre a Medicare a fin de que se expida una decisión oficial sobre el pago, la cual se me enviará en el Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable por el pago, pero **puedo apelar a Medicare** según las instrucciones en el MSN. Si Medicare paga, se me reembolsarán los pagos que he realizado, menos los copagos o deducibles.

☐ **Opción 2.** Quiero **D.** _____ mencionado anteriormente, pero que no se cobre a Medicare. Puede solicitar que se le pague ahora dado que soy responsable por el pago. **No tengo derecho a apelar si no se le cobra a Medicare.**

☐ **Opción 3.** No quiero **D.** _____ mencionado anteriormente. Entiendo que con esta opción **no** soy responsable por el pago y **no puedo apelar para determinar si pagaría Medicare.**

H. Información adicional:

En esta notificación se da a conocer nuestra opinión, no la de Medicare. Si tiene otras preguntas sobre la presente notificación o el cobro a Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Al firmar abajo usted indica que ha recibido y comprende la presente notificación. Puede solicitar recibir una copia.

I. Firma:	J. Fecha:

CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en un formato alternativo, por favor llame al: 1-800-MEDICARE o escriba al correo electrónico: AltFormatRequest@cms.hhs.gov.

Formulario CMS - R-131 (Exp. 01/31/2026) Formulario aprobabdo OMB No. 0938-0566

SUBJECT: **COMPLIANCE OFFICER**	SECTION: **Page 1 of 3**

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

PURPOSE:

To ensure that Sierra View (SVMC) has a dedicated Compliance Officer (CO) and to ensure SVMC establishes and maintains an effective Compliance Program.

POLICY:

1. Pursuant to the SVMC Board of Directors' Resolution of April 2, 2001; a formal Compliance Program was established. The resolution established that a CO will implement and oversee the Compliance Program, as well as SVMC's compliance with the requirements of federal and state laws and regulations, and health care program requirements.

2. Pursuant to the SVMC Board of Directors Resolution No. 06-28-16/01 establishing the Board of Director's direct oversight of the Compliance Program; the CO is the designated appropriate authority to effectively oversee the Program and has direct access to the Board of Directors.

3. The CO will facilitate a Compliance Committee (CC) to assist with the implementation of the Compliance Program.

AFFECTED AREAS/PERSONNEL:

COMPLIANCE OFFICER, COMPLIANCE DEPARTMENT & COMPLIANCE COMMITTEE

PROCEDURE:

1. The Chief Executive Officer (CEO) of SVMC shall designate an appropriate individual as identified below, to serve as the CO.

2. The CO shall possess the following minimum qualifications:

    a. A Bachelor's Degree with an emphasis in accounting, finance, business or healthcare administration or five (5) years' experience of broadly based, progressive experience of financial and business systems, fraud and abuse laws and regulations.

    b. Makes judgments, coordinates project teams, and takes reasonable action required to accomplish project objectives with minimal direct supervision.

3. The CO will have various job responsibilities regarding the implementation and oversight of the Compliance Program, which include, but are not limited to:

    a. Developing compliance standards and procedures to be followed by employees to reduce the possibility of non-compliant activities;

    b. Communicating compliance standards and distributing the Code of Conduct;

c. Coordinating and monitoring required employee compliance training, and ensuring employee evaluations include a compliance component;

d. Advising colleagues on compliance-related concerns and issues;

e. Initiating and directing compliance-related investigations;

f. Maintaining a system for the reporting of compliance-related concerns and issues by employees, including establishing and supporting a Compliance Hotline for anonymous reports or inquires by employees, and promoting SVMC's non-retaliation policy for good faith reporting;

g. Coordinating and directing system-wide monitoring and auditing procedures;

h. Identifying and encouraging, where necessary, appropriate corrective actions related to compliance;

i. Meeting directly with the Chief Executive Officer (CEO), and/or the Board of Directors (BOD) at any time, should issues require such a meeting, and serving as the liaison to the Board of Directors;

j. Meeting quarterly with the CEO on the status of the SVMC Compliance Program and presenting a Compliance Program report to the Board of Directors on a quarterly basis.

h. Overseeing Compliance Department staff and Compliance Department activities.

REFERENCES:

- Federal Register/Vol 70, No. 19/Monday January 31, 2005
- Federal Register/Vol. 63, No. 35/Monday, 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/

CROSS REFERENCES:

- COMPLIANCE PROGRAM/PLAN
- COMPLIANCE COMMITTEE

SUBJECT: **COMPLIANCE OFFICER**	SECTION: **Page 3 of 3**

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SUBJECT: **MANAGING CONSTRUCTION**	SECTION: ***Safety Management*** **Page 1 of 2**

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

PURPOSE:

Sierra View Medical Center (SVMC) is committed to providing safe, effective care to our patients at all times. During construction and renovation activities, there are a number of issues that must be addressed by administrative, clinical, facilities management, project planning, and management staff to assure a safe and secure environment for all patients, visitors, physicians, staff and the general public during construction and renovation of the facilities.

POLICY:

All projects will be designed to promote better care for the patients and an increased safe environment for staff, physicians and the general public. Each project will be managed to ensure that the potential impact or disruption to patient care areas and the caregiver is kept to a minimum. Every effort will be used to minimize disruption of the construction process, but, in all cases, patient care considerations will have the highest priority. Patient care quality and patient safety will not be compromised.

During design and construction, or renovation, the appropriate guidelines and regulations will be followed, including, but not limited to, Guidelines for Design and Construction of Healthcare Facilities, 2014 edition, published by the American Society for Healthcare Engineering. All appropriate state and local regulations will be followed, including obtaining all permits, licenses and approvals and maintaining compliance with relevant regulations. Each proposed project will be carefully reviewed initially and at various phases to ensure the proper design, engineering, and construction methods are followed. In addition, any unique problems requiring special consideration during construction will be discussed and mitigation strategies will be developed to minimize the disruption to the care environment.

The organization's Master Plan and each Project Construction Plan must include a Pro Active Risk Assessment, including a Pre-construction Risk Assessment, developed to minimize the impact of construction on patient care, staff safety, and business operations. The Pre-Construction Risk Assessment will cover air quality, infection control, noise, vibration, utility systems, and emergency preparedness with Interim Life Safety Measures. The risk assessment process will be repeated as often as necessary to assure effective management of the issues listed and conducted by individuals with expertise and experience in each area.

Sierra View Medical Center is accredited by the Joint Commission. The Joint Commission requires documentation of the risk assessment, the plans developed to manage the impact of construction, and implementation of the plans. The facility will document compliance with the programs elements. Appropriate training will be provided to the staff involved, associated with, or adjacent to the project. Training will also be provided to all contractors to ensure all construction workers are appropriately trained in safety issues associated with the project and hospital policy.

AFFECTED PERSONNEL/AREAS:

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

REFERENCES:

- The Joint Commission (2026~~1~~). Hospital Accreditation Standards. ~~EC.02.01.01.~~PE.01.01.01 EP1 & PE.03.02.01 Joint Commission Resources. Oak Brook, IL.
- Facility Guidelines Institute, Guidelines for Design and Construction of Hospitals, 2018 Edition
- Office of Statewide Health Planning & Construction Facilities Development Division, CA. Title 24.
- California Department of Public Health CA. Title 22.
- Infection Control Construction Permit process
- Contractor's Handbook Training Program
- Construction Risk Assessment Program
- Construction "Safety Permit" Program

CROSS REFERENCES:

- Interim Life Safety (LSM) Policy

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SUBJECT: **PARTICIPANT INPUT OF THE RETIREMENT POLICY**	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 a method for plan participants to provide input to the Retirement Plan Administration Committee (Committee) on any plan-related issues including asset classes or investment funds that they would like the Committee to consider.

POLICY:

The Committee will examine the risk/return objectives of each asset class, the investment sophistication of the entire set of participants, and the role played by the asset class in a prudent, diversified retirement savings portfolio.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

A. The Committee will accept requests at any time and will consider all community input. Requests received by December 31 will normally be considered during the Committee's first quarterly meeting of each calendar year. The Committee may consider and discuss requests at other Committee meetings at their discretion.

B. Any plan participant can make suggestions by providing them in writing to the below contact. To be considered, each request must be accompanied by a brief written explanation of the reason, concern, and objective for the request and how the change, if implemented, would benefit the entire plan participant population. Absent this information, the request will not be brought to the Committee.

Vice President of Human Resources
465 West Putnam Avenue
Porterville, California 93257
Email: tcanales@sierra-view.com

C. For investment-related requests, the Committee will consider investments objectives for the plan, including providing exposure to a range of asset classes with varying risk/reward profiles; optimizing returns within levels of risk that are reasonable and prudent for retirement plans with diversified investments; and controlling expenses consistent with service objectives.

D. The first step in considering a fund request is to determine whether that fund's asset class is or should be included as an asset class in the plan. The Committee will then screen specific fund requests against minimum requirements within an affirmed asset class and then perform a quantitative and qualitative evaluation. Both the asset class being considered as well as the potential investment product should be consistent with the current Investment Policy Statement for the Plan.

E. Consistent with Sierra View Local Health Care District's fiduciary responsibilities, the "popularity" or number of requests for a fund shall not be a factor in the Committee's recommendation.

The process for considering non-investment requests will be dependent on the type of request.

F. The Committee will acknowledge receipt of participant requests when received. Once the Committee has considered the request (typically at their first calendar-quarter meeting), the Committee will communicate the decision to the participant who made the request, along with the rationale for the decision.

SUBJECT: **PAYCHECKS AND PAYDAYS**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define the manner and frequency in which exempt and non-exempt employees will receive payment for work performed.

POLICY:

For payroll purposes, the "workweek" begins Sunday at 12:00 A.M. and ends on the following Saturday at 11:59 P.M.

A "workday" consists of twenty-four consecutive hours commencing at 12:00 AM and ending at 11:59 PM.

A pay period consists of fourteen (14) consecutive days, beginning on Sunday and ending on the second Saturday. Employee schedules may vary depending on position and operational needs. Employees may be scheduled to work three (3), four (4), or five (5) shifts per week. A normal work shift may consist of eight (8), ten (10), or twelve (12) paid hours. Scheduled shift lengths may be longer to accommodate an unpaid meal period, typically thirty (30) minutes, which is not considered hours worked unless otherwise authorized.

~~A pay period consists of fourteen consecutive workdays, normally beginning Sunday and ending two weeks later on Saturday. The normal workweek consists of five workdays per week. A normal shift consists of 8 hours per day, not including a one-half hour unpaid meal period, unless scheduled otherwise.~~

Paydays will be on the Friday that follows the end of each pay period. If a payday occurs on an observed holiday, checks will be distributed on the last working day before the holiday.

The General Accounting Department will distribute paychecks to department designees each payday. Checks will be released only to those individuals who are authorized to pick up departmental checks for distribution.

Checks will be released at 10:00 A.M. on Friday. Undistributed checks will be held for three days, at which time they will be returned to the General Accounting Department who will in turn mail them to the employees via certified mail. Pay via direct deposit will follow the same schedule as set forth in this policy.

Employees are responsible for accurately recording all hours worked in accordance with the policy, Recording Hours Worked.

In addition, Department Leadership along with ~~Directors, Managers and~~ Administration must timely submit all relevant information to the Payroll Department for processing in accordance with the policy, Recording Hours Worked.

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During holiday weeks and/or under special circumstances, the General Accounting Department may designate an earlier deadline.

WITHHOLDINGS

1. STATE/FEDERAL TAXES

   Federal and state taxes will automatically be withheld from each paycheck. The amount of withholding will be determined by the number of exemptions claimed by an employee on the most recent Employee's Withholding Exemption Certificate (form W-4) or the most recent change submitted by the employee through ~~Kronos~~ the Time keeping Self Service option.

2. SOCIAL SECURITY

   The employee's share of Social Security (F.I.C.A.) taxes will be withheld from each paycheck. The amount of withholding will be based upon the federally designated formula for each calendar year.

3. RETIREMENT SAVINGS PLANS

   Voluntary employee contributions to the company retirement plans (tax-sheltered annuities) will be taken from each paycheck on a pre or post tax basis depending on the plan. Federal and State taxes will only be calculated on post-tax retirement contributions.

4. EMPLOYEE WELFARE BENEFIT PLANS

   On a voluntary basis, employees may choose to authorize payroll deductions for participation in some or all of the employee benefit programs. The employee's authorization shall be in writing.

5. GARNISHMENTS AND OTHER PAYCHECK ATTACHMENTS

   Under certain circumstances, SVMC may be required to take deductions from employee paychecks in order to comply with legally required garnishments, tax levies, support orders, etc. Guidelines for paycheck attachments are covered in the Garnishments policy.

6. STATE DISABILITY INSURANCE

   State Disability Insurance (SDI) is a mandated deduction that provides financial assistance during periods of disability when employees are unemployed due to a non-occupational injury/sickness or during a California Paid Family Leave.

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PROBLEMS WITH PAYCHECKS

If an employee feels that his or her paycheck has been prepared incorrectly, the problem must be brought immediately to the attention of his or her Department Leadership ~~immediate supervisor~~ who will work with Payroll to help facilitate a prompt resolution of the problem.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

REFERENCES:

- Fair Labor Standards Act (2019). Retrieved from https://www.dol.gov/agencies/whd/flsa.
- California Labor Code (2019). Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml?tocCode=LAB&division=4.&title=&part=&chapter=&article=.
- Division of Labor Standards Enforcement (2019). Retrieved from https://www.dir.ca.gov/DLSE/dlse.html.

CROSS REFERENCES:

- Recording Hours Worked
- Overtime
- Garnishments

SUBJECT: **PERMITS, LICENSES, MANIFESTS AND SDS**	SECTION: **Page 1 of 3**

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

POLICY:

It is the policy of the Sierra View Medical Center to comply with local, state and federal laws and regulations when maintaining permits, licenses, manifests, and safety data sheets of the hazardous materials and waste.

PROCEDURE:

A. Permits and Licenses

- The Hospital will maintain a current copy of all license or permits required to receive or dispose of hazardous materials or waste.
- These licenses and permits will be available for inspection by local, state, and federal authorities having jurisdiction. Update Hazardous Material and Waste Licenses and Permits list as needed to document current status.
- These licenses and permits will also be documented on procurement requests or disposal manifests where such information is required.
- Contractors that remove hazardous waste must maintain a current license or permit depending on the waste type and must provide a copy to the Hospital. If there is any change in the requirements of the license or permit maintained by the contractor, such information will be provided to the Hospital as soon as possible.

B. Manifests

- All hazardous wastes removed from Sierra View Medical Center will be documented on a manifest. The contractors responsible for the disposal of the regulated wastes generally complete these manifests.
- Manifests are reviewed at the time of removal to assure they contain accurate information and are complete. Sierra View Medical Center and contractors work together to assure that the manifests meet the requirements of the state or federal agencies.
- Manifests are maintained in-house, by the Facilities Coordinator, in the Facilities Office. When the second (disposal) copy is received, that copy is matched with the original (i. e., generator) copy, and they are filed together. If the disposal copy is not received in the designated period (generally 30-35 days), the contractor is contacted to explain the discrepancy. If they do not respond before the mandated return period, the applicable state or federal agency is notified.
- Any missing manifests or problems with the disposal process will be immediately reported to the Safety Officer and to the Safety Committee.

C. Safety Data Sheets (SDS)

- Department Directors/Managers are responsible for obtaining an SDS for each identified hazardous chemical in the department and ensuring they are accessible to employees at all times.
- A master list of hazardous chemicals is kept at Sierra View Medical Center and the Director of Environmental Services will maintain the master file of all SDS.
- Sierra View Medical Center will rely on the information provided on the SDS supplied by the manufacturer/distributor for emergency response procedures.
- If an SDS is missing from a department manual for chemicals currently in use, one can be obtained from the master SDS manual or by calling the manufacturer directly.
- For new chemicals, a SDS can be obtained from the manufacturer through the department.
- Department Directors/Managers are responsible for reviewing the SDS, as well as educating staff, to ensure that all sections are understood and that the chemical is being used safely.

1. SDS are <u>not</u> required for:

   a. Any hazardous waste as such term is defined by the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended (42 U.S.C. 6901 et seq.), when subject to regulations issued under that Act by the Environmental Protection Agency;

   b. Tobacco or tobacco products;

   c. Food or alcoholic beverages which are sold, used, or prepared in a retail establishment (such as a grocery store, restaurant, or drinking place), and foods intended for personal consumption by employees while in the workplace;

   d. Any drug, as that term is defined in the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.), when it is in solid, final form for direct administration to the patient (e.g., tablets or pills); drugs which are packaged by the chemical manufacturer for sale to consumers in a retail establishment (e.g., over-the-counter drugs); and drugs intended for personal consumption by employees while in the workplace (e.g., first aid supplies);

   e. Cosmetics which are packaged for sale to consumers in a retail establishment, and cosmetics intended for personal consumption by employees while in the workplace; Any consumer product or hazardous

substance, as those terms are defined in the Consumer Product Safety Act (15 U.S.C. 2051 et seq.) and Federal Hazardous Substances Act (15 U.S.C. 1261 et seq.), respectively, where the employer can show that it is used in the workplace for the purpose intended by the chemical manufacturer or importer of the product, and the use results in a duration and frequency of exposure which is not greater than the range of exposures that could reasonably be experienced by consumers when used for the purpose intended;

f. Ionizing and non-ionizing radiation; and,

g. Biological hazards.

REFERENCES:

- The Joint Commission (2026~~1~~). Hospital Accreditation Standards. ~~EC.02.02.01~~PE.02.01.01 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **STANDARDIZED EMERGENCY CODES**	SECTION: ***Initiation of Emergency Operations Procedures*** **Page 1 of 4**

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.

SUBJECT: **STANDARDIZED EMERGENCY CODES**	SECTION: ***Initiation of Emergency Operations Procedures*** **Page 3 of 4**

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

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

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

SUBJECT: **UROLOGY CLINIC- URINE SPECIMEN COLLECTION AND TESTING (STANDARDIZED PROCEDURE)**	SECTION: **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:
VOLUNTARY DISCLOSURE OF VIOLATIONS (REPORTABLE EVENTS)	**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*** **Page 1 of 3**

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

PURPOSE:

To outline the methods used at Sierra View Medical Center (SVMC) to comply with federal, state, 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.

SUBJECT:	SECTION:
WEAPONS PREVENTION: SEARCHES AND METAL DETECTORS	***Security Management*** **Page 1 of 2**

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PURPOSE:

To provide for a safe environment for visitors, patients and personnel entering the Hospital.

POLICY:

- All persons entering the Hospital shall be subject to reasonable search as a condition of entry to the property. Persons with implanted medical devices such as pacemakers and defibrillators will be provided an alternate method of search by hand-pat procedure instead of the electronic metal detection scan. Visitors and/or guests refusing search will be denied entry to the property. Patients refusing search will be denied services until a safe environment may be established.

- Hand held metal detectors will be in operation 24 hours a day, year-round.

PROCEDURE:

1. Hand held metal detectors will be in use by Security at the entrance~~s~~ of the Emergency Department, as directed by the Security Department and the Environment of Care/Safety and Security Manager.~~.~~

2. A Security Officer will be present when metal detector is in operation.

3. All persons entering the Emergency Department area will be subject to a weapon screening.

4. Persons with implanted medical devices will be allowed a same sex pat-search as the weapons screening process.

5. Signs stating the following information will be posted at all entrances to the hospital:

   ~~—~~No firearms or weapons are allowed on this property. Sworn Law Enforcement officers are exempt from this policy (on and off duty)

   - All illegal weapons will be confiscated and turned over to the Porterville Police Department. Persons possessing a legal weapon will be directed to secure the item in their vehicle prior to entry.

6. Weapons, dangerous devices, contraband and suspected stolen property will be retained and secured in the Security Office under lock and key for law enforcement authorities.

7. Persons refusing search of hand luggage or purse may be allowed to return to their vehicle and store their possessions in a locked vehicle.

8. Persons entering through any hospital entrance will constitute consent to a reasonable search. Persons refusing to comply with instructions to enter the hospital through a detector-monitored entrance may be denied entry.

9. Persons seeking emergency medical services will not be refused services.

REFERENCES:

- The Joint Commission (2023) Hospital accreditation standards.~~EC.02.01.01~~ NPG.11.01.01 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Security Management Plan
- Drug/Alcohol in the Workplace – Human Resources Manual
- Weapons in House
- Visitor Guidelines – House-Wide Policy & Procedure Manual
- Access to the ED After Hours and Main Hospital Policy

SUBJECT: **SURGE CAPACITY PLAN**	SECTION: ***Emergency Management Program Patient Management*** **Page 1 of 4**

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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*

SUBJECT: **SURGE CAPACITY PLAN**	SECTION: ***Emergency Management Program*** ***Patient Management*** **Page 2 of 4**

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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)*** **Page 1 of 75**

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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 Performance~~atient Safety~~ Goals (NPSGs)***

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~~

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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~~

~~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 07006~~: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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SUBJECT:	SECTION:
UTILITY SYSTEM OPERATIONAL PLANS AND FAILURE PROCEDURES	***Utilities Management*** **Page 1 of 32**

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

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.

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	05/06/2026
BOARD OF DIRECTORS APPROVAL	
	05/26/2026
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
May 26, 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**
	• Aminoglycoside Protocol Per Clinical Pharmacist	1-4	
	• Central Venous Catheters, Care and Maintenance of	5-14	
	• Conduct Methicillin Resistant Staphylococus Aureus (MRSA) Screening	15-17	
	• Extravasation Management of Sympathomimmetic Vasoconstrictors (Pressors)	18-22	
	• Hyperbilirubinemia	23-27	
	• Medication Administration Times	28-31	
	• Medication Reconciliation	32-34	
	• Naming Conventions for the Master Patient Index (MPI)	35-36	
	• Pharmacy Organization	37-38	
	• Prone Positioning for the Non-Intubated Patient	39-42	
	• Propofol (Diprivan)	43-45	
	• Pyxis Access	46-49	
	• Scope of Service – Cardiac Cath Lab	50-52	
	• Standard Maintenance of Water Treatment System	53-56	
	• Sterile Hazardous Drug Handling	57-76	
	• Therapeutic Drug Substitution Protocol	77-87	
	• Waived and Point of Care Testing – Hemoglobin Testing (Hemocue HB801)	88-92	
II.	**Forms**		
	• Hysterectomy Informed Consent – English	93-94	
	• Hysterectomy Informed Consent – Spanish	95-96	
	• Notice of Privacy Practices	97-103	
	• Notice of Privacy Practices (Spanish)	104-110	

SUBJECT:	SECTION:
AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST	***Drug Protocols***

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

AFFECTED AREAS/PERSONNEL: *PHARMACY; NURSING; Providers*

PROTOCOL & PROCEDURE:

A. Patient Work-Up: Clinical pharmacist to perform initial evaluation of patient based upon available data.

1. Minimum required information:
   a. Age
   b. Sex
   c. Height
   d. Weight
   e. Serum creatinine
   f. Allergy history
   g. Indication of use
2. Reason for admission
3. Past medical & medication history
4. Vital signs & pertinent physical findings
5. Co-existing disease states
6. Current medications
7. Lab Data
   a. Urinalysis
   b. Chemistries
   c. Cultures & sensitivities
8. Other pertinent tests, results, and clinical data

B. Determine therapeutic goal(s): Using physician's database, determine therapeutic goals. If unclear, contact requesting physician to clarify matters. Indicate pharmacokinetic goals on initial work-up.

C. Using available pharmacokinetic software (or standard pharmacokinetic application equations), calculate dose(s), intervals based upon the therapeutic & pharmacokinetic data from population kinetic parameters.

D. Order doses & levels as appropriate to the patient's clinical condition.

1. If patient has received dose(s), evaluate active dosing parameters.
2. If the current order does not appear to be appropriate based upon the Therapeutic & Pharmacokinetic Goals, and population data kinetics, change the dose accordingly, as calculated. Indicate on pharmacy monitoring form reason(s) for changing dose/schedule.
3. Maintenance random levels should be performed weekly at minimum if the therapy will be prolonged beyond 7 to 10 days. Otherwise at pharmacist discretion (Ex changes in renal function).

E. Adverse Events: If the clinical pharmacist suspects an adverse event, place the aminoglycoside on hold and inform the physician immediately of the circumstances.

SUBJECT:	SECTION:
AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST	***Drug Protocols***

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

I. Extended Interval Dosing of Aminoglycosides

This is the preferred method when dosing for gram-negative infections. Extended Interval Dosing does NOT imply 24 hour dosing, but rather the use of empiric doses.

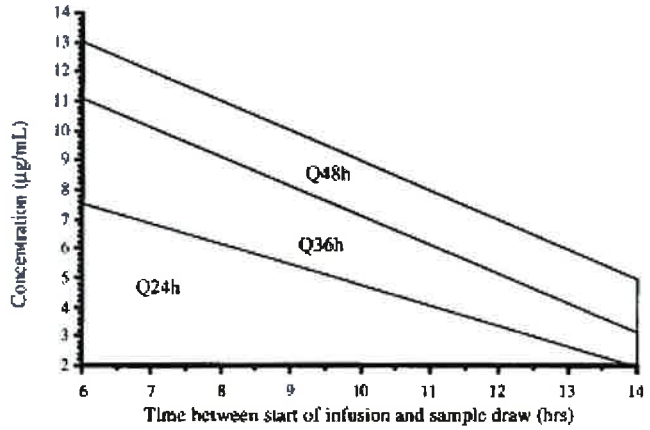
SVMC will utilize the Hartford Nomogram, which generally uses a dose of 7mg/kg of either gentamicin or tobramycin.

Exclusion criteria for extended interval dosing:
Renal insufficiency/Dialysis (CrCl <30 mL/min or rapidly declining renal function), Pregnancy, Synergy for G+ infections, Ascites/Cirrhosis, Burns (>20%).

Initial dose:
For patients with total body weight (TBW) < ideal body weight (IBW) calculate the dose based on TBW. For patients with TBW 1 to 1.2 times IBW, calculate the dose based on TBW or IBW. For patients with TBW >1.2 times IBW use adjusted body weight ([0.4 × {TBW − IBW}] + IBW).

Creatinine Clearance (mL/min)	Gentamicin or Tobramycin	Amikacin
≥ 60	7 mg/kg every 24 hours	15 mg/kg every 24 hours
40 to 59	7 mg/kg every 36 hours	15 mg/kg every 36 hours
30 to 39	7 mg/kg every 48 hours	15 mg/kg every 48 hours
<30 or renal replacement therapy	Not recommended	Not recommended

Initial Monitoring: Draw a random level, typically between 8-12 hours after the first dose. Results from this measurement are then used in conjunction with the nomogram to determine the necessary dosing interval. Maintenance monitoring should be performed weekly at minimum if the therapy will be active beyond 7 to 10 days. For monitoring of patients with normal renal function where the expected duration of therapy is <72 hours or three doses, the pharmacist may choose not to do routine monitoring. Example post-partum endometritis.



SUBJECT: **AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST**	SECTION: ***Drug Protocols***

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II. Conventional/Traditional Dosing

Initial doses are 3 to 5mg/kg/day in divided doses every 8 h ours. Targeting peak concentration dependent on indication and site of infection. The general target is a peak of 7 to 10 mcg/mL for more serious infections. Target trough concentrations should be <2mcg/mL; ideal target <1 mcg/mL.

Creatinine Clearance (mL/min)	Gentamicin or Tobramycin	Amikacin	Timing of Levels Peak	Troughs
>60	1.5 mg/kg Q8Hr	7.5 mg/kg Q12Hr or 5mg/kg Q8Hr	30 min after 3rd dose	Before 4th dose
40 to 59	1.5 mg/kg Q12Hr	5 to 7.5mg/kg Q12Hr	30 min after 2nd dose	Before 3rd dose
20 to 39	1.5 mg/kg Q24Hr	5 to 7.5mg/kg Q24Hr	30 min after 2nd dose	Before 3rd dose
<20	Administer usual dose every 36 to 48 hours.	5 to 7.5mg/kg once; subsequent based on serum con.	30 min after 1st dose	Before 2nd dose

Initial Monitoring: Draw a peak 30 minutes after 30 minute infusion has been completed or 1 hour following initiation of infusion; draw a trough 30 minutes prior to next dose. Obtain drug levels after the third dose unless renal dysfunction or toxicity is expected.

Goal Levels

Antibiotic	Indication	Target Peak	Target Trough
Gentamicin/Tobramycin	Life Threatening UTI Synergy for G+	7 to 10 mcg/mL 4-6 mcg/mL 3-4 mcg/mL	G negative < 2mcg/mL Synergy G+ <1 mcg/mL
Amikacin		20-40 mg/L	<8 mg/mL

Gram Positive Synergy Dosing

Initial Dosing

CrCl (mL/min)	Gentamicin Synergy Dosing	Timing of levels Peaks	Troughs
>60	1 mg/kg q8h	30 min after 3rd dose	Before 4th dose
40-59	1 mg/kg q12h	30 minutes after 2nd dose	Before 3rd dose
30-29	1 mg/kg q24h	30 minutes after 1st dose	Before 2nd dose
<20; AKI	1 mg/kg x1 dose; Redose when <1mcg/mL	30 minutes after 2st dose	Before 2nd dose, redoes when Cp <1mcg/mL

Monitoring

Goal levels	**Target Peak**	**Target Trough**
Gentamicin/Tobramycin	3-4 mcg/mL	<1mcg/mL

3

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SUBJECT:	SECTION:
CENTRAL VENOUS CATHETERS, CARE AND MAINTENANCE OF	*Nursing Procedures (NR)* 10 **Page 1 of 11**

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PURPOSE:

To provide standardized guidelines for continuous and intermittent central venous therapy, to minimize the incidence of catheter-related complications and to provide guidelines for removal of central venous catheters.

DEFINITIONS:
Central Line: An intravascular catheter that terminates at or close to the heart or in one of the great vessels (CDC, 2024).

POLICY:

1. Insertion of a central venous catheter requires signed informed consent.

2. The patient and, as appropriate, the family, will be educated on infection prevention strategies to help reduce central line-associated blood stream infection (CLABSI).

3. The Central Line Insertion Checklist must be completed on the Electronic Medical Record (EMR).

4. No central line is to be used until the catheter tip placement at the juncture of the right atrium and superior vena cava is verified by chest X-ray. **EXCEPTION**: *In an extreme emergency (i.e. code blue, trauma), a central line may be used without X-ray confirmation. However, free-flowing blood return must be present prior to use.*

5. If the physician places injection ports on the end of the central line upon insertion of a central venous catheter, the registered nurse (RN) will immediately replace ports with V-link (silver) valves.

6. Central venous catheters will be clamped at all times when not in use.

7. Flush unused lumens of the central line with 10 ml normal saline every 8 hours and before and after each use.

8. All central venous catheters will be dressed with a sterile, semi-permeable dressing. This dressing will be changed every 7 days or when damp, loose or soiled.

9. V-link valves will be changed every 7 days with sterile dressing change.

10. Central venous catheter V-link valves will be swabbed with an ***alcohol wipe for at leasat 15 seconds or an alcohol impregnated cap will be used*** and allowed to dry prior to accessing. Only a syringe is to be used for accessing valves. Do not use any device to pierce the valves (i.e. needle).

11. An infusion pump will be used on all central line infusions except in extreme emergencies.

12. Laboratory specimens may be drawn from central venous catheters unless a physician orders otherwise. *Exception: Blood cultures will be drawn from peripheral sites unless otherwise specified by the physician. If the line is used for TPN, stop TPN infusion, flush with 10 mL of normal saline and wait for 5 minutes; then specimen may be drawn.*
13. If a multilumen catheter is used to administer peripheral nutrition, designate one port for hyperalimentation, preferably the medial port. DO NOT use the designated hyperalimentation port for other purposes (e.g. administration of fluids, blood, or blood products.)
14. Central venous catheters established for the acute management of the patient may be removed by a registered nurse with a physician's orders. If any resistance is felt, the RN is to stop the procedure and notify the physician. RN should not remove catheters removed for dialysis example (Tri-Flow, Vas Cath) these should be removed by provider.

INDICATIONS FOR USE

- Fluids
- Blood Products
- Medications
- Dialysis
- Parenteral Nutrition
- Hemodynamic Monitoring
- Lack of Peripheral access
- Other

TRAINING AND COMPETENCY

NURSING

1. All RNs will be educated on central line management, including prevention of central line-associated bloodstream infections upon hire.
2. RN competency on central line management and infection prevention will be validated initially on hire and annually thereafter.
3. Nurses will be responsible for ensuring that the physician central line continuation orders are placed in the chart on a daily basis.

PHYSICIAN

1. Physicians will perform a daily evaluation of the need to continue a central line and document indications for continued use.

2. All physicians who are involved in central line insertion and management will complete a self-learning module on the prevention of central line-associated bloodstream infections initially.
3. Thereafter, education on the prevention of central line-associated bloodstream infections will be provided to physicians annually during medical staff meetings.

AFFECTED AREAS/PERSONNEL: *ALL NURSING UNITS*

PROCEDURE:

Flushing

1. Equipment
   a. Alcohol wipes
   b. Gloves
   c. Prefilled normal saline 10 mL syringe
2. Procedure
   a. Explain procedure to patient.
   b. Wash hands.
   c. Apply gloves.
   d. Cleanse needless connectorwith alcohol wipe or remove alcohol impregnated cap before use. Allow to dry.
   e. Aspirate to verify patency of line before injecting recommended amount of flush solution. *No medication or solution should be infused unless a free-flowing blood return is obtained.*
   f. Flush each unused lumen with 10 mL normal saline
   g. After flushing the catheter, maintain positive pressure by keeping your thumb on the plunger of the syringe while clamping catheter. Remove syringe. This prevents blood backflow and potential clotting of the line.
   h. If the catheter does not flush freely or you meet resistance, change the patient's body position (i.e. raise arm on side of catheter insertion, etc.). If you are still unable to flush the line, notify the physician.

3. Documentation

   a. Chart central line flush and line patency and reason for continued use in the electronic medical record (EMR) every shift.

Dressing Changes:

1. Equipment

   a. Clear semi-permeable dressing

   b. Anti-microbial dressing (Bio-Patch)

   c. Gauze, sterile

   d. Chlora-prep applicator 1

   e. Sterile gloves, non-sterile gloves

   f. Mask

2. Sterile Procedure

   a. Explain procedure to patient

   b. Assemble equipment

   c. Wash hands.

   d. Ask patient to turn head away from the insertion site or wear a mask

   e. Don gloves and mask

   f. Remove existing dressing and discard

   g. Assess insertion site

   h. Wash hands

   i. Prepare kit and/or supplies

   j. Put on sterile gloves

   k. Clean insertion site with chlora-prep applicator in a side to side motion "scrubbing" for 30 seconds. Allow to air dry for 30 seconds

l. Apply Anti-microbial dressing (Biopatch) at catheter site

m. Apply clear semipermeable dressing. Care should be taken not to kink, pinch, or compress the catheter with the dressing

n. Loop the tubing and secure with tape

o. Label dressing with date, time and initials

p. Instruct patient that skin may turn orange temporarily

q. Discard used supplies in appropriate receptacle

r. Wash hands

3. Documentation

a. Record dressing change in EMRinclude a description of the catheter site and skin condition.

b. Document appearance of the insertion site every shift.

Injection Port Changes:

1. Equipment

a. V-Link valves/needless connector

b. Gloves

c. Mask

d. Alcohol prep

e. Prefilled 10 mL normal saline syringes

2. Procedure

a. Explain procedure to patient

b. Assemble equipment

c. Wash hands
d. Don mask

e. Clamp the catheter

f. Ask patient to turn head away from insertion site or wear a mask

g. Remove old needless connector and discard

h. Connect new needles connector. Note: Remove air prior to flushing, either by flushing valve with normal saline prior to attaching or by aspirating air after attaching to the catheter

i. Flush each valve with a prefilled 10 mL normal saline syringe

j. Discard used supplies in appropriate receptacle

k. Wash hands

Blood Draws:

1. Equipment

a. Non-sterile gloves

b. Alcohol swabs

c. Prefilled 5 mL normal saline syringe

d. Prefilled 10 mL normal saline syringe

e. 10 mL syringe for blood draw

f. Specimen tubes

2. Procedure

a. Wash hands

b. Explain procedure to patient

c. Apply gloves

d. Cleanse needless connector with alcohol wipe or remove alcohol impregnated cap. Allow to dry.

e. Flush with 5 mL normal saline

f. Withdraw 5 mL blood and discard

g. Withdraw blood for specimens

h. Flush with 10 mL Normal Saline

i. Transfer blood into specimen tubes

j. Label specimen tubes with patient identification

SPECIAL CONSIDERATIONS FOR BLOOD BANK SPECIMENS

*All blood specimens drawn from a **central line** for the purpose of blood bank testing will be obtained and labeled by an RN and/or physician in the presence of certified/licensed lab personnel or licensed personnel with each initialing the specimen labels and/or additional forms as required, and both confirming that the BBK# has been transcribed correctly from the patient's wrist band to the specimen label.*

Removal:

NOTE: RNs may only remove non-tunneled central venous catheters (nurse should not remove catheters used for dialysis o like Vas. Cath, or Tri-Flow)

1. Equipment

   a. Goggles or face shield optional

   b. Mask

   c. Sterile and non-sterile gloves

   d. Chlora-prep applicator

   e. Suture removal kit

   f. Sterile gauze pads

   g. Occlusive dressing

   h. Culture container optional if culturing tip

2. Sterile Procedure

   a. Wash hands

   b. Explain procedure to patient

//

c. Apply personal protective equipment (non sterile gloves, goggles/face shield)

d. Place patient in supine or low semi-fowlers position

e. Don mask

f. Ask patient to turn head away from insertion site or wear a mask

g. Remove catheter dressing and discard

h. Cleanse site with chloraprep and allow to dry (30 seconds)

i. Apply sterile gloves

j. Cut sutures and remove

k. Instruct patient on Valsalva maneuver to decrease the risk of air embolism during removal. Instruct patient to take a deep breath and hold it, "bear down" for 10 seconds, then exhale. *NOTE: Valsalva maneuver is contraindicated in patients with increased intracranial pressure or if intubated.* If patient is on a ventilator, remove catheter at mid-exhalation.

l. Slowly remove the catheter while the patient is holding their breath, performing a Valsalva maneuver, or exhaling. Immediately apply firm, continuous pressure to the exit site using sterile 4 × 4 gauze until hemostasis is achieved. Maintain pressure for a minimum of 10 minutes, then assess for bleeding.
For femoral catheter sites, apply pressure for at least 10–15 minutes before assessing.
If the patient has one or more high-risk factors for bleeding, extend the duration of pressure accordingly. High-risk factors include, but are not limited to:
    - Anticoagulation therapy
    - Coagulopathy or abnormal coagulation laboratory values
    - Obesity
    - Large-bore catheters (e.g., multi-lumen or dialysis catheters)
    - Non-compressible or difficult-to-compress insertion sites

In these cases, pressure may need to be held for 15–20 minutes or longer, depending on clinical judgment and patient response.
Important: Do not repeatedly lift the dressing to check for bleeding, as this may disrupt clot formation. Each additional risk factor may increase the time required to achieve hemostasis.

m.

n. If bleeding or oozing continues, apply pressure for another 10 minutes. Repeat until bleeding stops. If line is removed from a jugular site, apply gentle pressure. *At this point consider absorbable hemostat dressing like surgical dressing*

o. Apply occlusive dressing. Dressing should be left in place for 24 hours.

p. Keep patient in supine position for 30-60 minutes, monitoring every 15 minutes for bleeding.

q. Following removal of a femoral line, the patient must be continuously monitored for 30 minutes, if GCS less than 15 continue intermittently monitoring for additional 30 minues (total 60 minutes). For Patient with GCS of 15 monitor intermittently for 60 minutes. After 60 minutes, if there is no bleeding or oozing, patient may flex hip and ambulate. ***Educate patient to call if they notice bleeding or feel wet ensure call light is within reach***

r. Document the following:

- Date and time of catheter removal
- Site assessment
- Culture specimen sent (if appropriate)
- Ease of catheter removal
- Inspection of intact catheter
- Length of time pressure applied to obtain hemostasis
- Application of occlusive dressing
- Patient tolerance of the procedure
- Patient and family education
- Any unexpected outcomes and interventions

SPECIAL CONSIDERATIONS

Caution should be taken when removing lines in patients with coagulation disorders and/or patients on anticoagulation therapy. Prior to removal, coagulation labs and platelets should be checked to ensure normal levels. If labs are not within normal limits, the physician should be notified for further orders.

Escalate Immediately for:

Persistent bleeding despite 20+ min pressure

Rapidly expanding hematoma

Hypotension

Severe groin pain

Suspected retroperitoneal bleed (rare but serious)

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SUBJECT:	SECTION:
CONDUCT METHICILLIN RESISTANT STAPHYLOCOCUS AUREUS (MRSA) SCREENING	**Page 1 of 3**

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POLICY:

PURPOSE: To reduce overall Hospital Acquired Infections (HAIs) and improve in-patient outcome by identifying patients at risk for known HAIs, and in this instance, specifically for methicillin resistant *Staphylococcus aureus* (MRSA) infections through active surveillance testing (AST).

BACKGROUND: Although many innovations and improvements have been made in treating patients for various types of conditions and diseases, it is crucial to monitor and prevent HAIs as they may be a major threat to patient safety. Of the various known HAIs, (CLABSIs, CAUTIs, VAPs and others) MRSA infections are easily monitored. Approximately 2 - 5% of all patients in U.S. hospitals carry MRSA bacteria in their nose or on their skin but most do not develop serious infections. MRSA is spread by contact with infected people or fomites carrying the bacteria. In facilities that care for vulnerable individuals such as GACH or SNF, MRSA infections may cause severe problems such as bloodstream infections, pneumonia, sepsis and even death. For this reason, the State of California passed legislation (CA SB 1058, Nile's Law, and SB 158) which aligns with guidelines from the CDC, and requires specific conditions be met for disease surveillance of patients, including the screening for MRSA infections.

DEFINITIONS:

AST: active surveillance testing;

CDC: The Centers for Disease Control and Prevention;

EMR: electronic medical record;

HAI/HAC: hospital acquired infections/conditions;

CAUTI: catheter associated urinary tract infection;

CLABSI: central line associated bloodstream infection;

GACH: general acute care hospital;

MRSA: methicillin resistant *Staphylococcus aureus*;

SNF: skilled nursing facility;

VAP: ventilator associated pneumonia;

A. **SCREENING CRITERIA:** Eligible healthcare professionals (See C. RESPONSIBILITIES) will use the following parameters to identify in-patients in need of MRSA AST and then test these inpatients. According to CA SB 1058, inpatients must be screened upon admission to determine the need for a MRSA swab test (see Figure 1). The test should be conducted within 24 hours of the patient's admittance. The MRSA bundle criteria section in the EMR is to assess if:

1. This is a pre-operative patient who is having hip or knee replacements. The patient is to be retested when discharge is ordered. Any patient that tests positive will be notified and educated about MRSA
2. The patient is being admitted to the ICU
3. The patient is discharged from an acute care facility within the past 30 days
4. The patient is or will be receiving inpatient dialysis
5. This is a dialysis patient entering the facility that shows evidence of increased risk of invasive MRSA. If so, the patient shall be tested for MRSA immediately prior to discharge from the facility (this does not apply to a patient who has tested positive for MRSA infection or colonization upon entering the facility)
6. The patient is admitted from a SNF

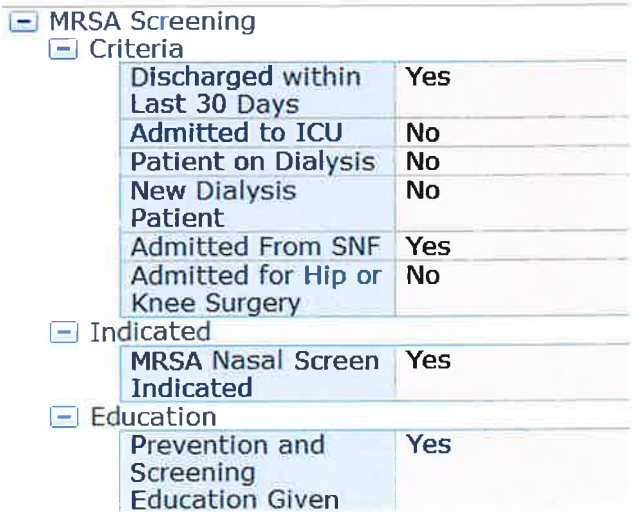

Figure 1: MRSA AST and nasal screen should be administered within the patient's first 24 hours of admission.

B. CONTRAINDICATIONS FOR SCREENING: A physician's order is required to withhold MRSA screening, swab testing and culture

C. RESPONSIBILITIES: Any of the following health care professionals with current California licenses may perform MRSA swab tests – Licensed Vocational Nurse (LVN), Registered Nurse (RN), Family Nurse Practitioner (FNP), Physician's Assistant (PA), Laboratory Technician, MD or DO.

D. PROCEDURE:

1. Conduct MRSA AST questionnaire entitled Criteria within the EMR
2. Inform the inpatient of the purpose for performing a swab for laboratory culture
3. A single 'yes' response within the Criteria section of the MRSA Screening questionnaire is sufficient to require an MRSA swab test
    a. Use a single regular culture swab
    b. Peel open and carefully remove the swab
    c. Insert the swab into the nostril at least 1 cm and swab the inside of the nose by rotating the swab against the anterior nasal mucosa for 3 seconds
    d. Repeat this procedure using the same swab in the second nostril
    e. Carefully place the swab into a labeled transport tube that has the inpatient's information for transport to the laboratory for culture
    f. Record the date that the screening culture collection was completed into the EMR
4. If an inpatient tests positive for MRSA:

a. The physician should inform the patient or the patient's representative immediately or as soon as is feasibly possible

b. The inpatient and/or caregiver shall receive verbal and written instructions regarding aftercare and precautions to prevent the spread of MRSA to others (Refer to ***Krames On Demand*** in SVMC Intranet, Infectious Disease, Diseases & Conditions, Methicillin-Resistant Staphylococcus aureus (MRSA) Infection, to print out an information sheet that may be personalized with patient name and special instructions)

c. The education shall be documented in the EMR under Interdisciplinary Education. Select Infection Control, document MRSA under education topic and complete the assessment.

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CROSS REFERENCE

Isolation & Standard Precautions Policy & Procedure

SUBJECT:	SECTION:
EXTRAVASATION MANAGEMENT OF SYMPATHOMIMMETIC VASOCONSTRICTORS (PRESSORS)	***Drug Protocols*** **Page 1 of 5**

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PURPOSE: To provide guidance on the management of extravasation of sympathomimetic vasoconstrictors (pressors)

DEFINITIONS:

1. "Pressors"- refers to medications including but not limited to the following:
    - Norepinephrine
    - Epinephrine
    - Phenylephrine
    - Dopamine
    - Dobutamine
    - Vasopressin

POLICY: Extravasation management of sympathomimetic vasoconstrictors

AFFECTED PERSONNEL/AREAS: *PHARMACY; EMERGENCY DEPARTMENT; INTENSIVE CARE*

GENERAL CARE:

A. **Initial Measures**

- Stop the infusion immediately. Do not flush the line, & avoid additional pressure on site
- Disconnect but leave cannula/needle in place.
- Gently aspirate extravasated solution (do NOT flush the line).
- Remove needle/cannula & elevate the extremity.
- Consider antidote's for further management.
- Report extravasation event & management post therapeutic intervention.

FIRST-LINE AGENT (Consider Nitroglycerin as first line for Vasopressin):

PHENTOLAMINE (REGITENE)

- *Peripheral extravasation of norepinephrine (labeled use) and other sympathomimetic vasopressors (off-label use), management:*
    - Local infiltration injection: Intradermal or SUBQ: 5 to 10 mg (diluted in 10 mL 0.9% sodium chloride) divided into multiple injections along the area of extravasation; if infiltrated catheter has not been removed, administer initial dose through the infiltrated catheter; administer as soon as possible and within 12 hours of extravasation; may readminister in 60 minutes if patient remains symptomatic. Apply dry warm compresses.

CONTRAINDICATIONS/PRECAUTIONS
Hypersensitivity to phentolamine, any component of the formulation, or related compounds; MI (or history of MI), coronary insufficiency, angina, or other evidence suggestive of coronary artery disease.

ADVERSE EFFECTS:
1% to 10%:
Cardiovascular: Bradycardia (2% to 4%), hypertension (<3%), tachycardia (4% to 6%)

Dermatologic: Pruritus (<3%)

Gastrointestinal: Diarrhea (<3%), upper abdominal pain (<3%), vomiting (<3%)

Hypersensitivity: Facial swelling (<3%)

Local: Injection-site reaction (<3%), localized tenderness (<3%), pain at injection site (4% to 6%)

Nervous system: Headache (4% to 6%), paresthesia (<3%)

Postmarketing (any formulation):

Cardiovascular: Acute myocardial infarction, cardiac arrhythmia, flushing, hypotension (including acute hypotension), orthostatic hypotension

Nervous system: Asthenia, cerebrovascular occlusion, cerebrovascular spasm, dizziness

Respiratory: Nasal congestion

ALTERNATIVE AGENTS:

TERBUTALINE
Dosing:
Extravasation management, sympathomimetic vasoconstrictors (off-label use):

Large extravasations: SUBQ: Infiltrate affected extravasation area with terbutaline 1 mg using a solution of terbutaline 1 mg diluted in 10 mL NS (administration volume varied from 3 to 10 mL); may repeat dose after 15 minutes (Ref).

Small/distal extravasations: SUBQ: Infiltrate affected extravasation area with terbutaline 0.5 mg using a solution of terbutaline 1 mg diluted in 1 mL NS; may repeat dose after 15 minutes

ADMINISTRATION:
Stop vesicant infusion immediately and disconnect IV line (leave needle/cannula in place); gently aspirate extravasated solution from the IV line (do NOT flush the line); remove needle/cannula; elevate extremity.

Large extravasations: SUBQ: Infiltrate affected extravasation area with terbutaline 1 mg using a solution of terbutaline 1 mg diluted in 10 mL NS (administration volume varied from 3 to 10 mL); may repeat dose after 15 minutes (Ref).

Small/distal extravasations: SUBQ: Infiltrate affected extravasation area with terbutaline 0.5 mg using a solution of terbutaline 1 mg diluted in 1 mL NS; may repeat dose after 15 minutes

CONTRAINDICATIONS/PRECAUTIONS:
Hypersensitivity to terbutaline, sympathomimetic amines, or any component of the formulation

ADVERSE EFFECTS:

>10%:

Central nervous system: Nervousness, restlessness

Endocrine & metabolic: Decreased serum potassium, increased serum glucose

Neuromuscular & skeletal: Tremor

1% to 10%:

Cardiovascular: Hypertension, tachycardia

Central nervous system: Dizziness, drowsiness, headache, insomnia

Dermatologic: Diaphoresis

Gastrointestinal: Dysgeusia, nausea, vomiting, xerostomia

Neuromuscular & skeletal: Muscle cramps, weakness

<1%, postmarketing, and/or case reports: Cardiac arrhythmia, chest pain, hyperglycemia (preterm labor), hypokalemia (preterm labor), hypotension (preterm labor), ischemic heart disease (preterm labor), lactic acidosis (Smith 2019), myocardial infarction (preterm labor), paradoxical bronchospasm, pulmonary edema (preterm labor)

NITROGLYCERIN TOPICAL 2% OINTMENT (First line for Vasopressin)

A. **Extravasation management, sympathomimetic vasoconstrictors (off-label use; based on limited case reports): Topical:**

- Apply a 1-inch strip to the site of ischemia; may repeat every 8 hours as necessary

CONTRAINDICATIONS/PRECAUTIONS:
Hypersensitivity to nitroglycerin, other nitrates or nitrites, or any component of the formulation (includes adhesives for transdermal product); concurrent use with phosphodiesterase-5 (PDE-5) inhibitors (avanafil, sildenafil, tadalafil, or vardenafil); concurrent use with soluble guanylate cyclase (sGC) stimulator.

ADVERSE EFFECTS:
>10%: Nervous system: Headache (patch, rectal ointment: 63% to 64%; lingual spray, sublingual powder: >2%)

1% to 10%:
Cardiovascular: Hypotension (patch: ≤4%; including orthostatic hypotension), syncope (patch: ≤4%)

Nervous system: Dizziness (lingual spray, patch, rectal ointment, sublingual powder: 2% to 6%), paresthesia (lingual spray, sublingual powder: >2%)

Frequency not defined: Local: Application-site irritation (patch)

Postmarketing (any formulation):

Cardiovascular: Asystole (Thomas 2016), bradycardia (Brandes 1990), flushing, rebound hypertension, tachycardia, unstable angina pectoris, vasodilation (cutaneous)

Dermatologic: Contact dermatitis (Roche Gamón 2006), exfoliative dermatitis, fixed drug eruption, skin rash

Endocrine & metabolic: Lactic acidosis (Smith 2019)

Gastrointestinal: Nausea, vomiting

Hematologic & oncologic: Methemoglobinemia (Imani 2019)

Hypersensitivity: Hypersensitivity reaction (including nonimmune anaphylaxis)

Local: Application-site rash

Nervous system: Asthenia, drowsiness

Respiratory: Dyspnea, hypoxia (transient)

REFERENCES:

- Nitroglycerin (Lexi-Drugs). (Last Updated: February 28,2026). Retrieved March 3rd, 2026 from https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7377?cesid=2tqKw88E7v8&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dnitroglycerin%26t%3Dname%26acs%3Dfalse%26acq%3Dnitroglycerin
- Phentolamine (Lexi-Drugs). (Last updated February 26, 2026). Retrieved March 3rd, 2026. From https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7381873?cesid=ag4AmFagj7G&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dphentolamine%26t%3Dname%26acs%3Dtrue%26acq%3DPhento

- Terbutaline (Lexi-Drugs). (Last Updated November 19th, 2025). Retrieved March 3rd, 2026, from https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7737?cesid=9UICF9LE38e&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dterbutaline%26t%3Dname%26acs%3Dtrue%26acq%3Dterbutaline

SUBJECT: **HYPERBILIRUBINEMIA**	SECTION: **Page 1 of 5**

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

PURPOSE:

To outline the risk assessment guidelines and nursing management of the infant/neonatal patient with documented hyperbilirubinemia.

POLICY:

Because most newborn infants develop some degree of jaundice, all newborn infants will be screened for hyperbilirubinemia upon admission, during their hospital stay, and prior to discharge. Visual inspection/assessment for evidence of jaundice will be completed immediately upon admissionand will occur with each shift assessments

Bilirubin is formed from the breakdown of erythrocytes. Hyperbilirubinemia may be physiologic or due to multiple factors including hemolytic disease, sepsis or liver dysfunction. Most jaundice is benign, but because of the potential toxicity of bilirubin, newborn infants must be monitored to identify those who might develop severe hyperbilirubinemia and in rare cases, acute bilirubin encephalopathy and kernicterus.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RNs)* Med/Surg, NICU, Post Partum

DEFINITIONS:

Hyperbilirubinemia or jaundice is a yellowing of the skin due to the presence of unconjugated (indirect) bilirubin in the blood from the breakdown of red blood cells.

Bilirubin is a byproduct formed from the breakdown of the red blood cells, which may accumulate to levels that cause the infant's skin and/or sclera to become yellowed.

Kernicterus is free or unconjugated bilirubin that circulates freely in plasma and can easily cross the blood- brain barrier, causing damage to brain cells.

Phototherapy is a treatment used to convert bilirubin in the infant's skin to a more water-soluble form which can be secreted into the intestines and excreted through the infant's stool and urine.

PROCEDURE:

Assessment: Risk for Hyperbilirubinemia in Infants:

1. Visual inspection/assessment for evidence of jaundice is to be completed upon admission and every shift.

2. If the infant appears to be jaundiced, the nurse will report to the pediatrician.

3. Phototherapy will be started based off physician's order

EQUIPMENT

- Phototherapy light (Neo-blue) or Bili Blanket

  Bassinet (Infants greater than 2.5 kg) or Isolette (Infants less than 2.5 kg or demonstrated temperature instability of 36.4 C or 97.5 F).
- Eye protection (Bili-mask)
- Dosimeter (bilimeter)

STEPS FOR INITIATING PHOTOTHERAPY

1. Remove all of the infant's clothing (photo-oxidation is dependent on skin exposure).
2. Fold diaper down where possible to expose skin and yet protect scrotum/ovaries.
3. To prevent injury to the retina by excessive exposure to phototherapy lights, cover the infant's eyes with the Bili mask. Secure in place, making sure the eyes are closed when the mask is applied and the nares are not occluded.
4. Turn on phototherapy light(s) to appropriate setting: single, double or greater.
5. Obtain dosimeter reading with Bili Meter upon initializing phototherapy and each shift
6. Dosimeter intensity

   Low/Single light therapy: 12-14 µW/cm2/nm
   High/double or greater therapy: 30-35 µW/cm2/nm
7. Appropriate distance from infant to bili lights is approximately:

   Bassinet: 4 inches or 10 cm
   Isolette: 15-18 inches or 38-46 cm
8. If the infant is in an open crib or isolette, check infant's temperature every 30 minutes until temperature stabilization has been assured (greater than 98° F).

FOR BILI BLANKET:

• Fully insert the fiber optic light pad connector into the light box.

• Verify that the air circulation vents on the sides and back of the light box are unobstructed.

• Obtain photometer reading with Bili Meter upon initializing phototherapy and every shift.

• Place the fiber optic light pad on a flat surface. Insert the Bili blanket fiber optic light pad into a Bili blanket pad cover. Replace the disposable cover when it becomes soiled and between patients.

• Place the pad on the mattress with the light emitting side up.

• Remove all clothing from the infant except their diaper. Place the infant with their back directly on the light emitting section of the pad. There should be nothing between the infant's skin and the fiber optic light pad. The infant may be covered or wrapped in a blanket along with the fiber optic light pad, and will receive effective phototherapy treatment as long as the light emitting section of the pad remains in contact with skin.

- When measuring light intensity, use appropriate dosimeter for bili blanket (bili blanket meter). Measurements should be conducted per manual guidelines.
- Small pad measure points (C +D)/2 > or equal to 60.0
- Large pad measure points (D +E+F)/3 > or equal to 40.0

• Discard disposable cover when treatment is completed

DIAGNOSTIC LAB DRAWS:

1. On-going lab draws will be per physician's orders. Physician will be notified promptly of all results.

2. Unmask infant and turn off phototherapy lights during blood draws to prevent false results.

3. Turn off phototherapy lights when drawing blood or bilirubin levels since lights may degrade the bilirubin in the blood.

FEEDINGS:

1. Bili masks are to be removed during feeding and for sensory stimulation at least every 3 to 4 hours for at least 10 minutes, unless order is for continuous therapy per physician. Try to cluster care with feeding to reduce the infant's time away from the bili lights.

2. Lights must be off if the mask is removed. Observe the eyes and document any signs of conjunctivitis, erythema, yellow drainage or discharge.

3. Infant should not be out from overhead lights for more than one-half hour at a time.

4. Encourage feedings every 2 or 3 hours or more unless otherwise ordered by the physician. . Breast feeding will continue to be promoted and supported during treatment of hyperbilirubinemia. Consult with the physician regarding use of formula with breast feeding if additional fluid is needed.

5. Weigh infant daily and notify physician of any weight loss greater than 10% from the birth weight/ admission weight

6. Assess and document infant's fluid intake and stool output (I and O) each shift. Notify physician of decreased PO intake and/or decreased urine output.

7. When weighing diapers, output should be greater than 2ml/kg/hr for the previous 12 hours.

TEACHING:

1. Teach parents about the disease process and principals of treatments.

2. Explain procedures, equipment, and transient side effects (loose stools, lethargy, transient rash).

3. Inform parents that their infant will not be discharged until results of any bilirubin levels are obtained.

4. Allow parents time to discuss concerns and ask questions.

5. Inform parents that their infant should be appropriately followed up in their pediatrician's office once discharged, for an assessment of jaundice.

DOCUMENTATION: Document all interventions in the patient's medical record such as: education, time of initiation of phototherapy, dosimeter reading, measurement from light, and eye protection.

REFERENCES:

- American Academy of Pediatrics Subcommittee on Hyperbilirubinemia. (2022). Management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation. Pediatrics, 150(3), e2022058859. https://doi.org/10.1542/peds.2022-058859

- American Academy of Pediatrics. (2023). *Hyperbilirubinemia clinical practice guideline resources and tools*. https://www.aap.org/en/patient-care/hyperbilirubinemia/
- GE HealthCare. (2021). *BiliSoft™ 2.0 phototherapy system: Operation manual* (Rev. ed.). https://image.tigermedical.com/Manuals/GEH2103959-001-20220226225714525.pdf

SUBJECT: **MEDICATION ADMINISTRATION TIMES**	SECTION: ***Medication Management (MM)*** **Page 1 of 4**

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

PURPOSE:

To ensure that medications administered at Sierra View Medical Center (SVMC) are done so in accordance with a Medical Staff approved standardized administration time schedule, to provide consistent patient care.

POLICY:

Standardized medication administration times are approved by the Medical Staff through the Pharmacy & Therapeutics (P&T) Committee. Exceptions are specifically designated by administration time in accordance with published recommendations, due to interactions with food, and for patient comfort. This is a house-wide policy.

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

PROCEDURE:

1. Routine orders are those written for a specified schedule.

   Unless specifically stated otherwise in the medication order, all medications are eligible for the following standard routine order times:

DAILY, QDAY, QD	0900
HS	2100
Q12HR/BID	0900, 2100
Q8HR/TID	0600, 1400, 2200
Q3HR	0100, 0400, 0700, 1000, 1300, 1600, 1900, 2200
Q4HR	0200, 0600, 1000, 1400, 1800, 2200
Q6HR/QID	0600, 1200, 1800, 2400

Medication-Specific Exceptions: (Below medications should not follow above scheduled dosing times)

1. Cholesterol lowering medications (i.e., "Statin" class, etc.)	2100
2. Coumadin (Warfarin)	1200

2. Non-routine administration times.

Medication orders for non-routine administration times will be administered as follows:

AC	Given ½ hour (30 minutes) before meals.
PC	Upon finishing the meal (or same as with meal).
STAT	To be filled by pharmacy immediately and administered within 30 minutes from the time of the order.
NOW	To be filled by pharmacy and administered within 60 minutes from the time of the order.
Pre-Op	Time designated.
One Time Only	Given once on the day the order is written.
PRN	Given only as needed by the patient. (Order must include dose, frequency and indication).

3. Critically Timed Medications

A. The majority of medications should be administered within 1 hour or their scheduling dosing time, but the following medications, due to pharmacokinetic considerations, should be administered within 30 minutes of their scheduled dosing time to ensure therapeutic effectiveness: effectiveness (See Table 1). Notification to provider should be done if Rx not administered within the designated time frame.
Any orders for medications due at or around mealtimes require nursing judgment for the exact scheduled time of administration that can change due to meal delivery time, patient status, and quantity of meal consumed.

Scheduled medication can be given a time critical designation by a provider by indication in the electronic medication administration record entry by placing a one-time STAT or NOW order.

Non-Time-Critical

Delayed or early administration within a specified range of either one or two hours should not cause harm or result in substantial sub-optimal therapy or pharmacological effect (see Table 2).

First or Loading Doses
Certain medications first doses are essential to be given in a timely manner. (See Table 3).

Table 1: Time Critical Medications

Time-Critical Scheduled Medications	Reason "Time-Critical"
Dosing scheduled more frequent than every 4 hours	Small dosing intervals require timely administration to avoid toxicity or sub-optimal therapy. For electrolyte replacements for sub-normal levels, if multiple products must be administered for a given order, the first dose will be considered time critical.
Opioids	Scheduled use for chronic pain or palliative care (not PRN); Inconsistencies with timely admin may result in unnecessary break-through pain
Immunosuppressants Tacrolimus (Prograf) Cyclosporine (SandIMMUNE) Sirolimus Mycophenolate	When used for prevention of organ transplant rejection.
Itraconazole Ketoconazole	Antacids may decrease serum concentrations. Itraconazole should be given 1 hr after or 2 hours before antacids and ketoconazole at least 2 hours before antacids.
Rapid Acting Insulin Lispro, Aspart, or glulisine	Administration required to occur within 15 minutes before a meal.
Pyridostigmine Neostigmine	Short duration of action: When used for the treatment of Myasthenia gravis. The timely administration is required to maintain symptomatic benefit.

Table 2: Non-Time Critical Medications

Non- Time-Critical Scheduled Medications	Timing
Daily, weekly, monthly medications Notify Provider if medication not administered within the time designated in next column.	Administer within 2 hours before or after the scheduled time; to prevent accidental omission of doses that might be more easily forgotten if delayed more than 2 hours.
Medications prescribed more frequently than daily, but not more frequently than every 4 hours.	Administer within 1 hour before or after the scheduled time.

Table 3: First/Loading Doses

First/Loading doses	Targeted time frame of administration
Antiepileptic agents (IV)	Within 15 minutes of medication order.
Antibiotics (IV)	Indication of Sepsis – within 30 minutes of order.
Anticoagulation (IV)	tPA for PE or stroke – within 15 minutes of order post verification of no contraindications

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The registered nurses' (RNs) electronic medication administration record (eMAR) will be updated to reflect the need to administer these medications within a 30-minute window of the dosing schedule.

If a medication is unable to be administered within the hour window (30 min window for critically timed meds) of the scheduled dosing time, then the RN should administer as soon as possible and provide note in the patient's chart explaining the circumstances that led to the delay in administration. Pharmacy will perform random audits of medication administration times on a quarterly basis.

4. Administration Adjustment Chart (1st doses)

SIERRA VIEW DISTRICT HOSPITAL - STANDARDIZED MEDICATION TIMES (ADJUSTMENT CHART)

QD — SCHEDULE IS QD (DAILY): 0900 HOURS *(IF 1ST DOSE ORDERED BETWEEN 0400 & 1400 HOURS)*

24	01	02	03	04	05	06	07	08	**09**	10	11	12	13	14	15	16	17	18	19	20	21	22	23
SEE DOSING SCHEDULE FOR 2100 HOURS				GIVE 1ST DOSE AND REPEAT THE FOLLOWING CALENDAR DAY											SEE DOSING SCHEDULE FOR 2100 HOURS								

* *Exception: H2 antagonists, i.e. Pepcid, Zantac, Tagamet, etc., give @ 1800 hours. Coumadin @ 1200 hours.*

Q3HR — SCHEDULE IS Q 3 H (EVERY 3 HOURS): 0100, 0400, 0700, 1000, 1300, 1900 & 2200 HOURS

24	**01**	02	03	**04**	05	06	**07**	08	09	**10**	11	12	**13**	14	15	16	17	18	**19**	20	21	**22**	23
GIVE 1ST DOSE & REPEAT @ 0400			GIVE 1ST DOSE & REPEAT @ 0700			GIVE 1ST DOSE & REPEAT @ 1000			GIVE 1ST DOSE & REPEAT @ 1300			GIVE 1ST DOSE & REPEAT @ 1900			GIVE 1ST DOSE & REPEAT @ 2200					GIVE 1ST DOSE & REPEAT @ 0100		

Q4HR — SCHEDULE IS Q 4 H (EVERY 4 HOURS): 0200, 0600, 1000, 1400, 1800 & 2200 HOURS

24	01	**02**	03	04	05	**06**	07	08	09	**10**	11	12	13	**14**	15	16	17	**18**	19	20	21	**22**	23
GIVE 1ST DOSE & REPEAT @ 0600				GIVE 1ST DOSE & REPEAT @ 1000					GIVE 1ST DOSE & REPEAT @ 1400				GIVE 1ST DOSE & REPEAT @ 1800				GIVE 1ST DOSE & REPEAT @ 2200				GIVE 1ST DOSE & REPEAT @ 0200		

Q6HR QID — SCHEDULE IS Q 6 H (EVERY 6 HOURS): 0600, 1200, 1800 & 2400 HOURS

24	01	02	03	04	05	**06**	07	08	09	10	11	**12**	13	14	15	16	17	**18**	19	20	21	22	23
GIVE 1ST DOSE & REPEAT @ 0600						GIVE 1ST DOSE & REPEAT @ 1200						GIVE 1ST DOSE & REPEAT @ 1800						GIVE 1ST DOSE & REPEAT @ 2400					GIVE 1ST DOSE & REPEAT @ 0600		

Q8HR TID — SCHEDULE IS Q 8 H (EVERY 8 HOURS): 0600, 1400 & 2200 HOURS

24	01	02	03	04	05	**06**	07	08	09	10	11	12	13	**14**	15	16	17	18	19	20	21	**22**	23
GIVE 1ST DOSE & REPEAT @ 0600						GIVE 1ST DOSE & REPEAT @ 1400								GIVE 1ST DOSE & REPEAT @ 2200							GIVE 1ST DOSE & REPEAT @ 0600			

Q12HR BID — SCHEDULE IS Q 12 H (EVERY 12 HOURS): 0900 & 2100 HOURS

24	01	02	03	04	05	06	07	08	**09**	**10**	11	12	13	14	15	16	17	18	19	20	**21**	22	23
GIVE 1ST DOSE & REPEAT @ 0900				GIVE 1ST DOSE & REPEAT @ 2100 HOURS												GIVE 1ST DOSE & REPEAT @ 0900 HOURS							

* *Exception: Diuretics give @0600 & 1800 & Oral Hypoglycemic @0730 & 1730*

HS — SCHEDULE IS HS: 2100 HOURS

24	01	02	03	04	05	060	07	08	09	10	11	12	13	14	15	16	17	18	19	20	**21**	22	23
GIVE 1ST DOSE AND REPEAT THE FOLLOWING CALENDAR DAY				SEE DOSING SCHEDULE FOR 0900 HOURS												GIVE 1ST DOSE AND REPEAT THE FOLLOWING CALENDAR DAY							

* *Exception: H2 antagonists, i.e. Pepcid, Zantac, Tagamet, etc., give @ 1800 hours. Coumadin @ 1200 hours.*

REFERENCES:

- The Joint Commission (2026). Hospital accreditation standards. MM.16.01.01. Oak Brook, IL.
- 42 CFR part 482, Conditions of participation for hospitals. Updated May 18, 2025. Accessed March 2, 2026. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482
- ISMP Acute Care Guidelines for Timely Administration of Scheduled Medications. Retrieved March 2, 2026. https://www.ismp.org/sites/default/files/attachments/2018-02/tasm.pdf

CROSS REFERENCES:

MEDICATION ORDERING

SUBJECT: **MEDICATION RECONCILIATION**	SECTION: ***Medication Management (MM)*** **Page 1 of 3**

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

PURPOSE:

To maintain and communicate accurate patient medication information.

POLICY:

Care providers will create an accurate list of a patient's medications on admission to the hospital or when seen in an outpatient setting, reconcile discrepancies and ensure that accurate medication information is communicated upon discharge.

DEFINITIONS:

Medication: For the purposes of this policy, the term medication denotes any of the following:

- Prescription medications
- Sample medications
- Herbal remedies, nutraceuticals, vitamins, and over the counter medications

Licensed Personnel:

Registered Nurse, Licensed Vocational Nurse, Prescriber

AFFECTED PERSONNEL: *LICENSED PERSONNEL (R.N., L.V.N.), PHARMACY*

PROCEDURE:

Obtaining Medication List

1. To the best of their ability, licensed personnel assigned to the patient will obtain complete information on the patient's home medication regimen before ordering medications including:

   A. Name of each medication
   B. Formulation/Strength (i.e.. extended release, 100 mg tablet)
   C. Dosage
   D. Route
   E. Frequency
   F. Date/time last taken

   The medication information will be entered into the electronic medical record. This should be done prior to ordering any medications, unless a delay in ordering may cause harm to the patient.

2. High Risk Medication Profile

An intern pharmacist, pharmacist or a pharmacy technician will obtain or confirm the home medication list and reconcile, as necessary, for high risk groups identified by the pharmacies high risk medication reconciliation dashboard upon admission & discharge from the hospital. Technicians and interns shall have annual training and proctoring by the pharmacy department. The department of pharmacy has quality assurance program aimed to monitor competency of its qualified staff in the production of medication reconciliation profiles. The program will consist of reviews of complaints in regards to any of the reconciliations. A review will be performed in these instances and corrective action initiated as determined by the investigation.

3. When obtaining the medication list, there are a variety of appropriate sources that may be used. . sources of information may include, but are not exclusive to:

   A. Patient (via interview)
   B. External Medication History available within the EMR
   C. Patient-owned medication lists
   D. Family members and other caregivers
   E. Pill bottles
   F. Pharmacy(ies) where patient fills prescriptions
   G. Medication lists and/or notes from outpatient providers and Skilled Nursing Facilities.
   H. Transfer orders from other facilities

4. Medication lists in the electronic medical record from previous visits must be reviewed and confirmed with each patient visit to ensure the list is kept accurate.

Physician Orders for Admission

1. The provider will also conduct a medication review as part of the medication reconciliation process to ensure the list is accurate prior to ordering medications. Before any medication is prescribed and/or administered or if treatment is affected by any medications that the patient is currently taking, the provider shall review the medication list to identify any potential adverse drug reactions.

2. Once the patient's current medications are listed, the physician indicates which medications to continue or discontinue during admission.

Medication Reconciliation for Patients in the Outpatient Setting

1. Licensed personnel will obtain a list of current medication to include, at minimum, dose, route and frequency for all patients entering an outpatient service for treatment/procedure when there is a potential a patient may receive medication.

2. The patient's current medication list will be available to the ordering physician for review.

3. The medication reconciliation process will be considered complete as long as the list is reviewed or updated by the personnel. However, if licensed personnel have any concerns, the issues will be discussed with the physician.

Medication Reconciliation at Discharge:

Outpatient Settings

1. When discharged from an outpatient setting, and the only additional medications prescribed are for a short duration, the medication information provided to the patient may include only those short term medications.

2. Where medication is administered and there is no change to the patient's continuing medication regimen and no new medications were prescribed and the patient has a current list of their medications, no list needs to be provided.

3. If the patient does not have a current list of their medication, then they will be provided a copy of the updated list upon discharge.

Inpatient Setting

1. Upon discharge from the inpatient setting, the patient will be provided with a current/updated list of medications from their nurse or provider.

2. Patients are informed to provide this list to their primary care physician and to read and follow the instructions on their medication bottles.

REFERENCES:

- Agency for Healthcare Research and Quality (AHRQ) 2014, Multi-Center Medication Reconciliation Quality Improvement Study (MARQUIS) Toolkit, innovations.ahrq.gov

- California Legislative Information. (n.d.). *Business and Professions Code - BPC § 6068* Division 2. Healing Arts. Chapter 9. Pharmacy. Article 7. Section 4118 California Legislative Information. https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=BPC&division=2.&title=&part=&chapter=9.&article=7.

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

SUBJECT: **NAMING CONVENTIONS FOR THE MASTER PATIENT INDEX (MPI)**	SECTION: **Page 1 of 2**

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

PURPOSE:

To ensure consistency and accuracy of the Master Patient Index (MPI).

POLICY:

All registration locations and processes will utilize the approved naming conventions.

AFFECTED AREAS/PERSONNEL: ALL *REGISTRATION/HIM PERSONNEL*

PROCEDURES:

- Patient names should be entered with surname first, then given name followed by middle name or initial, i.e. JAMISON JOHN JACOB
- We will be maintaining an "alias" file in the new system. Patients having other names that are in the system can be attached to one medical record number without destroying the system, i.e. JAMISON JAKE AND JAMISON JJ can all be traced back to #1 above under the same medical record number so long as birthdates and social security numbers also match.
- If more than one person has the same surname and given name and no middle initial can be obtained, patient will be #1, #2, etc., according to admission date.
- Names with prefixes of D, de, Des, Di, du, La, Mc, Mac, Van, Von, etc., will be entered as DARMAND, VONBUELOW, DELAVEGA, MACBETH, and so on. No apostrophes or separations will be recognized.
- Names beginning with St., as St. John will be entered as STJOHN.
- Compound or hyphenated names are filed as one word; thus Tyler-Evans would be TYLEREVANS, following through letter by letter.
- Names and religious titles, such as Brother Conrad, Mother Teresa, or Sister Mary are entered under the surnames, the titles being disregarded. See #2 above if a cross-reference might be useful. MURPHY TERESA MARIAS OR JACKSON CONRAD.
- Many names have multiple spellings (35 or Baer, 10+ for Burke) so a name search to see if that is the only identification may have to be done for several spellings. The telephone directory is a good resource if you can't always imagine the ways a name can be spelled. It is also why the new system has deeper searches than just the name, like phonetic listings, DOB, SSA, etc. Check the patient's driver's license, insurance card, or social security card to ensure the correct spelling of patient name.
- Name modifications such as Jr, Sr, III, will be entered in this system.

REFERENCES:

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

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

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

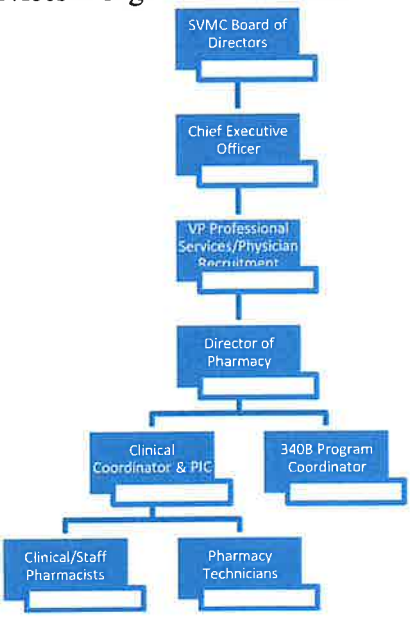
POLICY:

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

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

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

Department of Pharmaceutical Services – Organizational Chart



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- Title 42 CFR 482.25 Condition of Participation: Pharmaceutical Services. Accessed March 3, 2026. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482.
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  - MM.11.01.01

SUBJECT: **PRONE POSITIONING FOR THE NON-INTUBATED PATIENT**	SECTION: **Page 1 of 4**

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

PURPOSE:

Turning the patient with ARDS from a supine to a prone position can increase pulmonary capillary perfusion and oxygenation. The physiologic changes (fluid shifting from the posterior lung, allowing undamaged alveoli to be filled with oxygenated blood) that occur when turning a patient into a prone position improve ventilation. Prone positioning expands the dependent lung areas. Expanding dependent lung areas opens collapsed alveoli, increasing ventilation capacity and improving oxygenation.

Work of breathing can also be reduced with prone positioning because it reduces the pressure on the lungs from the cardiac structures and abdominal organs. Reducing work of breathing saves vital energy that the patient can use for healing and recovery.

POLICY:

Prone Position Considerations for the Non-Intubated Awake Patient:

Proning an awake patient may be used with frequent monitoring. This should be considered early in the diagnosis of severe hypoxemia and the following situations:

1. Isolated hypoxemic respiratory failure without substantial dyspnea (the "paradoxically well appearing" hypoxemic patient). A reasonable candidate might meet the following criteria:
    a) not in multi-organ failure
    b) expectation that patient has a fairly reversible lung injury and may avoid intubation
    c) no hypercapnia or substantial dyspnea
    d) normal mental status, able to communicate distress
    e) no anticipation of difficult airway
2. Patients who do not wish to be intubated (DNI). The main risk of awake proning is that it could cause excessive delays in intubation. In the DNI patient who is failing other modes of ventilation, there is little to be lost by trialing awake proning.
3. This could be attempted as a stop-gap measure (Rescue therapy) for a hypoxemic patient when intubation isn't immediately available (e.g. desaturation during transportation). Many awake patients are capable of proning themselves, so this could be achievable without any resources.

Contraindications: (Determine if the risks of prone positioning are outweighed by the patient's need for improved oxygenation)

• Severe Arrythmias	**Considerations:**
• Spine Instability	• Delirium and confusion
• Cardiac Surgery	• Inability to independently change position
• Ophthalmic surgery	• Recent nausea / vomiting
• Intraocular pressure	• Advanced pregnancy
• Severe obesity	
• Recent abdominal surgery	

AFFECTED PERSONNEL/AREAS: *PATIENT CARE AREAS*

SUBJECT: **PRONE POSITIONING FOR THE NON-INTUBATED PATIENT**	SECTION: **Page 2 of 4**

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

EQUIPMENT:

- Pillows
- Supplemental oxygen
- Continuous O2 monitor
- Foam dressings for pressure points

PROCEDURE:

Proning details:

Nursing Action	Special Considerations
Assessment: 1. Assess mobility 2. Assess mental status 3. Evaluate for contraindications and considerations	Prior to being encouraged to adopt the prone position, the patient should be assessed for the ability to independently change position in bed
Monitoring of the Patient 1. EKG leads may be moved to the back for comfort. However, can remain on the anterior chest wall for continuous monitoring 2. SPO2 probe (continuous) should be placed on the patient of not already in use	To minimize interruptions during prone positioning, have the patient consider physiologic needs and comfort strategies prior to prone position, if possible (i.e., toileting, nutrition, medications, call bell within reach, phone or other device in reach, utilizing music or television as a distraction, etc.). Consider EKG leads as a potential pressure point for pressure injury
Timing 1. On admission, a patient experiencing respiratory symptoms or requiring supplemental oxygen should receive an initial one-hour period of prone position. 2. EKG monitoring should remain in place 3. In the prone position, the patient should lie on his/her stomach, supported by their arms and a pillow in such a manner that oxygen supply tubing is not obstructed. a. An alternative to the arms supporting model is on his/her stomach supported by pillows with the head of bed slightly raised. 4. Pillows placed under the hips, or under legs as needed for comfort. 5. Prevention of pressure injury with foam dressings on pressure pints, slight repositioning and pillow support is needed. 6. After initial 1-hour period, the patient can	**Documentation** Patient's SpO2, oxygen device, L/min of O2, respiratory rate and effort should be assessed just prior to proning and 1 hour after prone. *Documenting the response to 1 hour in the prone position will help identify those who are most likely to benefit should prone position be needed for rescue therapy*

reposition themselves to supine but should be encouraged to adopt the prone position as often as tolerated and able. The goal should be for the patient to be in the prone position more often than not while in bed.	
Prone Position as Rescue therapy	**Documentation**
1. A patient who develops increasing oxygen need (an increase of >2L/min needed to maintain an SPO2>90%) is at risk for respiratory failure 2. If the patient is in the supine position, and it is safe to do so, place the patient in the prone position. 3. Notify the medical team of worsening hypoxemia 4. If the patient stabilizes (decreased RR, increased SPO2, decreased O2 need) reassess frequently	At the time of the event, • O2 L/min • O2 device • Resp rate • SPO2 Prone position as a rescue therapy should not be used as a replacement for an ICU transfer or intubation. It is important to involve the medical team before attempting prone positioning as a rescue therapy.
Escalation Criteria	
1. Do not delay intubation	If signs of increasing oxygen requirements, increasing rising respiratory rate, signs of fatigue or distress, and change in mental status call and RRT for evaluation and possible need of intubation

Additional information:

1. Prone positioning has no effect on PaCO2, pH, respiratory rate, or hemodynamics.
2. There is often an initial decline in oxygenation with position change and after return to the supine position.
3. Frequent assessment of toleration is required
    a. Close monitoring of patients with co-morbidities that predispose them to rapid deterioration.

REFERENCES:

- American Association of Critical-Care Nurses. (2022). Positioning the non-intubated hypoxemic patient: Evidence-based practice considerations. *AACN Practice Alert.* https://www.aacn.org/practice/alerts/non-intubated-positioning

- Fralick, M., Colwill, C., & Niven, A. S. (2021). Awake prone positioning for patients with hypoxemia due to COVID-19: A systematic review and meta-analysis. *JAMA, 325*(14), 1395–1405. https://doi.org/10.1001/jama.2021.3533

- Rosa, B. F., de Matos, J. L., Moura, L. V., de Souza, R. D., & Fontes, R. S. (2022). Awake prone positioning in non-intubated patients with COVID-19 acute respiratory failure: An updated systematic review. *Respiratory Care, 67*(3), 370–380. https://doi.org/10.4187/respcare.09176

SUBJECT: **PROPOFOL (DIPRIVAN)**	SECTION: ***Drug Protocols*** **Page 1 of 3**

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

PURPOSE:

For induction and maintenance of sedation in critically ill ventilated adult patients.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

Supplies:

- Premixed bottles typically available as 10 mg/mL in 20 mL and 100 mL bottles. Run with fat emulsion tubing. Do not administer in same IV catheter w/blood or plasma products.

INFUSION (10 mg/mL):

- **Initial therapy:** Start at 5 mcg/kg/min and increase by 5 mcg/kg/min every 5 minutes to a maximum rate of 50 mcg/kg/min (may exceed at Physician's discretion, WITH A CHANGE TO ORDER PARAMETERS) to maintain desired Richmond Agitation Assessment Scale (RASS) level of sedation. TARGET RASS ENDPOINT MUST BE SPECIFIED IN ORDER.

- **Titrations**: With every 5mcg/kg/min change in rate the RN is to document the patient's pre-titration RASS score.

- **WAKE-UP Daily Protocol ("Sedation Vacation/Sedation Holiday"):** Per physician's orders.

- For patients maintained at a RASS score of -5 to 0, Wean infusion as specified by physician.

Richmond Agitation Assessment Scale (RASS)

+4	Combative	Overtly combative or violent, immediate danger to staff
+3	Very Agitated	Pulls on or removes tubes or catheters or has aggressive behavior toward staff
+2	Agitated	Frequent nonpurposeful movement or patient ventilator dysynchrony
+1	Restless	Anxious or apprehensive but movements not aggressive or vigorous
0	Alert and calm	
-1	Drowsy	Not fully alert, but has sustained (more than 10 seconds) awakening, with eye contact/eye opening to voice
-2	Light sedation	Briefly (less than 10 seconds) awakens with eye contact to voice
-3	Moderate sedation	Any movement (but no eye contact) to voice
-4	Deep sedation	No response to voice, but any movement to physical stimulation
-5	Unarousable	No response to voice or physical stimulation

CONTRAINDICATIONS:

- Hypersensitivity to propofol or any component of the formulation; hypersensitivity to eggs, egg products, soybeans, or soy products; when general anesthesia or sedation is contraindicated.
- **Note:** Fresenius Propoven is also contraindicated in patients who are hypersensitive to peanuts.

PRECAUTIONS:

1. Must be administered via the IV smart pump , through a dedicated peripheral or central line (using fat emulsion tubing).
2. Vented tubing and infusion must be changed every 12 hours (vented tubing must be used).
3. Use cautiously in patients with hyperlipidemia, hypotension or hypovolemia.

ADVERSE EFFECTS:

- Cardiac conduction disturbances
- Hypersensitivity reactions
- Hypertriglyceridemia
- Hypotension
- Proprofol-related syndrome

MONITORING PARAMETERS:

- Cardiac monitor, blood pressure, oxygen saturation (during monitored anesthesia care sedation), arterial blood gas (with prolonged infusions). With prolonged infusions (eg, ICU sedation), monitor for metabolic acidosis, hyperkalemia, rhabdomyolysis or elevated CPK, hepatomegaly, and progression of cardiac and renal failure.
- Sedation: Assess and adjust sedation according to scoring system (Richmond Agitation-Sedation Scale [RASS] or Sedation-Agitation Scale [SAS]) (Barr, 2013); assess CNS function daily. Serum triglyceride levels should be obtained prior to initiation of therapy and every 3-7 days thereafter, especially if receiving for >48 hours with doses exceeding 50 mcg/kg/minute (Devlin, 2005); use intravenous port opposite propofol infusion or temporarily suspend infusion and flush port prior to blood draw.
- Diprivan®: Monitor zinc levels in patients predisposed to deficiency (burns, diarrhea, major sepsis) or after 5 days of treatment

REFERENCES:

- Propofol. Lexicomp Online. Lexi-Drugs. Retrieved April 1, 2026.
- Frank, Robert L. Procedural Sedation in Adults Outside the Operating Room. Retrieved April 1, 2026. https://www.uptodate.com/contents/procedural-sedation-in-adults-outside-the-operating-room
- Tietze, Karen; Fuchs, Barry. Sedative-analgesic medications in critically ill adults: Properties, dosage regimens, and adverse effects. Retrieved April 1, 2026. https://www.uptodate.com/contents/sedative-analgesic-medications-in-critically-ill-adults-properties-dosage-regimens-and-adverse-effects

SUBJECT: **PYXIS ACCESS**	SECTION: ***Medication Management (MM)*** **Page 1 of 4**

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

PURPOSE:

To describe the management of Pyxis access privileges, to define what personnel will have access to Pyxis, and the termination process.

POLICY:

1. Access privileges to Pyxis shall be managed to ensure adequate security for medications, including controlled substance, to provide for proper and appropriate documentation of medication use.

2. A Pyxis user is defined as anyone with access to Pyxis. User templates will be created based on job titles; each user will be assigned user templates with specific access rights based upon their job duties.

3. Access privileges will be terminated immediately whenever the employee no longer works for the hospital.

4. Staff to complete a Pyxis Tutorial prior to Pyxis access being granted.

5. Pyxis Administrator shall run a monthly report on last activity date. If the date has exceeded 6 months, the user's profile may be set inactive. Profile will be reactivated upon completion of Pyxis tutorials due to extended inactivity.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, RESPIRATORY THERAPY, ANESTHESIA, EDUCATION*

PROCEDURES:

Access Definition

1. User access may be requested for the following hospital staff:

   a. Pharmacist

   b. Pharmacy Technician

   c. RN Clinical Director/ Manager/Chief Nurse Executive

   d. Charge Nurse

   e. Staff Nurse

   f. Nursing Instructor

   g. Respiratory Therapist

h. Anesthesiologist

i. CRNA (Certified registered nurse anesthetist)

j. Medical Assistants in Urology Clinic

k. Medical Assistants in Rural Health Clinic

l. Medical Assistants at Academic Health Center

m. Medical Assistants at Surgery Clinic

n. IR Technician

o. Medical Imaging Technologist

p. Ultrasonographers

2. The pharmacy department shall designate an individual as the system manager. The system manager or designee will be responsible for creating and maintaining user template. The template will be reviewed and approved by the pharmacist in charge prior to activation.

Request Access

1. Regular

a. Access to Pyxis will be requested by the department director and/or manager on the Access Request Form initiated by Human Resources upon hire or on the Access Update Form located in the Approval Database in the FormStack database for an existing employee.

b. Access rights will be assigned by Pharmacy System Manager based on employee's position.

c. Anesthesiologist, Midwife, and CRNA/SRNA

- Access to Pyxis will be requested by Medical Staff on the Access Request Form initiated by Human Resources upon hire or on the Access Update Form located in the Approval Database in the Formstack database for an existing employee.

2. Travelers

a. Access by travelers will have access for only the length of their contract. Their access will automatically terminate on the date their contract expires.

b. Upon hire, human resources will initiate the Access Request form with the Traveler's name, user name, and date the contract will begin and expire.

c. Once the Access Request has been approved by Department leader, and sent to pharmacy via IT, access will be assigned by Pharmacy System Manager.

d. If a traveler's contract is extended beyond the original time specified, an Access Update form will be initiated by Human Resources at the time the contract is renewed. The form, which including the new contract dates (beginning and expiration dates), will be sent on for approval in the usual manner.

3. Temporary

a. A charge nurse may set up temporary users. These temporary users are given access to the particular Display Terminal (DT) for a limited timeframe (14 hours) with specified rights.

b. Temporary users include any nurse that has floated to a department where access has not been assigned.

c. Float Nurses and Registry Nurses will be given access for 14 hours to cover assign shift in the department only.

d. Traveling Nurse may be given Temporary Access for up to 14 hours if access for length of contract has not yet been approved.

Termination of Access

1. For routine voluntary termination, once the department director or manager receives the notice, a Termination Notice form located in the Approval Database in the Formstack database will be filled out by department director or manager and sent to Human Resources. Human Resources will forward this information to Pharmacy System Manager. Pharmacy System Manager will disable the user's login privileges at the end of the last scheduled day of work.

2. For immediate termination without advance notice, human resources will contact pharmacy immediately. Pharmacy System Manager or designee will disable the user's access privilege right away. The department director or manager will still need to fill out the Termination Notice form. If immediate access removal is needed after pharmacy operating hours, the house supervisor will contact the on-call pharmacist who will remove Pyxis access for that user.

3. Access may be revoked immediately at the discretion of the Pharmacist in Charge or their designee in their absence. Notification to Human Resources and the user's manager will be sent as soon as possible to initiate a full investigation of activity. Determination of reinstating the access will be dependent on the internal investigation.

REFERENCE:

- Hospital Accreditation Standards. (2026). Oak Brook, IL: Joint Commission Resources, Inc.
    a. MM.11.01.01
    b. MM.13.01.01

SUBJECT: **SCOPE OF SERVICE – CARDIAC CATH LAB**	SECTION: **Cardiac Cath Lab** **Page 1 of 2** 3

PURPOSE:

To provide diagnostic and interventional outpatient cardiac catheterization and vascular services for adult and geriatric patients.

AFFECTED PERSONNEL/AREAS: *ALL CATH LAB, Echocardiogram and Interventional Radiology Staff*

POLICY:

The Cardiac Catheterization Laboratory (CCL) provides services for diagnostic,angiography , therapeutic and interventional procedures. These services consist of:

- Right and left heart catheterization
- Angiography of the coronary arteries, left ventricle, and aorta
- Coronary and peripheral intervention, including balloon angioplasty and stenting
- Pacemaker/device placement and extraction
- Myocardial biopsy
- Electrophysiological studies
- Intra vascular ultrasound (IVUS)
- Fractional flow reserve (FFR)
- Endovascular interventions, including mechanical thrombectomy, thrombo-aspiration, or pharmaco-mechanical thrombolysis.
- Transesophageal echocardiography (TEE)

The CCL is comprised of physicians who specialize in interventional cardiology, and/or maintain the appropriate credentials to exercise specific procedural privileges. These physicians are ultimately responsible for care of the patients pre-procedurally, intra-procedurally, and post-procedurally.

Hours/Days of Operation: 0700-1600 Monday - Friday

CCL Admit/Recovery Areas: Provides care for CCL patients during the pre- and post-procedure periods under RN oversight.

Scope of Patient Care Needs: The CCL department provides a safe and comfortable environment for both patients and personnel in order to provide optimum assistance to the physicians in meeting the health needs of the patients. The CCL staff provides quality-conscious, competent, and cost-effective care with respect for life and dignity. Patients' physical, psychological, and social needs are assessed, evaluated, and documented prior to admission, upon admission, prior to discharge, and as needed throughout their stay in the CCL department.

Staffing Patterns: CCL procedures will only be performed if the necessary staff and equipment are available.

A. The CCL team consists of Registered Nurses (RNs) and Radiological Technologists (RTs).

B. Admit/Recovery is staffed by two RNs.

A. CCL procedure suite staffing includes one circulating Registered Nurse, one sedation Registered Nurse, one Radiological Tech,(RT) and one transcriber/monitor RN and/or RT.

C. During procedures where moderate sedation is administered, the policy titled "Procedural Sedation" will be adhered to.

D. Staff Accountability/Responsibility:

1. Medical Director: Directly accountable and responsible to the Department of Radiology/Pathology and the Governing Board.

2. Department Director: Directly accountable and responsible to the Administrative Director of Radiology and the Vice President of Physician Recruitment & Professional Services for all aspects of CCL operations.

3. RN: Accountable to the Department Director and is responsible for direct patient care and other duties as per job description.

4. RT: Accountable to the Department Director and is responsible for duties as per job description.

E. CCL equipment and supplies shall include the following, or include alternate equipment which meet the intent of the prescribed equipment:

- X-ray machine
- Image intensifier
- Pulse generator
- Camera
- Spot film device
- Videotape viewing equipment of fluoroscopic procedures
- Magnetic tape recording and playback equipment
- Motor-driven cardiac table
- Cinefluorography and radiography equipment
- Monitoring and recording equipment
- Pressure transducers
- Equipment for determining cardiac output
- Appropriate cardiac catheters and accessory equipment
- Resuscitation equipment
- GE Innova flat panel C-Arm
- Hemodynamic monitoring equipment
- Power injector
- CardioSave (IABP)

REFERENCES:

- California Code of Regulations (2019). Title 22. §70433-70439. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I

D7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCES:

- Procedural Sedation

SUBJECT: **STANDARD MAINTENANCE OF WATER TREATMENT SYSTEM**	SECTION: **Page 1 of 4**

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

PURPOSE:

To assure proper water system maintenance and to routinely produce high quality treated water (Association for the Advancement of Medical Instrumentation (AAMI) Standards).

POLICY:

Water Treatment system will be serviced and tested in accordance with AAMI guidelines.
Routine monitoring of microbiological contamination in dialysis water system focusing on preventing the Development of growth in the system.

Routine monitoring of microbiological contamination in dialysis water system will focus on prevention of microbial proliferation and biofilm formation and will include defined action levels and maximum allowable levels per AAMI standards.

The facility will maintain compliance with current CMS Conditions and applicable state regulations.

The facility will follow manufacturer Instructions for Use (IFU) for all equipment including the RO system and dialysis machines.

AFFECTED PERSONNEL/AREAS:

CRITCAL CARE RN'S, RENAL SERVICES RN'S, BIOMEDICAL PERSONNEL; MEDICAL DIRECTOR

PROCEDURE:

DAILY:

1. The daily maintenance log of the water system:
    a. A daily maintenance log to be completed by Sierra View Medical Center (SVMC) dialysis personnel.
    b. A daily total chlorine test to be done on the water system by SVMC dialysis personnel.
    c. Chlorine testing for treatments 8 hours or less with be done before each patient, testing for treatments last longer than 8 hours will be done every 8 hours *(testing procedure will follow manufacture recommendations for chlorine strips and machine used)*

MONTHLY:

1. A monthly bacteria culture of the hemodialysis water system.
2. A monthly bacteria culture of the hemodialysis dialysate.
3. A monthly endotoxin culture of the hemodialysis water system.
4. A monthly endotoxin test of hemodialysis dialysate.
5. A monthly disinfection of the Reverse Osmosis (RO) Unit system following operation and maintenance manual guidelines.
6. A monthly Preventative Maintenance Inspection performed by dialysis biomedical personnel.
7. A routine Preventative Maintenance Inspection of Domestic Water Booster Pump performed by facilities engineering.
8. A monthly sanitization of the hemodialysis water system.
    a. Additional sanitization of the water system is necessary if any of the following apply:
        - Promptly any time the levels of bacteria or endotoxin exceed action levels.
        - Promptly any time the water system has been shut down for more than 8 hours.
    b. The disinfection process will be performed only by trained personnel.
    c. A bacteria and Limulus Amoebocide Lysate (LAL) culture will be obtained promptly after disinfect.

NEW EQUIPMENT:

- The hemodialysis water system will have four bacteria and endotoxin cultures perform before use.

MONITORING AND DOCUMENTATION:

Review of documentation and of monitoring results will be done routinely at quality meetings.

Dialysis Water:

Action Level Bacteria: 50 CFU/mL

Maximum Allowable Bacteria: 100 CFU/mL

Action Level Endotoxin: 1.0 EU/mL

Maximum Allowable Endotoxin: 2.0 EU/mL

Dialysate:

Action Level Bacteria: 25 CFU/mL

Maximum Allowable Bacteria: 50 CFU/mL

Action Level Endotoxin: 0.25 EU/mL

Maximum Allowable Endotoxin: 0.5 EU/mL

Results at or above action levels will trigger:

Immediate notification of Medical Director

Investigation and root cause analysis

Disinfection of system

Repeat cultures

Documentation of corrective action

Results exceeding maximum allowable limits require:

Immediate removal of affected system from service

Patient risk assessment

Documentation and reporting per policy

REFERENCES:

- Centers for Medicare & Medicaid Services. (2024). *End-Stage Renal Disease facilities: Conditions for Coverage (CfCs & CoPs)*. CMS.gov. https://www.cms.gov/medicare/health-safety-standards/conditions-coverage-participation/end-stage-renal-disease-facilities

- Centers for Medicare & Medicaid Services. (n.d.). *End Stage Renal Disease (ESRD) Center — CfCs & CoPs Resources*. CMS.gov. https://www.cms.gov/medicare/coverage/end-stage-renal-disease-center
- CMS Conditions for Coverage fact sheet. (n.d.). *Conditions for Coverage for End Stage Renal Disease Facilities Issued*. CMS Newsroom. https://www.cms.gov/newsroom/fact-sheets/conditions-coverage-end-stage-renal-disease-facilities-issued
- Association for the Advancement of Medical Instrumentation. (2019). *ANSI/AAMI/ISO 23500-1:2019 — Preparation and quality management of fluids for haemodialysis and related therapies — Part 1: General requirements*. ANSI Webstore. https://webstore.ansi.org/standards/aami/ansiaamiiso235002019
- Association for the Advancement of Medical Instrumentation. (2019). *ANSI/AAMI/ISO 23500-2:2019 — Preparation and quality management of fluids for haemodialysis and related therapies — Part 2: Water treatment equipment for haemodialysis applications and related therapies*. ANSI Webstore. https://webstore.ansi.org/standards/aami/ansiaamiiso235002019-2402284
- International Organization for Standardization. (2024). *ISO 23500-3:2024 — Preparation and quality management of fluids for haemodialysis and related therapies — Part 3: Water for haemodialysis and related therapies* [Preview]. ISO. https://www.iso.org/standard/84370.html
- Association for the Advancement of Medical Instrumentation. (2019). *ANSI/AAMI/ISO 23500-5:2019 — Preparation and quality management of fluids for haemodialysis and related therapies — Part 5: Quality of dialysis fluid for haemodialysis and related therapies*. ANSI Webstore. https://webstore.ansi.org/standards/aami/ansiaamiiso235002019-2402287
- Mar Cor Purification. (2016). Millennium reverse osmosis unit. Operations and maintenance manual.
- Outset Medical. (2019). Tablo hemodialysis system user manual, PN-0004205 Rev. 08. San Jose, Ca: Outset Medical.

SUBJECT: **STERILE HAZARDOUS DRUG HANDLING**	SECTION: **Page 1 of 20**

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

PURPOSE:

To provide practice and quality standards for handling hazardous drugs (HDs) to promote patient safety, worker safety, and environmental protection. In addition, to provide for the safe receipt, storage, compounding, dispensing, administration, and disposal of sterile hazardous products and preparations at Sierra View Medical Center (SVMC).

DEFINITIONS:

A. Hazardous Drugs- Medications that in small quantities can produce severe adverse physiological effects. This category can be further subdivided into antineoplastic (Group 1), non-antineoplastic (Group 2), reproductive risk only (Group 3).

B. USP 797- Refers to a chapter from the United States Pharmacopeia publication. The USP is a nationally recognized authority that established quality standards for the preparation of sterile intravenous products.

C. USP 800- Refers to a chapter from the United States Pharmacopeia (USP) publication. The USP is a nationally recognized authority that established quality standards for the preparation of sterile hazardous products.

D. Class II Type A2 Biological Safety Cabinet (BSC)- A ventilated cabinet often used for preparation of hazardous drugs. A partial barrier system that rely on the movement of air to provide personnel, environmental, and product protection.

E. ISO Class 5- A reference to a space of air that contains no more than 3,520 particles per cubic that are 0.5 microns or larger.

F. PPE- Personnel Protective Equipment includes chemotherapy rated gloves, gowns, eye, face, head, shoe, sleeve coverings that are intended to prevent exposure to hazardous drugs.

G. Category 1 Compounded Sterile Preparation (CSP)- Category 1 is a risk-based approach defined in USP 797 that establishes a specific BUD for products, personnel qualifications, environmental monitoring. It assigns a BUD of 12 hours at room temperature and 24 hours refrigerated.

H. Category 2 Compounded Sterile Preparation (CSP)- Category 2 is a risk-based approach defined in USP 797 that establishes a typically longer BUD. It assigns a BUD of 4 days at room temperature and 10 days under refrigeration.

I. BUD- Beyond Use Date is either the date or hour after which a CSP must not be used or administration must not begin. The BUD is determined from the date and time that preparation of the CSP is initiated.

J. CSTD- Stands for Closed System Transfer Device "a drug transfer device that mechanically prohibits the transfer of environmental contaminants into the system and the escape of the hazardous drug or vapor concentrations outside the system."

SUBJECT: **STERILE HAZARDOUS DRUG HANDLING**	SECTION: 2 **Page 1 of 20**

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

POLICY:

It is the policy of SVMC that all injectable hazardous medications as defined by NIOSH (Group 1, 2 & 3), may be prepared at the Cancer Treatment Center in a negative pressure CACI/BSC by properly trained personnel who will practice safe established preparation techniques and proper handling procedures as outlined in USP 797, USP 800, and California State Board of Pharmacy regulations. No hazardous injectable on NIOSH Group 1, will be compounded at the main pharmacy, however products on Niosh Group 2 & 3 may be compounded at main pharmacy so long as an assessment of risk has been performed and any additional requirements there in are followed during the compounding process.

Medications compounded in the satellite compounding pharmacy shall only be administered to registered patients who are on the premises of the same physical plant as the hospital satellite compounding pharmacy location.

Group's 2 & 3 hazardous drugs compounded at the main pharmacy will follow normal USP 797 procedures and hospital sterile compounding procedures with additional direction on PPE/processes outlined in the Assessments of Risk Dictionary.

The following procedure defines the processes for hazardous compounding at the satellite compounding pharmacy.

AFFECTED PERSONNEL/AREAS: *PHARMACY, CANCER TREATMENT CENTER, NURSING*

A. PERSONNEL PREPARATION:

1. All activities not requiring a sterile environment (e.g., checking labels, doing calculations) should be completed before accessing the CACI/BSC.

2. Hand washing is a critical component to ensuring IV admixtures are aseptically prepared as well as reducing chemotherapy trace contamination of both product and personnel.

   a. Wash hands before and after cleaning hood or preparing chemotherapy products.

   b. Wash hands for 30 seconds using (digital timer provided). Wash up to elbows when possible.

   c. Utilize bactericidal soap.

   d. Pay particular attention to under fingernails and between fingers. Use nail picks to remove debris from underneath fingernails.

   e. No jewelry (rings, watches, etc.) may be worn during compounding.

   f. No nail polish, artificial nails, or cosmetics may be worn during compounding.

   g. After washing, use a lint-free (non-shedding) cloth or paper towel to dry hands.

   h. Prior to donning first pair of sterile HD-certified gloves, after washing hands as above, apply Sterillium© and allow contact time of at least 3 minutes.

3. Utilize gowns that are certified for use in the preparation of hazardous drugs. This will help protect both you as well as others from trace chemo contamination. Gowning will help protect you from any gross chemotherapy spills that could occur. Wearing protective garments (gown and gloves) is required when preparing, compounding, handling, cleaning, and disposing chemotherapy.

   a. After washing hands and applying Sterillium, don first (interior) set of sterile HD gloves.

   b. Sanitize outside the gloves with 70% isopropyl alcohol. Allow alcohol to dry.

   c. Don protective chemotherapy-approved gown.

   d. First set of gloves should be tucked under/inside the cuff of the gown.

   e. Don second set of chemotherapy-approved sterile gloves (double gloves are recommended for hazardous drugs as permeability varies with material, thickness, and exposure duration).

   f. Extend outer glove over the cuff of gown.

   g. Sanitize outer HD glove with 70% isopropyl alcohol, and allow alcohol to dry.

   h. Change gloves if they become contaminated, torn, or punctured.

   i. Change outer gloves whenever you must exit and re-enter the BSC by opening the face of the BSC for cleaning or decontamination.

   j. Gowns are not to be worn outside of the buffer area.

   k. TWO sets of booties must be worn while compounding.

   l. Two pairs of gloves that meet the ASTM D-6978 standard shall be worn for handling HD waste, cleaning HD spills, and performing cleaning in HD areas.

   m. Gloves must be changed every 30 minutes during HD compounding or between each different HD preparation.

B. CHEMOTHERAPY PREPARATION TECHNIQUE:

1. Nothing should interrupt the flow of air between the HEPA filter and the sterile starting components. To maintain sterility, nothing should be placed above the work surface. Starting components should be placed at least six inches from the sides and front edge of the hood without blocking air vents. Hands should also be positioned to assure that airflow in the critical area of the HEPA filter and the sterile starting components is not blocked.

2. BSCs must run continuously 24 hours a day and must be inspected and certified by qualified personnel every six months.

3. Nothing should be stored on top of the BSC.

4. Clean the drug preparation area, left to right and top to bottom, with an approved sterile water, 70% isopropyl alcohol, and sporicidal agent approved by designated person (with a dwell time of at least 3 minutes). This will be done at the beginning and the end of the shift, when there is a spill or as needed.

5. Keep the area free of solutions, additives, and equipment that are not required to prepare the product.

6. All products necessary for preparing the admixture or batch should be gathered and sanitized with sterile 70% alcohol and readied for placement in the CACI or BSC. Obtain the basic parenteral solutions, additive drugs, syringes, needles, swabs, labels, Chemo-transport bag, etc.

7. When using a BSC, place the medication label nearby for reference. You may also affix the label onto the final container to prevent errors. Then, place the sanitized starting components and supplies on top of the clean (sterile) disposable mat (if used) inside the PEC.

    a. Only one HD preparation may be handled in a C-PEC at one time, unless the multiple HD preparations are of the same drug, or are multiple HD preparations for a single patient.

8. If a disposable preparation mat is used for compounding it must be changed immediately if a spill occurs, after each different HD preparation unless multiple preparations of the same drug or for a single patient is occurring, and at the end of the daily compounding.

9. If an infusion container (IV bag) will be utilized, attach the IV tubing and completely prime the tubing in the hood, making sure it is free of all air bubbles.

10. Prime tubing with fluid from container PRIOR to adding chemotherapy agent whenever possible.

11. Clean diaphragms and injection ports with sterile 70% alcohol swab prior to needle puncture.

12. The safe handling of hazardous drug solutions in vials or ampoules requires the use of a syringe that is no more than three-fourths full when filled with the solution. This minimizes the risk of the plunger separating from the syringe barrel.

13. Ensure that the syringe is the appropriate volume and needle is the appropriate gauge and length.

14. Use CSTD (ONGUARD system or other approved CSTD depending on market availability and as approved by PIC (Designated person) for all compounding in the CACI/BSC.

15. When reconstituting, the syringe should remain in the CSTD, and the contents should be swirled carefully until dissolved.

16. With the vial inverted, the proper amount of drug solution should be withdrawn in small

aliquots (e.g., 1/4th to 1/5th of total volume in each aliquot) while equal volumes of air are exchanged for solution. The exact volume needed must be measured while the syringe is in the CTSD and any excess drug should remain in the vial.

- If the preparation is to be administered in a syringe then it may be capped and labeled at this point in the procedure. If the final dosage form is an IV bag, then continue with the following procedure.

17. When transferring drug to the IV bag, attach the CSTD to the IV bag containing the base solution. Avoid puncturing the sides of the port or bag.

18. Attach the syringe with the drug to the CSTD on the IV bag and slowly inject.

After the drug solution is inserted into the IV bag; the IV port, container set, and gloves. should be decontaminated with sterile alcohol 70%.

19. The injection port of the final product should then be covered with a protective shield and chemotherapy seal.

20. The final preparation should then be placed into the pass-through chamber, inner airlock door closed, and the clean inner gloves should be used for labeling and placement into the chemotherapy transport bag.

21. When using a negative pressure BSC, all items must be wiped down with 70% sterile alcohol prior to being placed inside. They must be at least 6 inches in the hood and placed such that that turbulent airflow does not exist.

22. Mat's shall be changed immediately if a spill occurs, after each HD drug, and at the end of daily compounding activity.

23. Only one HD preparation may be handled in a C-PEC at one time.

C. INSPECTION OF FINAL PRODUCT:

After completion of preparation, the pharmacist will notify the Cancer Treatment Center (CTC) nursing staff. One of the licensed registered chemo-certified nurses and the pharmacist will verify that the final product is free from visible particulate matter, turbidity, or discoloration. At this point, the final preparation is ready for administration to the patient. It will be sealed in a chemotherapy transport bag and taken by the nurse.

D. LIST OF HAZARDOUS DRUGS

1. A list of hazardous drugs that are handled at Sierra View Medical Center will be maintained by the pharmacy (PIC) and reviewed against the NIOSH list for changes annually.

E. RESPONSIBILITIES OF PERSONNEL HANDLING HAZARDOUS DRUGS

1. The pharmacist-in-charge will be responsible for developing and implementing appropriate procedures and overseeing entity compliance with USP 800.

a. Program integrity will be assured through the following:

- Testing of product, environment, and personnel.
- Correcting actionable results when necessary.

Hand-hygiene and use of PPE shall be employed at each phase of hazardous drug (HD) handling, e.g., receipt, transport, compounding, administration, spill, and disposal.

F. FACILITIES AND ENGINEERING CONTROLS

1. Designated areas for handling HDs

a. Segregated Compounding Area (Main Pharmacy) and Suite B

- A sign designating "hazard" must be displayed.
- Access to HD preparation area must be restricted to authorized personnel.
- Located away from breakrooms or areas for patients and visitors

b. Receipt and Unpacking of HDs located at Cancer Treatment Center

- A pharmacist will receive the HDs from the wholesaler.
- A properly-garbed staff member will unpack the HD shipments in the compounding area.

c. Storage at Cancer Treatment Center

- HDs will be stored in the HD room, behind a locked door.
- HDs will be stored as per manufacturer's recommendations and monitored as per SVMC policy MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL.

d. Hand washing shall occur after handling and PPE has been doffed.

e. Designated Administration Areas

- Cancer Treatment Center-Chemotherapy
- Operating Room- Bladder Instillation

G. RECEIPT

1. Receiving staff shall don ASTM gloves that meet the ASTM D-6978 standard.
2. Antineoplastic HDs must not be unpacked (removal from shipping containers) from their external shipping containers in positive-pressure areas.

a. If the shipping container appears damaged:

- Seal the container without opening and contact the supplier.
- If the unopened package is to be returned to the supplier, enclose the package in an impervious container and label the outer container "Hazardous".
- If the supplier declines return, dispose of as hazardous waste.

b. If a damaged shipping container must be opened:

- Seal the container in a plastic or an impervious container.
- Transport it to a negative-pressure CACI/BSC and place on a plastic-backed preparation mat.
- Open the package and remove undamaged items.
- Wipe the outside of the undamaged items with a disposable wipe.
- Enclose the damaged item(s) in an impervious container and label the outer container "Hazardous."
- If the supplier declines return, dispose of as hazardous waste.
- Deactivate, decontaminate, and clean the CACI/BSC and discard the mat and cleaning disposables as hazardous waste.
- Hand washing shall occur after handling and PPE has been doffed.

H. STORAGE

1. HDs must not be stored on the floor.
2. HDs must be stored on secured shelves with raised front lips.
3. Antineoplastic HDs must be stored separately from non-HDs in a manner that prevents contamination and exposure.
4. Refrigerated antineoplastic HDs must be stored in a dedicated refrigerator.
5. After stocking, hand washing shall be completed.

I. COMPOUNDING

1. One licensed registered chemotherapy nurse will double check, and initial, the pharmacist's calculations prior to compounding.
2. Hand washing is a critical component to ensuring IV admixtures are aseptically prepared as well as reducing chemotherapy trace contamination of both product and personnel.

a. Wash hands before and after cleaning the PEC or preparing chemotherapy products.

b. Wash hands for 30 seconds with timer. Wash to elbows when possible.

c. Utilize bactericidal soap.

d. Pay particular attention to under the fingernails and between fingers. Use a nail pick for debris under fingernails.

e. No jewelry (rings, watches, etc.) may be worn during compounding.

f. No nail polish, artificial nails, or cosmetics may be worn during compounding.

g. After washing, use a lint free (non-shedding) cloth or paper towel to dry hands.

h. Apply sterillium to bare hands prior to donning first pair of HD gloves.

3. Gowning will help protect both you as well as others from trace chemo contamination. Gowning and gloving is required when preparing, compounding, handling, cleaning and disposing of HDs.

a. After washing hands, don first (interior) set of HD gloves.

b. Sanitize HD gloves with 70% isopropyl alcohol.

c. Don protective chemotherapy-approved gown.

d. First set of gloves should be tucked under/inside the cuff of the gown. Donned gloves must meet the ASTM D-6978 standard.

e. Don second set of chemotherapy approved gloves (double gloves are recommended for hazardous drugs as permeability varies with material, thickness, and exposure duration).

f. Extend outer glove over the cuff of gown.

g. Sanitize and or soak outer glove with 70% isopropyl alcohol and allow product to dry.

h. Change gloves if they become contaminated, torn, or punctured.

i. Change outer gloves whenever you must exit and re-enter the PEC.

j. Gowns are not to be worn outside of preparation/buffer area.

4. Head, Hair, and Shoe Covers

   a. A second pair of shoe covers must be worn when entering the compounding area and compounding HDs. It also must be removed before leaving that area.

   b. Head covers/bouffants will be worn while compounding HDs.

5. Doffing of PPE after HD compounding

   a. Inside the PEC, remove outer pair of HD gloves and place them in a hazardous bag. Remove the hazardous bag from the PEC and dispose it in HD waste container in buffer area.
   b. Remove outer pair of booties and place in yellow HD waste container in buffer area.
   c. While in the HD buffer area, remove the HD gown and place in yellow HD waste container.
   d. Remove inner pair of HD gloves while in buffer area.
   e. Exit HD buffer room, enter the clean side of anteroom, and go to the sink.
   f. Remove bouffant/mask and place in yellow HD waste container found under the sink.
   g. Wash hands as stated above.
   h. Remove inner booties and step across LOD.
   i. Use Sterillium gel.

6. Eye and Face Protection

   a. Must be worn when there is a risk of splash or spills outside of CACI/BSC, i.e., cleaning a spill, or working above eye level.

   b. Goggles must be used, not eye glasses.

   c. Goggles plus face shield provide full protection.

7. Respiratory Protection

   a. Shall be worn when unpacking HDs that are NOT contained in plastic bags.

   b. A N95 surgical respirator provides barriers to splashes, droplets, and sprays but not to vapors or gases.

   c. A full face-piece, chemical cartridge-type respirator should be worn when risk of exposure to vapor or:

      - Attending HD spills larger than what can be contained with a spill kit.

      - Deactivating, decontaminating, and cleaning underneath work surfaces.

- Known or suspected airborne exposure to powders or vapors.

8. Engineering Controls

   a. Primary Engineering Control (PEC) – A CACI/BSC will be used for all phases of compounding that provides an ISO Class 5 or better air quality.

   b. Supplemental Control - A closed system transfer device will be used in compounding and administering HDs.

9. CACI/BSC

   a. Must operate continuously 24 hours a day and 7 days a week.

   - Will be recertified every 6 months.
   - If there is any loss of power or if repair or moving occurs:
     - All activities in CACI/BSC must be suspended.
   - Upon return of power
     - Decontamination, cleaning, and disinfection must occur and the BSC must be given the manufacturer specified time to recover before compounding resumes.
   - A sink must be available for hand washing.
   - An eyewash station must be readily available.
   - Water sources and drains must be located at least 1 meter away from CACI/BSC.
   - CACI/HD hood must be externally vented.
   - Must provide an ISO Class 5 or better environment.

10. STERILE COMPOUNDING

   - All sterile NON-HD compounding must follow USP 797 standards.
   - LABELING
     - HDs shall be labeled "Caution Chemotherapy-Dispose of properly" or "hazardous- dispose of properly" and "Compounded by Pharmacy".

- All product labels shall include:
  - Name of pharmacy
  - Name of medication, strength, and volume
  - IV admixed medications shall include the solution used.
  - Instructions for storage, handling, and administration or rate of infusion
  - Beyond use date
  - Date of compounding
  - Lot number or pharmacy reference number

All compounded HDs will undergo visual inspection for particulate matter, turbidity, and evidence of contamination. Products with suspected adulterants will be discarded into the yellow HD waste container after the patient information has been removed and destroyed.

11. SVMC Policy IV PREPARATION AND DISPENSING shall be applied. HD guidelines from USP 800 shall supersede non-HD procedures where conflict exists.

12. Hand washing and donning PPE shall occur before compounding. Hand washing shall occur after doffing PPE.

A. TRANSPORT OF HDs

1. LABELING

   a. HDs must be clearly labeled as per USP 797 at all times during transport and include labels of "Chemotherapy-dispose of properly" or "Hazardous drugs-dispose of properly".

2. PACKAGING

   a. During packaging staff shall don gloves that meet the ASTM D-6978 standard
   b. A designated HD transport tote will be labeled "Hazardous Drugs" and will be used solely for HDs.

   c. The transport tote will be cleaned before and after transport of HDs by properly garbed pharmacy technicians.

   d. Hand washing shall occur after PPE has been doffed.

B. ADMINISTERING

1. Sterile intravenous HDs will be administered via needleless closed system transfer device.

2. PPE used when administering HDs will be disposed of in a chemotherapy waste receptacle.

3. During administration gloves that meet the ASTM D-6978 standard and chemotherapy gowns shall be worn. Eye & Face protection shall be worn whenever a risk of spill or splash is of concern or when working above eye level.

4. Hand washing shall occur after proper PPE has been doffed.

C. DISPOSAL

1. All personnel who perform custodial waste removal and cleaning activities will be trained to prevent and protect themselves from accidental exposure and contamination of the environment.

2. During disposal gloves that meet the ASTM D-6978 standard shall be worn.

3. Hand washing shall occur after proper PPE has been doffed.

D. DISPENSING OF FINAL DOSAGE FORMS

1. Any hazardous drug that does not require any further manipulation other than counting or repackaging of the final dosage form must not be placed into an automated counting machine unless otherwise specified by its Assessment of Risk.

E. DEACTIVATING, DECONTAMINATION, CLEANING, AND DISINFECTING

1. All personnel who perform deactivation, decontamination, cleaning, and disinfection in HD handling areas will be:

   a. Trained annually

   b. All personnel performing these activities will wear impervious personnel protective equipment, double gloves (chemo-grade), and eye protection if splashing is likely.

2. CACI/BSC MAINTENANCE

   a. Do not use a spray bottle. Lint free wipes shall be used.

   b. Disposal meets FDA regulations.

   c. All cleaning activities will be documented.

3. Deactivation

   a. Shall occur daily, after a spill, or as deemed warranted.

   b. A process whereby the HD compound is rendered inert. SVMC will use sporicidal agent approved by designated person with verified deactivation compounds per USP 800 that include deactivating compounds such as peroxide. Examples of (but not limited to) appropriate products include Periodox & Decon-Spore.

4. Decontamination

   a. Performed prior to any compounding, in between compounding different HDs, at the end of a shift, when a spill occurs, before and after certification, voluntary interruption, and if ventilation tool is moved.

      - Removal of HD residue
        - Sterile Alcohol 70%

5. Cleaning

   a. Shall occur prior to any compounding, in between compounding different HDs, at the beginning and end of a shift, when a spill occurs, before and after certification, voluntary interruption, at least every 30 minutes when compounding involving human staff is occurring, and if ventilation tool is moved.

      - Removal of organic and inorganic material

      SVMC will use sporicidal agent approved by designated person, such as Peridox© or Decon-Spore, with a contact time of 3 minutes when agent is visibly wet.

6. Disinfecting

   a. A process of inhibiting or destroying microorganisms. This shall be performed prior to any compounding, in between compounding different HDs, at the end of a shift, when a spill occurs, before and after certification, voluntary interruption, and if ventilation tool is moved. SVMC will use sporicidal agent approved by designated person, such as Peridox© or Decon-Spore, with a contact time of at least 3 minutes.

   b. Must occur after surfaces are cleaned using sterile 70% alcohol

   c. SVMC Policy: STERILE PRODUCTS: STERILE PRODUCT QUALITY ASSURANCE shall be applied and followed.

7. Spill Control

   a. Pharmacy personnel involved in handling or compounding HDs will receive annual training to be qualified in the use of personnel protective equipment, respirator, and spill management.

   b. Spills must be contained and cleaned immediately by qualified personnel with appropriate PPE.

   c. Signs must be used to restrict access to spill.

   d. Spill kits must be available at all times while HDs are being handled.

   e. All used spill kit items must be disposed of as hazardous waste.

   f. Spill kits are located in CTC HD Pharmacy and Main Pharmacy.

   g. Face pieces must be used if capacity of kit is exceeded or if vapors are known or suspected.

   h. Material Safety Data Sheets are accessible 24 hours a day via the SVMC intranet.

   i. When a spill occurs, protect the patients or employees who had cytotoxic drugs spilled on them.

   a. If skin is exposed, wash the affected areas with copious amounts of non-medicated soap and water for 20 minutes.

   b. If mucous membranes are exposed (i.e. eyes), rinse with copious amounts of clean water for at least 15 minutes.

8. Spills should be cleaned up immediately by the person responsible. An Environmental Services Supervisor is available during business hours. Call the Supervisor to assist if the spill is complicated (i.e., >50ml or >12 inches in diameter, or difficult to contain, for example liquid mercury spills) or the area is difficult to clean. The supervisor may also be called as an information resource on cleaning spills.

9. A written procedure for spill management is included in each spill kit. Components of a spill kit include, but may not be limited to, the following:

   a. 2 pairs of disposable HD gloves

   b. Low permeability gown and shoe covers

   c. Goggles or face shield

   d. Respirator mask (unless included in face shield)

   e. Plastic backed absorbent sheets or spill pads (sufficient to absorb a spill of up to 1000mL)

f. Disposable towels or swabs for absorbing and cleaning liquid spills

g. At least 2 sealable plastic waste bags "Cytotoxic Waste"

h. Disposable scoop for collecting glass fragments

i. Puncture-resistant container for glass fragments, clearly labeled as cytotoxic waste container

j. Cleaning solution for cleaning and decontamination of area

k. Instructions on the management of a cytotoxic chemotherapy spill

l. Warning signs to alert other staff to the hazard and isolate the area of the spill

F. General clean-up procedure:

1. Assess the size and scope of the spill.

2. Spills that cannot be contained by two spill kits may require outside assistance and supervisor should be alerted.

3. Post signs to limit access to spill area.

4. Obtain spill kit.

5. Don PPE, including inner and outer gloves and mask.

6. Once fully garbed, contain spill using spill kit.

7. Carefully remove any broken glass fragments and place them in a puncture-resistant container.

8. Absorb liquids with spill pads.

9. Absorb powder with damp disposable pads or soft toweling.

10. Spill cleanup should proceed progressively from areas of lesser to greater contamination.

11. Completely remove and place all contaminated material in the disposal bags.

12. Rinse the area with water and then clean with detergent, sodium hypochlorite solution/wipes and neutralizer.

13. Rinse the area several times and place all materials used for containment and cleanup in disposal bags. Seal bags and place them in the appropriate final container for disposal as

hazardous waste.

14. Carefully remove all PPE using the inner gloves. Place all disposable PPE into disposal bags. Seal bags and place them into the appropriate final container.

15. Remove inner gloves; contain in a small, sealable bag; and then place into the appropriate final container for disposal as hazardous waste.

16. Wash hands thoroughly with soap and water.

17. Once a spill has been initially cleaned, have the area re-cleaned by housekeeping, janitorial staff, or environmental services.

G. After the spill has been cleaned up and the people who came in contact with the cytotoxic drugs have washed the involved skin areas for 20 minutes, consider the following:

1. If the spill is on a patient, notify the physician.

2. If the spill is on an employee:

   a. Call Employee Health Services during business hours or the emergency room for further instructions. The Employee Health nurse or emergency room physician will assess for injury related to the exposure with particular attention to the skin, eyes, and mucous membranes. If a baseline CBC has not been drawn, a CBC with differential will be done.

   b. A CBC with differential and follow-up exam will be done by the Employee Health Service nurse at the time of the expected nadir (the lowest point of circulating blood counts (e.g., WBCs and RBCs) of the drug.

3. Complete an incident report if a spill occurs anywhere or if a spill occurs on a patient or employee.

H. DOCUMENTATION AND STANDARD OPERATING PROCEDURES

1. Must be reviewed by the pharmacist-in-charge every 12 months.

2. Any changes to policy or records must be communicated and documented to all personnel handling HDs.

I. MEDICAL SURVELLIANCE

1. Pharmacy personnel involved in routine handling of HDs will be enrolled into SVMC's medical surveillance program which is administered through employee health.

2. All employees with potential exposure to cytotoxic drugs will be informed by their

department of the potential risks and the need to follow the procedures related to handling of chemotherapy. Training in the policies will be provided as appropriate for the department involved.

3. Employees will be informed by their department of the potential reproductive hazards and if they so request, staff members who are pregnant or breast-feeding, will be transferred to comparable duties that do not involve handling cytotoxic drugs.

4. ACTIONS IN RESPONSE TO EXPOSURE-RELATED HEALTH CHANGES

   a. Post-exposure examination tailored to type of exposure.

   b. Compare performance of controls with recommended standards.

   c. Conduct environmental wiping samples.

   d. Verify that all engineering controls are operating properly.

   e. Verify and document that employee complied with existing policies.

   f. Develop and document a plan of action that will prevent future exposure.

   g. Ensure a confidential two-way communication between employee and employee health regarding notification of a change in health condition.

   h. Provide and document a follow-up medical survey to demonstrate actions that are effective.

   i. Ensure that any exposed employee receive notification of any adverse health effect.

   j. Provide ongoing medical surveillance of all employees that handle HDs to ensure plan implemented is effective.

J. TRAINING

1. Personnel will be trained annually

   a. According to OSHA standards 1910.120 Hazardous Waste Operations Emergency Response

   b. USP 797

   c. USP 800

   d. California State Law. CCR 1735, CCR 1751.

e. Sierra View Medical Center Policy and Procedures related to USP 797 and 800.

f. Chemo Check Workbook ™

g. Environmental Services, Nursing, and Pharmacy shall read and sign "Hazardous Drug Risk" form that acknowledges risk of HDs to employees.

h. Staff shall not handle HD's until after passing reevaluations in the deficient area(s).

K. QUALITY ASSURANCE PROGRAM

1. Quality Indicators found in SVMC policy COMPOUNDED STERILE PREPARATION:QUALITY ASSURANCE PROGRAM that shall be followed include:

a. Personnel Performance

b. Equipment and Facilities

c. Product and Environment

- At a minimum of every 6 months, or as needed to verify containment, the following shall be done upon the interior of PEC, pass-thru chambers, surfaces in staging or work areas near PEC, areas adjacent to PEC, areas immediately outside buffer area, patient administration areas:
  - Environmental Wipe Sampling for Trace Chemo:
- In the event of a positive result, the pharmacist-in-charge shall:
  - Identify, document, and contain the cause of contamination
  - Reevaluate the workplace practices
  - Re-train personnel
  - Perform deactivation, decontamination, cleaning, and improving engineering controls
  - Repeat wipe-sampling to validate decontamination complete
- End Product Sampling
  - Sterility
  - Potency

L. HAZARD COMMUNICATION PROGRAM

1. Standards of handling HDs shall be implemented and evaluated thru annual employee competencies.

2. All containers of HDs shall be labeled with the identity of the material and appropriate hazard warning.

3. Material Data Sheets are available for all employees 24 hours a day via the SVMC intranet.

4. Personnel shall receive training on exposure prior to handling HDs or when there are hazard changes.

5. Personnel of reproductive capability shall confirm in writing that they understand the risk of handling HDs.

M. CONTAINMENT REQUIREMENTS

1. For dosage forms (tablets or capsules, solid intact medications) that are administered to patients without modification shall be handled as per assessment of risk.

2. The selected containment strategy (handling precautions) will be communicated to staff via Electronic Medical Record and auxiliary stickers or pharmacy labels.

3. The facility risk assessment shall be reevaluated annually.

4. All HD API's and antineoplastic HD's will be transported in an imperious plastic container and labeled as HD on the outside of the container.

N. In the event of a drug recall, the procedure found in SVMC policy DRUG RECALL PROCEDURE shall be followed.

O. All medications used for compounding sterile products, both hazardous and nonhazardous, will be procured from a registered wholesaler or from an FDA registered manufacturer.

P. Documentation Retention

1. All records of compounding and materials used to compound sterile preparations shall be maintained in a readily retrievable form for three (3) years from the date the record was last in effect.

U. Whenever a change in a policy or procedure occurs, the pharmacist-in-charge will notify the staff via a meeting or email. Staff shall sign off on changes acknowledging changes and intent to comply. Any material failure to follow the pharmacy's written policies and procedures shall constitute a basis for disciplinary action by the Board of Pharmacy.

V. All policies related to sterile HD IV compounding will be reviewed annually by the pharmacist-in-charge, and recordation of the annual review shall be present on each policy and be readily retrievable upon request by the Board of Pharmacy.

1. The pharmacy will maintain records of the acquisition, storage, and destruction of any components used in compounding.

R. A pharmacy technician may, at the discretion of the pharmacist, remain in the pharmacy but may only perform nondiscretionary tasks. The pharmacist will be responsible for reviewing any tasks completed in the temporary absence, i.e., restroom break, etc.

REFERENCES:

- 2026 Lawbook for Pharmacy. Business and Professions Code 4000. https://www.pharmacy.ca.gov/laws_regs/lawbook.pdf
- "ASHP Guidelines on Handling Hazardous Drugs." *American Journal of Health-System Pharmacy* 63, no. 12 (June 15, 2006): 1172–1191. doi:10.2146/ajhp050529. Accessed: April 1, 2026.
- Occupational Safety and Health Administration (OSHA) Guidelines for Controlling Occupational Exposure to Hazardous Drugs Accessed April 1, 2026. https://www.osha.gov/hazardous-drugs/controlling-occex
- United States Pharmacopeial Convention. (2019). *USP <800>: Hazardous drugs—Handling in healthcare settings*. United States Pharmacopeial Convention. https://www.usp.org/. Accessed April 1, 2026.

CROSS REFERENCES:

- MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL
- IV PREPARATION AND DISPENSING
- COMPOUNDED STERILE PREPARATION: QUALITY ASSURANCE PROGRAM
- DRUG RECALL PROCEDURE
- STERILE PRODUCTS: STERILE PRODUCT QUALITY ASSURANCE

SUBJECT: **THERAPEUTIC DRUG SUBSTITUTION PROTOCOL**	SECTION: ***Clinical Pharmacy Drug Protocols*** **Page 1 of 11**

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

PURPOSE:

To promote cost effective, rational drug therapy by controlling the number of similar medications within a given therapeutic class that will be available on formulary.

POLICY:

A therapeutically equivalent drug may be dispensed following the development of objective interchange guidelines by the medical and pharmacy staff through the Pharmacy and Therapeutic Committee.

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

PROCEDURE:

The Pharmacy and Therapeutics Committee will identify potential therapeutic classes of medications, which may provide an opportunity for therapeutic interchange. Upon identification, experts in the area of therapeutic classification will be changed with selecting an appropriate therapeutic class representative drug. In making this selection, the following factors should be considered: mechanism of action, adverse effect profile, dosing schedule, monitoring parameters, potential drug interactions, and cost. Following the agent selection, objective interchange guidelines will be established and will be reviewed with other members of the medical staff.

The P&T Committee will review these guidelines. Following approval by P&T, the Medical Executive Committee of the institution will review and approve. Once approved the medications within "Non-Form" section will become non-formulary.

Medications with a DAW or dispense as written designation will be reviewed through the non-formulary process.

If patient has documented allergy to therapeutic substitute, the substitute will not take place.

DEFINITIONS:

1. Therapeutic Substitutions- Is the replacement of the originally prescribed drug with an alternative molecule with assumed equivalent therapeutic effect. The alternative drug may be within the same class or from another class with assumed therapeutic equivalence.

2. Biosimilar- FDA approved medication that is highly similar to the reference product. For approval, the structure and function of an approved biosimilar were compared to reference product and shown to have no clinically meaningful differences in safety, purity, or potency (safety and effectiveness) compared to the reference product.

Appendix A: Proton Pump Inhibitor:

Pantoprazole (Protonix®) will be the preferred (medication substituted to) proton pump inhibitor at Sierra View Medical Center. Lansoprazole (Prevacid®) 30mg Solutabs may be used if PPI needed to be delivered via G-tube. Orders written for oral dexlansoprazole (Dexilant®), esomeprazole (Nexium®), lansoprazole (Prevacid®), omeprazole (Prilosec®) or rabeprazole (Aciphex®) are autosubstituetd by Pharmacy per the table below.

Preferred Agent					
Pantoprazole (Protonix®)	**Omeprazole (Prilosec®)**	**Esomeprazole (Nexium®)**	**Rabeprazole (Aciphex®)**	**Lansoprazole (Prevacid®)**	**Dexlansoprazole (Dexilant®)**
20mg daily	10mg daily	20mg daily	20mg daily	15mg daily	30mg daily
40mg daily	20mg daily	20mg daily	20mg daily	30mg daily	60mg daily
40mg BID	20mg bid or 40mg daily	40mg daily	20mg BID	30mg BID	30mg BID
80mg BID	40mg bid	80mg daily	40mg BID	60mg BID	60mg BID

Note: In the event of a drug shortage for Pantoprazole; Esomeprazole will be the substitute agent.

Appendix B: Nasal Corticosteroid Products

Substitutive Agent-Therapeutic Interchange	Non-Form
Fluticasone Nasal 1 spray each nostril daily	Beclomethasone Nasal, 1-2 spray each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Budesonide Nasal, 1-2 spray each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Flunisolide Nasal, 2 sprays each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Mometasone Nasal, 2 sprays each nostril daily
Fluticasone Nasal 2 spray each nostril daily	Triamcinolone Nasal, 2 sprays each nostril daily

Note: In the event of a drug shortage for Fluticasone nasal, Triamcinolone Nasal is the substitute agent.

Appendix C: Inhaled Combination Medication Therapeutic Interchange

Substitutive Agent- Therapeutic Interchange	Non-Form
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Budesonide/Formoterol (Symbicort) 80/4.5 mcg 2 puffs BID 160/4.5 mcg 2 puffs BID
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID 500/50 mcg 1 puff BID	Fluticasone/Salmeterol(Advair HFA) 45/21 mcg 2 puffs BID 115/21 mcg 2 puffs BID 230/21 mcg 2 puffs BID
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Fluticasone/Vilanterol (Breo) 100/25 mcg daily 200/25 mcg daily
Albuterol MDI same dose and frequency plus Tiotropium (Spiriva Respimat) 2 INH daily	Ipratropium/Albuterol (Combivent)
Fluticasone/Salmeterol (Advair) 250/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Mometasone/Formoterol (Dulera) 100/5 mcg 2 puffs BID 200/5 mcg 2 puffs BID
Tiotropium (Spiriva Respimat) 2 inhalations (2.5mcg) daily	Tiotropoium (Spiriva Handihaler) Inhale contents of one capsule daily

Appendix D: Insulin Therapeutic Interchange

Substitutive Agent- Therapeutic Interchange	Non-Form
Insulin Lispro (Humalog) 1:1 conversion	Insulin Aspart (Novolog)
Insulin glargine 1:1 conversion	Insulin degludec (Tresiba)
Insulin glargine 1:1 conversion	Insulin detemir (Levemir)

Note biosimilar's for substitutive therapeutic interchange may be used.

Appendix E: Antihistamine agents

Substitutive Agent- Therapeutic Interchange	Non-Form
Loratadine (Claritin) 10mg daily	Cetirizine (Zyrtec) Oral 5mg or 10mg daily
Loratadine (Claritin) 10mg daily plus Equivalent Pseudoephedrine up to 60mg po QID	Cetirizine/Pseudoephedrine (Zyrtec-D) All doses
Loratadine (Claritin) 10mg daily	Desloratidine (Clarinex) Oral 5mg daily
Loratadine (Claritin) 10mg daily	Fexofenadine (Allegra) Oral all doses
Loratadine (Claritin) 10mg daily Equivalent Pseudoephedrine up to 60mg po QID	Fexofenadine/Pseudoephedrine (Allegra-D) All doses
Loratadine (Claritin) 10mg daily	Levocetirizine (Xyxal) Oral 2.5 to 5mg daily
Loratadine (Claritin) 10mg daily Equivalent Pseudoephedrine up to 60mg po QID	Loratidine/Pseduoephedrine (Claritin D)

Appendix F: HMG CoA Reductase Inhibitors

Substitutive Agent- Therapeutic Interchange	Non-Form
Atorvastatin (Lipitor) 5mg daily 10mg daily	Fluvastatin (Lescol) 40mg daily 80mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Lovastatin (Mevacor) 20mg daily 40mg daily 80mg daily
Atorvastatin (Lipitor) 20mg daily 40mg daily 80mg daily 80mg daily	Rosuvastatin (Crestor) 5mg daily 10mg daily 20mg daily 40mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Simvastatin (Zocor) 10mg daily 20mg daily 40mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Pitavastatin 1mg daily 2mg daily 4 mg daily

Note: In the event of a drug shortage for Atorvastatin, Rosuvastatin will be the substitute agent.

Hepatic impairment prior to treatment initiation:

Child-Turcotte-Pugh Class A: No dosage adjustment necessary

Child-Turcotte-Pugh class B: Initial 20mg once daily; maximum recommended dose 20mg/day

Child-Turcotte-Pugh class C: Convert patient to rosuvastatin per table.

Appendix G: Angiotensin II Receptor Blocker

Substitutive Agent- Therapeutic Interchange	Non-Form
Losartan 25mg 50mg 100mg 150mg	Telmisartan (Micardis) 20mg 40mg 80mg ----
Losartan 25mg 50mg 100mg 150mg	Olmesartan (Benicar) 5-10mg 20mg 40mg -----
Losartan 25mg 50mg 100mg 150mg	Irbesartan (Avapro) 75mg 150mg 300mg ---
Losartan 25mg 50mg 100mg 150mg	Candesartan (Atacand) 4-8mg --- 16mg 32mg
Losartan 25mg 50mg 100mg 150mg	Azilsartan (Edarbi) 40mg 80mg --- ---
Losartan 25mg 50mg 100mg 150mg	Eprosartan (tevetan) 400mg 600mg 800mg ---

Appendix H: Angiotensin Converting Enzyme (ACE)

Substitutive Agent- Therapeutic Interchange Equivalent Daily Dosage	Non-Form
Lisinopril 10mg (Max 40mg)	Benazepril 10mg
Lisinopril 10mg (Max 40mg)	Enalapril 5mg
Lisinopril 10mg (Max 40mg)	Fosinopril 10mg
Lisinopril 10mg (Max 40mg)	Moexipril 7.5mg
Lisinopril 10mg (Max 40mg)	Perindopril 4mg
Lisinopril 10mg (Max 40mg)	Quinapril 10mg
Lisinopril 10mg (Max 40mg)	Ramipril 2.5mg
Lisinopril 10mg (Max 40mg)	Trandolapril 2mg

Appendix I: Biosimilar Medications

Note- Preferred agents should be utilized for inpatient and outpatient use. If a patient's payer requires use of a non-preferred agent, the non-preferred biosimilar may be used.

Therapeutic Interchange (Preferred agent)	Reference Product	Comments
Mvasi (Bevacizumab-awwb)	Avastin (Bevacizumab)	As required by payor
Ogivri (trastuzumab-dkst) Kanjinti (Trastuzumab-anns)	Herceptin (Trastuzumab)	As required by payor
Stimufend (pegfilgrastim-fpgk)	Pegfilgrastim (Neulasta)	As insurance allows Pegfilgrastim biosimilar and products is NON-FORMULARY for inpatients. Filgrastim should be used for inpatients
Releuko (Filgrastim-ayow)- preferred Zarxio (Filgrastim-sndz)	Neupogen (Filgrastim)	As required by payor
Renflexis (infliximab-abda)- preferred Inflectra (infliximab-dyyb)	Remicade (Infliximab)	As required by payor
Retacrit- epoetin alpa-epbx	Procrit/Epogen- epoetin alpha	
Truxima (rituximab-abbs)- preferred Riabni (rituximan-arrx)	Rituxan-rituximab	As required by payor
Albuminex (Albumin (human) kjda)- preferred	Albuked (Albumin (human))	As required by payor

Cancer Treatment Center Procedure:

If it is discovered that a patient's insurance rejects said biosimilar as part of the patient's treatment, the patient's care plan will be adjusted by the CTC pharmacist to reflect the approved agent. Example: Mvasi is rejected but insurance will cover Avastin→Pharmacist will be allowed by physician to make the adjustment in the patient's care plan.

1. Upon receipt of new care plan, CTC pharmacist will confirm with said list and if necessary, adjust the medication within the care plan to reflect the current approved medication from Addendum A if necessary to conform to insurance authorized and physician requested care plan.

2. After pharmacist adjustment in care plan, they will forward to insurance authorizer for approval. Once approved, Pharmacy will order as needed.

Dose Rounding for Continuous Infusion of Oncology Medications

1. Upon receipt of new orders for chemotherapy or biotherapy, the pharmacist will verify all calculations for dosage of agents ordered by the MD.
2. The pharmacist will evaluate the availability of the medications ordered. If the medication is available as a single use vial, the pharmacist shall calculate the difference in the dose ordered and the dose rounded to vial size.
3. For all single use vials of chemotherapy the pharmacist shall round the dose to a vial size within a 10% range of the dose ordered.
4. For all single use vials of monoclonal agents, the pharmacist shall round the dose to vial size within a 10% range of the dose ordered.
5. The provider will not be notified for dose changes of up to 5% for either chemotherapy or monoclonal agents.
6. The provider will be notified for dose changes greater than 5% and up to 10% for either chemotherapy or monoclonal agents.
7. Patients enrolled in clinical trials are excluded from the policy (unless dose rounding is specifically allowed in the investigational protocol)
8. If the physician does not wish to have the rounding policy applied, they will document on the order "no dose rounding" within the treatment plan within the administration instructions section.

Duplicate Orders

- Pharmacists may delete duplicate orders of the same medication, dose, and route with varying schedules. It will be assumed the new order with updated schedule is intended to replace the previous order (update frequency, dose, etc). E.g. Acetaminophen 650mg PO Q4HRS prn pain and Acetaminophen 650mg po Q6hrs prn pain. Pharmacist can authorize to delete the old order, and verify the new order while adding additional comments not to exceed 4gm/day as they see necessary.

Interchange between liquid and solid dosage forms

Pharmacists may automatically interchange between liquid and solid forms and route. EG patient is receiving medication and/or feedings via NG,OG,PEG; Pharmacist after discussion with patient's nurse will switch from oral to liquid form if available. Exception-Phenytoin with consult to patient provider.

Therapeutic Duplications

Duplicate orders for the same indication are only appropriate if clear instructions around the circumstances each order applies to are indicated by the ordering practitioner. Any duplicative order without clear distinction will be assessed and addressed by the reviewing pharmacist.

Any parenteral (IV, IM, SQ) or rectal (PR) medication ordered as needed (PRN), will have direction added by pharmacist to "use when unable to tolerate oral" if another order for an oral alternative is ordered for the same as needed indication.

> Example: Order written for Ondansetron 4mg IV q8h prn Nausea/vomiting with an existing Ondansetron 4mg PO q8h prn Nausea/vomiting. Pharmacist to clarify in the comment field of the IV order: Ondansetron 4mg IV q8h prn Nausea/vomiting, use when unable to tolerate oral

> Example: Order written for Oxycodone 5mg PO q4h prn pain scale 4-7 with an existing Hydromorphone 0.4mg IV q4h prn pain scale 4-7. Pharmacist to clarify in the comment field: Hydromorphone 0.4mg IV q4h prn pain scale 4-7, use when unable to tolerate oral

Any order for a parenteral (IV, IM, SQ) as needed (i.e., PRN) opioid will be discontinued when a subsequent order for a parenteral PRN opioid is placed unless there is clear criteria included on the order for when to administer one opioid over the other (e.g. breakthrough pain).

> Example: Order written for HYDROmorphone (Dilaudid®) 0.5 mg IV q4h PRN pain 8-10 ordered on a patient with an existing order for Morphine 2 mg IV q4h PRN pain 8-10. Pharmacist will discontinue the existing Morphine order and validated the new HYDROmorphone (Dilaudid®) order.

Any order for a short-acting PRN oral opioid will be discontinued when a subsequent order for a short-acting oral PRN opioid is placed unless there is clear criteria included on the order for when to administer one opioid over the other (e.g. Breakthrough pain).

> Example: Order written for Oxycodone Immediate Release (IR) 5 mg PO q4h prn pain 8-10 ordered on a patient with an existing order for Tramadol (Ultram) 50 mg PO q4h prn pain 8-10. Pharmacist will discontinue the existing Tramadol order and validate the new Oxycodone order.

Any orders for parenteral or oral as needed (i.e. PRN) opioids will discontinued when a subsequent order for a PCA or epidural is placed unless a clear indication that both can be administered concurrently via an order clarified with the provider.

Any orders for parenteral or oral as needed (i.e. PRN) opioids will be left unvalidated if ordered at the same time as a PCA or epidural unless a clear indication that both can be administered concurrently via an order clarified with the provider. Upon PCA or epidural discontinuation, parenteral or oral as needed opioids will be validated.

Any orders with overlapping pain scales ordered at the same time will be clarified that the higher dose of medication is clarified to the higher pain scale as long as no medication is indicated for that pain scale.

> Example: Orders written for Oxycodone Immediate Release 2.5mg PO q4h prn pain 4-7 and Oxycodone Immediate Release 5mg PO q4h prn pain 4-7. Pharmacist will adjust the Oxycodone Immediate Release 5mg PO q4hr prn pain 4-7 to a pain scale of 8-10 upon validation.

Any orders with pain scales of 1-3 or 4-7 and no order or information that include the higher pain scales may be clarified to include the higher pain scale as long as no medication is indicated for that pain scale.

> Example: Order written for Tramadol 50mg PO q4hr prn pain 4-7. Pharmacist will adjust the Tramadol 50mg PO q4hr prn pain 4-7 to a pain scale of 4-10 upon validation.

Appendix: IV to PO Subsection

PURPOSE: To provide a process for changing parenteral medications to the oral/enteral route when medically appropriate. The advantages of this program are to provide an oral/enteral dosage form with comparable bioavailability to the intravenous form, which has been shown to decrease length of hospitalization.

To reduce the added risks associated with continued intravenous therapy.
To lower overall medication and associated costs to the patient and the hospital.

Additional benefits include greater patient comfort, decreased nursing needs, & easier ambulation. Orders for approved intravenous (IV) medications are automatically changed to PO (by mouth) administration form when medical staff approved conditions and guidelines are met, and the switch is appropriate.

PROCEDURE: Patients must meet the following criteria in order to be considered for automatic IV to PO conversion of the selected medications. If the patient does not meet all criteria listed below, they will not be considered for automatic IV to PO conversion.

Inclusion Criteria

- The patient must be on IV therapy for at least 24 hours before IV to PO conversion consideration.
- The patient is tolerating scheduled medications and diet (orally, or via NG or G tube).

- The patient is not on a pre-operative or -procedure or post-operative or -procedure fast.
- The patient has not experienced any recurrent nausea, vomiting or diarrhea for at least 24 hours.
- The patient does not have an active gastrointestinal bleed.

Additional criteria for antibiotic/antifungal agents

- The patient is afebrile for at least 24 hours (temp < 100.4° F).
- The patient is clinically improving (white blood cell count decreasing, bands decreasing, improved signs and symptoms as documented in prescriber progress notes).
- The infection is at a site where an oral agent will achieve an adequate level (not endocarditis, meningitis, brain abscess, orbital cellulitis, other CNS infections, osteomyelitis, and endophthalmitis).
- The patient is not septic, and is hemodynamically stable (heart rate ≤ 100 beats/minute, respiratory rate ≤ 24 breaths/minute, and systolic blood pressure > 90 mm Hg without vasopressor support).
- For documented fungemia, fluconazole will continue IV for 7 days before PO switch.

The pharmacist may automatically switch the following medications to the oral dosage form, if the conditions under section 1 of this policy are met:

Antimicrobials

Medication	Intravenous Dose	Oral Equivalent
Azithromycin	250 mg IV daily 500 mg IV daily	250 mg PO daily 500 mg PO daily
Ciprofloxacin	200 mg IV every 12 hours 400 mg IV every 12 hours 400 mg IV every 8 hours	250 mg PO every 12 hours 500 mg PO every 12 hour 750 mg PO every 12 hours
Clindamycin	600mg-900mg IV every 8 hours	300mg-450 mg PO every 8 hours
Doxycycline	100 mg IV every 12 hours	100 mg PO every 12 hours
Levofloxacin	250 mg IV daily 500 mg IV daily 750 mg IV daily	250 mg PO daily 500 mg PO daily 750 mg PO daily
Fluconazole	100 mg IV daily 200 mg IV daily 400 mg IV daily	100 mg PO daily 200 mg PO daily 400 mg PO daily
Linezolid	600 mg IV every 12 hour	600 mg PO every 12 hours
Metronidazole	500 mg IV every 8 hours	500 mg PO every 8 hours
Rifampin	600 mg IV daily	600 mg PO daily
Trimethoprim / Sulfamethoxazole (TMP/SMX)	5-20 mg TMP/kg/day in 3-4 divided doses IV	As close to 1:1 conversion of TMP as possible: 1 double strength = 160 mg TMP 1 single strength = 80 mg TMP
Voriconazole	3-4 mg/kg IV every 12 hours (maintenance dose)	<40 kg: 100 mg PO every 12 hours ≥40 kg: 200 mg PO every 12 hours

Others

Medication	Intravenous Dose	Oral Equivalent
Acetaminophen IV (Ofirmev) (restricted only for those with strict NPO)	IV to PO is equivalent	Same dose regimen and frequency. May need to adjust in multiples of 325mg. IV acetaminophen doses limited to 2 doses for PRN orders and 4 doses for scheduled orders.
Famotidine	20 mg IV every 12 hrs.	20 mg PO every 12 hours

Pantoprazole	40 mg IV daily	40 mg PO daily (lansoprazole 30mg NG daily)
Folic Acid	1mg IV daily	1mg PO daily
Levetiracetam	500 mg IV every 12 hours	500 mg PO every 12 hours
Metoclopramide	10 mg IV every 6 hours PRN	10 mg PO Q6H every 6 hours PRN
Thiamine	100 mg IV daily	100 mg PO daily
Multivitamin	10 ml IV daily	1 tablet PO daily

The pharmacist will review the criteria and effect the change when appropriate. He/She will enter an order in the patient's chart under "Physician Orders" as "Change I.V. (*insert drug name*) to P.O. per protocol". The notation "Per SVMC Policy" will be entered or written adjacent to the pharmacist's signature.

REFERENCES:

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SUBJECT: **WAIVED AND POINT OF CARE TESTING – HEMOGLOBIN TESTING (HEMOCUE HB801)**	SECTION: **Page 1 of 5**

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

PURPOSE:

To define and describe the policy and process to safely obtain a hemoglobin level in coordination with instructions provided with the HemoCue Hb 801 analyzer, and in compliance with Clinical Laboratory Improvement Amendment of 1988 (CLIA '88) guidelines and procedure guidelines based on manufacturer's instructions.

POLICY:

A. Personnel performing hemoglobin testing will be trained utilizing this policy and procedure and complete a competency prior to performance. Training will include reading Waived and Point of Care Testing – Hemoglobin Testing policy.

B. Personnel will have competency validated annually.

C. Education Department will maintain records of all individuals who have completed training and competency validation.

D. Quality control procedures will be completed each day the machine might be used by an operator and documented on the quality control log.

E. Proficiency testing will be performed three times per year to assess the accuracy of an instrument relative to an accepted reference and to test competence of validated operators.

F. Standard precautions will be observed throughout the patient testing procedure.

AFFECTED PERSONNEL/AREAS: *MEDICAL ASSISTANTS, BIOMEDICAL PERSONNEL*

EQUIPMENT:

- HemoCue Hb 801
- Microcuvette
- Lancet
- Alcohol prep pad
- Gloves
- Gauze 2x2
- Bandaid

PROCEDURE:

A. Upon receipt of an order, a capillary blood specimen will be collected and tested to determine the patient's hemoglobin level.

B. Turn analyzer on.

C. Gather supplies: lancet, microcuvette (confirm in date), alcohol prep pad, cotton ball or gauze and bandaid.

D. Clean the finger with alcohol prep pad and allow to dry.

E. Warm patient's finger and using your thumb, lightly press the finger from the top of the knuckle towards the tip. This stimulates the blood flow towards the sampling point.

F. Use lancet to obtain specimen from the side of the fingertip, not the center. While applying light pressure towards the fingertip, puncture the finger with lancet.

G. Wipe away the first 2 or 3 drops of blood.

H. Re-apply light pressure towards the fingertip until another drop of blood appears. When the blood drop is large enough, fill the microcuvette in one single step. Do NOT refill.

I. Do not let more than 40 seconds pass between step filling and inserting the microcuvette into the microcuvette holder.

J. Wipe off excess blood from the outside of the microcuvette with a clean, lint-free wipe, being careful not to touch the open end of the microcuvette, which could result in blood being drawn out of the microcuvette.

K. Look for air bubbles in the filled microcuvette. If present, discard the microcuvette and fill a new microcuvette from a new drop of blood. Small bubbles around the edge can be ignored.

L. Make sure the analyzer is in Ready state. Insert the filled microcuvette into the microcuvette holder and press down. The result will be displayed within a second.

M. When a result is displayed, remove and discard the microcuvette. The result is displayed for 10 seconds after measurement.

N. Document result in the electronic health record.

O. Remove microcuvette and dispose of in sharps container.

QUALITY CONTROL

A. HemoCue Hb 801 analyzer has an internal quality control, the "selftest". Every time the analyzer is turned on, it will automatically verify the performance of the optronic unit of the analyzer. This test is performed every second hour if the analyzer remains switched on. Upon passing the "selftest", the display will show the Hemocue symbol and three flashing dashes, indicating the analyzer is ready to perform a measurement. An error code will be displayed if the "selftest" fails.

B. If an error code displays, turn off the analyzer and turn it on again after 30 seconds. Take a new microcuvette and repeat the measurement. If the problem continues, see specific error code Troubleshooting Guide in the manufacturer's instruction manual.

C. In addition to the automatic "selftest", a quality control using liquid control solutions will be performed on the days of testing. This process is completed by testing both Level 1 (low) and Level 3 (high) control solutions.

D. If either Level 1 (low) or Level 3 (high) fail, the quality control may be repeated ONLY ONCE. If the control fails a second time, the operator is to remove the device from the patient care area and send to the Biomedical Department for repair or replacement.

E. Quality control solutions should be stored in refrigerator at 2 to 8° C. Solutions in an unopened bottle are stable until manufacturer's expiration date indicated on bottle. After opening, the product is stable at 2 to 30° C for 30 days. When opened, the vials must be dated with the **expiration** date, including month/day/year. Expired solutions must be discarded.

MAINTENANCE OF HEMOCUE ANALYZER

A. STORAGE
   a. The analyzer is to be stored at (10-40° C) 50-104° F.
   b. Microcuvettes are to be stored at (10-40° C) 50-104° F. Microcuvettes in the vial (opened or unopened) are stable until expiration date, printed on the package.
   c. Microcuvettes in the vial (opened or unopened) can be stored for a shorter period of time (6 weeks) between -18-50° C (0-122° F). Keep all unused microcuvettes in the original package.

B. CLEANING
   a. Analyzer should be cleaned and disinfected on a regular basis.
   b. Cleaning agents: water, alcohol (20-70%), mild detergent, or recommended disinfectant.
   c. Disinfectant: Super Sani-Cloth Germicidal Disposable Wipe, EPA Reg. No. 9480-4. Only use disinfectant recommended by HemoCue.
   d. Turn off the analyzer, and remove the microcuvette holder.
   e. Lightly dampen a cotton swab with cleaning agent. Clean all surfaces in the cavity; make sure to clean all the way down.
   f. Clean the microcuvette holder with cleaning agent. Let the microcuvette holder dry outside of the analyzer, while moving on to the next step.
   g. Lightly dampen a wipe with cleaning agent, and clean all outer surfaces. Now the analyzer is ready for disinfection.
   h. Before disinfection, the analyzer must be cleaned (previous steps).
   i. Wipe the microcuvette holder repeatedly with a new Super Sani-Cloth Germicidal Disposable Wipe. Make sure that all surfaces stay wet for 2 minutes.
   j. Wipe all outer surfaces repeatedly with a Super Sani-Cloth Germicidal Disposable Wipe. Make sure that all surfaces stay wet for 2 minutes.

k. Make sure that the surfaces in the previous steps (I and J) have been wiped repeatedly in order to stay wet for the whole 2 minutes (wet-time/contact time).
l. Remove any excess disinfectant, or allow to air dry. Make sure all parts are completely dry before attaching the microcuvette holder, and turning on the analyzer.

C. BATTERY
   a. If AC power is available, plug the supplied power adapter into the power inlet at the back of the analyzer.
   b. If no power is available, insert 3 type AA (1.5 V Alkaline or 1.2 V NiMH) disposable or rechargeable (131901 3.6 V 2.6 Ah) batteries into the battery compartment.
   c. If the battery symbol appears on the display, the batteries are running low on power. The analyzer will continue to give accurate results, but the batteries should be replaced as soon as possible.

LIMITATIONS OF PROCEDURE:

A. Measuring range of the analyzer is 1.0-25.6 g/dL (10-256 g/L, 0.62-15.9 mmol/L).

B. The HemoCue Hb 801 analyzer is only to be used together with HemoCue Hb 801 microcuvettes.

C. The HemoCue Hb 801 analyzer exhibits no interference from the following substances up to the following concentration levels:

Tested Interfering Substances	**Tested Concentration Level**
Acetaminophen	1324 µmol/L
Ascorbic acid	342 µmol/L
Creatinine	442 µmol/L
HbCO	10 %
HbO2	≤50 %
Hemolysis	10 g/L
Ibuprofen	2425 µmol/L
MetHb*	25 %
Platelets	2000 x 10^9/L
Total protein	15 g/dL
Salicylic acid	4.34 mmol/L
Simvastatin	49 µmol/L
Tetracycline	34 µmol/L
Triglyceride	1500 mg/dL
Urea	42.9 mmol/L
Uric acid	1.4 mmol/L
Warfarin	32.5 µmol/L

REFERENCES:

- HemoCue (2025). *HemoCue Hb 801 Operating Manual.*
- Joint Commission. (2026). Standards on Waived Testing WT.03.01.01, WT.04.01.01, WT.05.01.01

CROSS REFERENCES:

- Waived and Point of Care Testing – Competency and Quality

1. This form is called an "informed consent form." Its purpose is to inform me about the hysterectomy procedure.

2. The following operation(s) will be performed on me:

   _____

3. I was told that hysterectomy means removal of the uterus (womb) either through an incision in the lower abdomen and/or through the vagina. Sometimes additional surgery may be indicated to remove or repair other organs such as the ovaries, tubes, appendix, bladder, rectum, and vagina.

4. I was told that the hysterectomy procedure is considered irreversible and that, unless I am already sterile or postmenopausal, it will result in permanent infertility.

5. I have been told that this procedure may subject me to a variety of discomforts, risks and complications. These include nausea, vomiting, pain, bleeding, infection, poor healing, hernia, or formation of adhesions. Unexpected reaction may occur from any drug or anesthetic given. Unintended injury may occur to other pelvic or abdominal structures such as the tubes, ovaries, bladder, ureter (tube from kidney to bladder), or bowel. Nerves going from the pelvis to the legs may be injured. Any such injury may require immediate or later additional surgery to correct the problem. Dangerous blood clots may form in the legs or lungs. Physical and sexual activity will be restricted during the recovery period. Finally, I understand that it is impossible to list every possible undesirable effect and that the condition for which surgery is done is not always cured or significantly improved, and in rare cases may even worsen.

6. I have been told that I can expect the following benefits from the proposed operation(s), but that no results can be guaranteed:

   _____

   _____

7. I have been told that the following are alternatives to hysterectomy, and those that are checked may apply to me: Leave the problem untreated and accept the natural course of the condition. Attempt to control some problems with hormones or other medications. Attempt to control some problems with uterine artery embolization. Remove just the diseased or abnormal tissue and repair the remainder. Use mechanical devices for pelvic support. Other: _____

8. I have the right to consult a second physician before having the hysterectomy

9. I have the right to withdraw my consent to the hysterectomy at any time before it is performed My withdrawal of consent shall not affect my right to future care or treatment or result in the loss or withdrawal of any state or federally funded program benefits to which I might otherwise be entitled.

10. I have been told the following:

a. The approximate length of the hospital stay: _____

b. The approximate length of time for recovery: _____

c. The approximate cost to me of the surgeon's fee: _____

11. I have been told that pain during the procedure will be controlled by the use of regional or general anesthesia. I understand that the anesthesia is not under the control of my surgeon. I will discuss with my anesthesiologist the risks and benefits of the specific anesthesia I choose.

12. Upon my authorization and consent, the hysterectomy and any additional proposed procedures will be performed by Dr._____. My surgeon may work with his or her associate(s) and any other members of medical staff at _____ Hospital. These physicians, including the anesthesiologists, are not employees or agents of the hospital. They are independent medical practitioners

13. I acknowledge that my surgeon has described this procedure to me in terms which I understand and has answered all questions to my satisfaction.

Patient Signature: _____ Date:_____

Witness: _____

Interpreter: (Print Name) _____

Signature:_____Language:_____

PHYSICIAN CERTIFICATION

I certify that I have discussed the hysterectomy and any additional proposed procedure(s) with this patient. I have described the risks, benefits, and alternatives to the procedure, and I have answered all of her questions.

Physician Signature: _____ Date:_____

1. Este formulario se llama 'formulario de consentimiento informado'. Su propósito es informarme sobre el procedimiento de histerectomía.

2. Se me realizaran la(s) siguiente(s) operación(es):

   _____

3. Se me ha explicado que la histerectomía significa la extirpación del útero (matriz), ya sea a través de una incisión en la parte baja del abdomen y/o a través de la vagina. En ocasiones, puede indicarse una cirugía adicional para extirpar o reparar otros órganos, tales como los ovarios, las trompas de Falopio, el apéndice, la vejiga, el recto y la vagina.

4. Se me ha informado que el procedimiento de histerectomía se considera irreversible y que, a menos que ya sea estéril o posmenopáusica, resultara en infertilidad permanente.

5. Se me ha informado que este procedimiento puede someterme a una variedad de molestias, riesgos y complicaciones. Estos incluyen nauseas, vómitos, dolor, sangrado, infección, mala cicatrización, hernia o formación de adherencias. Puede ocurrir una reacción inesperada a cualquier medicamento o anestesia administrada. Pueden ocurrir lesiones involuntarias en otras estructuras pélvicas o abdominales, tales como las trompas de Falopio, los ovarios, la vejiga, el uréter (el tubo que va del riñón a la vejiga) o el intestino. Los nervios que van desde la pelvis hasta las piernas pueden resultar lesionados. Cualquiera de estas lesiones puede requerir cirugía adicional, ya sea inmediata o posterior, para corregir el problema. Pueden formarse coágulos de sangre peligrosos en las piernas o los pulmones. La actividad física y sexual estará restringida durante el periodo de recuperación. Finalmente, entiendo que es imposible enumerar todos los posibles efectos indeseables y que la condición por la cual se realiza la cirugía no siempre se cura o mejora significativamente, y en casos raros incluso puede empeorar.

6. Se me ha informado que puedo esperar los siguientes beneficios de la(s) operación(es) propuesta(s), pero que no se pueden garantizar los resultados:

   _____

   _____

7. Me han explicado que las siguientes son alternativas a la histerectomía, y que las que se marcan podrían aplicarse a mi caso: Dejar el problema sin tratar y aceptar la evolución natural de la afección. Intentar controlar algunos problemas con hormonas u otros medicamentos. Intentar controlar algunos problemas con la embolización de la arteria uterina. Extirpar solo el tejido enfermo o anormal y repara el resto. Utilizar dispositivos mecánicos para el soporte pélvico. Otro:_____

8. Tengo derecho a consultar a un segundo medico antes de someterme a la histerectomía

9. Tengo derecho a retirar mi consentimiento para la histerectomía en cualquier momento antes de que se realice. Mi retiro del consentimiento no afectará mi derecho a recibir atención o tratamiento en el futuro ni resultará en la pérdida o retirada de ningún beneficio de programas financiados por el estado o el gobierno federal a los que pudiera tener derecho.

10. Me han dicho lo siguiente:

a. La duración aproximada de la estancia hospitalaria: _____

b. Duración aproximada del tiempo de recuperación: _____

c. El costo aproximado para mí de los honorarios del cirujano: _____

11. Se me ha informado que el dolor durante el procedimiento será controlado mediante el uso de anestesia regional o general. Comprendo que la anestesia no se encuentra bajo el control de mi cirujano. Conversaré con mi anestesiólogo sobre los riesgos y beneficios de la anestesia específica que elija.

12. Con mi autorización y consentimiento, la histerectomía y cualquier procedimiento adicional propuesto serán realizados por el Dr. _____. Mi cirujano puede trabajar con su(s) asociados(s) y cualquier otro miembro del personal médico en el Hospital _____. Estos médicos, incluidos los anestesiólogos, no son empleados ni agentes del hospital. Son profesionales médicos independientes.

13. Reconozco que mi cirujano me ha descrito este procedimiento en términos que comprendo y ha respondido a todas mis preguntas a mi entera satisfacción

Firma del Paciente: _____ Fecha: _____

Testigo: _____

Interprete (nombre en letra de molde):_____

Firma: _____ Lenguaje: _____

Certificación Medica

Certifico que he conversado con esta paciente sobre la histerectomía y cualquier procedimiento adicional propuesto. He descrito los riesgos, los beneficios y las alternativas al procedimiento, y he respondido a todas sus preguntas.

Firma del Médico: _____ Date:_____

SIERRA VIEW MEDICAL CENTER
NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES

Effective March 1st, 2026

This Privacy Notice describes the practices of all employees, staff, and other Sierra View Medical Center (SVMC) personnel, any health care professional authorized to enter information in your SVMC chart, all departments, units and facilities of SVMC, any member of a volunteer group we allow to help you while you are using SVMC services, and all physicians, residents, medical students, students, and allied health professional who provide care at any SVMC facility.

Your medical and mental health treatment information and records are personal and private. Sierra View Medical Center is committed to protecting your health information. The medical and mental health information we create and maintain is known as Protected Health Information/electronic Protected Health Information or PHI/ePHI. We are required by Federal and State laws to protect the privacy of your medical and mental health information and obtain a signed authorization by you for certain disclosures.

We are required by law to provide you with this Notice of our legal duties and privacy practices with respect to your medical and mental health information. This Notice explains how we may legally use and disclose your protected health information and your rights regarding the privacy of your protected health information. We are required to follow all the terms of this notice. We reserve the right to change the provisions of this Notice and make it effective for all protected health information we maintain.

The information privacy practices described in this Notice will be followed by:

- Any health care professional who treats you at any of our locations
- All facilities, departments and units, including hospitals, surgical centers, clinics, and other affiliates
- All workforce members such as employees, medical staff, trainees, students, volunteers, and other persons under our direct control whether or not they are paid by us
- Other health care providers that have agreed to abide by this Notice of Privacy Practices

If you have any questions and/or would like additional information, you may contact the Compliance/Privacy Officer at (559)791-3838 or the Compliance Hot Line at (559)791-4777.

Thank you.

91

How We May Use And Disclose Your Protected Health Information

The following categories describe different ways that we use and disclose your protected health information. For each category, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose your protected health information will fall within one of the categories. We will separately describe the ways we use and disclose HIV/AIDS and substance and/or alcohol abuse information later in this Notice.

1. Treatment

We may use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. We may also disclose your health information to other providers who may be treating you or involved in your care.

2. Payment

We may use or disclose your protected health information to obtain payment for the health care services provided to you. For example, we may include information with a bill to Medi-Cal or Medicare that identifies you, your diagnosis, and services provided in order to receive payment.

3. Health Care Operations

We may use and disclose your protected health information to support the business activities of Sierra View Medical Center. For example, we may use your protected health information to review and evaluate our treatment and services or to improve the care and services we offer. In addition, we may disclose your health information with other staff or business associates, who perform billing, consulting, auditing, investigatory, and other services for Sierra View Medical Center.

4. Hospital Directory

We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your genera condition (e.g., good, fair, etc.) and your religious affiliation. Unless there is a specific written request from you to the contrary, this directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This information is released so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

5. Fundraising Activities

We may use information about you, or disclose such information to a foundation related to the hospital, to contact you in an effort to raise money for the hospital and its operations. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out.

6. Marketing And Sale

Most uses and disclosures of medical information including uses of patients photographs for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

7. Required by Law

We will use and disclose your protected health information when required by Federal, State, or local law. 98

8. Health Oversight Activities

We may disclose your protected health information to Federal or State agencies that audit, investigate, and inspect government health benefit programs.

9. Public Health Activities

We may use and disclose your protected health information to public health authorities or government agencies for reporting certain diseases, injuries, illnesses, and events as required by law. For example, we may disclose your medical information to a local government agency in order to assist the agency during the investigation of an outbreak of disease in the area.

10. Victims of Abuse, Neglect, or Domestic Violence

We may disclose your protected health information to other government agencies to report suspected abuse, neglect, or domestic violence. We will only disclose this information if you agree, if the law requires us to, or when it is necessary to protect someone from serious harm.

11. Lawsuits and Legal Actions

We may disclose your protected health information in response to a court order, subpoena, or other lawful process, as allowed by law, for legal proceedings.

12. Law Enforcement

We may disclose your protected health information to law enforcement officials, such as the police, sheriff, to Immigration and Custom's Enforcement (ICE), or FBI, in response to a search warrant or court order, to locate or identify a missing person, a suspect, or a fugitive. In addition, we may disclose your information to report a crime that happens at our clinics or offices, or to report certain types of wounds, injuries, or deaths that may result from a crime.

All patients have the right to receive care regardless of immigration status. This Hospital does not collect or document immigration, citizenship, or place-of-birth information, and such information will not be disclosed except as required by law.

13. Coroners, Medical Examiners, and Funeral Directors

We may disclose your protected health information to funeral directors, coroners, and medical examiners to identify a dead person, determine what caused the death, or for other official duties.

14. Organ and Tissue Donation

We may disclose your protected health information to organizations that take care of organ, eye, or tissue donations and transplants.

15. Research

We may use and disclose your protected health information for research, if approved by an Institutional Review Board (IRB). An IRB is a committee responsible for reviewing the research proposal and establishing protocols to ensure the privacy of your protected health information.

16. To Stop a Serious Threat to Health or Safety

We may use or disclose your protected health information if it is necessary to lessen the imminent threat of a serious threat to health or safety.

99

17. Inmates

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution to protect your health and safety, or to protect the health and safety of others at the institution.

18. Military Activity and National Security

If you are or were a member of the armed forces, we may disclose your protected health information to military authorities. We may also share your protected health information with authorized Federal officials when necessary for national security, intelligence activities, or the protection of the President or other government officials.

19. Government Programs for Public Benefits

We may use or disclose your protected health information to help you qualify for government benefit programs, such as Medicare, Medi-Cal, Supplemental Security Income, or other benefits or services available. We may also contact you to tell you about possible treatment options or health-related benefits or services, upon written authorization.

20. Workers' Compensation

We will use and disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

21. Family and Friends Involved in or Paying for Your Care

We may disclose your protected health information to a friend, family member, or any other person you identify as being involved with your medical care or payment for care. For example, you may bring a friend or family member to your appointment and have that person in the exam room while talking with a health care provider. You may inform us verbally or in writing if you object to disclosures to your family and friends.

22. Disaster Relief

We may disclose your protected health information to public or private entities in a disaster to provide needed medical care or to help you find members of your family.

23. Appointment Reminders

We may use the contact information that you provided us to remind you of your upcoming medical appointments with Sierra View Medical Center.

24. Immunization Records

We may disclose your child's proof of immunization to their school, if State or other law requires the school to have such information prior to admitting your child as a student. We will obtain the parent's or guardian's authorization prior to doing so, though this may be done informally.

25. Confidential Communication/Sensitive Services

You have the right to privacy and confidentiality for gender-affirming health care services provided in California. Your information will not be shared for purposes that would penalize or restrict access to lawful gender-affirming care.

100

Uses And Disclosures Of Your Protected Health Information Requiring Your Permission

We will obtain your written permission through an authorization for other uses and disclosures of your protected health information not covered by this Notice. You may revoke the authorization in writing at any time and we will stop disclosing protected health information about you for the reasons stated in you written authorization. Any disclosures made prior to the revocation are not affected by the revocation. We are also required to retain our records of the care you receive from Sierra View Medical Center.

Uses And Disclosures Of HIV/AIDS Information

We may disclose any public health records relating to HIV/AIDS we develop or acquire that contain your protected health information as provided by law for public health purposes or to other public health agencies or corroborating medical researchers when the information is necessary to carry out their duties in investigation, control, or surveillance of disease.

Your physician who orders an HIV test on your behalf may disclose the result of your HIV test to your health care providers for purposes related to your diagnosis, care, or treatment.

Uses And Disclosures Of Your Substance And Alcohol Abuse Information

The confidentiality of your alcohol and drug abuse records we maintain is protected by Federal law and regulations. Generally, we are not allowed to disclose to an outside person your participation in the program or identify you as an alcohol or drug abuser unless:

(1) You consent in writing;

(2) The disclosure is allowed by a court order; or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Federal law and regulations do not protect any information about a crime committed by you either at our program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Your Rights Regarding Protected Health Information About You

1. Right to Inspect and Copy

You have the right to inspect and copy your protected health information in our designated record set, which includes medical and billing records, as long as we maintain that information. You have the right to access your records in any format that the Sierra View Medical Center maintains them in and you may direct them to be sent to a third party. A request must be submitted in writing and a fee may be charged for the costs of copying, mailing, and for any other supplies used in fulfilling your request. We may deny your request to inspect and copy your records. If this occurs, we will send you a written statement as to why and we will explain your right, if any, to have the denial reviewed.

2. Right to Request an Amendment

You have the right to request that we amend your protected health information if you feel that it is incomplete or inaccurate. The request must be in writing and provide reasons that support your request including what information is incomplete or inaccurate. /0/

We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- The information is correct and accurate.
- The information was not created by us.
  The person who created it is no longer available to make the amendment.
- The information is not part of the records you are permitted to inspect and copy.

If we deny your request for amendment, you have the right to file a written addendum, not to exceed five (5) pages. You may request in writing that the written addendum be added to your medical records, along with your original request to change your medical information and the written denial to make the change.

3. Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures" which is a list of disclosures we made of your protected health information. The request must be made in writing and can only include disclosures that occurred between the date of your request and up to six years before this date, but not before April 14, 2003. The list will not include disclosures:

- Based on your written authorization;
- To treat you or to receive payment for your treatment;
- For certain business reasons;
- To family members or friends involved in your medical treatment or care;
- To jails, prisons, or law enforcement; or
- For reasons related to legal actions.

For Electronic Health Records (EHR), the accounting of disclosures would also include disclosures of your protected health information made to carry out treatment, payment, and health care operations. This requirement is limited to disclosures within the three (3) year period prior to your request and after January 1, 2014.

You can request one free accounting of disclosures in a 12 month period, but may be charged for additional lists.

4. Right to Request Restrictions

You have the right to request a restriction or limitation on how we use or disclose your protected health information for treatment, payment, or health care operations. For example, you could ask us to limit the information we share with someone who is involved in your care or the payment for your care. For example, you might ask that we limit disclosures to your spouse. We may ask that you give us your request in writing. If we agree to your request, we will not use or disclose the protected health information in violation of such restriction except if we believe this information is required to provide you with necessary medical treatment or care.

We are not required to agree to your request except that you have the right to restrict disclosures to a Health Plan or its business associate if you or someone on your behalf pays out of pocket in full for the health care item or service unless we are required by law to disclose the protected health information. We require the payment be made in full at the time of the request for restriction. If payment is not made, the restriction will be void and disclosure of protected health information will be made to your Health Plan for payment. In some cases where a restriction of disclosure cannot be made or involves another party, we will discuss with you in detail.

5. Right to Request Confidential Communications

You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or send mail to a special address. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

6. Right to Revoke an Authorization

You have the right to take back or revoke your written authorization to use and disclose your protected health information at any time. You must let us know in writing. If you take back your written authorization, we will stop sharing your protected health information. However, we cannot take back any information already used or shared while the authorization was valid.

Sierra View Medical Center is required by law to keep a record of the medical treatment you receive from the facility, whether or not you give us written permission to use or share it. You do not have the right to have information removed from your record.

7. Right to a Paper Copy of this Notice

You have the right to receive a paper copy of this notice any time you request it, unless you are an inmate at the jail.

8. Breach Notification

In the event of a breach of your unsecured protected health information, Sierra View Medical Center will notify you of the circumstances of the breach.

9. Right to File a Complaint

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of State of the U.S. Department of Health and Human Services. To file a complaint with the hospital, contact the Compliance/Privacy Officer at (559)791-3838, the Compliance Hot Line at (559)791-4777, or in writing to Sierra View Medical Center, C/O Compliance/Privacy Officer, 465 W. Putnam, Porterville, California 93257.

You will not be retaliated against for filing a complaint.

Our Responsibilities

We must follow the terms of this Notice while it is in effect. We reserve the right to change this Notice and our privacy practices at any time. Changes in our privacy practices will apply to any protected health information we already have and to protected health information we create or receive in the future. We will also post and make the new Notice available at Sierra View Medical Center locations in the waiting areas or at the reception desk. The Notice will also be available on Sierra View Medical Center's website at *http://www.sierra-view.com/NoticeofPrivacyPractices*.

SIERRA VIEW MEDICAL CENTER
AVISO DE PRÁCTICAS DE PRIVACIDAD

AVISO DE PRÁCTICAS DE PRIVACIDAD

Efectivo el 1 de marzo de 2026

Este Aviso de Privacidad describe las prácticas de todos los empleados, el Personal y otro Personal de Sierra View Medical Center (SVMC), cualquier profesional de la salud autorizado para ingresar información en su cuadro de SVMC, todos los departamentos, unidades e instalaciones de SVMC, cualquier miembro de un grupo de voluntarios a quien le permitimos que le ayude mientras usted usa los servicios de SVMC y todos los médicos, residentes, estudiantes de medicina, estudiantes y profesionales de la salud aliados que ofrecen atención en cualquier instalación de SVMC.

Su información y registros de tratamiento médico y de salud mental son personales y privados. Sierra View Medical Center se compromete a proteger su información de salud. La información médica y de salud mental que creamos y mantenemos se conoce como Información protegida de salud/Información protegida de salud electrónica o PHI/ePHI. Las leyes federales y estatales nos exigen que protejamos la privacidad de su información médica y de salud mental y que obtengamos una autorización firmada por usted para ciertas divulgaciones.

La ley nos exige que le brindemos este Aviso de nuestros deberes legales y prácticas de privacidad con respecto a su información médica y de salud mental. Este Aviso explica cómo podemos legalmente usar y divulgar su información protegida de salud y sus derechos con respecto a la privacidad de su información protegida de salud. Estamos obligados a seguir todos los términos de este aviso. Nos reservamos el derecho de cambiar las disposiciones de este Aviso y hacerlo vigente para toda la información protegida de salud que mantenemos.

Las prácticas de privacidad de la información descritas en este Aviso serán seguidas por:

- Cualquier profesional de la salud que lo trate en cualquiera de nuestras ubicaciones
- Todas las instalaciones, departamentos y unidades, incluidos hospitales, centros quirúrgicos, clínicas y otros afiliados
- Todos los miembros de la fuerza laboral, tales como empleados, personal médico, aprendices, estudiantes, voluntarios y otras personas bajo nuestro control directo, independientemente de que les paguemos o no.
- Otros proveedores de atención médica que aceptaron acatar este Aviso de prácticas de privacidad

Si tiene alguna pregunta y/o desea información adicional, puede comuníquese con el Oficial de Cumplimiento/Privacidad al (559)791-3838 o con la Línea Directa de Cumplinmiento al (559)791-4777.

Cómo podemos utilizar y divulgar su información protegida de salud

Las siguientes categorías describen diferentes formas en que utilizamos y divulgamos su información protegida de salud. Para cada categoría, explicaremos lo que queremos decir e intentaremos dar algunos ejemplos. No se enumerarán todos los usos o divulgaciones en una categoría. Sin embargo, todas las formas en que se nos permite utilizar y divulgar su información protegida de salud recaerán en una de las categorías. Describiremos por separado las formas en que utilizamos y divulgamos información sobre el VIH/SIDA y sobre el abuso de sustancias y/o alcohol más adelante en este Aviso.

1. Tratamiento

Podemos utilizar y divulgar su información protegida de salud para proporcionar, coordinar o administrar su atención médica y cualquier servicio relacionado. También podemos divulgar su información de salud a otros proveedores que lo pueden tratar o involucrarse en su cuidado.

2. Pago

Podemos utilizar o divulgar su información protegida de salud para obtener el pago de los servicios de atención médica que se le brindan. Por ejemplo, podemos incluir información con una factura a Medi-Cal o Medicare que lo identifique, a su diagnóstico y a los servicios prestados para recibir el pago.

3. Operaciones de atención médica

Podemos utilizar y divulgar su información protegida de salud para respaldar las actividades comerciales de Sierra View Medical Center. Por ejemplo, podemos usar su información protegida de salud para revisar y evaluar nuestro tratamiento y servicios o para mejorar la atención y los servicios que ofrecemos. Además, podemos divulgar su información de salud con otro personal o socios comerciales, que realizan servicios de facturación, consultoría, auditoría, investigación y otros servicios para Sierra View Medical Center.

4. Directorio del hospital

Podemos incluir cierta información limitada sobre usted en el directorio del hospital mientras sea paciente en el hospital. Esta información puede incluir su nombre, ubicación en el hospital, su condición general (por ejemplo, buena, regular, etc.) y su afiliación religiosa. A menos que exista una solicitud específica por escrito de usted para lo contrario, esta información de directorio, excepto su afiliación religiosa, también se puede divulgar a las personas que pregunten por usted por su nombre. Su afiliación religiosa puede ser dada a un miembro del clero, como un sacerdote o rabino, incluso si no preguntan por usted por su nombre. Esta información se divulga para que su familia, amigos y clérigos puedan visitarlo en el hospital y, en general, saber cómo está.

5. Actividades de recaudación de fondos

Podemos utilizar su información o divulgar dicha información a una fundación relacionada con el hospital para comunicarnos con usted en un esfuerzo por recaudar dinero para el hospital y sus operaciones. Usted tiene el derecho de excluirse de recibir comunicaciones de recaudación de fondos. Si recibe una comunicación de recaudación de fondos, esta le dirá cómo excluirse.

6. Comercialización y venta

La mayoría de los usos y divulgaciones de información médica, incluidos los usos de las fotografías de los pacientes con fines de comercialización y las divulgaciones que constituyen una venta de información médica, requieren su autorización.

7. Requerido por la ley

Utilizaremos y divulgaremos su información protegida de salud cuando así lo requiera la ley federal, estatal o local.

8. Actividades de supervisión de la salud

Podemos divulgar su información protegida de salud a agencias federales o estatales que auditan, investigan e inspeccionan los programas de beneficios de salud del gobierno.

9. Actividades de salud pública

Podemos utilizar y divulgar su información protegida de salud a autoridades de salud pública o agencias gubernamentales para informar ciertas enfermedades, lesiones, afecciones y eventos según lo exija la ley. Por ejemplo, podemos divulgar su información médica a una agencia del gobierno local para ayudar a la agencia durante la investigación de un brote de enfermedad en el área.

10. Víctimas de abuso, abandono o violencia doméstica

Podemos divulgar su información protegida de salud a otras agencias gubernamentales para reportar sospechas de abuso, negligencia o violencia doméstica. Solo divulgaremos esta información si usted está de acuerdo, si la ley así lo exige o si es necesario para proteger a alguien de daños graves.

11. Demandas y acciones legales

Podemos divulgar su información médica protegida en respuesta a una orden judicial, citación u otro proceso legal, según lo permita la ley, para procedimientos legales.

12. Aplicación de la ley

Podemos divulgar su información protegida de salud a agentes del orden público, como la policía, el sheriff, al Servicio de Inmigración y Control de Aduanas (ICE) o al FBI, en respuesta a una orden de registro u orden judicial, para localizar o identificar a una persona desaparecida, un sospechoso o un fugitivo.

Además, podemos divulgar su información para denunciar un delito que ocurre en nuestras clínicas u oficinas o para informar sobre ciertos tipos de heridas, lesiones o muertes que pueden resultar de un delito.

Todos los pacientes tienen derecho a recibir atención médica sin importar su estatus migratorio. Este hospital no recopila ni documenta información relacionada con inmigración, ciudadanía o lugar de nacimiento, y dicha información no será divulgada excepto cuando lo exija la ley

13. Médicos forenses, examinadores médicos y directores de funerarias

Podemos divulgar su información protegida de salud a directores de funerarias, médicos forenses y examinadores médicos para identificar a una persona muerta, determinar qué causó la muerte u otros deberes oficiales.

14. Donación de órganos y tejidos

Podemos divulgar su información protegida de salud a organizaciones que se ocupan de las donaciones y trasplantes de órganos, ojos o tejidos.

15. Investigación

Podemos usar y divulgar su información protegida de salud para investigación, si es aprobada por una Junta de Revisión Institucional (IRB). Una IRB es un comité responsable de revisar la propuesta de investigación y establecer protocolos para garantizar la privacidad de su información protegida de salud.

16. Para detener una amenaza grave a la salud o la seguridad

Podemos utilizar o divulgar su información médica protegida si es necesario para disminuir la amenaza inminente de una amenaza grave para la salud o la seguridad.

17. Reclusos

Si usted es un recluso de una institución correccional, podemos divulgar su información protegida de salud a la institución correccional para proteger su salud y seguridad o para proteger la salud y seguridad de otros en la institución.

18. Actividad militar y seguridad nacional

Si es o fue miembro de las fuerzas armadas, podemos divulgar su información protegida de salud a las autoridades militares. También podemos compartir su información protegida de salud con funcionarios federales autorizados cuando sea necesario para la seguridad nacional, las actividades de inteligencia o la protección del presidente u otros funcionarios gubernamentales.

19. Programas gubernamentales para beneficios públicos

Podemos utilizar o divulgar su información protegida de salud para ayudarlo a calificar para los programas de beneficios del gobierno, tales como Medicare, Medi-Cal, Seguridad de Ingreso Suplementario u otros beneficios o servicios disponibles. También podemos comunicarnos con usted para informarle sobre posibles opciones de tratamiento o beneficios o servicios relacionados con la salud, previa autorización por escrito.

20. Compensación de los trabajadores

Utilizaremos y divulgaremos su información protegida de salud para la compensación de los trabajadores o programas similares que brinden beneficios por lesiones o enfermedades relacionadas con el trabajo.

21. Familia y amigos involucrados o que pagan por su cuidado

Podemos divulgar su información protegida de salud a un amigo, familiar o cualquier otra persona que usted identifique como implicada en su atención médica o en el pago de su atención. Por ejemplo, puede llevar a un amigo o familiar a su cita y tener a esa persona en la sala de examen mientras habla con un proveedor de atención médica. Puede informarnos verbalmente o por escrito si se opone a las divulgaciones a su familia y amigos.

22. Alivio de desastres

Podemos divulgar su información protegida de salud a entidades públicas o privadas en un desastre para proporcionar la atención médica necesaria o para ayudarlo a encontrar a miembros de su familia.

23. Recordatorios de citas

Podemos utilizar la información de contacto que nos proporcionó para recordarle sus próximas citas médicas con Sierra View Medical Center.

24. Registros de inmunización

Podemos divulgar la prueba de inmunización de su hijo a su escuela, si el estado u otra ley requieren que la escuela tenga dicha información antes de admitir a su hijo como estudiante. Obtendremos la autorización de los padres o tutores antes de hacerlo, aunque esto puede hacerse de manera informal.

25. Comunicación confidencial / Servicios sensibles

Usted tiene derecho a la privacidad y confidencialidad con respecto a los servicios de atención médica de afirmación de género brindados en California. Su información no será compartida para fines que penalicen o restrinjan el acceso a la atención de afirmación de género legal.

Usos y divulgaciones de su información médica protegida que requieren su permiso

Obtendremos su permiso por escrito a través de una autorización para otros usos y divulgaciones de su información protegida de salud que no esté cubierta por este Aviso. Puede revocar la autorización por escrito en cualquier momento y dejaremos de divulgar información protegida de salud sobre usted por las razones indicadas en su autorización escrita. Cualquier divulgación hecha antes de la revocación no se ve afectada por la revocación. También estamos obligados a conservar nuestros registros de la atención que recibe de SVMC.

Usos y divulgaciones de información sobre VIH/SIDA

Podemos divulgar cualquier registro de salud pública relacionado con el VIH/SIDA que desarrollemos o adquiramos que contenga su información protegida de salud según lo dispuesto por ley para fines de salud pública u otras agencias de salud pública o investigadores médicos que lo corroboren cuando la información sea necesaria para llevar a cabo sus tareas de investigación, control o vigilancia de enfermedades.

Su médico que ordena una prueba de VIH en su nombre puede divulgar el resultado de su prueba de VIH a sus proveedores de atención médica para fines relacionados con su diagnóstico, atención o tratamiento.

Usos y divulgaciones de su información sobre abuso de sustancias y alcohol

La confidencialidad de sus registros de abuso de alcohol y drogas que mantenemos está protegida por la ley y los reglamentos federales. En general, no se nos permite divulgar a una persona externa su participación en el programa ni identificarlo como consumidor de alcohol o drogas, a menos que:

(1) Usted manifieste su consentimiento por escrito;

(2) La divulgación está permitida por una orden judicial; o

(3) La divulgación se realiza al personal médico en una emergencia médica o al personal calificado para investigación, auditoría o evaluación del programa.

Las leyes y normativas federales no protegen ninguna información sobre un delito cometido por usted ni en nuestro programa ni contra ninguna persona que trabaje para el programa ni sobre ninguna amenaza para cometer dicho delito.

Las leyes y reglamentos federales no protegen ninguna información sobre sospecha de abuso o negligencia infantil de ser reportada en virtud de la ley estatal a las autoridades estatales o locales apropiadas.

Sus derechos con respecto a la información protegida de salud sobre usted

1. Derecho a inspeccionar y copiar

Usted tiene derecho a inspeccionar y copiar su información protegida de salud en nuestro conjunto de registros designado, que incluye registros médicos y de facturación, siempre que mantengamos esa información. Usted tiene derecho a acceder a sus registros en cualquier formato en el que Sierra View Medical Center los mantenga y puede enviarlos a un tercero. Se debe presentar una solicitud por escrito y se puede cobrar una tarifa por los costos de copiado, envío por correo y cualquier otro material utilizado para cumplir con su solicitud. Podemos denegar su solicitud para inspeccionar y copiar sus registros. Si esto ocurre, le enviaremos una declaración por escrito con los motivos y le explicaremos su derecho, si corresponde, a que se revise la denegación.

2. Derecho a solicitar una enmienda

Tiene derecho a solicitar que modifiquemos su información protegida de salud si considera que es incompleta o inexacta. La solicitud debe ser por escrito y proporcionar los motivos que respaldan su solicitud, incluida la información incompleta o inexacta.

Podemos denegar su solicitud si no está por escrito o no incluye un motivo para respaldar la solicitud. También podemos denegar su solicitud si:

- La información es correcta y precisa.
- La información no fue creada por nosotros.
- La persona que lo creó ya no está disponible para realizar la enmienda.
- La información no es parte de los registros que se le permite inspeccionar y copiar.

Si denegamos su solicitud de enmienda, usted tiene derecho a presentar un anexo por escrito que no exceda de cinco (5) páginas. Puede solicitar por escrito que la adición escrita se agregue a sus registros médicos, junto con su solicitud original para cambiar su información médica y la denegación por escrito para realizar el cambio. ;

3. Derecho a un informe de divulgaciones

Usted tiene derecho a solicitar un "informe de divulgaciones", que es una lista de divulgaciones que realizamos de su información protegida de salud. La solicitud debe hacerse por escrito y solo puede incluir divulgaciones que ocurrieron entre la fecha de su solicitud y hasta seis años antes de esta fecha, pero no antes del 14 de abril de 2003. La lista no incluirá divulgaciones:

- Basadas en su autorización escrita;
- Para tratarlo o para recibir el pago de su tratamiento;
- Por ciertos motivos comerciales;
- Para miembros de la familia o amigos involucrados en su tratamiento o cuidado médico
- A las cárceles, prisiones o la aplicación de la ley; o
- Por razones relacionadas con acciones legales.

Para los registros electrónicos de salud (EHR), el informe de las divulgaciones también incluiría las divulgaciones de su información protegida de salud realizadas para llevar a cabo el tratamiento, el pago y las operaciones de atención médica. Este requisito se limita a las divulgaciones dentro del período de tres (3) años anterior a su solicitud y después del 1 de enero de 2014.

Puede solicitar un informe gratuito de divulgaciones en un período de 12 meses, pero puede que le cobren por listas adicionales.

4. Derecho a solicitar restricciones

Tiene derecho a solicitar una restricción o limitación sobre cómo usamos o divulgamos su información protegida de salud para tratamiento, pago u operaciones de atención médica. Por ejemplo, puede pedirnos que limitemos la información que compartimos con alguien que está involucrado en su atención o en el pago de su atención. Por ejemplo, puede solicitar que limitemos las divulgaciones a su cónyuge. Podemos pedirle que nos entregue su solicitud por escrito. Si aceptamos su solicitud, no usaremos ni divulgaremos la información protegida de salud en violación de dicha restricción, excepto si creemos que esta información es necesaria para proporcionarle el tratamiento o cuidado médico necesario.

No estamos obligados a aceptar su solicitud, excepto que tiene derecho a restringir las divulgaciones a un plan de salud o a su socio comercial si usted o alguien en su nombre paga de su bolsillo en su totalidad por el artículo o servicio de atención médica, a menos que se nos exija por ley divulgar la información protegida de salud. Requerimos que el pago se realice en su totalidad en el momento de la solicitud de restricción. Si no se realiza el pago, la restricción será nula y se divulgará la información protegida de salud a su plan de salud para el pago. En algunos casos donde una restricción de divulgación no puede hacerse o involucra a otra parte, lo conversaremos con usted en detalle.

5. Derecho a solicitar comunicaciones confidenciales

Tiene derecho a solicitar cómo nos comunicamos con usted para preservar su privacidad. Por ejemplo, puede solicitar que lo llamemos solo a su número de trabajo o enviar un correo a una dirección especial. Su solicitud debe hacerse por escrito y debe especificar cómo o dónde debemos comunicarnos con usted. Atenderemos todas las solicitudes razonables.

6. Derecho a revocar una autorización

Usted tiene derecho a retirar o revocar su autorización escrita para usar y divulgar su información protegida de salud en cualquier momento. Debe informarnos por escrito. Si retira su autorización por escrito, dejaremos de compartir su información protegida de salud. Sin embargo, no podemos recuperar ninguna información ya utilizada o compartida mientras la autorización era válida.

Sierra View Medical Center está obligada por ley a llevar un registro del tratamiento médico que recibe de la instalación, ya sea que nos dé o no un permiso por escrito para usarlo o compartirlo. Usted no tiene derecho a que se elimine información de su registro.

7. Derecho a una copia impresa de este aviso

Usted tiene derecho a recibir una copia en papel de este aviso cada vez que lo solicite, a menos que sea un recluso en la cárcel.

8. Aviso de incumplimiento

En el caso de una violación de su información protegida de salud no segura, Sierra View Medical Center le notificará las circunstancias de la violación.

9. Derecho a presentar una queja

Si cree que se han violado sus derechos de privacidad, puede presentar una queja ante el hospital o con el Secretario de Estado del Departamento de Salud y Servicios Humanos de Estados Unidos. Para presentar una queja con el hospital, comuníquese con el Oficial de Cumplimiento/Privacidad al (559) 791-3838, el Línea directa de cumplimiento al (559)791-4777, o por escrito a Sierra View Medical Center, C/O Oficial de Cumplimiento/Privacidad, 465 W. Putnam, Porterville, California 93257

No se tomarán represalias en su contra por presentar una queja.

Nuestras responsabilidades

Debemos seguir los términos de este Aviso mientras esté en vigencia. Nos reservamos el derecho de cambiar este Aviso y nuestras prácticas de privacidad en cualquier momento. Los cambios en nuestras prácticas de privacidad se aplicarán a cualquier información protegida de salud que ya tenemos y a la información protegida de salud que creamos o recibimos en el futuro. También publicaremos y pondremos disponible el nuevo Aviso en las ubicaciones de Sierra View Medical Center en las áreas de espera o en la recepción. El Aviso también estará disponible en el sitio web de Sierra View Medical Center en *http://www.sierra-view.com/NoticeofPrivacyPractices*.

SIERRA VIEW
MEDICAL CENTER

MEETING MINUTES

MINUTES FROM PREVIOUS MEETING SUBMITTED FOR APPROVAL

MEETING MINUTES

BOARD OF DIRECTORS MONTHLY MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly **April 28, 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:

- Liberty Lomeli, Chair - Present
- Bindusagar Reddy, Vice Chair - Present
- Areli Martinez, Secretary – Present
- Hans Kashyap, Director – Present
- Martha A. Flores, Director – Present

Others Present: Donna Hefner, President/Chief Executive Officer, Craig McDonald, Chief Financial Officer, Melissa Crippen, Vice President of Quality and Regulatory Affairs, Ron Wheaton, Vice President of Professional Services & Physician Recruitment, Brandy Irwin, Chief Nursing Officer, Tracy Canales, Vice President of Human Resources and Marketing, Valerie Reyes-Chavez Marketing and Foundation Events Specialist, Terry Villareal, Clerk to the Board, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff, Dianne Johnson, PAHS Scholarship Committee Chairman, Tim Suorsa, PAHS Scholarship Committee Finance Chairman, PAHS Students.

I. Approval of Agenda:

Discussion on correction needing to be made to the address listed in Closed Session Item D on the agenda. Address was inadvertently listed as N Putnam and should be changed to W Putnam. Chair LOMELI inquired if there was a motion to approve the agenda with changes. Vice Chair REDDY moved to approve the agenda, the motion was seconded by Director MARTINEZ. The motion was carried with the following vote:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

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

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

1. General Update;

2. Report on Peer Review/Credentials

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

1. 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.

Closed Session items were addressed out of order. Review of Item F was initiated but could not be completed prior to the start of Open Session; therefore, it will be revisited along with the remaining items. Items D, E, G, and H were deferred until the conclusion of Open Session due to insufficient time for discussion before Open Session began.

III. Open Session: Chair LOMELI adjourned Closed Session at 5:34 p.m., reconvening in Open Session at 5:35 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, Vice Chair REDDY made a motion to approve the Quality of Care/Peer Review/Credentials as presented. The motion was seconded by Director FLORES. The motion was carried with the following vote by the Board:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

B. Quality Division Update

1. Quality Division Report
Following review and discussion, Vice Chair REDDY made a motion to approve the Quality Division Update as presented. The motion was

seconded by Director MARTINEZ. The motion was carried with the following vote by the Board:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

C. 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
Discussion initiated and deferred to the end of the meeting

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 Vice Chair REDDY, seconded by Director FLORES, and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director FLORES and seconded by Director MARTINEZ to approve the March 24, 2026, Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

VII. Business Items

A. Porterville Academy of Health Science (PAHS) Health Career Scholarship

Porterville Academy of Health Sciences (PAHS) provided a presentation highlighting the impact of its pathway on students, including several who plan to remain in the community to pursue careers in healthcare. Director Martinez initially made a motion to match last year's donation amount of $15,000; however, the motion was subsequently withdrawn to allow for consideration of an increased contribution of $20,000. Following review and discussion, Director KASHYAP made a motion to approve a $20,000 donation, which was seconded by Director MARTINEZ. The vote of the Board is as follows:

FLORES Yes
KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

B. March 2026 Financial Report

Craig McDonald, CFO presented the March monthly financial report.

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

FLORES Yes
KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

C. Capital Report – Quarter Ending March 31, 2026

Craig McDonald, CFO presented the Quarterly Capital Report.

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

FLORES Yes
KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

D. Investment Report – Quarter Ending March 31, 2026

Craig McDonald, CFO presented the Quarterly Investment Report.

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

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

VIII. SVLHCD Board Chair Report

None

IX. CEO Report

- Our CEO shared some highlights on the Physician Appreciation Dinner held at River Island Country Club. SVMC honored milestone years of service, including 10, 20 and 30 years.
- Parking lot improvements are under way and communications will be sent out to the public on closures.
- The Chaplaincy Department introduced their Care Cart, this is one way we care for our employees, so they can care for our patients.
- Our newest Daisy award winner is Gabriel. A big thank you to him for his compassion that made a difference for a patient having a difficult night.
- Employee of the month is David, his kindness and respect for others are felt across the teams he supports.
- Leader of the month is Gary, who has been with SVMC since 2013 and continues to be a strong source of support for teams across our organization.
- Our latest Coffee and Coworkers was held in our courtyard and had a St. Patrick's Day theme with some fun activities.
- Employees wore Blue and Green on a Friday in April in recognition of Organ Donor Month.
- Our Team from the Sierra View Community Health Center in Terra Bella attended the Resource Round Up at Carl F. Smith Middle School.
- We were proud to be a Gold Sponsor of the Porterville Chamber Spring Festival.
- Laura, our Stoke and Sepsis Program Coordinator, presented at the Third Annual Neuro Symposium in Visalia. Her presentation highlighted the importance of clear processed, real-time data, and collaboration across teams to help improve response times and patient outcomes.
- Our upcoming Nurses Week theme will be *Go for the Gold: Power of the Nurse and* Hospital Week theme will be *Hospital Through the Decades.*

X. Announcements:

Regular Board of Directors Meeting – May 26, 2026, at 5:00 p.m.

XI. Closed Session: Board adjourned Open Session at 6:29 p.m., reconvening in Closed Session at 6:41 p.m. to discuss the following items:

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.

D. Designation of Sierra View Local Health Care District Real Property Negotiations Cal. Gov. Code § 54956.8.
Property: 380 W 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.

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).

XII. Open Session: Chairman LOMELI adjourned Closed Session at 8:31 p.m., reconvening in Open Session at 8:32 p.m.

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

D. Designation of Sierra View Local Health Care District Real Property Negotiator

Following review and discussion, it was moved by Vice Chair REDDY, seconded by Director KASHYAP to appoint Ron Wheaton as the negotiator for real property purchase at 380 W. Putnam Avenue, Porterville, CA. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

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

After review and discussion Vice Chair REDDY made a motion to direct leadership to negotiate a contract with Chandler Asset Management for management of Sierra View assets and to return the matter to the Board when a final contract proposal is available, motion was seconded by Director MARTINEZ. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

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

H. Conference With Legal Counsel
Information Only; No Action Taken

XIII. Adjournment

The meeting was adjourned at 8:34 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

SPECIAL MEETING MINUTES

BOARD OF DIRECTORS MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

Special Board Meeting **May 8, 2026** at 8:00 A.M. in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman Lomeli called the meeting to order at 8:11 a.m.

Board Attendance:

- Liberty Lomeli, Chair - Present
- Bindusagar Reddy, Vice Chair - Present
- Areli Martinez, Secretary – Present
- Hans Kashyap, Director – Present
- Martha A. Flores, Director - Present

Others Present: Donna Hefner, President/Chief Executive Officer and Alexander Reed-Krase, Legal Counsel.

I. Approval of Agenda:

Vice Chair REDDY moved to approve the agenda, the motion was seconded by Director FLORES. The motion was carried with the following vote:

FLORES	Yes
REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 8:12 a.m. to discuss the following items:

A. Pursuant to Gov. Code Section 54954.5(e) and Gov. Code Section 59457(b)(1): PUBLIC EMPLOYEE DISMISSAL/RELEASE.

III. Open Session: Chair LOMELI adjourned Closed Session at 8:30 a.m., reconvening in Open Session at 8:30 a.m.

A. Pursuant to Gov. Code Section 54954.5(e) and Gov. Code Section 59457(b)(1): PUBLIC EMPLOYEE DISMISSAL/RELEASE.

Report of Action Taken By Board During Closed Session Pursuant to Cal. Gov. Code Section 54957.1(a)(5):

Vice Chair REDDY moved to dismiss Chief Financial Officer Craig McDonald, without cause as allowed by his employment contract with the District, the motion was seconded by Director FLORES.

The motion was carried with the following vote by the Board:

FLORES	Yes
REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
KASHYAP	Yes

IV. Public Comments
None

V. Announcements:
Regular Board of Directors Meeting – May 26, 2026, at 5:00 p.m.

VI. Adjournment

The meeting was adjourned at 8:31 a.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: ark

SIERRA VIEW
MEDICAL CENTER

Business Items

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS RESOLUTION NO: 05-26-26/01
ORDERING BOARD OF DIRECTORS ELECTION; CONSOLIDATION OF ELECTIONS

WHEREAS, California Elections Code requires a general district election be held in each district to choose a successor for each elective officer whose term will expire on the first Friday in December following the election to be held on the first Tuesday after the first Monday in November in each even numbered year; and

WHEREAS, other elections may be held in whole or in part of the territory of the district, and it is to the advantage of the district to consolidate pursuant to Elections Code Section 10400; and

WHEREAS, Elections Code Section 10520 requires each district involved in a general election to reimburse the county for the actual costs incurred by the county elections official in conducting the election for that district; and

WHEREAS, Elections Code Section 13307(3c) requires that before the nominating period opens, the governing body must determine whether a charge shall be levied against each candidate submitting a candidate's statement to be sent to the voters;

WHEREAS, Elections Code Section 12112 requires the elections official of the principal county to publish a notice of the election once in a newspaper of general circulation in the district; and

WHEREAS, pursuant to the Elections Code, the governing body of any special district or city may, by Resolution, request the Board of Supervisors of the County to permit the county elections official to render specified services to the special district or city relating to the conduct of an election;

NOW, THEREFORE, BE IT RESOLVED that an election be held within the territory included in this district on the 3 day of November 2026, for the purpose of electing members to the Board of Directors of said District in accordance with the following specifications:

1. The Election shall be held on Tuesday, the 3 day of November 2026 . The purpose of the election is to choose members of the board of directors for the following seats:

Sierra View Local Health Care District Zone 2 Board Director Short Term 2026-2028
Sierra View Local Health Care District Zone 3 Board Director 2026-2030
Sierra View Local Health Care District Zone 5 Board Director 2026-2030

2. This governing board hereby requests and consents to the consolidation of this election with other elections which may be held in whole or in part of the territory of the district, as provided in Elections Code 10400.

3. The District will reimburse the County for the actual cost incurred by the County Registrar of Voters office in conducting the general district election upon receipt of a bill stating the amount due as determined by the Elections Official.

4. The District has determined that the **Candidate** will pay for the Candidate's Statement. The Candidate's Statement will be limited to 200 words.

5. The district directs that the County Registrar of Voters of the principal county publish the notice of election in the following newspaper, which is a newspaper of general circulation that is regularly circulated in the territory: **Porterville Recorder**.

6. The Board of Supervisors of Tulare County is hereby requested to permit the County Registrar of Voters to render services to the special district relating to the conduct of the November 3, 2026 General Election as follows:

a. Distribute and file nomination papers and candidate statements for candidates for district offices.
b. Make all required publications.

c. Prepare, print and mail to the qualified electors of the district sample ballots and voter pamphlets.
d. Provide Vote by Mail ballots for said Municipal Election for use by registered voters in the manner provided by law.
e. Order consolidation of precincts, appoint precinct boards, designate polling places and instruct election officers concerning their duties.
f. Conduct and canvass the returns of the election and certify the votes cast.
g. Prepare, print and deliver to the polling places supplies, including the official ballots and a receipt for said supplies.
h. Recount votes, if requested, in accordance with state law.
i. Conduct the above election duties in accordance with the Voting Rights Act of 1975.
j. Perform all other pertinent services required to be performed for said election other than the requirements of the Fair Political Practices Commission; said Fair Political Practices Commission requirements to be performed by the district clerk.

PASSED AND ADOPTED, by the Board of Directors of Sierra View Local Health Care District of Tulare County, State of California at a regular meeting of the Board on May 26, 2026.

The vote of the Board is as follows: (Official Seal)

Yes: _____

No: _____

Absent: _____

By: _____ Attest: _____
Chairman Secretary

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS RESOLUTION NO: 05-26-26/02
APPOINTING TREASURER FOR THE BOARD OF
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

WHEREAS, The Board's Bylaws at 5.5 and 7.4 require the Board of Directors appoint a Treasurer for the Board and to do so by passing a resolution when appointing a new Treasurer to ensure there is a record of compliance with all Federal, State and Local laws and regulations.

WHEREAS, The Board's former Treasure / Chief Financial Officer ceased to be employed by Sierra View District Hospital on May 8, 2026, resulting in a vacancy in the office of Treasurer for the Board.

WHEREAS, The Board has determined that the office of Treasurer of the Board should be filled to serve between the present and until the Board's annual appointment of officers, typically held in December of each year;

WHEREAS, The Board has determined that the individual best suited to be Board Treasure is the Interim Chief Financial Officer, Roger Larsen;

IT IS THEREFORE RESOLVED, that the Board hereby appoints Interim Chief Financial Officer, Roger Larsen as Treasurer for the Board of Directors of Sierra View Local Health Care District.

IT IS RESOLVED FURTHER: that the Board delegates to the Chief Financial Officer ("CFO") for Sierra View Local Health Care District all powers and authority necessary to ensure that the Board, and thereby Sierra View Local Health Care District, is in compliance with all Local, State and Federal laws and regulations that apply to a Board Treasurer's duty to manage public funds, including but not limited to all powers necessary to conduct those duties outlined in Cal. Health & Safety Code § 32127.

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PASSED AND ADOPTED, by the Board of Directors of Sierra View Local Health Care District of Tulare County, State of California at a regular meeting of the Board on May 26, 2026.

The vote of the Board is as follows: (Official Seal)

Yes: _____

No: _____

Absent: _____

By: _____ Attest: _____
Chairman Secretary

SIERRA VIEW MEDICAL CENTER

FINANCIALS

FINANCIAL REPORTS FROM THE PREVIOUS MONTH

FINANCIAL PACKAGE
Apr-26

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
April 2026

Statistic	Apr-26 Actual	Apr-26 Budget	Apr-26 Over/ (Under)	Apr-26 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 25 YTD	Increase/ (Decrease) Apr-25	% Change
Utilization											
SNF Patient Days											
Total	24	-	24	0.0%	117	-	117	0.0%	127	(10)	-7.9%
Medi-Cal	24	-	24	0.0%	117	-	117	0.0%	127	(10)	-7.9%
Sub-Acute Patient Days											
Total	1,021	998	23	2.3%	10,285	10,277	8	0.1%	9,828	457	4.6%
Medi-Cal	456	493	(37)	-7.6%	4,763	5,123	(360)	-7.0%	4,899	(136)	-2.8%
Acute Patient Days	1,518	1,637	(119)	-7.3%	15,982	16,525	(543)	-3.3%	16,540	(558)	-3.4%
Acute Discharges	431	434	(3)	-0.7%	4,533	4,381	152	3.5%	4,396	137	3.1%
Medicare	151	188	(37)	-19.8%	1,702	1,786	(84)	-4.7%	1,793	(91)	-5.1%
Medi-Cal	214	187	27	14.2%	2,184	2,037	147	7.2%	2,043	141	6.9%
Contract	61	56	5	8.5%	603	531	72	13.5%	533	70	13.1%
Other	5	2	3	153.5%	44	27	17	63.5%	27	17	63.0%
Average Length of Stay	3.52	3.77	(0.25)	-6.6%	3.53	3.77	(0.25)	-6.5%	3.76	(0.24)	-6.3%
Newborn Patient Days											
Medi-Cal	155	163	(8)	-5.2%	1,629	1,547	82	5.3%	1,516	113	7.5%
Other	39	32	7	23.5%	398	311	87	27.9%	333	65	19.5%
Total	194	195	(1)	-0.5%	2,027	1,858	169	9.1%	1,849	178	9.6%
Total Deliveries	112	94	18	19.1%	1,105	966	139	14.4%	961	144	15.0%
Medi-Cal %	80.36%	83.43%	-3.07%	-3.7%	79.69%	83.43%	-3.74%	-4.5%	82.43%	-2.74%	-3.3%
Case Mix Index											
Medicare	1.5541	1.6368	(0.0827)	-5.1%	1.5585	1.6368	(0.0783)	-4.8%	1.6077	(0.0492)	-3.1%
Medi-Cal	1.2138	1.1975	0.0163	1.4%	1.1430	1.1975	(0.0545)	-4.6%	1.1966	(0.0536)	-4.5%
Overall	1.3193	1.3724	(0.0531)	-3.9%	1.299	1.3724	(0.0734)	-5.3%	1.3686	(0.0696)	-5.1%
Ancillary Services											
Inpatient											
Surgery Minutes	7,767	7,863	(96)	-1.2%	70,272	78,143	(7,871)	-10.1%	74,330	(4,058)	-5.5%
Surgery Cases	100	93	7	7.1%	846	918	(72)	-7.8%	874	(28)	-3.2%
Imaging Procedures	1,363	1,506	(143)	-9.5%	15,291	14,922	369	2.5%	15,157	134	0.9%
Outpatient											
Surgery Minutes	13,855	14,118	(263)	-1.9%	147,882	139,898	7,984	5.7%	137,328	10,554	7.7%
Surgery Cases	204	196	8	4.3%	1,925	1,939	(14)	-0.7%	1,869	56	3.0%
Endoscopy Procedures	165	187	(22)	-11.5%	1,727	1,848	(121)	-6.6%	1,823	(96)	-5.3%
Imaging Procedures	4,016	4,194	(178)	-4.2%	41,702	41,560	142	0.3%	41,181	521	1.3%
MRI Procedures	327	304	23	7.7%	3,207	3,009	198	6.6%	2,995	212	7.1%
CT Procedures	1,371	1,262	109	8.7%	14,038	12,503	1,535	12.3%	12,284	1,754	14.3%
Ultrasound Procedures	1,557	1,360	197	14.5%	14,982	13,473	1,509	11.2%	13,174	1,808	13.7%
Lab Tests	33,453	32,307	1,146	3.5%	345,354	320,137	25,217	7.9%	320,485	24,869	7.8%
Dialysis	2	3	(1)	-40.7%	70	33	37	109.5%	36	34	94.4%

Sierra View Medical Center
Financial Statistics Summary Report
April 2026

	Apr-26				YTD					Increase/	
Statistic	**Actual**	**Budget**	**Over/ (Under)**	**% Var.**	**Actual**	**Budget**	**Over/ (Under)**	**% Var.**	**Fiscal 25 YTD**	**(Decrease) Apr-25**	**% Change**
Cancer Treatment Center											
Chemo Treatments	1,912	2,014	(102)	-5.0%	19,600	19,953	(353)	-1.8%	19,367	233	1.2%
Radiation Treatments	1,678	1,920	(242)	-12.6%	16,866	19,025	(2,159)	-11.3%	18,638	(1,772)	-9.5%
Cardiac Cath Lab											
Cath Lab IP Procedures	12	14	(2)	-14.2%	147	139	8	6.0%	123	24	19.5%
Cath Lab OP Procedures	52	33	19	56.2%	345	330	15	4.6%	341	4	1.2%
Total Cardiac Cath Lab	64	47	17	35.3%	492	469	23	5.0%	464	28	6.0%
Outpatient Visits											
Emergency	3,600	3,419	181	5.3%	35,446	34,411	1,035	3.0%	34,537	909	2.6%
Total Outpatient	15,403	14,313	1,090	7.6%	148,424	141,832	6,592	4.6%	141,538	6,886	4.9%
Staffing											
Paid FTE's	887.38	900.16	(12.78)	-1.4%	879.12	900.16	(21.04)	-2.3%	875.12	4.00	0.5%
Productive FTE's	770.28	772.13	(1.85)	-0.2%	759.17	772.13	(12.96)	-1.7%	749.06	10.11	1.3%
Paid FTE's/AOB	4.89	5.22	(0.34)	-6.4%	4.97	5.25	(0.28)	-5.4%	5.15	(0.18)	-3.6%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,318	11,426	(108)	-0.9%	11,280	11,269	11	0.1%	11,278	2	0.0%
Cost/Adj.Patient Day	2,839	2,936	(97)	-3.3%	2,849	2,924	(75)	-2.6%	2,809	40	1.4%
Revenue/Adj. Discharge	53,304	56,242	(2,939)	-5.2%	52,521	55,725	(3,204)	-5.7%	54,927	(2,406)	-4.4%
Cost/Adj. Discharge	13,372	14,451	(1,080)	-7.5%	13,266	14,458	(1,193)	-8.2%	13,680	(414)	-3.0%
Adj. Discharge	1,156	1,050	106	10.1%	11,554	10,543	1,011	9.6%	10,604	951	9.0%
Net Op. Gain/(Loss) %	7.08%	-0.81%	7.89%	-975.8%	3.82%	-0.81%	4.63%	-572.2%	-1.87%	5.69%	-304.1%
Net Op. Gain/(Loss) $	1,178,891	(121,754)	1,300,645	-1068.3%	6,086,494	(2,342,140)	8,428,634	-359.9%	(2,664,778)	8,751,272	-328.4%
Gross Days in Accts Rec.	100.67	95.03	5.64	5.9%	100.67	95.03	5.64	5.9%	84.38	16.29	19.3%
Net Days in Accts. Rec.	41.92	57.75	(15.83)	-27.4%	41.92	57.75	(15.83)	-27.4%	36.76	5.16	14.0%

Sierra View Local Health Care District
Balance Sheet

	Apr-26	Mar-26
Assets		
Current Assets:		
Cash & Cash Equivalents	12,473,634	5,283,173
Short-Term Investments	130,966	-
Assets Limited As To Use	4,732,424	4,252,091
Patient Accounts Receivable	202,740,657	206,680,032
Less Uncollectables	(13,319,913)	(13,102,195)
Contractual Allowances	(167,127,320)	(169,988,215)
Other Receivables	31,460,398	35,203,437
Inventories	4,404,261	4,454,079
Prepaid Expenses and Deposits	4,721,115	5,581,359
Less Receivable - Current	301,020	301,020
Total Current Assets	**80,517,242**	**78,664,781**
Assets Limited as to use, Less		
Current Requirements	32,915,001	32,839,063
Long-Term Investments	142,787,055	142,623,422
Property, Plant and Equipment, Net	68,898,373	69,479,405
Intangible Right of use Assets	167,271	177,597
SBITA Right of use Assets	2,372,941	2,096,272
Lease Receivable - LT	456,616	481,975
Other Investments	250,000	250,000
Prepaid Loss on Bonds	1,048,981	1,069,960
Total Assets	**329,413,480**	**327,682,474**
Liabilities and Funds Balances		
Current Liabilities		
Bond Interest Payable	405,883	304,412
Current Maturities of Bonds Payable	4,235,000	4,235,000
Current Maturities of Long Term Debt	85,875	171,662
Account Payable and Accrued Expenses	4,712,261	5,008,902
Accrued Payroll and Related Costs	8,342,193	7,588,796
Estimated Third-Party Payor Settlements	5,177,260	5,714,625
Lease Liability - Current	129,125	129,125
SBITA Liability - Current	1,759,193	1,472,212
Total Current Liabilities	**24,846,789**	**24,624,733**
Self-Insurance Reserves	2,014,484	2,041,096
Capital Lease Liab LT	0	0
Bonds Payable, Less Curr Reqt	29,040,000	29,040,000
Bonds Premium Liability - LT	1,623,376	1,668,896
Lease Liability - LT	57,690	68,647
SBITA Liability - LT	1,066,374	1,089,230
Other Non Current Liabilities	-	-
Deferred Inflow - Leases	701,060	725,557
Total Liabilities	**59,349,773**	**59,258,160**
Unresticted Fund	258,350,395	258,350,395
Profit or (Loss)	11,713,312	10,073,919
Total Liabilities and Fund Balance	**329,413,480**	**327,682,474**
	-	-

Sierra View Local Health Care District
Income Statement

For Period **Apr-26**

	ACTUAL	BUDGET	VARIANCE	% VARIANCE	ACTUAL YTD	BUDGET YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	5,309,692	5,339,009	(29,317)	(1%)	54,529,393	54,629,589	(100,196)	(0%)
Inpatient - Ancillary	17,717,532	19,070,222	(1,352,690)	(7%)	184,084,961	189,499,966	(5,415,005)	(3%)
Total Inpatient Revenue	**23,027,224**	**24,409,231**	**(1,382,007)**	(6%)	**238,614,354**	**244,129,555**	**(5,515,201)**	(2%)
Outpatient - Ancillary	38,612,744	34,646,147	3,966,597	11%	368,226,684	343,384,624	24,842,060	7%
Total Patient Revenue	**61,639,969**	**59,055,378**	**2,584,591**	4%	**606,841,038**	**587,514,179**	**19,326,859**	3%
Medicare	(17,963,528)	(19,468,235)	1,504,707	(8%)	(186,761,003)	(193,622,907)	6,861,904	(4%)
Medi-Cal	(20,118,572)	(18,155,874)	(1,962,698)	11%	(201,955,158)	(180,605,918)	(21,349,240)	12%
Other/Charity	(7,130,983)	(6,942,145)	(188,838)	3%	(60,171,891)	(68,907,833)	8,735,942	(13%)
Discounts & Allowances	(142,436)	(18,481)	(123,955)	671%	(1,670,930)	(183,863)	(1,487,067)	809%
Bad Debts	(732,169)	(236,221)	(495,948)	210%	(5,463,568)	(2,350,056)	(3,113,512)	132%
Total Deductions	**(46,087,688)**	**(44,820,956)**	**(1,266,732)**	3%	**(456,022,550)**	**(445,670,577)**	**(10,351,973)**	2%
Net Service Revenue	**15,552,281**	**14,234,422**	**1,317,859**	9%	**150,818,488**	**141,843,602**	**8,974,886**	6%
Other Operating Revenue	1,089,333	818,039	271,294	33%	8,544,143	8,251,965	292,178	4%
Total Operating Revenue	**16,641,614**	**15,052,461**	**1,589,153**	11%	**159,362,631**	**150,095,567**	**9,267,064**	6%
Salaries	5,949,062	5,949,973	911	0%	60,220,217	60,139,078	(81,139)	(0%)
S&W PTO	857,179	706,637	(150,542)	(21%)	6,828,519	7,131,332	302,813	4%
Employee Benefits	1,565,601	1,460,204	(105,397)	(7%)	15,116,041	14,602,040	(514,001)	(4%)
Professional Fees	1,858,812	1,886,177	27,365	1%	18,731,123	18,885,716	154,593	1%
Purchased Services	1,011,821	904,743	(107,078)	(12%)	9,068,836	9,073,122	4,286	0%
Supplies & Expenses	2,472,886	2,295,941	(176,945)	(8%)	24,109,354	22,848,454	(1,260,900)	(6%)
Maintenance & Repairs	247,902	303,754	55,852	18%	2,804,971	3,037,540	232,569	8%
Utilities	249,536	306,217	56,681	19%	2,844,159	3,062,170	218,011	7%
Rent/Lease	14,564	30,041	15,477	52%	360,425	300,410	(60,015)	(20%)
Insurance	99,334	122,727	23,393	19%	1,168,557	1,227,270	58,713	5%
Depreciation/Amortization	1,037,016	811,079	(225,937)	(28%)	8,438,848	8,110,790	(328,058)	(4%)
Other Expense	99,010	396,722	297,712	75%	3,585,088	4,019,785	434,697	11%
Impaired Costs	-	-	-	0%	-	-	-	0%
Total Operating Expense	**15,462,723**	**15,174,215**	**(288,508)**	(2%)	**153,276,138**	**152,437,707**	**(838,431)**	(1%)
Net Gain/(Loss) From Operations	**1,178,891**	**(121,754)**	**1,300,645**	**(1,068%)**	**6,086,493**	**(2,342,140)**	**8,428,633**	**(360%)**
District Taxes	138,477	138,477	-	0%	1,384,770	1,384,770	-	0%
Investment Income	1,184,680	488,226	696,454	143%	5,500,678	4,882,260	618,418	13%
Other Non - Operating Income	29,898	40,308	(10,410)	(26%)	290,124	403,080	(112,956)	(28%)
Interest Expense	(87,392)	(70,649)	(16,743)	(24%)	(727,451)	(706,490)	(20,961)	(3%)
Non-Operating Expense	(63,471)	(39,852)	(23,619)	(59%)	(379,445)	(398,532)	19,087	5%
Total Non-Operating Income	**1,202,193**	**556,510**	**645,683**	116%	**6,068,675**	**5,565,088**	**503,587**	9%
			-				-	
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	**2,381,084**	**434,756**	**1,946,328**	**448%**	**12,155,168**	**3,222,948**	**8,932,220**	**277%**
Net Incr/(Decr) in the Fair Value Invstmt	(741,690)	162,500	(904,190)	(556%)	(441,856)	1,625,000	(2,066,856)	(127%)
Net Gain/(Loss)	**1,639,393**	**597,256**	**1,042,137**	174%	**11,713,312**	**4,847,948**	**6,865,364**	142%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
April-26

	Current Month	YTD
Cash flows from operating activities:		
Operating Income/(Loss)	1,178,891	6,086,493
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation/Amortization	1,037,016	8,438,848
Provision for bad debts	217,718	(900,884)
		-
Change in assets and liabilities:		-
Patient accounts receivable, net	1,078,480	(1,996,199)
Other receivables	3,743,039	(11,191,943)
Inventories	49,818	88,649
Prepaid expenses and deposits	860,244	(2,101,197)
Advance refunding of bonds payable, net	20,980	209,796
Accounts payable and accrued expenses	(296,641)	(785,687)
Deferred inflows - leases	(24,497)	(244,970)
Accrued payroll and related costs	753,397	(853,241)
Estimated third-party payor settlements	(537,365)	768,547
Self-insurance reserves	(26,612)	(114,605)
Total adjustments	6,875,576	(8,682,885)
Net cash provided by (used in) operating activities	8,054,467	(2,596,392)
Cash flows from noncapital financing activities:		
District tax revenues	138,477	1,384,770
Noncapital grants and contributions, net of other expenses	(64,838)	(256,564)
Net cash provided by (used in) noncapital financing activities	73,639	1,128,206
Cash flows from capital and related financing activities:		
Purchase of capital assets	(445,659)	(5,777,911)
Proceeds from sale of assets	-	5,000
Proceeds from debt borrowings	-	-
Proceeds from lease receivable, net	25,359	250,019
Principal payments on debt borrowings	-	(4,235,000)
Interest payments	(176)	(1,308,051)
Issuance of bonds payable and bond premium liability	-	-
Net change in notes payable and lease liability	(109,288)	(868,660)
Net changes in assets limited as to use	(556,271)	130,697
Net cash provided by (used in) capital and related financing activities	(1,086,036)	(11,803,905)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(905,324)	(4,173,183)
Investment income	1,184,680	5,500,678
Net cash provided by (used in) investing activities	279,356	1,327,495
Net increase (decrease) in cash and cash equivalents:	7,321,426	(11,944,596)
Cash and cash equivalents at beginning of month/year	5,283,173	24,549,196
Cash and cash equivalents at end of month	12,604,599	12,604,599
	12,604,599	12,604,599
	(0.00)	0.00

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
April 2026

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
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
Apr-26	**13,143,789**	**7,283,225**	**20,427,014**

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

April 2026 Summary of Other Activity:

108,712	Cal Viva DHDP FY24 Phase 1
2,661,272	Health Net DHDP CY24 Phase 1
2,803,892	Health Net QIP IGT CY24 Final
34,555	Beta Healthcare Group Dividend 2nd Installment
428	LA Care Healthplan DHDP CY24 Phase 2
718,220	M-Cal IP DSH 02/26 - 03/26
334,866	M-Care interim payments
621,280	Miscellaneous
7,283,225	04/26 Total Other Activity