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

AGENDA
June 23, 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): **Quality Division Update**

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): **Discussion Regarding Trade Secrets Pertaining to Operational and Strategic Planning** (1 Item). Estimated Date of Disclosure – December 1, 2026

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): **Discussion Regarding Trade Secrets Pertaining to Operational and Strategic Planning** (1 Item). Estimated Date of Disclosure – December 1, 2026

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

F. Pursuant To Gov. Code Section 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

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

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

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

F. 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. May 26, 2026 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove May 26, 2026, Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

A. May 2026 Financials
Recommended Action: Approve/Disapprove May Report as Presented

B. SVLHCD Fiscal Year 2027 Operating Budget
Recommended Action: Approve/Disapprove SVLHCD FY 26/27 Operating Budget

C. SVLHCD Fiscal Year 2027 Capital Budget
Recommended Action: Approve/Disapprove SVLHCD FY 26/27 Capital Budget

X. SVLHCD Board Chair Report

XI. SVMC CEO Report

XII. Announcements:

- Regular Board of Directors Meeting – July 28, 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

Post-surgery care for a dorsal slit typically involves managing pain, healing the incision, and avoiding complications. Pain is usually managed with over the counter medications {Tylenol or Ibuprofen) and the incision is typically dressed initially, then allowed to heal without further dressing. Sexual activity should be avoided for at least 4 weeks, and patients should follow their doctor's specific instructions for wound care and return to normal activities.

• Pain Management:

Pain is expected after the procedure for a few days. Take over the Counter medications.

• Dressing:

The incision area is typically dressed initially, but this dressing is usually removed within 24-48 hours. After removal, clean with betadine and gauze 3 times a day. Make sure to wash your hands before and after.

• Wound Care:

The incision area may show some bruising and swelling, which typically subside within a few days. Crusts on the wound may form and fall off within a week.

• Healing:

Complete healing takes about 2-3 weeks, and the sutures are absorbable and dissolve within that time.

• Sexual Activity:

It's crucial to avoid sexual activity for at least 4 weeks, or as instructed by your doctor, to allow the wound to heal properly.

• Follow-up:

A follow-up appointment with the surgeon is usually scheduled to monitor healing and address any concerns.

• Potential Complications:

Bleeding, pain, infection, and damage to the glans or urethra are potential complications, but proper technique and post-operative care minimize these risks.

If you have persistent bleeding or fever over 101 please call the office (559) 791-3914 or go to the nearest Emergency Room.

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

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

Nurse Signature: _____ Name: _____
(print)

INTERPRETER'S STATEMENT

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

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

Name: _____
(print)

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

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

PATIENT'S LABEL

El cuidado posquirúrgico para una incisión dorsal (dorsal slit) generalmente implica controlar el dolor, cicatrizar la incisión y evitar complicaciones. El dolor generalmente se controla con medicamentos de venta libre (Tylenol o Ibuprofeno) y la incisión típicamente se venda al principio, para luego dejarla sanar sin necesidad de vendajes adicionales. Se debe evitar la actividad sexual durante al menos 4 semanas, y los pacientes deben seguir las instrucciones específicas de su médico para el cuidado de la herida y el regreso a las actividades normales.

• Manejo del Dolor:

Se espera sentir dolor durante unos días después del procedimiento. Tome medicamentos de venta libre.

• Vendaje:

El área de la incisión típicamente se venda al principio, pero este vendaje generalmente se retira dentro de 24 a 48 horas. Después de retirarlo, limpie con betadine (betadina) y gasa 3 veces al día. Asegúrese de lavarse las manos antes y después.

• Cuidado de la Herida:

El área de la incisión puede presentar algunos hematomas e hinchazón, que generalmente disminuyen en unos pocos días. Pueden formarse costras en la herida y caerse en una semana.

• Curación:

La curación completa toma alrededor de 2 a 3 semanas, y las suturas son absorbibles y se disuelven dentro de ese período.

• Actividad Sexual:

Es fundamental evitar la actividad sexual durante al menos 4 semanas, o según las indicaciones de su médico, para permitir que la herida sane adecuadamente.

• Cita de Seguimiento:

Por lo general, se programa una cita de seguimiento con el cirujano para monitorear la curación y resolver cualquier inquietud.

• Complicaciones Potenciales:

El sangrado, el dolor, la infección y el daño al glande o a la uretra son complicaciones potenciales, pero una técnica adecuada y los cuidados posoperatorios minimizan estos riesgos.

Si tiene sangrado persistente o fiebre de más de 101, llame a la oficina al (559) 791-3914 o vaya a la Sala de Emergencias más cercana

Firma: _____ Fecha: _____ Hora: _____ AM/PM
(paciente/padre o madre/curador/tutor)

Si es firmado por alguien que no sea el paciente, indique el nombre y el parentesco o relación

_____

Firma de la Enfermera / del Enfermero: _____ Nombre: _____
(letra de molde)

INTERPRETER'S STATEMENT

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

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

Name: _____
(print)

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

PATIENT'S LABEL

Program Description

The Comprehensive Perinatal Services Program (CPSP), as outlined by the California Department of Public Health, is a voluntary program designed to provide comprehensive perinatal support services during pregnancy and the postpartum period. Services may include:

- Health education related to pregnancy, labor, delivery, postpartum and newborn care
- Nutrition assessment, counseling, and follow-up
- Psychosocial assessment and support services
- Care coordination, case management, and referrals

Consent for Services

I understand that:

- Participation in CPSP is voluntary, and I may withdraw consent at any time without affecting my access to medical care, treatment, or benefits.
- CPSP services are designed to support positive maternal and infant health outcomes.
- Services may be provided by a multidisciplinary team, including licensed and non-licensed healthcare professionals operating within their scope of practice.
- My care will be provided in a manner consistent with standards set forth by The Joint Commission and applicable California regulations.

Patient Rights (Regulatory Compliance)

In accordance with California Code of Regulations, Title 22 and The Joint Commission standards, I acknowledge that:

- I have the right to participate in decisions regarding my care and services.
- I have the right to receive information in a language or format I understand, including interpreter services at no cost.
- I have the right to accept or refuse any CPSP service.
- I have the right to be treated with dignity, respect, and without discrimination.
- I have the right to voice grievances regarding my care without fear of retaliation.

Confidentiality & Privacy

My personal health information will be protected in accordance with **the Health Insurance Portability and Accountability Act (HIPAA) and California Title 22 confidentiality requirements.** Information may be shared among CPSP team members and relevant healthcare providers for purposes of treatment, care coordination, payment, and healthcare operations.

Informed Consent Acknowledgment

By signing below, I confirm that:

- I have received an explanation of CPSP services, including benefits and limitations.
- I have had the opportunity to ask questions and receive answers to my satisfaction.
- I understand my rights as a patient under state and federal regulations.
- I voluntarily consent to participate in the CPSP program.

Patient Signature: _____ **Date:** _____

Estimated Due Date (EDD): _____

Staff Name/Title: _____

Staff Signature: _____ **Date:** _____

Interpreter Use (if applicable)

Consistent with The Joint Commission communication standards and Title 22 requirements:

Interpreter Name/ID: _____

Language: _____

I certify that I have accurately and completely interpreted the information provided to the patient.

Interpreter Signature: _____ **Date:** _____

Descripción del programa

El Programa de Servicios Perinatales Integrales (CPSP, por sus siglas en inglés), tal como lo establece el Departamento de Salud Pública de California, es un programa voluntario diseñado para brindar servicios integrales de apoyo perinatal durante el embarazo y el periodo posparto. Los servicios pueden incluir:

- Educación para la salud relacionada con el embarazo, el trabajo de parto, el parto, postparto y el cuidado del recién nacido
- Evaluación nutricional, asesoramiento y seguimiento
- Evaluación psicosocial y servicios de apoyo
- Coordinación de la atención, gestión de casos y referencias

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Consentimiento para los servicios

Entiendo que:

- La participación en el CPSP es voluntaria y puedo retirar mi consentimiento en cualquier momento sin que ello afecte mi acceso a la atención médica, el tratamiento o los beneficios.
- Los servicios del CPSP están diseñados para favorecer resultados positivos en la salud materna e infantil.
- Los servicios pueden ser proporcionados por un equipo multidisciplinario, que incluye profesionales de la salud con y sin licencia, quienes actúan dentro de su ámbito de práctica profesional.
- Mi atención se brindará de manera congruente con los estándares establecidos por The Joint Commission y las regulaciones aplicables de California.

Derechos del paciente (Cumplimiento normativo)

De conformidad con el Título 22 del Código de Regulaciones de California y los estándares de The Joint Commission, reconozco que:

- Tengo derecho a participar en las decisiones relativas a mi atención y a los servicios que recibo.
- Tengo derecho a recibir información en un idioma o formato que comprenda, lo cual incluye servicios de intérprete sin costo alguno.
- Tengo derecho a aceptar o rechazar cualquier servicio de CPSP.
- Tengo derecho a ser tratada con dignidad, respeto y sin discriminación.
- Tengo derecho a expresar mis quejas o inquietudes con respecto a mi atención sin temor a represalias.

Confidencialidad y privacidad

Mi información personal de salud estará protegida de conformidad con la Ley de Portabilidad y Responsabilidad del Seguro Médico (HIPAA, por sus siglas en inglés) y los requisitos de confidencialidad establecidos en el Título 22 de California. La información podrá ser compartida entre los miembros del equipo del CPSP y los proveedores de atención médica pertinentes con fines de tratamiento, coordinación de la atención, facturación y operaciones de atención médica.

Reconocimiento del consentimiento informado

Al firmar a continuación, confirmo que:

- He recibido una explicación sobre los servicios del CPSP, incluyendo sus beneficios y limitaciones.
- He tenido la oportunidad de formular preguntas y recibir respuestas a mi entera satisfacción. · Comprendo mis derechos como paciente conforme a las regulaciones estatales y federales.
- Doy mi consentimiento voluntario para participar en el programa CPSP.

Patient Signature: _____ **Date:** _____

Estimated Due Date (EDD): _____

Staff Name/Title: _____

Staff Signature: _____ **Date:** _____

~~**PURPOSE:**~~

~~Sierra View Medical Center (SVMC) recognizes the importance of allowing new employees time to acclimate to a new position and the working environment when joining the District. The introductory period is established to ensure the District and new employees have a period of time to get acquainted, for all orientation to be completed and documented, and to ensure competency and training of the new employee.~~

~~**POLICY:**~~

~~Beginning with the first day of employment in a position, each employee will be considered to be on an introductory status of ninety (90) days. During this introductory period, all initial orientation and skills checklists applicable to each position are to be completed and documented to determine the employee's competency in the position to which s/he has been hired.~~

~~At~~No later than ~~the completion of the ninety day introductory period, the department director must complete the formal performance evaluation form and meet with the employee to convey whether the employee's performance during the Introductory Period is satisfactory or unsatisfactory. The introductory evaluation form should be forwarded to Human Resources to be stored in the employee's personnel file.~~

~~Any current SVMC employee who transfers into a new position is not subject to an Introductory Period under this policy, but will be evaluated at the completion of ninety (90) days~~review no later than ~~to~~months ~~to ,ensure they have been fully oriented and~~oriented, and ~~to allow for documented assess~~ theirments ~~of their competencies based on their new role.~~

~~Employment with Sierra View Medical Center is "at will". That is, the employee or SVMC may terminate the employment relationship with or without cause or notice, at any time. (Please refer to the At-Will Employment policy for additional details.)~~

~~**AFFECTED PERSONNEL/AREAS:** *ALL EMPLOYEES*~~

~~**PROCEDURE:**~~

~~During the first ninety (90) day employment period, the employee's orientation and performance will be monitored and reviewed by his/her manager/director to assist the employee. During this time, the employee's director/manager will meet with the employee to discuss and evaluate the employee's progress in the position. The department Director/manager should meet, at minimum, with their newly hired employee within 30 days of their employment and again at 60 days~~no later than the ~~as part of the performance management check-in process (outlined in Create an Extraordinary Onboarding Experience for your New Employee guide). These check-ins are designed for both the Director/Manager and the~~

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~~employee to express concerns, needs and expectations concerning the employee's performance and/or position. Both of these check-in meetings must be documented and recorded on the 90-Day Introductory Evaluation form.~~

~~**Extension of Introductory Period**~~

~~Introductory Periods may be extended upon request for up to 90 additional days. Requests to extend an Introductory Period shall be directed to the Staff Relations and Development Partner, who will make a decision in conjunction with the respective department's leadership. If an extension of the Introductory Period is granted, it will be approved at thirty (30) day increments not to exceed ninety (90) days.~~

~~The initial Introductory Period will be completed and the extension documented along with the performance and/or behavioral deficiencies. If at the end of the extended Introductory Period, performance is still not satisfactory, the department director shall meet with Human Resources to discuss separation of employment.~~

~~Separation of employment prior to the expiration of the introductory period requires approval by the employee's department director, the respective Vice President, and the Vice President of Human Resources. Disciplinary action during an introductory period is not subject to the progressive steps as identified in the Performance Accountability & Commitment Plan policy.~~

~~Employees who have successfully completed their ninety-day introductory period will be subject to the District's Performance Accountability and Commitment Policy for performance and conduct related concerns. Completion of the Introductory Period does not mean guaranteed or continued employment, nor does it alter the "at-will" status of the employment relationship.~~

~~**Benefits During the Introductory Period:**~~

~~Effective the first of the month following thirty (30) days of employment, the new employee will become eligible for insurance benefits if holding a benefited classification. (Please refer to the Benefits policy for further details.) Eligibility for health benefits are not affected by an extension of the introductory period should one be granted.~~

~~Vacation/Holiday time begins accruing upon employment, but may not be utilized during the first ninety (90) days of employment. Accrual balances and adjustments to accruals will begin to appear on paycheck stubs the first pay period following the initial ninety (90) days of employment. (Please refer to the Vacation/Holiday and the Exempt Employee Compensation policy for details.)~~

~~The Hospital will provide each employee with a lump sum of 3 days of Protected Sick Leave (PSL) at the beginning of each 12-month period (employee's date of hire). An employee is not eligible to use PSL~~

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~~until the 91st day of employment with the Hospital. Unused days do not carry over to the following year. (Please refer to the Sick Leave policy for details).~~

~~**Forms:**~~

- ~~Introductory Period Evaluation Form~~

~~**REFERENCES:**~~

- ~~United Stated Department of Labor (2020). Continuation of Health Coverage (COBRA). Retrieved from https://www.dol.gov/general/topic/health-plans/cobra.~~

~~**CROSS REFERENCES:**~~

- ~~Personal Conduct~~
- ~~Benefits~~
- ~~Sick Leave~~
- ~~Holiday/Vacation~~
- ~~At-Will Employment~~
- ~~Performance Accountability and Commitment~~
- ~~Exempt Employee Compensation~~

PURPOSE:

The purpose of the introductory period is to provide new employees with time to acclimate to their position and work environment upon joining Sierra View Medical Center (SVMC). This period allows SVMC and the employee an opportunity to become familiar with one another while ensuring all required orientation, training, competency assessments, and documentation are completed.

DEFINITIONS: N/A

POLICY:

Beginning on the first day of employment, all newly hired employees will serve an introductory period of six (6) months.

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During this period, all required orientation checklists, training, and competency checklists applicable to the employee's position must be completed and documented to ensure the employee can successfully perform the essential functions of the role. The Introductory Period serves as a way to document the performance of a new employee in their role.

No later than the completion of the introductory period, the department leader must complete a formal introductory performance review and meet with the employee to discuss whether performance during the introductory period has been satisfactory. The completed review must be signed and forwarded to Human Resources for inclusion in the employee's personnel file.

Current Sierra View Medical Center (SVMC) employees who transfer into a new position are not subject to a new introductory period. However, transferred employees will receive a performance review no later than six (6) months after assuming the new role to ensure orientation has been completed and competencies related to the new position have been assessed and documented.

Employment with Sierra View Medical Center is "at will." Either the employee or SVMC may terminate the employment relationship at any time, with or without cause or notice. Nothing in this policy alters or supersedes the at-will employment relationship. Please refer to the At-Will Employment Policy for additional information.

AFFECTED PERSONNEL/AREAS: *All Staff; Physician Residents should refer to the GME Policies for performance reviews.*

EQUIPMENT: N/A

PROCEDURE:

A. During the six (6) month introductory period, the employee's orientation and performance will be monitored by the employee's leader and assigned trainers to support successful integration into the role.

Leaders should routinely meet with newly hired employees to discuss progress, provide feedback, address concerns, and review performance expectations. At a minimum, documented check-ins should occur:

- Within the first 30 days of employment
- At approximately 60 days
- At approximately 90 days
- At the completion of the six-month introductory period

These meetings should include discussion of performance strengths, opportunities for improvement, orientation progress, and competency development.

All introductory period check-ins and evaluations must be documented using the designated Introductory Review template in the assigned system.

Routine check-ins should align with the organization's performance management and onboarding practices outlined in the "Create an Extraordinary Onboarding Experience for Your New Employee" guide located on the intranet.

B. EXTENSION OF INTRODUCTORY PERIOD

An introductory period may be extended when additional time is needed to evaluate performance or complete required competencies.

Requests for extension must be submitted to the Employee Relations Specialist and reviewed in collaboration with departmental leadership and the HR Manager.

Extensions will be approved for an additional one time, thirty (30) day period and should be issued during the six month of the Introductory Period.

The reason for the extension, including any identified performance or behavioral deficiencies, must be documented. If performance remains unsatisfactory at the conclusion of the extended introductory period, department leadership will consult with Human Resources regarding separation of employment.

Commented [TC1]: Should we say that a request for an extension has to be _____ amount of time before the introductory period ends?

Commented [CW2R1]: I had made some additional changes to this but maybe didn't save it(?) I think allowing an additional 90-days for the introductory period is too lengthy now that we have a six month original period. I am recommending we have one, 30-day extension and if they are still not meeting the expectation, there is discussion about separation at that point in time. Thoughts/

C. DISCIPLINARY ACTION DURING THE INTRODUCTORY PERIOD

Employees in the introductory period are not subject to all progressive discipline steps outlined in the Performance Accountability & Commitment Plan Policy.

However, when appropriate, leaders are encouraged to provide coaching, training, and corrective action before considering termination of employment. This process helps ensure employees are informed of performance concerns, understand expectations, and are provided a reasonable opportunity to improve.

D. SEPARATION OF EMPLOYMENT IN THE INTRODUCTORY PERIOD

Prior to separating an employee during the introductory period, leaders must consult with the Human Resources Employee Relations Specialist. Human Resources will review performance documentation and partner with departmental leadership regarding the recommended course of action.

If separation is approved, the leader must complete the required termination documentation and submit it to Human Resources for final review and processing.

Employees who successfully complete the introductory period will thereafter be subject to the Performance Accountability & Commitment Plan Policy for performance and conduct concerns.

Successful completion of the introductory period does not guarantee continued employment and does not alter the at-will employment relationship.

E. BENEFITS DURING THE INTRODUCTORY PERIOD

Employees in benefited positions become eligible for insurance benefits effective the first day of the month following thirty (30) days of employment. Please refer to the Benefits Policy for additional details.

Eligibility for benefits is not affected by an extension of the introductory period.

Vacation and holiday accruals begin upon employment but may not be used during the first ninety (90) days of employment.. Please refer to the Vacation/Holiday and Exempt Employee Compensation Policies for additional information.

The Hospital provides full-time employees with a lump sum of Protected Sick Leave (PSL) at the beginning of each 12-month period based on the employee's hire date. Per diem employees accrue one (1) hour of PSL for every thirty (30) hours worked.

Employees are not eligible to use PSL until the 91st day of employment. Unused PSL does not carry over to the following year. Please refer to the Sick Leave Policy for additional information.

REFERENCES:

CROSS REFERENCES:

Vacation/Holiday
PSL

SUBJECT: **OWNERSHIP OF MEDICAL RECORDS**	SECTION: **Page 1 of 1**

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

POLICY:

The medical record is the property of Sierra View Medical Center (SVMC) and is maintained for the benefit of the patient, the medical staff and the hospital. SVMC is responsible for safeguarding both the record and its informational content against loss, defacement, tampering and from the use by unauthorized individuals.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL PERSONNEL*

CHANGE OF OWNERSHIP:

1. In the event that the ownership of the hospital changes, both the previous licensee and the new licensee will provide the Department of Health, prior to change of ownership, written documentation that:

    a. The new licensee will have custody of the patients' records upon transfer of the hospital and that the records are available to both new and former licensee and other authorized persons.

    b. Arrangements have been made for the safekeeping of patients' records, as required, and that the records are available to both the new and former licensees and other authorized persons.

CESSATION OF OPERATION:

- In the event that the hospital ceases operation, arrangement will be made for safe preservation of patients' records.

- The Department of Health shall be notified within 48 hours of cessation and arrangements will be made for the safe preservation of the medical records.

REFERENCE:

- Cal. Code Regs. Tit. 22, § 70751 - Medical Record Availability

SUBJECT: **PERFORMANCE REVIEW PROCESS**	SECTION: **Page 1 of 6**

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

PURPOSE:

~~To provide consistency in the review of staff performance and the planning, allocation and distribution of approved annual budget for wage and salary increases for Sierra View Medical Center (SVMC) employees. staff performance reviews in a consistent manner related to job performance, areas of strength and opportunity and annual review of department and organizational goals.~~

Performance reviews are distributed once a year to all staff in an effort to align employee goals with department and organizational goals. In addition to providing feedback and establishing goals related to the employee's performance, the performance review will also measure the success of modeling SVMC values.

Performance reviews are not tied to discretionary merit increases. This allows for meaningful dialogue related to performance management between leaders and staff and allows a focus on coaching, feedback and professional development.

POLICY:

Staff performance reviews shall be ~~evaluated on a regular basis~~launched via SVMC's Human Capital Management (HCM) System ~~automated workflow~~ each Apri ~~March~~. The templates are designed to assist leaders and staff to communicate ~~to themstaff~~ how they are performing based on their job descriptions, department expectations, organizational expectations and how performance improvements can be made.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES, ~~VOLUNTEERS~~, ~~APPLICABLE CONTINGENT WORKFORCE~~*

PHYSICIAN RESIDENTS: REFER TO YOUR SPECIFIC GME RESIDENCY POLICIES

PROCEDURE:

Employees of Sierra View Medical Center (SVMC):

~~SVMC uses a "pay for performance" compensation system. This means full-time and part-time employees may be eligible to receive a merit increase based on job performance. Job performance is the primary factor when determining the amount of increase to be given. Per Diem employees are not eligible for merit or lump-sum payments under the compensation system.~~

~~1. Evaluating Job Performance~~

~~Position descriptions are used to measure performance to achieve a realistic work appraisal for exempt managers and supervisors and non-exempt positions. Exempt directors, administrative directors, and vice presidents are evaluated on the exempt performance appraisal form. Employees receive a copy of their position description upon hire and thereafter when a job~~

~~change occurs, and when performance is reviewed. Specific performance measures appear within the position specific evaluation tool.~~

Performance reviews will include a self-assessment by each employee as well as an assessment from the department leader. The assessment includes competencies based on SVMC values, open-ended questions related to performance for both leaders and staff to answer, and compliance attestations. The on-line performance review assessment will be launched at the same time for all staff with the same review ~~evaluation~~ period~~cycle~~. The performance review period ~~cycle~~ ~~wil~~will be from May 1st through April 30th each year.

New Hires must have completed at least nine months of employment by the time annual performance reviews are distributed in order to participate in the April review cycle following their hire date. If they have not reached nine months of service by that time, their first review will take place the following year.

~~2. Evaluating Competency~~

~~The performance evaluation process shall include assessment of the employee's competency to perform job responsibilities for those positions identified that must have annual competency review. Competency consists of the knowledge, skill, critical thinking, attitude and ability to function in the job. Competence is evidenced through credentialing, education and observed behaviors and the actual performance of the role functions in a specific setting. During the initial and annual performance appraisal process, competency is evaluated to determine ability to meet job requirements and to identify opportunities for improvement. In response to the appraisal, the manager/director may develop an action plan to improve performance. *(See Policy: COMPETENCY ASSESSMENT PROCESS)*~~

~~Salary adjustments are postponed for employees failing to achieve competency standards. Unlike performance evaluations, employees regain merit eligibility when competency standards are attained. Salary adjustments delayed for this purpose are not retroactive.~~

~~3. Evaluation Review Dates~~

~~Non-exempt and exempt employees in non-management roles are evaluated on their evaluation review date. The evaluation review date could be on the annual date of hire or at time of transfer to a new position (with or without a salary increase). When an employee transfers into a new position, their annual review date is reset to the date of transfer.~~

~~Exempt managers, directors, administrative directors, and vice presidents are evaluated in the month of September regardless of their date of hire, promotion date or change of job title and responsibilities. If the employee has worked less than 1 year in the new management role, the merit increase will be prorated accordingly. If the employee is within 90 days of accepting their new role, there will be no prorated merit increase.~~

Performance problems must be identified and corrected immediately. Employees experiencing trouble achieving performance or competency standards may be placed on a Performance Accountability and Commitment Plan (PACP) and be re-evaluated before their next scheduled annual performance review date.

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~~4. Reviews at 90 Days of Employment~~

~~New employees and employees transferring into a new role will receive a 90-day evaluation to determine if their performance is satisfactory or unsatisfactory. The 90-day evaluation is not associated with a merit increase. The Director/Manager is to meet with the employee minimally every 30 days to identify any barriers or significant performance deficiencies impeding success. If it is determined that the employee does not meet the expected performance standards, Human Resources is to be consulted to determine appropriateness of either extending the introductory period or separation of employment. Recommendations will be made to the Department Director with approval from their respective Vice President. Thereafter, performance evaluations occur annually, unless the employee transfers.~~

~~5.~~ Responsibilities

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~~Department Directors/Managers~~ *Leaders* are responsible for ~~initiating and~~ completing employee performance ~~evaluations~~ reviews and documenting employee ~~competency~~ performance ~~i~~n a timely manner. ~~Department Directors/Managers will select no less than three (3) individuals who work with the employee to complete the Peer Feedback Tool. The Peer Feedback Tool is to be kept anonymous and feedback to be shared with the employee. It is to be used as a coaching tool. The Peer Feedback Tool does not influence and is not considered toward the calculation for the merit increase. Retroactive wage adjustments occur when a delay is the result of a department director's failure to complete a timely evaluation. Anniversary dates shall not be amended to reflect delays in annual wage adjustments.~~

Annual performance ~~evaluations~~ reviews must be completed ~~and turned in to the Human Resources department~~ by ~~the employee's evaluation due date~~apJuly 31 each year. ~~Directors/Managers~~ Leaders are responsible for completing the performance review electronically and within the designated timeline. ~~form and competency assessments, if applicable within this period. An electronic Evaluation Scoring Sheet (merit recommendation included) must be approved and arrive in Human Resources by the employee's evaluation due date. Wage adjustments occurring as a result of this policy shall become effective on the employee's evaluation due date.~~

Employees on a Leave of Absence during ~~their evaluation due date~~ the performance review period will have 30 days from their return date to complete their performance review.~~be given their evaluation given the performance review within 30 days of their return date. If wages were paid during the leave period, retroactive pay will be based on their annual evaluation date~~.

~~Employees assume responsibility for maintaining licensure, annual orientation, TB screening and in-service requirements. Employees will be asked to complete an Employee Self Evaluation prior to receiving their annual performance evaluation. Annual wage adjustments are postponed when employees fail to fulfill these requirements. Employees are not eligible~~

~~for retroactive salary adjustments if they fail to complete the above requirements.~~
~~Employee review dates are not amended to reflect delays in annual wage adjustments.~~

~~6. Salary and Review Process~~
1. Discretionary Merit Increase
2. ~~Before reviewing the annual performance evaluation with employees, Directors shall ensure wage and salary adjustments fall within individual salary grade ranges. If proposed salary recommendations exceed the range maximum, department directors shall follow salary adjustment instructions contained within "*MAXIMUM SALARY GRADES, MEETING OR EXCEEDING (LUMP SUM PAYMENTS)*" policy. Employees at or near the maximum of their grade ranges are eligible for a lump sum payment, which does not increase their actual base hourly rate of pay. The employee remains eligible for this lump sum payment during successive years in which they remain at the maximum of their pay range or until the range maximum is increased, allowing for resumption of full merit participation.~~

Leaders are encouraged to schedule a one-on-one session with the employee to provide the feedback on the performance review and allow the employee to also share their goals, barriers and performance review measures.. Performance reviews sessions shall occur in a private setting and the leader should make arrangements to ensure the performance review feedback session is uninterrupted.

It is important for the leaders to communicate performance measures and standards to an employee. This will help the employee understand how the overall performance rating is determined and how improvement can be made to achievesuccess. The leader shall provide an explanation for individual and overall ratings and allow the employee to respond with their input appropriately.

3. Employee Rebuttal

Employees disagreeing with the outcome of their performance review may do so by writing their comments in the space allotted on the signature page of the performance review template If the employee believes there are discriminatory or harassing remarks impacting their performance review they are encouraged to speak with Human Resources.

DISCRETIONARY MERIT INCREASE

The discretionary merit increase allows SVMC to recognize and reward employees in good standing. It separates growth and goal-focused conversations from compensation and empowers leaders to support their teams with objective feedback.

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Each June 1st, employee's who have met the eligibility criteria will receive a discretionary merit increase as approved by the Board. The percentage for discretionary merit increases may vary each year based on the approved budget.

Eligibility is based on full-time and part-time employment status as of April 30th. Additionally, to be eligible for the discretionary merit increase, employees must not have been issued a notice of corrective action during the performance review cycle period between May 1st through April 30th. Per diem employees are not eligible for the discretionary merit increase.

Full-time and part-time employees who are at the cap of their current salary grade shall receive a lump sum bonus based on the approved percentage of the discretionary merit increase.

Full-time new hires and transfer will have prorated eligibility determined by Human Resources.
Employees who have received a Notice of Corrective Action (NOCA) ~~at the written and/or final written level~~ during the (12) twelve-month ~~evaluation~~ performance review period will not be eligible to receive a discretionary ~~-~~merit increase~~. amount. It is the responsibility of the Director/Manager to review the employee's disciplinary status prior to completing the evaluation and the scoring sheet. Leaders are to notate the deduction on the Evaluation Scoring Sheet and discuss with the employee at the time of the evaluation. Employees who have been issued a NOCA and transfer to a different position that changes their evaluation date will have the transfer date as the new (12) twelve month period for addressing the NOCA.~~ Human Resources will track NOCA's submitted to Human Resources and each year will determine eligibility of the discretionary merit increase for each performance review cycle.

~~The leader completing the evaluation must obtain the signature of their direct supervisor prior to discussing the review with the employee. This provides opportunities to discuss performance related issues and obtain general agreement on an employee's contribution during the review period. Any review with an overall increase of 1% -3% shall be discussed with the department's Vice President. Employees are asked to sign their performance review document. If an employee refuses, the reviewer shall sign and make a notation.~~

~~The Director/Manager Leaders are encouraged to shall schedule a one-on-one session with the employee to go over their ethe performance review valuation. The employee shall be given sufficient notification and time to prepare for their performance review. Performance reviews sessions shall occur in a private setting and arrangements shall be made to ensure the process is uninterrupted.~~

~~It is important for the Director/Manager leaders to communicate performance measures and standards to an employee. This will help the employee understand how the overall performance rating is determined and how improvement can be made to achieve a higher ratingsuccess. The Director/Manager leader shall provide an explanation for individual and overall ratings and allow the employee to respond with their input appropriately.~~

~~7. Employee Rebuttal~~

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~~Employees disagreeing with the outcome of their evaluation performance review or offering additional commentary may do so by writing their comments in the space allotted on the signature page of the performance review evaluation document.template. If the employee believes there are discriminatory or harassing remarks impacting their evaluation, performance review they are encouraged to speak with Human Resources.~~

~~**Volunteers and Applicable Contingent Workforce:**~~

~~Applicable Contingent Workforce receive an annual review or are reviewed sooner if performance standards are not achieved. Managers and Directors must complete a performance evaluation for each traveler at the completion of their assignment. Volunteers and Contingent Workforce are not eligible for merit increases or lump-sum payments as a result of their review.~~

~~**Registry Staff Exception**~~

~~Registry staff receives an initial review at the completion of their first scheduled shift. Thereafter, they are evaluated annually by their Employer with input from their primary Department Director.~~

REFERENCES:

- Title 22 California Code of Regulations Division 5 (2012) Chapter 1 page 18, retrieved from http://nursealliance ca.org/files/2012/06/Title-22-Chapter-5.pdf.
- The Joint Commission (2020). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- COMPETENCY ASSESSMENT PROCESS
- MAXIMUM SALARY GRADES, MEETING OR EXCEEDING (LUMP SUM PAYMENTS)
- INTRODUCTORY PERIOD

SUBJECT:	SECTION:
STANDARDS OF NURSING PRACTICE AND PROFESSIONAL PERFORMANCE	***Leadership (LD)***

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

PURPOSE:

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

POLICY:

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

AFFECTED PERSONNEL/AREAS: *ALL REGISTERED NURSES*

PROCEDURE:

STANDARDS OF PRACTICE:

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

A. **Standard 1. Assessment:** The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation.

1. Collects pertinent data, including but not limited to demographics, social determinants of health, health disparities, and physical functional, psychosocial, emotional, cognitive, sexual, cultural, age-related, environmental, spiritual/transpersonal, and economic assessments in a systematic, ongoing process with compassion and respect for the inherent dignity, worth, and unique attributes of every person.

2. Recognizes the importance of the assessment parameters identified by WHO (World Health Organization), *Health People 2020*, or other organizations that influence nursing practice.

3. Integrates knowledge from global and environmental factors into the assessment process.

4. Elicits the healthcare consumer's values, preferences, expressed and unexpressed needs, and knowledge of the healthcare situation.

5. Recognizes the impact of one's own personal attitudes, values, and beliefs on the assessment process.

6. Assesses family dynamics and impact on healthcare consumer health and wellness. Identifies barriers to effective communication based on psychosocial, literacy, financial, and cultural considerations.

7. Assesses the impact of family dynamics on healthcare consumer health and wellness.

8. Engages the healthcare consumer and other interprofessional team members in holistic, culturally sensitive data collection.

9. Prioritizes data collection based on the healthcare consumer's immediate condition or the anticipated needs of the healthcare consumer or situation.

10. Uses evidence-based assessment techniques, instruments, tools, available data, information, and knowledge relevant to the situation to identify patterns and variances.

11. Applies ethical, legal, and privacy guidelines and policies to the collection, maintenance, use, and dissemination of data and information.

12. Recognizes the healthcare consumer as the authority on their own health by honoring their care preferences.

13. Documents relevant data accurately and in a manner accessible to the interprofessional team.

ADDITIONAL COMPETENCIES FOR THE GRAUDATE-LEVEL PREPARED REGISTERED NURSE:

1. Assess the effect of interaction among individuals, family, community, and social systems on health illness.

2. Synthesize the results and information leading to clinical understanding.

B. **Standard 2. Diagnosis**: The registered nurse analyzes the assessment data to determine the actual or potential diagnoses problems, and issues. The registered nurse:

1. Identifies actual or potential risks to the healthcare consumer's health and safety or barriers to health, which may include but are not limited to interpersonal, systematic, cultural, or environmental circumstances.

2. Uses assessment data, standardized classification systems, technology, and clinical decision support tools to articulate actual or potential diagnoses, problems, and issues.

3. Verifies the diagnoses, problems, and issues with the individual, family, group, community, population, and interprofessional colleagues.

4. Prioritizes diagnoses, problems, and issues based on mutually established goals to meet the needs of the healthcare consumer across the health-illness continuum.

5. Document diagnoses, problems, and issues in a manner that facilitates the determination of the expected outcomes and plan.

ADDITIONAL COMPETENCIES FOR THE GRAUDATE-LEVEL PREPARED REGISTERED NURSE:

1. Uses information and communication technologies to analyze diagnostic practice patterns of nurses and other members of the interprofessional team.

2. Employs aggregate-level data to articulate diagnoses, problems, and issues of healthcare consumers and organizational systems.

3. Formulates a differential diagnosis based on the assessment, history, physical examination, and diagnostic test results.

C. **Standard 3. Outcomes Identification**: The registered nurse identifies expected outcomes for a plan individualized to the patient or the situation and will:

1. Engages the healthcare consumer, interprofessional team, and others in partnership to identify expected outcomes

2. Formulates culturally sensitive expected outcomes derived from assessments and diagnoses.

3. Uses clinical expertise and current evidence-based practice to identify health risks, benefits, costs, and/or expected trajectory of the condition.

4. Collaborates with the healthcare consumer to define expected outcomes integrating the healthcare culture, values and ethical considerations.

5. Generates a time for the attainment of expected outcomes.

6. Develop expected outcomes that facilitate continuity of care.

7. Modify expected outcomes based on the evaluation of the status of the healthcare consumer and situation.

8. Document expected outcomes as measurable goals.

9. Evaluates the actual outcomes in relation to expected outcomes, safety, and quality standards.

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

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

2. Differentiates outcomes that require care process interventions from those that require system-level actions.

3. Integrates scientific evidence and best practices to achieve expected outcomes.

4. Advocates for outcomes that reflect the healthcare consumer's culture, values, and ethical concerns.

D. **Standard 4. Planning**: The registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes and will:

1. Develop an individualized plan in partnership with the person, family, and others considering the person's characteristics or situation, including but not limited to, values, beliefs, spiritual and health practices, preferences, choices, developmental level, coping style, culture and environment, and available technology.

2. Establish the plan priorities with the patient, family, and others as appropriate.

3. Include strategies in the plan that address each of the identified diagnoses or issues. These may include, but are not limited to, strategies for:

   a. Promotion and restoration of health;

   b. Prevention of illness, injury, and disease;

   c. The alleviation of suffering; and

   d. Supportive care for those who are dying.

4. Include strategies for health and wholeness across the lifespan.

5. Provide for continuity in the plan.

6. Incorporate an implementation pathway or timeline in the plan.

7. Consider the economic impact of the plan on the patient, family, caregivers, or other affected parties.

8. Integrate current scientific evidence, trends and research.

9. Utilize the plan to provide direction to other members of the healthcare team.

10. Explore practice settings and safe space and time for the nurse and the patient to explore suggested, potential, and alternative options.

11. Define the plan to reflect current statues, rules and regulations, and standards.

12. Modify the plan according to the ongoing assessment of the patient's response and other outcome indicators.

13. Document the plan in a manner that uses standardized language or recognized terminology.

E. **Standard 5. Implementation**: The registered nurse implements the identified plan and will:

1. Partner with the patient, family, significant others, and caregivers as appropriate to implement the plan in a safe, realistic, and timely manner.

2. Demonstrate caring behaviors toward patients, significant others, and groups of people receiving care.

3. Utilize technology to measure, record, and retrieve patient data, implement the nursing process, and enhance nursing practice.

4. Utilize evidence-based interventions and treatments specific to the diagnosis or problem.

5. Provide holistic care that addresses the needs of diverse populations across the lifespan.

6. Advocate for health care that is sensitive to the needs of patients, with particular emphasis on the needs of diverse populations.

7. Apply appropriate knowledge of major health problems and cultural diversity in implementing the plan of care.

8. Apply available healthcare technologies to maximize access and optimize outcomes for patients.

9. Utilize community resources and systems to implement the plan.

10. Collaborate with healthcare providers from diverse backgrounds to implement and integrate the plan.

11. Accommodate for different styles of communication used by patients, families, and health providers.

12. Integrate traditional and complementary healthcare practices as appropriate.

13. Implement the plan in a timely manner in accordance with patient safety goals.

14. Promote the patient's capacity for the optimal level of participation and problem-solving.

15. Document implementation and any modifications, including changes or omissions, of the identified plan.

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

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

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

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

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

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

4. Use ongoing assessment data to revise the diagnoses, outcomes, the plan, and the implementation as needed.

5. Disseminate the results to the patients, family, and others involved, in accordance with federal and state regulations.

6. Participate in assessing and assuring the responsible and appropriate use of interventions in order to minimize unwarranted or unwanted treatment and healthcare consumer suffering.

7. Document the results of the evaluation.

STANDARDS OF PROFESSIONAL PERFORMANCE

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

A. **Standard 7. Ethics:** The registered nurse practices ethically and will:

A. Use *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001) to guide practice.

B. Deliver care in a manner that preserves and protects patient autonomy, dignity, rights, values, and beliefs.

C. Recognize the centrality of the healthcare consumer and family as core members of any healthcare team.

D. Uphold patient confidentiality within legal and regulatory parameters.

E. Assist patients in self-determination and informed decision-making.

F. Maintain a therapeutic and professional patient-nurse relationship within appropriate professional role boundaries.

G. Contribute to resolving ethical issues involving patients, colleagues, community groups, systems, and other stakeholders.

H. Take appropriate action regarding instances of illegal, unethical, or inappropriate behavior that can endanger or jeopardize the best interests of the patient or situation.

I. Speak up when appropriate to question healthcare practice when necessary for safety and quality improvement.

J. Advocate for equitable patient care.

Standard 8. Culturally Congruent Practice.

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

1. Participate in ongoing educational activities related to appropriate knowledge base and professional issues.

2. Demonstrate a commitment to lifelong learning through self-reflection and inquiry to address learning and personal growth needs.

3. Seek experiences that reflect current practice to maintain knowledge, skills, abilities, and judgment in clinical practice or role performance.

4. Acquire knowledge and skills appropriate to the role, population, specialty, setting, role, or situation.

5. Seek formal and independent learning experiences to develop and maintain clinical and professional skills and knowledge.

6. Identify learning needs based on nursing knowledge, the various roles the nurse may assume, and the changing needs of the population.

7. Participates in formal or informal consultations to address issues in nursing practice as an application of education and knowledge base.

8. Share educational findings, experiences, and ideas with peers.

9. Contribute to a work environment conducive to the education of healthcare professionals.

10. Maintain professional records that provide evidence of competence and lifelong learning.

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

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

2. Incorporate evidence when initiating changes in nursing practice.

3. Participate, appropriate to education level and position, in the formulation of evidence-based practice through research.

4. Share personal or third-party research findings with colleagues and peers.

D. **Standard 14. Quality of Practice**: The registered nurse contributes to quality nursing practice and will:

1. Demonstrate quality by documenting the application of the nursing process in a responsible, accountable, and ethical manner.

2. Use creativity and innovation to enhance nursing care.

3. Participates in quality improvement. Activities may include:

a. Identify aspects of practice important for quality monitoring;

b. Use of indicators to monitor quality, safety, and effectiveness of nursing practice;

c. Collect data to monitor quality and effectiveness of nursing practice;

d. Analyze quality data to identify opportunities for improving nursing practice;

e. Formulate recommendations to improve nursing practice or outcomes;

f. Implement activities to enhance the quality of nursing practice;

g. Develop, implement, and/or evaluate policies, procedures, and guidelines to improve the quality of practice;

h. Participate on and/or lead interprofessional teams to evaluate clinical care or health services;

i. Participate in and/or lead efforts to minimize costs and unnecessary duplication;

j. Identify problems that occur in day-to-day work routines in order to correct process inefficiencies:'

k. Analyze factors related to quality, safety, and effectiveness,

l. Analyze organizational systems for barriers to quality patient outcomes; and

m. Implement processes to remove or weaken barriers within organizational systems.

E. **Standard 9. Communication**: The registered nurse communicates effectively in a variety of formats in all areas of practice and will:

1. Assess communication format preferences of patients, families, and colleagues.
2. Assess her/his own communication skills in encounters with patients, families, and colleagues.
3. Seek continuous improvement of communication and conflict resolution skills.
4. Convey information to patients, families, the interprofessional team, and others in communication formats that promote accuracy.
5. Question the rationale supporting care processes and decisions when they do not appear to be in the best interest of the patient.
6. Disclose observations or concerns related to hazards and error in care or the practice environment to the appropriate level.
7. Maintain communication with other providers to minimize risks associated with transfers and transition in care delivery.
8. Contribute his/her own professional perspective in discussions with the interprofessional team.

F. **Standard 11. Leadership**: The registered nurse demonstrates leadership in the professional practice setting and the profession and will:

1. Oversee the nursing care given by others while retaining accountability for the quality of care given to the patient.
2. Abide by the vision, the associated goals, and the plan to implement and measure progress of an individual patient or progress of an individual patient or progress within the context of the healthcare organization.
3. Demonstrate a commitment to continuous, lifelong learning and education for self and others.
4. Mentor colleagues for the advancement of nursing practice, the profession, and quality health care.
5. Treat colleagues with respect, trust, and dignity.
6. Develop communication and conflict resolution skills.

7. Participate in professional organizations.

8. Communicate effectively with the patient and colleagues.

9. Seek ways to advance nursing autonomy and accountability.

10. Participates in efforts to influence healthcare policy involving patients and the profession.

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

1. Partner with others to effect change and produce positive outcomes through the sharing of knowledge of the patient and/or situation.

2. Communicate with the patient, the family, and healthcare providers regarding patient care and the nurse's role in the provision of that care.

3. Promote conflict management and engagement.

4. Participate in building consensus or resolving conflict in the context of patient care.

5. Apply group process and negotiation techniques with patients and colleagues.

6. Adhere to standards and applicable codes of conduct that govern behavior among peers and colleague to create a work environment that promotes cooperation, respect, and trust.

7. Cooperate in creating a documented plan focused on outcomes and decisions related to care and delivery of services that indicates communication with patients, families, and others.

8. Engage in teamwork and team-building process.

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

1. Provide age-appropriate and developmentally appropriate care in a culturally and ethnically sensitive manner.

2. Engage in self-evaluation of practice on a regular basis, identifying areas of strength as well as areas in which professional growth would be beneficial.

3. Obtain informal feedback regarding her/his own practice from patients, peers, professional colleagues, and others.

4. Participates in peer review as appropriate.

5. Take action to achieve goals identified during the evaluation process.

6. Provide the evidence for practice decisions and actions as part of the informal and formal evaluation processes.

7. Interact with peers and colleagues to enhance her/his own professional nursing practice or role performance.

8. Provide peers with formal or informal constructive feedback regarding their practice or role performance.

I. **Standard 16. Resource Utilization**: The registered nurse utilizes appropriate resources to plan and provide nursing services that are safe, effective, and financially responsible and will:

1. Assess individual patient care needs and resources available to achieve desired outcomes.

2. Identify patient care needs, potential for harm, complexity of the task, and desired outcome when considering resource allocation.

3. Delegate elements of care to appropriate healthcare workers in accordance with any applicable legal or policy parameters or principles.

4. Identify the evidence when evaluating resources.

5. Advocate for resources, including technology, that enhance nursing practice.

6. Modify practice when necessary to promote positive interaction between healthcare consumers, care providers, and technology.

7. Assist the patient and family in identifying and securing appropriate services to address needs across the healthcare continuum.

8. Assist the patient and family in factoring costs, risks, and benefits in decisions about treatment and care.

J. **Standard 17. Environmental Health**: The registered nurse practices in an environmentally safe and healthy manner and will:

1. Attain knowledge of environmental health concepts, such as implementation of environmental health strategies.

2. Promote a practice environment that reduces environmental health risks for workers and patients.

3. Assess the practice environment for factors such as sound, odor, noise, and light that threaten health.

4. Advocate for the judicious and appropriate use of products in health care.

5. Communicate environmental health risks and exposure reduction strategies to patients, families, colleagues, and communities.

6. Utilize scientific evidence to determine if a product or treatment is an environmental threat.

7. Participate in strategies to promote healthy communities.

REFERENCE:

- ~~"Nursing: Scope and Standards of Practice", American Nurses Association, 2015, 3rd Edition. Silver Spring, MD.~~
- American Nurses Association. (2021). Nursing: Scope and standards of practice (4th ed.). American Nurses Association. https://www.nursingworld.org

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SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	06/03/2026
BOARD OF DIRECTORS APPROVAL	
	06/23/2026
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
June 23, 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**
• Admission Guidelines for the Ambulatory Surgery Department	1-2	
• Admission/Treatment Criteria for PDC Clients Receiving Services at Sierra View Medical Center	3-4	
• Air Quality Control	5-7	
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• Complaints and Grievances, Handling of	27-30	
• Deaths Reportable to the Coroner	31-32	
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SUBJECT: **ADMISSION GUIDELINES FOR THE AMBULATORY SURGERY DEPARTMENT**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide guidelines for patient admissions to the Ambulatory Surgery Center.

POLICY:

1. Anesthesia Patient Classification Criteria will be used to identify appropriate patients for the Ambulatory Surgery Setting. (See Anesthesia Patient Classification Policy.)

2. ASA I and ASA II will be done without restriction. ASA III cases can be performed with appropriate consultation between the physician/surgeon and the anesthesiologist. ASA IV and ASA V will not be done at the Ambulatory Surgery Center.

   Definitions:
   a) ASA I A normally healthy patient for elective operation.
   b) ASA II A patient with mild systemic disease. (Examples: chronic bronchitis, moderate obesity, diet-controlled diabetes mellitus, old myocardial infarction, and mild hypertension.
   c) ASA III A patient with severe systemic disease that limits activity but is not incapacitating. (Examples: coronary artery disease with angina, insulin-dependent diabetes mellitus, morbid obesity, moderate to severe pulmonary insufficiency).
   d) ASA IV A patient with incapacitating disease that is a constant threat to life. (Examples: organic heart disease with marked cardiac insufficiency, persisting angina, intractable arrhythmia, advanced pulmonary, renal, hepatic, or endocrine insufficiency).
   e) ASA V A patient who is not expected to survive 24 hours with or without an operation. (Example: ruptured abdominal aneurysm with profound shock)

3. Children will be three years of age and above. Anesthesia will review charts of patients under 5 years of age prior to the day of surgery.

4. Preoperative workup requirements will be given by the surgeon/anesthesiologist.

5. The anesthesiologist reserves the right to postpone any elective case that is medically unfit for surgery, including non NPO status.

6. Monitored Anesthesia Care (MAC), Procedural Sedation, and General Anesthesia may be used in the provision of care at the Ambulatory Surgery Center.

7. Minimal and Moderate Sedation may be administered by the Registered Nurse, under the direction and orders of the Surgeon. Guidelines have been established by the Medical Director. A second RN will perform circulating duties.

8.

9. Patients who receive procedural sedation or any type of anesthesia will identify a responsible adult to receive discharge instructions and drive them home after their procedure/surgery. It is recommended that an adult care for them, in the first 24 hours after discharge.

10. Patients with infections or communicable diseases requiring extensive isolation precautions, , history of difficult intubations, and patients with a BMI greater than 50, must have their procedure completed at the hospital in the main operating room with an anesthesia provider.

AFFECTED AREAS/PERSONNEL:

AMBULATORY SURGERY CENTER PERSONNEL AND MEDICAL STAFF

REFERENCES:

American Society of anesthesiologist (2023). *Recovery: what should you expect if you have general anesthesia.* Retrieved from: https://ASAHQ.ORG/MADEforthismoment.

CROSS REFERENCES:

- ANESTHESIA PATIENT CLASSIFICATION
- SCOPE AND COMPLEXITY OF SERVICES AT THE AMBULATORY SURGERY DEPARTMENT

SUBJECT:	SECTION:
ADMISSION/TREATMENT CRITERIA FOR PDC CLIENTS RECEIVING SERVICES AT SIERRA VIEW MEDICAL CENTER	***Ethics, Rights and Responsibilities (RI)*** **Page 1 of 2**

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

PURPOSE:

To define the guidelines to be followed when a Porterville Developmental Center (PDC) client is admitted or treated at Sierra View Medical Center (SVMC).

POLICY:

It will be the responsibility of Nursing to ensure that all communication between PDC and SVMC regarding PDC clients be coordinated through the coordinator of Nursing Services office by the ACNS/NOD on duty at 782-2356 (office) or 782-2222. ***Note***: If residence staff is contacted directly by SVMC, they will notify the ACNS office.

AFFECTED AREAS/ PERSONNEL: *ALL PATIENT CARE AREAS*

PROCEDURE:

1. PDC staff will accompany the client and give all necessary paperwork and report to the admitting staff in the outpatient area.
   a. SVMC will accept our Consent for Surgery, Form 5683, signed by the Medical Director/Designee in the absence of client's parents (under 18) or conservator.
   b. Off hours admissions may be made without Medicare/Medical cards or stickers. These need to be taken to SVMC the next normal working day.
2. PDC staff may leave client after completing admission process and reporting to the outpatient admitting staff, if there are no behavioral issues.
3. PDC staff will stay with client until client goes into surgery or after receiving pre-sedation, if the client exhibits any of the following:
   a. Severe acting out behavior (hitting, biting, screaming, etc.)
   b. Safety is compromised by attempting to roll off gurney, injure self, etc.
4. PDC staff may be required to accompany client during Endoscopy procedures performed under conscious sedation. Operating Room (OR) Coordinator/Manager will make the determination.
5. On occasion, it may be necessary for the Psychiatric Technician to accompany the client into the surgical suite until the patient is anesthetized. The necessity of the Psychiatric Technician accompaniment is determined by the Anesthesiologist/Surgeon and the Circulating Registered Nurse (RN).

SUBJECT:	SECTION:
ADMISSION/TREATMENT CRITERIA FOR PDC CLIENTS RECEIVING SERVICES AT SIERRA VIEW MEDICAL CENTER	***Ethics, Rights and Responsibilities (RI)*** **Page 2 of 2**

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STAFF ASSISTANCE

Staff from SVMC may request assistance from PDC staff when any of the below listed criteria are present. (Prior to calling PDC for assistance, SVMC staff should notify the Shift Manager to ensure criteria for 1:1 are met or to explore alternative solutions).

CRITERIA FOR 1:1 CLIENT SUPERVISION

1. Unable to prevent client from pulling out IVs, surgical tubes, sutures or removing dressings, etc., even though restraints are in place.

2. Restraints are contraindicated due to the surgical site and the behavior of the client endangers his/her own life (refer to #1).

3. Restraints are not feasible, as it only intensified the client's uncooperative behavior, which predisposes the client to harm.

4. Client requests that PDC staff stay with him/her.

COMPROMISE SOLUTION

In the event of a request for 1:1 when the client has no known behavior problems and/or criteria in Section 3 are not met, PDC may send a staff person from the Coordinator of Nursing Services Office to evaluate the client's behavior and meet with SVMC Nursing Manager to reach a workable solution.

SUBJECT: **AIR QUALITY CONTROL**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define parameters of Relative Humidity (RH), Temperature and Airflow patterns within the perioperative environment, related to decreasing risks of fire hazards, microbial growth and particulates and increasing patient safety.

POLICY:

Relative Humidity in a restricted area shall be maintained within a range of 20% to 60%.
RH in a semi-restricted area is related to the function performed in that area:

- clean/sterile storage - maximum 60%
- soiled workroom/decontamination room – no recommendations
- sterilizer equipment access or corridors – no recommendations

RH in an unrestricted area is related to the function performed in that area:

- PACU – 20% to 60 %
- GI/Endoscopy suites/procedure rooms - 20% to 60 %

Temperature should be maintained within the limits recommended for each area (ie, unrestricted, semi-restricted, restricted) which are referenced in ASHE, the accepted professional guidelines for HVAC.

Temperature ranges for restricted areas should be 68˚F to 75˚F (20˚C to 24˚C) but the range may be adjusted for a limited time based on the individual (ie, pediatric, intentional hypothermia) needs of the patient.

Temperature ranges for semi-restricted areas depend on the use of the area.

- clean/sterile storage – 72˚F to 78˚F (22˚C to 26˚C)
- soiled workroom/decontamination room – 72˚F to 78˚F (22˚C to 26˚C)
- sterilizer equipment access or corridors – no recommendations

Temperature ranges for all unrestricted areas should be between 70˚F and 75˚F (21˚C and 24˚C)

Airflow direction should be maintained within the HVAC design parameters, per ANSI/ASHRAE/ASHE Standard 170-2008: Ventilation of Health Care Facilities. Section 7.4.1, and applicable others, such as California Mechanical Code.

- The restricted area should have a positive pressure relationship to the adjacent areas.

- The pressure relationship of the semi-restricted area should be based on the use of the area.
  - clean/sterile storage – positive
  - soiled workroom/decontamination room – negative
  - sterilizer equipment access or corridors – no recommendations

Free standing fans, dehumidifiers or other devices should not be used in restricted or sterile processing areas.

Doors should be kept closed except during entry and exit of patients and personnel. When doors are open, the HVAC system may be unable to maintain environmental controls such as pressurization or outside air exchanges.

AFFECTED AREAS/ PERSONNEL:

MAIN OR, OB OR, ASD, CENTRAL PROCESSING DEPARTMENT (CPD) STAFF, CARDIAC CATH LAB

PROCEDURE:

1. Temperature and humidity will be monitored and recorded in the department log daily. Routinely, Orderlies will perform this task. Call-Back RN will be responsible for making weekend and holiday entries when the department is normally closed. If no cases are done within a full 24 hour period, an entry of "closed" will be made in the log.

2. Variance (Out of Range) results will be documented and reported immediately by entering an electronic Engineering Service Request. The request may be made by any employee. If Temperature reading is below range, the RN and Anesthesia provider will collaborate to maintain normothermia. If Humidity is greater than 5% out of range for 2 hours, the manager/director will be notified.

3. Engineering Department will make necessary adjustments to heating/air conditioning through facility control.

4. A re-check should be made within two hours of the correction, and new results documented in log.

If Humidity is up to 5% out of range for at least 2 hours - Engineering will need to adjust the system mechanically to bring humidity to acceptable limits. If Humidity is 5% below acceptable range or 10% above acceptable range over 8 hours, the following steps will be taken.

1. Perform an assessment in collaboration with OR Director/Manager, Representative from plant operations, and Infection Preventionist to identify infection control and fire risk.
2. Determine how long and how far out of range the humidity is
3. Determine if any visible evidence of contamination of the suite (i.e. condensation on the walls, on the surfaces and/or sterile items) and fire risk.
4. Based on the assessment, the measures to be taken immediately may include: * Rescheduling procedures to area of the surgical suites where the humidity is functioning within accepted parameters * Delaying elective procedures * Limiting surgical procedures to emergency procedures only * Closing the affected OR(s) or * Take no action

QUALITY ASSURANCE:

Daily documentation of temperature and relative humidity results and actions will be monitored by on-going review of the department log, by Charge RN or Manager.

REFERENCES:

- ANSI/ASHRAE/ASHE. Standard 170-2021.Ventilation of Health Care Facilities. Atlanta, GA: ASHRAE; -2021.
- NFPA 99 Health Care Facilities Code. Quincy, MA: National Fire Protection Association; 2021.

Joint Commission Online. CMS Adopts ASHRAE-Defined Range for Relative Humidity in Anesthetizing Locations. 2018. Temperature and Humidity Requirements – Guidance for Storage of Sterile Supplies. April 2021.

SUBJECT: **ANTEPARTUM TESTING**	SECTION: 5 **Page 1 of 6**

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

PURPOSE:

To establish nursing guidelines for antepartum assessment of fetal well-being.

POLICY:

A. Antepartum testing will be initiated on physician order for patients at increased risk for interruption of fetal oxygenation.

B. Scheduled Outpatient Non-stress tests performed in the Maternal Child Health (MCH) Department will have:

1. Minimum testing time of 20 minutes

2. Maximum testing time of 40 minutes. If the test is exceeding 40 minutes, call physician and send to Labor and Delivery for further evaluation.

AFFECTED PERSONNEL/AREA: *MCH STAFF, REGISTERED NURSES (RNs)*

INDICATIONS FOR ANTEPARTUM FETAL SURVEILLANCE:

1. Maternal conditions:

a. Antiphospholipid syndrome

b. Thyroid disorders (poorly controlled)

c. Hemoglobinopathies (sickle cell, sickle cell-hemoglobin, or sickle cell-thalassemia disease)

d. Cyanotic heart disease

e. Systemic lupus erythematosus

f. Chronic renal disease

g. Hypertensive disorders

h. Diabetes

i. In vitro fertilization

j. Substance use

k. Pre pregnancy BMI $\geq$ 35.0

1. Maternal age older than 35 years of age

2. Fetal conditions:
   a. Growth restriction
   b. Multiple gestation
   c. Decreased fetal movement
   d. Fetal anomalies and aneuploidy

3. Placental:
   a. Chronic placental abruption
   b. Vasa previa
   c. Velamentous cord insertion
   d. Single umbilical artery
   e. Isolated oligohydramnios
   f. Polyhydramnios

4. Obstetric-related conditions:
   a. Previous stillbirth
   b. History of other adverse pregnancy outcomes in immediately preceding pregnancy
   c. Cholestasis
   d. Abnormal serum markers
   e. Late term

EQUIPMENT:

- External Fetal Heart Monitor
- IV pump (if – contraction stress test (CST)

PROCEDURE:

1. Obtain patient history.
2. Obtain baseline vital signs.
3. Begin patient/family teaching.
4. Place on external fetal monitor. The supine position should be avoided. Obstruction of blood flow to uterus should be avoided.
5. Assure patient is comfortably positioned (semi-Fowler, lateral recumbent position).
6. Determine baseline fetal heart rate and variability.

NON-STRESS TEST (NST)

1. To perform an NST, the fetal heart rate (FHR) is monitored with an external transducer for at least 20 minutes, but it may be necessary to monitor the tracing for 40 minutes or longer to take into account the variations of the fetal sleep-wake cycle.

2. Tracing is observed for fetal heart rate (FHR) accelerations that peak (but do not necessarily remain) at least 15 beats per minute above the baseline and last 15 seconds from baseline to baseline (15x15).

3. Vibroacoustic stimulation may elicit FHR accelerations that are valid in the prediction of fetal well-being.

    a. To perform vibroacoustic stimulation, the device is positioned on the maternal abdomen and a stimulus is applied for 1-2 seconds.

4. Interpretation:

    a. Reactive non-stress test – there are two or more FHR accelerations detected within a 20 minute period.

    b. Non-reactive non-stress– there is not sufficient FHR accelerations over a 40 minute period.

    c. Notes:
        - The NST of the normal preterm fetus is frequently non-reactive.
        - Accelerations of at least 10 beats per minute above the baseline and at least 10 seconds from baseline to baseline (10x10) are sufficient in predicting fetal well-being in pregnancies less than 32 weeks gestation.
        - Variable decelerations that are non-repetitive and brief (less than 30 seconds) are not associated with fetal compromise or the need for obstetric intervention.

CONTRACTION STRESS TEST (CST)

1. CST evaluates FHR response to uterine contractions through the use of electronic fetal monitor.

2. Obtain baseline by monitoring FHR tracing for 20 minutes. If spontaneous uterine contractions are not present, uterine stimulation is produced through IV oxytocin or nipple stimulation, until three contractions of at least 40 seconds duration occur within a 10-minute time frame.

3. Nipple stimulation: The patient is instructed to massage one nipple by any method most comfortable to her for 5 minutes, then change to the other side for 5 minutes, continuing to alternate sides until uterine activity is elicited. A warm wash cloth can be used with the massage. Provide privacy for the patient.

4. Oxytocin is administered by constant infusion pump on secondary line (Follow Oxytocin Administration including B/P q 30 minutes). An IV line must be started and the oxytocin piggy-backed into the lowest port. **Never** run oxytocin agents as a main line on a pregnant patient. Unless otherwise instructed, use the following procedure:

   a. Initial rate begins at 1 milliunit per minute (mU/min).

   b. Increase the rate by 1mu/min every 30 minutes until three uterine contractions of moderate strength by palpation lasting at least 40 seconds are elicited in ten minutes.

   c. The results of the CST can be categorized as follows:

      - Negative CST (normal): No late or significant variable decelerations
      - Positive CST (abnormal): Late decelerations following 50% or more of contractions (even if the contraction frequency is less than three in 10 minutes)
      - Equivocal or Suspicious CST: Intermittent late or significant variable decelerations
      - Equivocal-Tachysystole CST: FHR decelerations that occur in the presence of contractions more frequent than every 2 minutes or lasting longer than 90 seconds
      - Unsatisfactory CST: Fewer than three contractions in a 10-minute period or quality of tracing inadequate for interpretation

5. Discontinue nipple stimulation or oxytocin infusions if any one of the following occur:

   a. Conclusive test results are achieved

   b. Unsatisfactory data noted

   c. Equivocal CST despite one hour of adequate uterine contractions

d. Contractions are more frequent than four in ten minutes

e. Excessive uterine activity

f. Fetal heart rate decelerations

6. Be prepared to administer terbutaline for tocolysis

CONTRAINDICATIONS:

Any condition(s) in which producing uterine contractions is a significant risk to the mother or fetus such as placenta previa, vasa previa, preterm labor, cervical incompetence multiple gestation or previous classical cesarean section.

DOCUMENTATION:

1. Contact the patient's healthcare provider, if warranted by abnormal findings, to give results of test and to obtain follow-up orders, documenting actions and results.

2. Interpretation of fetal heart rate strip.

3. IV solutions and IV start on the EMAR (Electronic Medication Administration Record).

4. Monitoring of patient until uterine contractions return to baseline.

5. Assessment of patient's verbal understanding and response to test.

6. Physician is to sign off on all NSTs/ CSTs.

REFERENCE:

- American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 8th ed. Elk Grove Village (IL): AAP; Washington, DC: American College of Obstetricians and Gynecologists; 2017

- American College of Obstetricians and Gynecologist. (2021). Practice Bulletin No. 229: Antepartum fetal surveillance. Obstetrics & Gynecol 2021; 137:e116-123

- Lyndon, A., Wisner, K. (2021). *Fetal heart monitoring principles and practices* (6th ed). Dubuque, IA: Kendall Hunt

- Miller, L. A., Miller, D.A., Cypher, R. L. (2022). Mosbys pocket guide to fetal monitoring: a multidisciplinary approach (9th ed.). St. Louis, MO: Elsevier/Mosby.

SUBJECT: **ASEPTIC TECHNIQUE, UTILIZATION OF**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide guidance to perioperative personnel for preparing, maintaining, and monitoring a **sterile field**. The expected outcome is that the patient is free from signs and symptoms of infection.

POLICY:

- Perioperative personnel will implement practices that reduce the incidence of surgical site infections when preparing or working in the OR or **invasive procedure** room and when performing or assisting with operative or other invasive procedures.
- A sterile field will be prepared for patients undergoing surgical and other invasive procedures.
- All perioperative personnel moving within or around a sterile field will do so in a manner that prevents contamination of the sterile field.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR), OB OR, Endoscopy, INTERVENTIONAL RADIOLOGY AND CARDIAC CATH LAB TEAM MEMBERS*

PROCEDURE:

Preparing

- Perioperative personnel entering the OR or invasive procedure room for any reason (eg, stocking supplies, bringing in procedural supplies and equipment) will wear surgical attire and a surgical head covering that covers the scalp and hair (and beard if present).
- Perioperative personnel will perform hand hygiene before entering the OR, invasive procedure room, and areas where sterile supplies have been opened.
- Perioperative personnel will wear clean surgical masks that cover the mouth and nose and are secured in a manner to prevent venting when open sterile supplies are present and when preparing, performing, or assisting with surgery and other invasive procedures.
- Sterile fields will be prepared in the location where they will be used and, once prepared, will not be moved to another room.
- Sterile fields will be prepared as close as possible to the time of use.
- Sterile supplies will be opened for only one patient at a time in the OR or procedure room.
- Perioperative personnel will perform a surgical hand scrub and put on a surgical gown and gloves before setting up sterile supplies.
- Surgical drapes will be used to establish a sterile field.
    - Perioperative team members will place surgical drapes on the patient, furniture, and equipment in the sterile field and will handle them in a manner that prevents contamination.
        - Unsterile equipment will be covered with sterile barrier materials on the top, bottom, and sides before being introduced or positioned over a sterile field.
        - Surgical drapes will be handled as little as possible.
        - Draping materials will be held in a controlled manner that prevents the sterile drape from coming into contact with unsterile surfaces.

- During draping, gloved hands will be shielded by cuffing the drape material over the gloved hands.
- Surgical drapes will be placed in a manner that prevents the front of the surgical gown from contacting an unsterile surface and does not require a scrubbed team member to lean across an unsterile area.
- Surgical drapes will be placed from the surgical site to the peripheral areas.
- The portion of the surgical drape that establishes the sterile field will not be moved after it has been positioned.
- Only the top surface of a sterile, draped table will be considered sterile. Items that fall below the sterile area will be considered contaminated.

o Surgical equipment (eg, tubing, cables) will be secured to the sterile drapes with nonperforating devices.

Maintaining

- Only sterile items will come into contact with the sterile field.
- Scrubbed team members will remain close to the sterile field and touch only sterile areas or sterile items.
- Scrubbed team members will keep their hands and arms above waist level at all times.
- Scrubbed team members' arms will not be folded with the hands in the axillary region.
- Scrubbed team members will avoid changing levels and be seated only when the entire operative or invasive procedure will be performed at that level.
- When changing position with one another, scrubbed team members will turn back to back or face to face while maintaining distance from each other, the sterile field, and unsterile areas.
- Unscrubbed personnel will face the sterile field on approach, not walk between sterile fields or scrubbed persons, remain outside of a vertical unidirectional ultraclean air delivery system air curtain, and not walk between the horizontal unidirectional ultraclean air delivery system air curtain and the sterile field.
- Conversations in the presence of a sterile field will be kept to a minimum.
- The number and movement of individuals involved in an operative or other invasive procedure will be kept to a minimum.
- The sterile field will be covered if it will not be used immediately (eg procedural delay, sterile field for closure, multiple tables).
- Portions of a sterile field that are not being used (eg, implants, instruments not in use) may be covered.
- Whole sterile fields will be covered with a sterile drape that allows the cover to be removed in a manner that will not compromise the sterility of the table.
- Measures to protect the integrity of an entire covered sterile field will be implemented. Potential measures include
  - posting a sign,
  - limiting traffic, or
  - directly observing the sterile field.

  o The sterile field may be covered with a sterile drape designed for this purpose or by the sterile two- "cuffed"-drape method.

- Perioperative personnel will observe for, recognize, and immediately correct breaks in **sterile technique** when preparing, performing, or assisting with operative or other invasive procedures and will implement measures to prevent future occurrences.
- When a break in sterile technique occurs, corrective action will be taken immediately unless the patient is at risk. When the break in sterile technique cannot be corrected immediately, corrective action will be taken as soon as it is safe for the patient.
- If organic material (eg, blood, hair, tissue, bone fragments) or other debris (eg, bone cement, grease, mineral deposits) is found on an instrument or item in a sterile set, the entire set will be considered contaminated and perioperative team members will take immediate corrective actions.
  - Corrective actions, at a minimum, will include removing the entire set and any other items that may have come into contact with the contaminated item from the sterile field and changing the gloves of any team member who may have touched the contaminated item.
  - Additional corrective actions will be implemented based on the specific factors associated with the individual event.
- If an instrument in a sterile set is found assembled or clamped closed or has retained debris/bioburden or moisture (unless it had been subjected to immediate use steam sterilization), the entire set will be considered contaminated and perioperative team members will take immediate corrective actions.
  - Corrective actions, at a minimum, will include removing the entire set and any other items that may have come into contact with the contaminated item from the sterile field and changing the gloves of any team member who may have touched the contaminated item.
  - Additional corrective actions will be implemented based on the specific factors associated with the individual event.

REFERENCES:

- AORN Standards & Recommended Practices & Guidelines. Sterile Technique. April 18, 2024.

SUBJECT: **AUTOCLAVE QUALIFICATION TESTING**	SECTION: **Page 1 of 1**

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

PURPOSE:

To delineate the process for verification of an autoclave for routine use after any major repair, malfunction, positive biological or major interruption of utilities.

POLICY:

Any autoclave taken out of service for a major repair, malfunction, positive biological or major interruption of utilities, will be verified that it is operating within required parameters prior to putting the unit back into routine use.

AFFECTED AREAS/ PERSONNEL:

CPD, SURGERY, ASD/ CPD STAFF,

PROCEDURE:

This qualification testing will be conducted in the health care facility by health care personnel in cooperation with the manufacturer.

1. PRE-VAC: Three cycles will be run with a process challenge device containing a biological indicator, one right after the other, in an otherwise empty chamber. All biological indicators must have negative outcome.

2. GRAVITY: Three cycles will be run with a process challenge device containing a biological indicator, one right after the other, in an otherwise empty chamber. All biological indicators must have negative outcome.

3. Three consecutive Bowie-Dick test cycles will then be run in an empty chamber, one right after the other, and the test sheets examined.

A total of nine cycles will be run and all test cycles must have favorable outcomes before autoclave is placed back into service.

When all cycles are complete and favorable test results are received, the autoclave may be placed back into routine service.

REFERENCE:

- AAMI ST79 2017. Comprehensive guide to steam sterilization and sterility assurance in health care facilities. Retrieved: June 2023. https://www.hmark.com/wp-content/uploads/2020/08/ST79_White_Paper_2020-04-16.pdf

SUBJECT: **BLOOD GLUCOSE MONITORING-NEWBORNS**	SECTION: **Page 1 of 6**

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

PURPOSE:

To set nursing guidelines for identification, screening and monitoring infants at risk for developing hypoglycemia prior to notification of the attending physician.

POLICY:

A. All at risk infants will have blood glucose monitoring done to ensure stable blood glucose levels:

1. LGA: Infant's birth weight ≥ than the 90th percentile at any given age (see attached growth chart)
2. SGA : Infants birth weight < than the 10th percentile at any given age (see attached growth chart)
3. Preterm infants (less than 37 weeks)
4. Post-term infants (greater than 42 weeks)
5. Infants of diabetic mothers
6. Infants requiring resuscitation or with apgar score less than 7 at 5 minutes
7. Stressed infants (sepsis, respiratory distress, cold)
8. Clinical Manifestations
9. Macrosomia: 4,000 grams or greater birth weight

B. **Any baby may be screened at nurse's discretion if symptomatic or other risk factors.**

C. Bedside glucose test (BSGT) will be done:

1. Half hour of age
2. 1 hour of age
3. 2 hours of age
4. 4 hours of age
5. 6 hours of age
6. Blood glucose Monitoring continue until there are two consecutive blood glucoses of 45 or greater prior to two consecutive feedings.

D. Personnel who are competent in blood glucose monitoring will perform the test.

AFFECTED AREAS/ PERSONNEL: *MATERNAL CHILD HEALTH (MCH) DEPARTMENT / REGISTERED NURSES (RN)s & LICENSED VOCATIONAL NURSES (LVN)s*

EQUIPMENT:

- Bedside glucometer
- Test strips
- Lancet
- Alcohol prep
- 2 x 2 gauze
- Bandage-

PROCEDURE:

1. Laboratory policy for glucose monitor quality testing will be followed.
2. Turn on glucometer and prepare for test.
3. Lateral and medial posterior surfaces of the foot only are to be used.
4. Perform heel stick:
    a. Cleanse site with alcohol prep.
    b. Pierce skin with lancet to obtain blood sample.
    c. Wipe away first drop of blood with 2 x 2.
    d. Collect sample directly on test strip.
    e. Follow machine instructions and wait for results.
    f. Apply gauze to site to control bleeding.
5. Results:
    a. For blood sugar 40 mg/dl or greater, no nursing intervention is required.

b. For blood sugar less than 40 mg/dl, provide appropriate feeding (breast feeding or formula):

- Recheck blood sugar in 30 minutes.
- If NPO, notify physician.

c. For blood sugar 30 mg/dl or less:

- Obtain and send serum glucose level to Lab.
- Notify physician.

6. Blood glucose monitoring will be completed:

a. At half hour, 1 hr., 2 hr., 4 hr., and 6 hr. of age or as ordered per physician.

b. If blood glucose levels are then stable and infant is asymptomatic, blood glucose monitoring may be discontinued.

c. For infants or diabetic mothers or infants who are ill, symptomatic or unstable, blood glucose monitoring will be repeated per physician order or performed as necessary.

d. Blood glucose monitoring continued until there are two consecutive blood glucoses of 45or greater prior to two consecutive feedings.

DOCUMENTATION:

Document as indicated on newborn record: :

- Date, time
- BSGT results
- Indications for BSGT
- Actions taken by nurse
- Notification of physician

REFERENCE:

- American Academy of Pediatrics & American College of Obstetrics and Gynecologist . (2017). *Guidelines for perinatal care* (8th Ed.). Elk Grove Village, IL: Authors.

- Olsen, I. E., Groveman, S. A., Lawson, M. L., Clark, R. H., & Zemel, B. S. (2010). New Intrauterine Growth Curves Based on United States Data. Pediatrics, 125(2). doi:10.1542/peds.2009-0913
- Schlaudecker, E. P., Munoz, F. M., Bardají, A., Boghossian, N. S., Khalil, A., Mousa, H., . . . Black, S. (2017). Small for gestational age: Case definition & guidelines for data collection, analysis, and presentation of maternal immunisation safety data. Vaccine, 35(48), 6518-6528. doi:10.1016/j.vaccine.2017.01.040
- Troiano, N. H., Harvey, C.J., & Chez, B.F. (2013). High-risk & critical care obstetrics (3rd ed.). Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins Health.
- Verklan, M. T., & Walden, M. (2015). Core curriculum for neonatal intensive care nursing (5th ed.). St. Louis, MO: Elsevier Saunders.

CROSS REFERENCE:

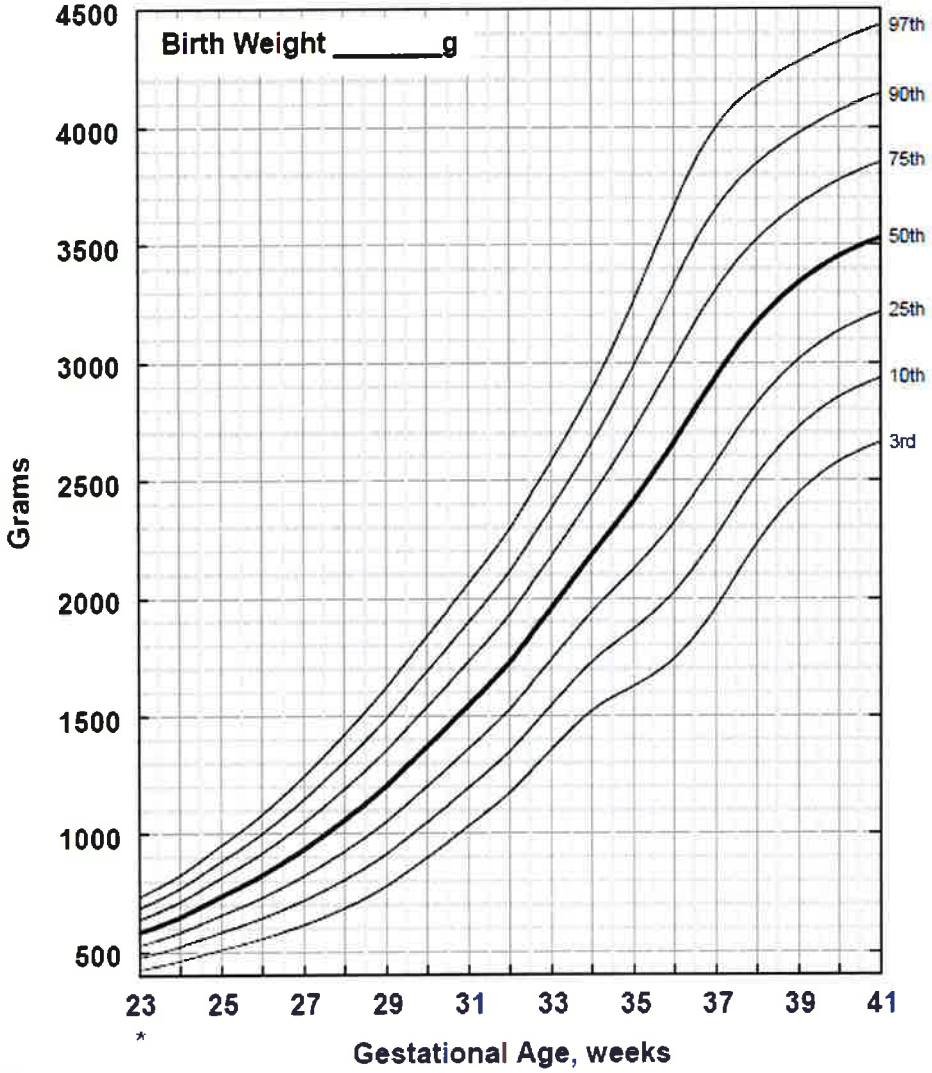
- Waived & Point of Care Testing – Gluclose Meter Testing

Intrauterine Growth Curves

Name _____

Record # _____

FEMALES



Reproduced with permission from: Olsen IE, Groveman S, Lawson ML, Clark R, Zemel B. New intrauterine growth curves based on U.S. data. *Pediatrics*. Volume 125. Pages e214-e244. Copyright 2010 by the American Academy of Pediatrics. Data source: Pediatrix Medical Group

BIRTH SIZE ASSESSMENT

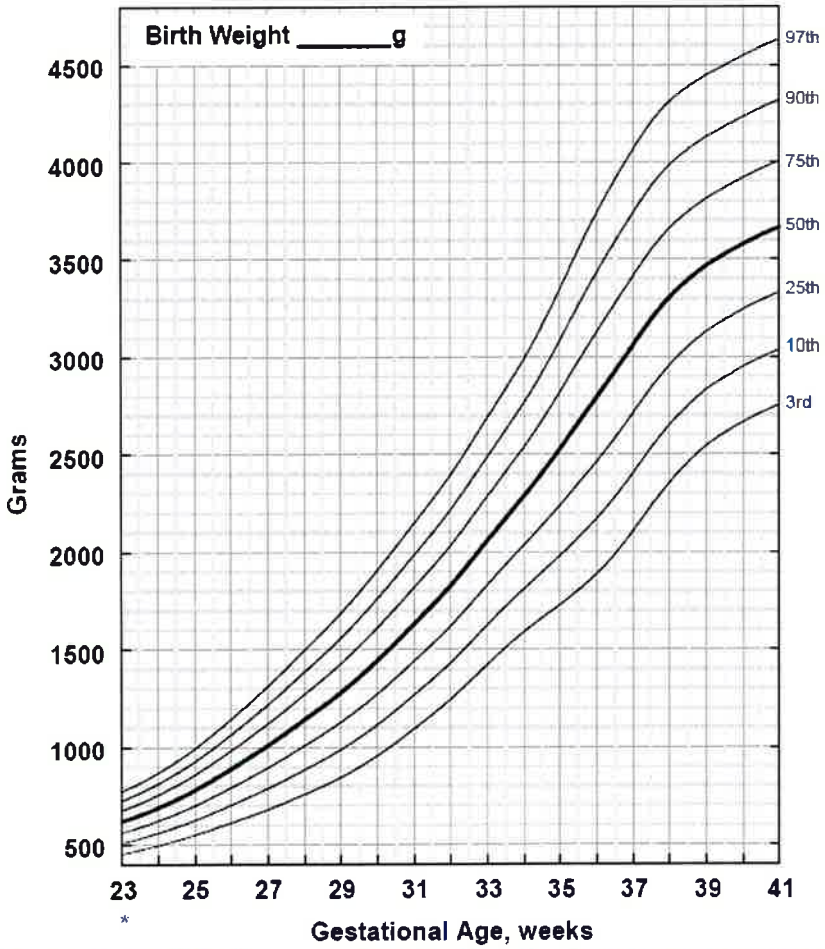
Date of birth: / / (wks GA)	Select one
Large-for-gestational age (LGA) >90th percentile	☐
Appropriate-for-gestational age (AGA) 10-90th percentile	☐
Small-for-gestational age (SGA) <10th percentile	☐

* 3rd and 97th percentiles on all curves for 23 weeks should be interpreted cautiously given the small sample size.

Intrauterine Growth Curves Name _____

Record # _____

MALES



Reproduced with permission from: Olsen IE, Groveman S, Lawson ML, Clark R, Zemel B. New intrauterine growth curves based on U.S. data. *Pediatrics*. Volume 125. Pages e214-e244. Copyright 2010 by the American Academy of Pediatrics. Data source: Pediatrix Medical Group

BIRTH SIZE ASSESSMENT:

Date of birth: / / (wks GA)	Select one
Large-for-gestational age (LGA) >90th percentile	☐
Appropriate-for-gestational age (AGA) 10-90th percentile	☐
Small-for-gestational age (SGA) <10th percentile	☐

* 3rd and 97th percentiles on all curves for 23 weeks should be interpreted cautiously given the small sample size.

SUBJECT: **CAR SEAT SAFETY**	SECTION: **Page 1 of 4**

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

PURPOSE:

To establish guidelines to promote safe transportation of infants at the time of discharge.

POLICY:

1. Maternal Child Health (MCH) staff will ensure that at the time of discharge the legal guardians are aware of Child Passenger Restraint System.

2. MCH staff will provide parents literature on child car seat safety and discussed this information with them.

3. Parent or guardian will sign the internal car seat data collection form

4. Parents will be encouraged to read the car seat and car owner's manual instructions before bringing the car seat in for pre-discharge monitoring or discharge.

5. Hospital staff will not make the final installation and/or placement of child safety seat or the child.

6. Parents who do not have access to infant car seat will be referred to social services.

7. Pre-discharge monitoring will be performed on all high-risk infants while positioned in the car seat. High-risk infants include but are not limited to:

    a. Infants < 37 weeks gestation

    b. Infants less than 5 pounds/2500 grams.

    c. Those with medical conditions placing the infant at high risk for apnea or oxygen desaturation

    d. Infants identified by the provider as pre-discharge monitoring candidates

AFFECTED AREAS/ PERSONNEL: *MCH STAFF, RN'S & LVN'S*

PROCEDURE:

1. Advise legal guardians at the time of admission of the legal necessity for a car seat upon discharge of the infant.

2. Provide literature and discuss car seat safety for infants.

3. Parents/legal guardian will be encouraged to bring care seat when feasible before discharge to determine proper size based on newborn's weight and not wait on the day of discharge.

4. Pre-discharge monitoring – Car Seat Challenge:

a. It is optimal to perform the car seat challenge 1 to 7 days before discharge.

b. The car seat challenge should begin after greater than 1 hour interval from the last feeding. Duration of observation is for a minimum of 90 minutes, or estimated travel time home, whichever is longer.

c. Upon initiating the pre-discharge monitoring, the infant is positioned in the car seat with pulse oximetry monitoring in place with the following alarm settings:

- Apnea (cessation of respirations) for >15 seconds
- Bradycardia- Heart rate <80 bpm
- Oxygen saturation <85%

d. Interpretation guidelines:

- PASS = no apnea, bradycardia, or oxygen desaturation (as defined above) during the observation period.
- FAILURE = any episode of apnea, bradycardia, or desaturation (as defined above) during the observation period.

e. In the event of apnea, bradycardia, and/or oxygen desaturation, clinical stimulation, repositioning, oxygen, and other appropriate interventions should be performed.

f. These events and interventions will be communicated to the pediatrician and documented on the data collection form.

g. After notification of the pediatrician of failed pre-discharge monitoring, repeat testing will be done as ordered or in the same seat in 90 minutes.

h. If needed, repeat testing may be done with infant positioned in a car bed.

i. Documentation of repeat testing is required on pre-discharge monitoring car seat data collection form.

j. Parents should be educated regarding the restrictions of associated activities (i.e., infants cannot be placed in swings etc. where upright sitting positions are required) if the infant requires car bed.

DOCUMENTATION:

1. Document patient/family education and instructions provided on Electronic Medical Record (EMR).

2. Document use of car seat upon discharge.

3. Document education on EMR that car seat instructions and safety were reviewed with parent or guardian.

4. Document pre-discharge monitoring on EMR.

REFERENCES:

- American Academy of Pediatrics. (2021). *Car safety seats: A guide for families*. Pediatrics Patient Education. https://doi.org/10.1542/peo_document208

- American Academy of Pediatrics, & American College of Obstetricians and Gynecologists. (2022). *Guidelines for perinatal care* (9th ed.). American Academy of Pediatrics.

- Centers for Disease Control and Prevention. (2024). *Child passenger safety: Get the facts*. https://www.cdc.gov/transportationsafety/child_passenger_safety/index.html

- National Highway Traffic Safety Administration. (2023). *Car seats and booster seats*. U.S. Department of Transportation. https://www.nhtsa.gov/road-safety/car-seats-and-booster-seats

SUBJECT: **CAR SEAT SAFETY**	SECTION: **Page 4 of 4**

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

PRE-DISCHARGE MONITORING IN CAR SEAT DATA COLLECTION FORM

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

Family educated about car seat challenge? Yes_____ No_____
Is family bringing in their own seat? Yes_____ No_____

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

INSTRUCTIONS PROVIDED: **Nurses Initial**_____

Parents instructed to review car seat **AND** car owner's manual instructions for child safety seat installation. Always secure infants rear facing **IN THE BACK SEAT** (Until child reaches the highest weight or height allowed by their car seat-40 lbs or greater). _____

Never place an infant in front of an air bag _____

Informed of California Law for car seat use for children under 6 yrs. _____

Parent/Guardian Signature _____ Date _____

Nurse Signature _____ Date _____

PASS **FAIL** **Physician Signature** _____

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

SUBJECT: **COMPLAINTS AND GRIEVANCES, HANDLING OF**	SECTION: ***Patients' Rights and Organizational Ethics (RI)*** **Page 1 of 4**

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

PURPOSE:

To establish a process to address, respond, resolve and track patient complaints and grievances.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to implement practices consistent with regulatory standards to manage patient concerns related to the care and services they receive. The hospital ensures that patient and/or patient representative grievances or complaints are communicated in a timely, reasonable and consistent manner to the appropriate departments for investigation, problem resolution and follow-up.

Sierra View Medical Center allows and encourages patients and families to voice concerns and recommend changes freely without being subject to coercion, discrimination, reprisal or unreasonable interruption of care.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL PERSONNEL*

DEFINITIONS:

Complaint- An issue considered resolved by staff present when the patient is satisfied with actions taken on their behalf, or the nature of the complaint does not meet the definition of a grievance.

Post discharge verbal communication regarding patient care that would routinely have been handled by staff present if the communication had occurred during the current stay, are not required to be defined as a grievance.

Grievance- A "**patient grievance**" is a written (email or fax is also considered "written") or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present[i]) by a patient and/or patient's representative, regarding any of the following:

- The patient's care
- Abuse or neglect
- Issues related to the hospital's compliance with the Centers for Medicare & Medicaid Services (CMS) Hospital Conditions of Participation (CoP),
- A Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR §489.
- If complaint is postponed for later resolution.

- Requires investigation, and/or requires further actions for resolution, then the complaint is a grievance.
- Information obtained from patient satisfaction surveys does not usually meet the definition of a grievance. If an identified patient writes or attaches a written complaint on the survey and requests resolution, then the complaint meets the definition of a grievance.
- Whenever the patient and/or patient's representative requests their complaint be handled as a formal complaint or grievance or when the patient requests a response from the hospital, then the complaint is a grievance.

COMPLAINTS:

The patient may contact any of the staff providing care as well as the appropriate director, manager, charge nurse, lead tech, or the House Supervisor. Patient Safety Liaison/designee or Manager of Patient Safety & Risk, if Patient Safety Liaison is unavailable, may be contacted to assist staff, manager or designee in problem solving and resolution.

Complaint Process

The initial person receiving the complaint will enter an electronic patient event report.

The Patient Safety Liaison will notify all appropriate leaders within the electronic event reporting system, and the assigned leaders will document their findings on the event report.

GRIEVANCES:

Patient Information

At the time of admission or presentation for care, each patient will be provided information regarding how to file a grievance. Included in this information will be the process for reporting grievances:

- Internally to the organization
- To the Quality Improvement Organization (QIO) for California
- To the California Department of Public Health
- The grievance process will provide prompt resolution of grievances related to care and services.
- The patient will be assured that exercising this right will not compromise patient care and will not be subject to coercion, discrimination, reprisal or interruption of care.

- The patient will be assured of confidentiality.
- The patient will be informed of whom to contact within Sierra View Medical Center to file a grievance. The patient will also be informed of the right to file the grievance directly with a state agency. A list of state agency advocacy agencies along with phone numbers and addresses will be provided to patients and/or authorized patient representative.
- The patient may also contact the Joint Commission in response to any quality of care concerns they may have.

Grievance Process:

The initial person receiving the grievance will enter an electronic patient event report.

The assigned leaders on the event report will conduct an investigation of the grievance and enter their findings into the online patient event report.

The patient and or patient's representative will receive written communication from the organization within 7 business days of the receipt of the grievance. This written communication shall outline the results of the investigation and actions taken therein.

The written response shall include the name of the hospital, a contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. Written responses will be provided in the patient or patient representative's language of choice.

When a grievance will not be resolved or the investigation is not or will not be completed within the 7 business day timeframe, the patient or patient's representative will be informed within those 7 business days that follow up will be provided in the form of a written response with an estimated time frame based upon the required follow up.

If the patient or patient representative is unsatisfied with the final written response that was sent to them, the grievance will be reviewed again by the grievance committee if new information or concerns are identified.

A grievance is resolved when the patient is satisfied with the actions taken on their behalf. In situations where the organization has taken appropriate and reasonable actions on the patient's behalf in order to resolve the grievance and the patient or the patient's representative remains unsatisfied with the actions taken, the organization will consider the grievance closed.

OVERSIGHT AND REPORTING:

The patient grievance process is approved by the governing board. The governing board is responsible for the effective operation of the grievance process. The governing board by approval of this policy officially has delegated the oversight and responsibility for implementing this grievance process to the Grievance Committee.

Complaints or grievances involving the members of the medical staff are forwarded to the Performance Improvement and Medical Staff department for review, investigation and follow up.

The data collected regarding patient grievances will be reported through the Performance Improvement and Patient Safety Committee.

REFERENCES:

- Centers for Medicare and Medicaid Services. (2019, September 30). Code of Federal Regulations: 482.13 Condition of participation: Patient's rights. Retrieved April 24, 2026, from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-B/section-482.13

- The Joint Commission (2026). Hospital accreditation standards. RI.14.01.01 EP 1-3. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- House Wide Policy Manual: PATIENT RIGHTS AND RESPONSIBILITIES Link

SUBJECT: **DEATHS REPORTABLE TO THE CORONER**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 2**

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

PURPOSE:

To identify all appropriate cases that are reportable to the Coroner's Office in keeping with *California Governmental Code Section 27491.*

POLICY:

It is the duty of anyone having knowledge thereof, to report to the Coroner any death which falls into the classes herein listed:

- No physician in attendance.
- All solitary deaths (unattended by physician or other persons in period proceeding death)
- Medical attendance less than 24-hours at the receiving facility.
- Wherein the deceased has not been attended by a physician *in the twenty (20) days prior to death.*
- Following an accident or injury. (Primarily or contributory, occurring immediately or at some remote time.)
- All deaths in which the patient is comatose throughout the period of physician's attendance, whether at home or hospital.
- Drowning, fire, hanging, gunshot, stabbing, cutting, starvation, exposure, acute alcoholism, drug addiction, strangulation, or aspiration.
- Accidental Poisoning (food, chemical, drug, therapeutic agents).
- Known or suspected Homicide.
- Known or suspected Suicide.
- Involving any criminal action or suspicion of a criminal act.
- All deaths in the operating room.
- All deaths where a patient has not fully recovered from an anesthetic, whether in surgery, recovery room or elsewhere.
- Occupation diseases or occupational hazards.
- Known or suspected contagious disease, constituting a public hazard.
- Related to or following, known or suspected self-induced or criminal abortion.

- Associated with a known or alleged rape or crime against nature.
- Where the suspected cause of death is *Sudden Infant Death Syndrome.*
- All deaths of unidentified persons.
- Physician unable to state the cause of death.
- In prison or while under sentence.
- Deaths of patients in state mental hospitals serving the ***mentally*** disabled and operated by the State Department of Mental Health
- Deaths of patients in State Hospitals serving the ***developmentally*** disabled and operated by the State Department of Developmental Services.

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

PROCEDURE:

When a death occurs and it has been suspected or determined by the above criteria to be a Coroner's Case, it is the responsibility of the Hospital staff to notify the County Coroner's Office:

1. Call Tulare County Sheriff's Coroner and notify them of the death. *(559) 685-2593.*

2. The body will not be released to the mortuary until the hospital staff is instructed to do so by the coroner's investigator or Deputy Sheriff.

Failing to notify the Coroner's Office constitutes a violation of California Government Code Section 27491 *and may be prosecuted as a misdemeanor.*

REFERENCES:

- California Government Code § 27491. (2026). Retrieved March 26, 2026, from https://leginfo.legislature.ca.gov/
- California Department of Public Health. (2024). Death reporting and public health guidelines.
- Centers for Disease Control and Prevention. (2024). Guidelines for death investigation and certification.
- Tulare County Sheriff's Office. (). Coroner division policies and procedures.

SUBJECT: **DIET ORDERS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish the procedure for processing diet orders.

POLICY:

All diet orders, including therapeutic diets, NPO orders, tube feeding orders and parenteral nutrition orders are processed through the electronic medical record (EMR).

AFFECTED AREAS/PERSONNEL: *FOOD AND NUTRITION SERVICE, PATIENT CARE AREAS*

PROCEDURE:

1. Diet orders, late trays, etc. are received via the EMR. If the system is down, Food & Nutrition Services (FNS) will follow the standard operating procedure for EMR downtime.

2. Nutrition education requests are entered as a consult in the EMR.

3. Patients that state they have special diet needs that are stricter than the current diet order will be provided their desired modifications until clarification is obtained from the attending physician.

4. The dietitian can take verbal or telephone orders from physicians for diet, tube feeding, and parenteral nutrition orders. The orders will be placed in the chart according to hospital policy to be signed by the physician.

5. Any special dietary needs known by nursing should be identified in the diet order in the EMR – under modifications, allergies, likes, dislikes, etc.

6. Any between-meal diet changes or needs shall be made in the EMR.

7. All diet orders shall follow the terminology approved in the diet manual.

8. Diet orders for various levels of nutrients (such as calories, protein grams, sodium milligrams, etc.) will include the specific desired level.

9. Diet orders will include the desired texture consistency.

10. Dietitian will be consulted whenever the Food & Nutrition Services (FNS) staff have questions regarding diet orders.

11. When a patient requests an item not allowed on their therapeutic diet, the dietitian can be consulted. When possible, the diet will be modified to accommodate the request. If the request is unable to be accommodated within the prescribed order, the charge nurse or dietitian will consult the physician for possible diet order changes when appropriate.

12. Oral syringe feedings are not a preferred method of PO intake. However, if deemed appropriate by the physician, a written order will be entered into the EMR.

REFERENCES:

- California Code of Regulations (2026). Title 22. § 70273.(a),
  Retrieved from
  https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Centers for Medicare and Medicaid Services, Conditions of Participation (2025). § 70273(a), § 70273(d), § 70273(e).
  Retrieved from https://www.cms.gov/Regulations-and-Guidance.

- The Joint Commission (2026). Hospital accreditation standards. PC.02.01.03.

SUBJECT: **DISCHARGE OF NEWBORN TO SOMEONE OTHER THAN THE BIRTH MOTHER**	SECTION: **Page 1 of 3**

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

PURPOSE:

To set guidelines for the discharge of infants to someone other than the birth mother.

POLICY:

1. A Health Facility Minor Release Form must be signed by the mother to legally discharge an infant to someone other than the birth mother:
   a. Adoption
   b. Child Protective Services (CPS)
   c. Discharge without the mother
2. The form must state:
   a. Name of person infant to be released to including father or relative
   b. Form of identification (social security number and/or driver's license,,state identification –ID and passport)
   c. Date
   d. Witness to signature
3. The CPS will discharge an infant on hold to a CPS representative upon discharge order from the pediatrician.
4. The infant for adoption will be discharged to the adoptive parents or adoption agency upon discharge order from the pediatrician with appropriate/legal document /or court judgement identifying the adoptive parents.
5. No baby will be discharged to any person, other than the mother, without signed consent by the mother.
6. If the mother abandoned the baby without signing a consent, the Social Services will coordinate with CPS who in turn will determine need for foster care to whom the baby can be discharged.

AFFECTED AREAS/ PERSONNEL: *MATERNAL CHILD HEALTH STAFF, REGISTERED NURSES, LICENSED VOCATIONAL NURSES*

PROCEDURE:

SUBJECT: **DISCHARGE OF NEWBORN TO SOMEONE OTHER THAN THE BIRTH MOTHER**	SECTION: **Page 2 of 3**

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

1. Check identification of person picking up the baby. Identification must correspond with the name given on the Health Facility Minor Release Form.
2. The person picking up the baby must bring the mother's hospital identification band if the mother has been discharged already and is unable to pick the infant up herself.
3. Baby may be dressed for discharge in mother's room if she is remaining in the hospital and her condition allows for it.
4. Infant is discharged following routine, well baby, discharge procedure.
5. The baby will be placed in the car seat. A member of the hospital nursing staff will carry the car seat out of the hospital to the car.
6. Print any social services notes on mother's chart and place on the baby's chart with discharge note if applicable.
7. Document to whom infant was discharged.
8. Place a completed copy of the Health Facility Minor Release form in each chart, give one to the birth mother and one to the person receiving the baby.
9. For adoption only; the discharge nurse or social worker is responsible for sending the original of the Health Facility Minor Release Form to the address at the top of the form within 48 hours.
10. Teaching of Care of the newborn must be completed and documented in the infant's chart.

DOCUMENTATION:

Document discharge:

- Person to whom infant was discharged
- Identification verification
- Date and time of discharge
- Use of car seat
- Condition of infant
- Education provided to the person receiving the infant

REFERENCES:

- Comprehensive Accreditation Manual for Hospitals. The Joint Commission. (2018), Oakbrook IL.

- Title XXII §70547(b)(19)(22)
- American Academy of Pediatrics & American College of Obstetrics and Gynecologist . (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors.

SUBJECT:	SECTION:
DISINFECTANTS: THEIR SELECTION AND USE	***Surveillance, Prevention, Control of Infection (IC)***

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

PURPOSE:

To establish infection control standards for selection, review and approval of changes to established Environmental Protection Agency (EPA) and Food and Drug Administration (FDA) approved cleaning products.

POLICY:

Products selected and used at Sierra View Medical Center (SVMC) for cleaning and disinfecting will be EPA- approved and FDA-approved products. These products will be reviewed and approved by the Pharmacy and Therapeutics/Infection Prevention Council annually, or no less than every two years.

AFFECTED PERSONNEL/AREAS: *ALL AREAS*

PROCEDURE:

To make the right selection of a product:

A. Study the manufacturer's recommendations carefully, particularly the restrictions.

B. Consult with the microbiologist for assistance in interpreting company claims and laboratory studies.

C. Be sure which products can be used in specific areas and on particular types of equipment.

D. Be sure that personnel will have the necessary personal protective equipment (PPE), such as gloves, and can be properly instructed in the use of the product.

E. Purchase products in sizes appropriate for storage, usage, and economy.

The three main categories of disinfectants used at SVMC are: phenolic, quaternary ammonium compounds and iodine solution. Each is generally used for certain purposes only.

A. Phenolic

These are highly effective disinfectants and are used on surfaces that do not have direct contact with patients. They act as bactericidal, fungicidal, viricidal, and tuberculocidal. The effectiveness of the phenolic solutions depends on the strength and combination of ingredients in a particular product.

B. Quaternary Ammonium Compounds

These are most commonly used in the food service area because they destroy or inhibit the organisms most commonly found in these areas. They are effective against vegetative bacteria,

enveloped virus, and some fungi. They are less caustic than the phenolic and do not have the pungent odor of the phenolic.

C. Iodine Solutions

Iodine solutions have been used in health care settings primarily as antiseptics on skin/tissue. Idophors have been used both as antiseptics and disinfectants because they act as bactericide and viricide. Besides its use as antiseptic, idophors can be used on equipment that is not highly soiled, such as endoscopes and thermometers.

NOTE: Hospitals must attempt to keep down the number of different products stocked for disinfection uses. Thus, proper selection is extremely important. The products chosen should be effective for the job to be done, and personnel should be fully instructed in proper usage. New products should be given a ***controlled trial period.***

REFERENCES:

- Basak SS, Adak A. Physiocochemical methods for disinfection of contaminated surfaces – a way to control infectious diseases. J Environ Health Sci Eng. 2024:22 (1): 53-64. Published 2024 March 7. Accessed April 23, 2026 from: https://pmc.ncbi.nlm.nih.gov/articles/PMC11180059/#Sec3

- Rutala WA, Weber DJ and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008. CDC Update June 2024. Accessed March 6, 2026 from: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/

- The Joint Commission. (2026) Infection Prevention and Control. IC.04.01.01, EP 3 - Disinfection and Sterilization. Accessed March 9, 2026 from: https://powerdms.com/manuals/publication/100516/general/standard/24714168

SUBJECT: **NEONATAL BLOOD SPECIMEN COLLECTION**	SECTION: **Page 1 of 5**

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

PURPOSE:

To establish guidelines for collection of neonatal blood specimens.

POLICY:

1. Trained Lab/Nursing/Respiratory Therapy Personnel will perform neonatal specimen collection.
2. Personnel will collect the smallest amount of blood required for ordered lab studies.
3. Collectors will follow established laboratory guidelnes for specimen collection.
4. Staff collecting the specimen will follow Standard Precautions used for specimen collection.
5. Staff who will perform Heel stick specimen collection in the mother's room unless the mother/family requested not to draw the specimen in the mother's room.
6. Maternal Child Health staff or lab tech will transport infants if the specimen collection needs to be drawn in the Neonatal Intensive Care Unit.
7. Cotton balls, gauze pads and bandage- will not be applied to upper extremities of infants.

AFFECTED AREAS/ PERSONNEL: *MCH DEPARTMENT/NURSING & LAB TECHS*

EQUIPMENT:

- Syringe with needle or 25 gauge butterfly infusion set
- Chlorhexidine 2%
- Alcohol swabs
- 2 X 2 gauze
- Small tourniquet (rubber band)
- Pediatric blood culture medium
- Sterile needle
- Microtainers
- Capillary tubes if blood gas
-
- Neonatal lancet

- Blood gas kit

PROCEDURE:

Blood Culture/Venipuncture:

1. Apply tourniquet and locate vein to be accessed.
2. Cleanse skin over venipuncture site:
   a. Swab site in circle with alcohol pad.
   b. Apply 2% chlorhexidine gluconate and 70% isopropyl alcohol in widening circle until entire area is saturated.
   c. Allow to dry on the skin for at least 1 minute (timing is critical).
   d. Do not touch the disinfected site.
3. Swab top of culture medium bottle with alcohol. Allow to air dry.
4. Obtain sample with either needle or butterfly and syringe.
   a. Insert slowly into vein.
   b. Apply gentle suction to withdraw blood.
   c. Withdraw needle from vessel.
5. Activate all safety features for transferring the blood into the bottle.
6. Apply gauze 2 x 2 maintaining pressure on the site to stop bleeding.
7. Change needle on syringe.
8. Do not hold culture bottle. Place on flat surface to inject blood sample into culture bottle.
9. Label with name, medical record number, date and time. (Use LIS label if available).
10. Cleanse iodine from infant's skin.
11. Send to Lab with appropriate lab label.

Capillary Blood Gas:

1. Apply heel warmer for 10 minutes prior to specimen collection.
2. Cleanse site -- lateral position of the plantar surface of the foot with 70% alcohol.
3. Dry site with gauze.
4. Puncture skin using a newborn lancet or needle.
5. Collect blood in capillary tube making sure that are no air bubbles are present.
6. Obtain a continuous flow to avoid clotting.
7. Cap ends and place in a cup of ice.
8. Give specimen to laboratory personnel.
9. Apply gauze and pressure until bleeding stops.

Heel Stick Blood Sampling:

1. Select a site on the lateral position of the plantar surface of the foot.
2. May use heel warmer prior to specimen collection.
3. Cleanse the site with 70% alcohol.
4. Dry site with gauze.
5. Puncture skin using a newborn lancet.
    a. Do not puncture greater than 2.4 mm deep.
    b. Do not puncture the posterior curvature of the heel.
    c. Do not puncture the previous puncture site.
6. The first drop of blood should be wiped away as it may contain tissue fluid.
7. Hold the baby's foot downward to increase blood flow.
8. Gently pump the extremity above the puncture site to improve blood flow.
9. Provide pain management: Pacifier for nonnutritive sucking or sucrose.

10. Avoid squeezing or milking the site to prevent bruising.

11. When obtaining metabolic screen:

    a. Complete all information on California Department of Public Health (CDPH) screening form.

    b. Allow blood to drip onto circle.

    c. Avoid touching the filter paper to the skin.

    d. Allow paper to dry in a horizontal position at room temperature for at least 3 hours.

12. When obtaining bilirubin levels, ensure that phototherapy light remains off until the specimen is put into the light protection tube.

13. Tubes should be sealed quickly to avoid exposure to atmospheric oxygen.

14. After specimen collection, hold gauze over site until bleeding stops.

15. Label specimen with name, medical record number, date and time.

16. Send to lab with appropriate lab label.

Arterial Blood Gas:

1. Perform Allen's test to verify collateral circulation to the hand via the ulnar artery.

    a. If collateral circulation is adequate, continue with procedure.

    b. If collateral circulation is not adequate, test the patient's other hand.

    c. If collateral circulation to both hands is inadequate, notify the physician.

2. Gather and prepare blood gas kit.

3. Palpate the pulse.

4. Cleanse site thoroughly with alcohol prep.

5. With the needle bevel up and pulse isolated, enter the patient's skin at 45 degree angle.

6. Once the skin has been punctured, slowly advance the needle in a straight line until the artery is entered (blood will spurt into the needle hub and start to fill the syringe).

7. If artery is missed, slowly withdraw the needle until the tip is just beneath the skin. Adjust needle angle and proceed as before until the sample is obtained.
8. When the sample is obtained, using a quick steady motion, remove the needle from the patient's arm, putting pressure over the puncture site using a gauze pad.
9. Hold pressure over the puncture site for a minimum of five minutes or longer if necessary.
10. Expel any air bubbles from sample.
11. Quickly seal the syringe to maintain anaerobic conditions.
12. Label sample with name, medical record number, date and time.
13. Place the sample in ice and transport to blood gas machine.
14. Once bleeding has been stopped, feel for pulse distal to the puncture site to ensure that the patient's circulation has not been interrupted.

DOCUMENTATION:

- Date and time test drawn, test name and person drawing specimen
- Infant's response to procedure
- Results of Allen's test if arterial specimen is collected
- Site of obtained specimen

REFERENCE:

- PC, IC, §70547 (b)(22)(d)(g)
- Verklan, M. T., & Walden, M. (2015). Core curriculum for neonatal intensive care nursing (5th ed.). St. Louis, MO: Elsevier Saunders.

SUBJECT: **NEONATAL PAIN MANAGEMENT**	SECTION: **Page 1 of 9**

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

PURPOSE:

To define the process of assessment and management of neonatal pain in infants greater than 32 weeks gestation.

POLICY:

1.

2. Appropriate pain management can decrease complications and facilitate healing.

3. Pain scores will be assessed at the following times:

   a. When vital signs are measured with the likelihood that pain is being experienced in all hospitalized newborns

   b. Whenever the infant is distressed/agitated/appears to be in pain

   c. Before and after painful procedures

   d. Within 60 minutes of pain management intervention

4. The RN will assess pain using the N-PASS a Neonatal Pain, Agitation, and Sedation Scale, a negative 10 to 10 point scale. (See attached assessment chart, Appendix A & B.)

5. Physician's order is required for Sucrose (Sweet-Ease®) and pharmacologic pain management.

6. Sucrose Contraindications:

   a. Sucrose Intolerance/ Congenital Sucrase- Isomaltase Deficiency (CSID)

   b. Fructose Intolerance

   c. Glucose- Galactose malabsorption

   d. Muscle Relaxed Neonates and Infants

7. Pharmacologic and non-pharmacologic/behavioral interventions may be used for pain management.

8. Non-pharmacologic/behavioral interventions include but are not limited to (See attached Appendix C):

   a. Position changes, correct positioning for procedures

   b. Non-nutritive sucking (pacifier)

c. Sucrose

d. Swaddling/nesting/holding

e. Decreased environmental stimuli (light, noise, abrupt movements)

f. Decreased handling with rest periods between procedures

g. Soothing vocalization, recorded intrauterine sounds

h. Breastfeeding

i. Kangaroo Care

AFFECTED AREAS/ PERSONNEL: *MCH DEPT./RN'S*

EQUIPMENT:

- Sucrose (Sweet-Ease®) 24% solution
- Pacifier
- 3 ml syringe

PROCEDURE:

1. Anticipation and prevention of pain in the neonate are superior to later attempts to relieve pain. Before undergoing a painful procedure, newborns should receive preemptive medication to prevent the adverse effects and suffering that result from uncontrolled prolonged pain. Routine procedures that cause pain in the neonate include but are not limited to:

   a. Heel stick

   b. Venipuncture

   c. Lumbar puncture

   d. Immunizations/IM injections

   e. Arterial puncture

2. Obtain physician order for Sweet-Ease®

3. Recommended dosing protocol

a. In each 24% Sweet-Ease® - one pacifier dip = 0.2 ml

b. Non-intubated preterm infants 27 – 37 weeks: 0.2 – 0.4 mL orally per procedure (1 – 2 dips)

c. Full term infants greater than 37 weeks gestation: up to 2 mL orally (10 dips) per procedure.

d. For administration using a pacifier

- Dip a pacifier in the Sweet-Ease®
- Give pacifier for the infant to begin sucking 1 – 2 minutes before procedure.
- Allow the infant to continue to suck on the pacifier.

e. For administration using a dropper (for intubated infants)

- Apply 1 or 2 drops on the infant's tongue or buccal surface.

f. Allow continuous sucking on pacifier throughout procedure.

g. Assess infant's response to sucrose administration.

h. Repeat dose as needed during and immediately following procedure if indicated by pain score.

4. The analgesic effect is cumulative when the above dosing protocol is followed.

5. Sucrose administration should be limited to one procedure an hour, not to exceed 8 doses per day.

6. Discard the remainder of the Sweet-Ease® solution after use. Excess solution is provided to accommodate dipping the pacifier.

7. A new unit dose cup must be obtained with each dose administration, unless repeat dosing is administered for the same procedure.

8. Assess pain level within 60 minutes after sucrose administration.

9. If infant is agitated or irritable despite maximum dosage of oral sucrose, additional comfort measures and/or analgesia are to be considered.

10. Notify physician for pharmacologic intervention for moderate to severe pain.

a. Acetaminophen

- Dose 12 – 15 mg/kg/dose orally
- Repeat every 8 hours as needed for infants 32 – 36 weeks
- Repeat every 6 hours as needed for infants greater than 36 weeks

b. Morphine sulfate

- Dose 0.05 – 2 mg/kg/dose slow IV push
- Repeat every 4 hours as needed

c. Naloxone should be readily available to reverse adverse effects:

- Dose 0.1 mg/kg/IVP

DOCUMENTATION:

Document as indicated on newborn record:

- N-PASS pain score prior to and within 60 minutes after sucrose administration
- Sucrose administration time and total dose required
- Infant's response to sucrose administration and any observed adverse effects

REFERENCES:

- American Academy of Pediatrics & American College of Obstetrics and Gynecologist . (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors.
- Beltramini, A., Milojevic, K., & Pateron, D. (2017). Pain Assessment in Newborns, Infants, and Children. Pediatric Annals, 46(10). doi:10.3928/19382359-20170921-03
- Hummel, P., Puchalski, M., Creech, S. D., & Weiss, M. G. (2007). Clinical reliability and validity of the N-PASS: Neonatal pain, agitation and sedation scale with prolonged pain. Journal of Perinatology, 28(1), 55-60. doi:10.1038/sj.jp.7211861
- Kenner, C., & Lott, J. (2016). Neonatal Nursing Care Handbook: An Evidence-Based Approach to Conditions and Procedures (2nd ed.). Oxford: Springer Publishing Co I.
- The Royal Children's Hospital Melbourne. (2015, November). Retrieved June 30, 2018, from http://www.rch.org.au/

- Verklan, M. T., & Walden, M. (2015). Core curriculum for neonatal intensive care nursing (5th ed.). St. Louis, MO: Elsevier Saunders.

- Young, T. E., & Mangum, B. (2010). Neofax 2010. Montvale, NJ: Thomson Reuters

Appendix A:

N-PASS
Neonatal Pain, Agitation, and Sedation Scale

Assessment	Sedation		Sedation/Pain	Pain / Agitation	
Criteria	-2	-1	0/0	1	2
Crying Irritability	No cry with painful stimuli	Moans or cries minimally with painful stimuli	No sedation/ No pain signs	Irritable or crying at intervals Consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	No sedation/ No pain signs	Restless, squirming Awakens frequently	Arching, kicking Constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	No sedation/ No pain signs	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex ↓ muscle tone	No sedation/ No pain signs	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	< 10% variability from baseline with stimuli	No sedation/ No pain signs	↑↑ 10-20% from baseline SaO_2 76-85% with stimulation – quick recovery ↑	↑ ↑ 20% from baseline $SaO_2 \leq 75\%$ with stimulation – slow recovery ↑ Out of sync with vent

+1 if greater than 30 weeks gestation/corrected age.

Appendix B: Guidelines for Pain Management

Crying / Irritability

-2 → No response to painful stimuli
- ¬ No cry with needle sticks
- ¬ No reaction to ETT or nares suctioning
- ¬ No response to care giving

-1 → Moans, sighs, or cries (audible or silent) minimally to painful stimuli, e.g. needle sticks, ETT or nares suctioning, care giving

0 → No sedation signs or No pain/agitation signs

+1 → Infant is irritable/crying at intervals – but can be consoled
- ¬ If intubated – intermittent silent cry

+2 → Any of the following:
- ¬ Cry is high-pitched
- ¬ Infant cries inconsolably
- ¬ If intubated – silent continuous cry

Behavior / State

-2 → Does not arouse or react to any stimuli:
- ¬ Eyes continually shut or open
- ¬ No spontaneous movement

-1 → Little spontaneous movement, arouses briefly and/or minimally to any stimuli:
- ¬ Opens eyes briefly
- ¬ Reacts to suctioning
- ¬ Withdraws to pain

0 → No sedation signs or No pain/agitation signs

+1 → Any of the following:
- ¬ Restless, squirming
- ¬ Awakens frequently/easily with minimal or no stimuli

+2 → Any of the following:
- ¬ Kicking
- ¬ Arching
- ¬ Constantly awake
- ¬ No movement or minimal arousal with stimulation (noe sedated, inappropriate for gestational age or clinical situation)

Facial Expression

-2 → Any of the following:
- ¬ Mouth is lax
- ¬ Drooling
- ¬ No facial expression at rest or with stimuli

-1 → Minimal facial expression with stimuli

0 → No sedation signs or No pain/agitation signs

+1 → Any pain face expression observed intermittently

+2 → Any pain face expression is continual

Extremities / Tone

-2 → Any of the following:
- ¬ No palmar or planter grasp can be elicited
- ¬ Flaccid tone

-1 → Any of the following:
- ¬ Weak palmar or planter grasp can be elicited
- ¬ Decreased tone

0 → No sedation signs or No pain/agitation signs

+1 → Intermittent (<30 seconds duration) observation of toes and/or hands as clenched or fingers splayed
- ¬ Body is *not* tense

+2 → Any of the following:
- ¬ Frequent (≥30 seconds duration) observation of toes and/or hands as clenched, or fingers splayed
- ¬ Body is tense/stiff

Vital Signs: HR, BP, RR, & O_2 Saturations

-2 → Any of the following:
- ¬ No variability in vital signs with stimuli
- ¬ Hypoventilation
- ¬ Apnea
- ¬ Ventilated infant – no spontaneous respiratory effort

-1 → Vital signs show little variability with stimuli – less than 10% from baseline

0 → No sedation signs or No pain/agitation signs

+1 → Any of the following:
- ¬ HR, RR, and/or BP are 10-20% above baseline
- ¬ With care/stimuli infant desaturates minimally to moderately (SaO_2 76-85%) and recovers quickly (within 2 minutes)

+2 → Any of the following:
- ¬ HR, RR, and/or BP are > 20% above baseline
- ¬ With care/stimuli infant desaturates severely (SaO_2 < 75%) and recovers slowly (> 2 minutes)
- ¬ Out of sync/fighting ventilator

Appendix C:

Non-Pharmacological/Behavioral Pain Management Interventions

Non-nutritive sucking – non-nutritive sucking has been reported to have a calming effect. Pacifiers can induce sleep and decrease crying in neonates. It is important a pacifier fit the infant's mouth. If too short and/or bulbous, a pacifier can cause abnormal tongue movement that can interfere with sucking. If too long/big, a pacifier can cause an infant to gag or choke. Under no circumstances will "makeshift" pacifiers be permitted. Pacifiers will not be taped to an infant's mouth or tied around the infant's neck. The use of a pacifier will be discouraged in breastfed infants except during painful procedures. The actual effect of non-nutritive sucking only lasts as long as the newborn continues to suck.

Positioning – sometimes, simply repositioning can facilitate comfort. When infants are well positioned, hand-to-mouth activity, proper flexion, self-soothing and self-regulatory behaviors are encouraged.

Sucrose – sucrose has been used primarily as a technique for management of procedure related pain. It may be used in conjunction with medical management. Administering sucrose and non-nutritive sucking simultaneously appears to have a synergistic effect. Sucrose should be administered at least 2 minutes prior to the painful procedure. Sucrose must be given by mouth directly on the tongue or buccal surface. Sucrose is not effective given via naso-gastric or oral-gastric tubes; it should be absorbed via the oral mucosal membranes. Sucrose dosing is based on weight and should not be given to infants less than 27 weeks corrected gestational age or who weigh less than 1000 grams. Sucrose use requires notification and approval from the physician prior to use.

Swaddling – swaddling helps facilitate an infant need to self-regulate, increases feelings of security, self-control and decreases stress. Infants who are swaddled after a painful procedure calm more quickly than unswaddled infants.

Kangaroo Care- Refers to a neonate lying on the bare skin of their mother or father upright at 40-60 degree angle and covered by parents gown/shirt with additional blankets as required.

SUBJECT: **PATIENT SAFETY EVENT**	SECTION: ***Risk / Patient Safety*** **Page 1 of 6**

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

PURPOSE:

To provide confidential communication and documentation regarding unusual occurrences.

DEFINITIONS:

Unusual Occurrence: Any preventable event that occurred or has the potential to occur that results in an undesirable outcome. (Refer to Serious Clinical Adverse Event policy).

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to document and report unusual occurrences and to channel the report to the specified personnel for necessary follow up. Sierra View Medical Center has adopted a Just Culture model for occurrence reporting that enables the hospital to carry out its responsibility for providing quality care in a safe environment.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL PERSONNEL*

PROCEDURE:

NOTE: Complying with the documentation and reporting requirement of this policy SHOULD NOT DELAY APPROPRIATE RESPONSE PROTOCOLS IN ANY WAY.

Unusual occurrences are to be documented using the Occurrence notification process in the electronic patient safety event module. Documentation and reporting of Occurrence notifications may be done using a paper form when the electronic patient safety event module is unavailable.

1. Disruptive behaviors will also be reported via the occurrence notification process but will be handled as per the House-wide Policy: *Disruptive Behavior, Identification and Management of.*

2. In case of theft, disturbance or solicitation, security should be notified and an officer will investigate and make the report.

3. The SVMC employee or medical staff member involved in, observing, or discovering the unusual event is responsible for initiating the Occurrence notification process.

4. Once the Occurrence notification has been recorded, it shall be forwarded to, at minimum, the immediate supervisor and/or department director for investigation through the Risk/Patient Safety Department. The investigation is to be completed within 7 days, barring unforeseen circumstances that may delay interviewing some staff.

5. More than one Occurrence notification may be submitted per event.

6. Express the factual evidence of the event as witnessed by the reporter.

7. Avoid editorializing or applying personal views.

8. For clarification of the event, reference may be made to additional documents (i.e., assessment documentation, EKG, laboratory values, medication records, and/or Photographs, etc.).

NOTE: Failure to self-report unusual occurrences may be grounds for disciplinary action.

DOCUMENTATION:

NOTE: DO NOT DOCUMENT IN THE MEDICAL RECORD THAT AN "INCIDENT OR OCCURRENCE REPORT WAS COMPLETED" Do record any and all changes in a patient's condition and the actions taken to address those changes.

CONFIDENTIALITY:

1. Occurrence notifications are protected from discovery by Attorney Client Privilege and/or California Evidence Code, Section §1157.

2. Confidentiality privileges may be waived if:

   a. The Occurrence notification is inadvertently disclosed to anyone other than appropriate individuals privileged to information.

   b. The Occurrence notification is copied or duplicated in any manner.

   c. A reference is made in the medical record that an Occurrence or Incident Report/ notification was filed or completed.

3. Access to Occurrence notification information is strictly controlled by the Risk Management Department. Access will be granted on a need to know basis as determined by Risk Management.

4. All involved parties are required to maintain confidentiality and preserve the privacy of those employees, Medical Staff, volunteers or others involved in communicating or investigating any claims made in occurrence notifications to the extent possible.

5. Hospital policy also prohibits persons from retaliating against one another for having filed an occurrence notification or for participating in the complaint and investigation process. (Refer to the House-wide policy*: Disruptive Behavior, Identification & Management of*).

   a. Occurrence notifications shall not be shared with other employees, or openly displayed and discussed.

b. Occurrence notifications will not be placed or recorded in employee files or patient's medical record.

c. Occurrence notification will not be shared with regulatory surveyors, however a high level overview of investigation findings may be appropriately shared.

REPORT OF FINDINGS OF INVESTIGATION AND FOLLOW-UP

1. Risk Management will assist key stakeholders in conducting a thorough investigation to determine the nature and extent of the event.

2. Occurrences having Medical Staff involvement will be forwarded to the Medical Staff Department and will be subject to investigations and remedy as per the Medical Staff Bylaws.

3. Occurrences where equipment was found to be faulty and subject to the Safe Medical Device Act (SMDA) of 1990, will be reported by the Risk Management Department as per the Environment of Care Policy & Procedure Manual, *Medical Equipment Management Plan*.

4. Occurrences that are referred to and deemed by Crisis Management Team as being actual or suspected serious clinical adverse events will be handled as per the house-wide policy, Serious Clinical Adverse Event.

5. **PRESERVATION OF EVIDENCE AND SEQUESTERING OF EQUIPMENT AND SUPPLIES**

A. In the case of an item potentially involved in an adverse occurrence, the user department shall notify their Department Supervision immediately. They shall then notify the Manager of Patient Safety & Risk and the Administrator on call (AOC) in accordance with the Occurrence Procedure and sequester the item.

1. An emergent incident occurring during off hours (evening and nights) weekends and holidays, the user department shall immediately contact the House Supervisor. The House Supervisor will contact the AOC who will decide the action to be taken. Monday through Friday during regular business hours, the user department shall immediately contact the Department Director and the Manager of Patient Safety & Risk.

2. No action to clean, repair, change settings, test, operate or dispose of a sequestered item shall be taken until specifically authorized by the Manager of Patient Safety & Risk and AOC Representative.

3. Equipment, instruments or supplies potentially involved in an adverse occurrence are not to be returned to the manufacturer until authorization is given by the Manager of Patient Safety & Risk.

B. Specific information that shall be recorded on the Occurrence Report Form include:

1. Type of equipment/supplies
2. Manufacturer's name
3. Model
4. Serial number
5. Lot number
6. Sterility control number
7. Hospital property number
8. Maintenance equipment number
9. Alarm status
10. Power supply
11. Location of equipment and supplies
12. Contact Plant Operations for documentation of ongoing maintenance on equipment and system.

If a serious injury occurs, the Senior Quality Leader and the Manager of Patient Safety & Risk shall be notified immediately.

C. Sequestering of the equipment/supplies shall be determined based on the following:

1. If there is a belief that an adverse patient/visitor/employee injury was caused by the equipment/supplies.

2. If the continued use or presence of the equipment/supplies presents an immediate threat to any patient/visitor/employee.

3. If it is decided by the equipment operator, Administration, Manager of Patient Safety & Risk, and the Hospital Attorney that the design, maintenance or operator error contributed to the injury in any way or may result in potential injury.

D. When the decision to sequester an item is made, the equipment/supplies shall be disconnected from the patient and power supply without changing any control settings or turning the equipment off (if possible.) No cleaning or processing of the equipment/supplies shall occur until Risk Management has approved it. All equipment and associated supplies shall be preserved as found. The equipment/supplies shall be tagged and removed from service.

E. Following the sequestering of the equipment/supplies, an in-house investigation shall be initiated. In addition to standard investigation issues, copies of the following additional documents, specific to the equipment/supplies shall be collected and reviewed by the Bio-Med Engineer and Risk Management:

1. Purchase Order Agreement
2. Instruction Manual
3. Training Manual
4. In-service Education Outline and Attendance Log
5. Service Agreement
6. Inspection/Preventive Maintenance/Correction Action
7. Procedures and Records
8. Relevant Hazard/Recall Notices and associated documentation
9. Any documentation from American Health Systems Purchasing Department

F. The Risk Management department shall consult with the local adjuster regarding advisability of an independent investigation.

G. Equipment involved in an accident, causing serious injury, may undergo an outside investigation by an independent third party. An outside firm shall inspect the equipment/supplies as soon as possible after the event. This shall be coordinated by the local adjuster and Bio-Med Engineer.

H. In cases where potential damage from equipment exists, but no injury is known and litigation unlikely, returning equipment to the manufacturer may be appropriate if approved by the Bio-Med Engineer and the Manager of Patient Safety & Risk.

1. Before sending any equipment/supplies to the manufacturer, the Bio-Med Engineer shall document the hospital's own or any associated independent testing, as well as ensure that the equipment/supplies and the suspected problem have been thoroughly analyzed and documented according to manufacturer's specifications.

2. All communications with manufacturers shall be carefully and completely documented, and a written acknowledgement shall be requested from the manufacturer. Correspondence with the manufacturer and shipment of the equipment/supplies shall be sent by certified mail, return requested. Shipping documents should be carefully filed.

REFERENCES:

- The Joint Commission (2026). Hospital Accreditation Standards. Joint Commission Resources. Oak Brook, IL.
- California Evidence Code §1157
- Department of Health and Human Services, FDA: 21 CFR Parts 803 and 804
- Safe Medical Device Act of 1990.

CROSS REFERENCES

- House-Wide Policy & Procedure Manual, Disclosure of Adverse Event
- Environment of Care Policy & Procedure Manual, Medical Equipment Management Plan
- House-wide Policy and Procedure Manual, Serious Clinical Adverse Event

SUBJECT: **PEDIATRIC MEDICATION ADMINISTRATION GUIDELINES**	SECTION: **Page 1 of 4**

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

PURPOSE:

The policy defines the guidelines for medication management for pediatric patients in the Medical Surgical Department.. The guidelines also address how to safely and accurately administer medication to a child, taking into account their weight, surface area, and the ability of the child to absorb, metabolize, and excrete the medication.

POLICY:

Medications shall be administered based on a physician order and the necessity of care the patient requires.

1. Those involved in the medication management process shall determine the following, but not limited to:

    a. Age

    b. Sex

    c. Current medications

    d. Diagnosis and co-morbidities

    e. Relevant laboratory data

    f. Allergies and past sensitivities

    g. Weight and Height as appropriate

    h. Pregnancy and lactation status as appropriate

    i. Any other information required for safe medication management

2. To avoid medication errors, always follow current medication safety steps in preparing and administering medication to a pediatric patient.

    a. RIGHT CHILD. Always check the identification band of the child before administering the medication. Never assume that the child in the bed is the child assigned to that bed. If the identification band is missing, the nurse must identify the child by asking a parent, guardian or the child, and then replace the band immediately.

    b. RIGHT DRUG. Check the label on the medication. If the label is not clear or confusing, do not give the medication. Call the pharmacist and have the drug relabeled. Check the drug's expiration date; do not administer outdated drugs. Check the consistency and color of the drug and be aware of the signs of deterioration.

c. RIGHT DOSE. If in doubt about how much medication is an appropriate dose, check a reference before administering it. Always clarify poorly written orders. Check drug references before mixing any medications to determine the compatibility of the drugs.

d. RIGHT ROUTE. Some drugs are never given by certain routes because the route would hinder the action of the drug.

e. RIGHT TIME. Always make a note of when the medication is to be given.

f. RIGHT EDUCATION. Education must be given to the patient (if age appropriate) and family on the following: the name of the medication being administered, common usages, contraindications, side-effects, toxic effects, and the side effects the child's parents or caregiver should be aware of.

g. RIGHT DOCUMENTATION. Always double check all documentation and save in the EMAR this should include verification process.

3. Pediatric patient weights shall be documented on admission in kilograms (kg).

4. The nurse's manner of approach should indicate that she firmly expects the child to take the medication. This manner convinces the child of the necessity of the procedure. Establishing a positive relationship with the child will allow him to express feelings, concerns, and fantasies regarding medication.

5. Never give a child a choice of whether or not to receive the medicine.

6. Explanation about the medication should appeal to the child's level of understanding (i.e., color, comparison to something familiar).

7. Never lie. Do not tell a child that a shot will not hurt.

8. It is often necessary to mix distasteful medications or crushed pills with a small amount of applesauce or juice.

9. Never threaten a child with an injection if he refuses an oral medication.

10. Medication should not be mixed with large quantities of food or with any food that is taken regularly (e.g., milk).

11. Medication should not be given at mealtime unless specifically prescribed.

12. The nurse must know the following about each medication that he/she is administering: common usages and dosages, contraindications, side-effects, and toxic effects and explain the side effects to the child's parents or caregiver.

13. Assure the child that it is all right to be afraid and that it is okay to cry.

14. Do not talk in front of the child as if the child were not there. Include the child in the conversation when talking to parents.

15. Obtain parental cooperation. Parents may be able to calm a frightened child, persuade the child to take the medication and achieve cooperation for care.

16. As a safe practice, medications shall not be left at the patient's bedside. Medications require a second licensed person to verify the correct dose. The second licensed person will check the dosage calculation, as applicable, and the dose that is prepared properly. Both licensed persons, one of which is an RN, will contest in the EMAR that the calculation and dose given was correct and verified.

AFFECTED PERSONNEL/AREAS: *RNs*

PROCEDURE:

1. Allergies will always be checked before the administration of medications.

2. Identifying the patient:
Always check a child's identification bracelet using BMV (bedside medication verification) process before administering a medication.

3. Buretrols will be used on all pediatric patients under the age of 13 years old when an IV is running.

4. **Nursing will refer to the book "Pediatric Nursing Procedures" written by Bowden and Greenberg for specific administration processes such as oral, rectal, subcutaneous, intramuscular, etc.**

DOCUMENTATION:

1. The nurse/pharmacists that verifies the dosage prior to the administration of the drug shall document in the EMR (electronic medical record) his/her electronic signature in the patient's EMAR (electronic medication administration record).

2. The Administering RN will document in the EMAR the time, route and dosage of the medication.

3. If giving the child immunizations, the lot number and expiration date of the vaccine, along with the most recently updated VIS (Vaccine Information Sheet) will be documented.

REFERENCES:

Hockenberry, M. J., Gibbs, K. D., & Duffy, E. A. (2025). *Wong's essentials of pediatric nursing*. Elsevier Health Sciences.

Alrabadi, N., Shawagfeh, S., Haddad, R., Mukattash, T., Abuhammad, S., Al-Rabadi, D., Farha, R. A., AlRabadi, S., & Al-Faouri, I. (2021). Medication errors: a focus on nursing practice. *Journal of Pharmaceutical Health Services Research*, *12*(1), 78–86. https://doi.org/10.1093/jphsr/rmaa025

Bowden, V. R., & Greenberg, C. S. (2023). Pediatric nursing procedures (4th ed.). Elsevier Health Sciences.

CROSS REFERENCES:

MEDICATION ADMINISTRATION

SUBJECT: **RISK MANAGEMENT PLAN**	SECTION: ***Improving Organizational Performance (PI)*** **Page 1 of 6**

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

PURPOSE:

The Risk Management Plan is designed to support the mission and vision of the organization as it pertains to clinical risk, as well as potential business, operational, and property risks.

GUIDING PRINCIPLES:

The Risk Management Plan is an overarching, conceptual framework that guides the development of a program for risk management and patient safety initiatives and activities. The plan is operationalized through a formal, written risk management and patient safety program.

The organization's Risk Management Plan stimulates the development, review, and revision of the organization's practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of the Plan provide the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Claims management
- Complaint resolution
- Trend analysis of events, near misses, and claims

GOVERNING BODY LEADERSHIP

The success of the organization's Risk Management Program requires top-level commitment and support. The Governing Board authorizes the formal program and adoption of this Plan as documented in Board meeting minutes.

Risk management will provide quarterly reports. to the governing body summarizing activities, achievements, and ongoing risk management issues that have occurred since the prior report. As necessary, the Board will receive interim reports of new risk exposures that require board intervention and action.

PROGRAM GOALS AND OBJECTIVES

The Risk Management Program goals and objectives are to:

- Minimize adverse effects of errors, events, and system breakdowns when they occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.
- Facilitate compliance with regulatory, legal, and accrediting agency requirements.
- Protect human and intangible resources (e.g., reputation).

SCOPE AND FUNCTIONS OF THE PROGRAM

The organization's Risk Management program interfaces with many operational departments and services throughout the organization. Risk Management's role is to influence, persuade and educate leaders within the organization in order to achieve quality care in a safe environment and protect the organization's resources.

Recognizing that the effectiveness of risk management activities is contingent upon collaboration and integration with facility-wide performance improvement activities, Risk Management will work with the various committees structured to enhance the performance of the facility in the communication and resolution of risk-related issues. Risk management will collaborate with any hospital department as needed to help mitigate risk and/or improve patient safety.

5.1 Functional Interfaces

Risk Management will collaborate with any hospital department as needed to help mitigate risk and/or improve patient safety.

5.2 Risk Management Program Functions

Risk Management functional responsibilities include, but are not limited to:

- Promoting the quality of patient care, in collaboration with quality/performance improvement activities.
- Enhancing patient satisfaction.
- Minimizing the frequency and severity of adverse events.
- The timely reporting of events as it pertains to the following:
  - Centers for Medicare and Medicaid Services (CMS) established reportable requirement for certain restraint and seclusion events.
  - Assists in Food and Drug Administration (FDA), Safe Medical Device Act both mandatory and voluntary reporting elements related to device malfunctions and/or biological malfunctions.
- Assisting in the maintenance of a robust event reporting system that is used to report actual events or events with the potential of causing adverse patient outcomes or other injuries to people, property or other assets of the organization. (Refer to house wide policy & procedure, *Patient Safety Event*).

- Managing of patient and family complaints/grievances as required by CMS. (refer to house-wide policy and procedure, Complaints and Grievances, Handling of)
- Maintaining a robust insurance portfolio to safeguard the organization against financial risk arising from claims made.
- Decreasing the likelihood of lawsuits through effective claims management, and investigating and assisting in claim resolution to minimize financial exposure in coordination with the liability insurer and its representatives.
- Enhancing environmental safety for patients, visitors and staff through participation in various improvement committees.
- Utilizing risk management strategies to identify and minimize the frequency and severity of near misses, incidents and claims.
- Monitoring adverse events and injuries to minimize financial loss to include employment-attributed injury and illnesses (worker's comp).
- Evaluating systems that can contribute to patient care, error or injury.
- Educating stakeholders on emerging and known risk exposures and risk reduction initiatives.
- Serving as a resource for staff concerning actual or potential legal matters related to the provision of care.
- Contributing to the achievement of requirements implemented by accrediting organizations.
- Complying with state-specific scope of practice, applicable laws, regulations and standards.
- Monitoring the effectiveness and performance of risk management and patient safety actions. Performance monitoring data may include:
  - Claims and claim trends
  - Ongoing risk assessment information
  - Patient's and/or family's perceptions of how well the organization meets their needs and expectations
  - Quality performance data

- Research data
- Completing insurance and deeming applications.

1. ADMINISTRATIVE AND COMMITTEE STRUCTURE AND MECHANISMS FOR COORDINATION

The Risk Management Program is administered through the Risk Department's leadership, and reports to the Vice President of Quality & Regulatory Affairs. Department leadership interfaces with administration, staff, medical providers, and other professionals and has the authority to cross operational lines in order to meet the goals of the program. The Leader (or alternate as designated by VP) chairs the activities of the Patient Safety Committee and the Threat Assessment Team. The two committee's activities are an integral part of patient safety, quality improvement, and risk mitigation activities.

Risk Leadership is responsible for overseeing day-to-day monitoring of patient safety and risk management activities to include the investigation of and reporting to the insurance carrier actual or potential clinical, operational, or business claims or lawsuits arising out of the organization, according to requirements specified in the insurance policy and/or contracts. Risk Leadership serves as the primary contact between the organization and other external parties on matters relative to risk identification, prevention, and control, as well as risk retention and risk transfer. Risk Leadership or alternative as designated by VP of Quality and Regulatory Affairs oversees the reporting of events to external organizations, per regulations and contracts, and communicates analysis and feedback of reported risk management and patient safety information to the organization for action.

2. ANNUAL PROGRAM EVALUATION

Risk Management/Patient Safety, in concert with members of the Performance Improvement and Patient Safety (PIPS) Committee, analyzes data and trends. During the year, events that have shown a trend of reoccurrence, a high likelihood of harm to patients or staff, or that have created delays in care across two or more departments are reviewed by responsible leadership in collaboration with Risk Management and Patient Safety. The events are reviewed via the Crisis Management Team (CMT) and Root Cause Analysis (RCA) process. CMTs and RCAs are reported quarterly to the PIPS Committee. At the end of each year, a risk assessment is conducted based on CMT, RCA, and Incident Reporting System data using a numeric scoring to assign a degree of likelihood, consequence and response to arrive at a collective risk score and a hierarchy of action. Specific risk reduction goals will focus on elements scored in the upper quartile. The reduction of risk-related exposures is a facility-wide initiative and is owned by everyone. The successful attainment of the identified goals will involve stakeholders who have influence and experience with key components of the issue.

7.1 GOALS FOR 2026-2027

1. Continue occurrence reporting training house wide to ensure quality data
2. Continue Just Culture training to support Culture of Safety in organization.

3. Maintain a current and robust insurance portfolio
4. Remain current on grievance and complaints (logs and correspondence)

3. PROTECTION OF RISK MANAGEMENT INFORMATION

Any and all documents and records that are part of the risk management process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections can include attorney client privilege, patient safety work product, and peer review protections.

REFERENCES:

- California Evidence Code §1157 (January 1, 2018). Retrieved May 6, 2026 from, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=EVID&sectionNum=1157.
- Department of Health and Human Services, FDA: 21 CFR Parts 803 and 806 (April 1, 2021). Retrieved May 6, 2026 from, https://www.ecfr.gov/current/title-21/chapter-I/subchapter-H
- California Health & Safety Code, §1279.1(b): 1279.2, 1279.3, 1279.4, &100171 (January 1, 2008). Retrieved May 6, 2026 from, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1279.1.&lawCode=HSC
- *The Safe Medical Devices Act of 1990 and the Medical Device Amendments of 1992.* (1993). Washington, D.C.: U.S. Dept. of Health and Human Services, Public Health Services / Food and Drug Administration, Center for Devices and Radiological Health.
- Code of Federal Regulations 482.13(e)-(g) (September 30, 2019). Retrieved May 6, 2026 from, https://www.law.cornell.edu/cfr/text/42/482.13.
- The Joint Commission (2026). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES

- Housewide Policy & Procedure Manual, *Serious Clinical Adverse Event*
- Housewide Policy & Procedure, *Complaints and Grievances, Handling of*
- Housewide Policy & Procedure, *Patient Safety Plan*

- *Environment of Care Policy and Procedure Manual, Medical Device Tracking & FDA Reporting Product Recalls*

DATE:_____ **TIME OUT:**_____ **START TIME:**_____ **END TIME:**_____

TIME OUT CONDUCTED
- □ Correct Patient (Verified by 2 ID's)
- □ Consent signed
- □ Correct procedure
- □ Correct side/site
- □ Correct patient position
- □ Equipment available
- □ Medications drawn immediately prior to block procedure

Signature_____

Indication for regional block:
- □ Surgeon order states patient will experience excessive post-surgical pain and refers administration of a peripheral nerve bock to anesthesia
- □ Anesthesia technique for surgery
- □ Risk/benefits explained to patient and accepted
- □ Standard monitors and O_2 applied
- □ OT/PT
- □ Sleep apnea potential, less narcotic requirement
- □ Less narcotic, less nausea, earlier discharge

Regional: RIGHT
- □ Axillary
- □ Wrist/Ankle
- □ Interscalene
- □ Infraclavicular
- □ Supraclavicular
- □ Femoral
- □ Sciatic
- □ Popliteal

LEFT
- □ Saphenous
- □ LFCN
- □ ACB
- □ iPack
- □ FIC
- □ Other

Position:
- □ Supine
- □ Prone
- □ LLD
- □ RLD
- □ Sitting
- □ Other

Prep:
- □ Alcohol
- □ Chloraprep
- □ Betadine
- □ Other_____
- □ Drape

Needle(s) _____g
Insulted Stimuplex
- □ Short-bevel
- □ Insulated
- □ Tuohy
- □ Long-bevel
- □ Pencil-tipped

Technique:
- □ Injection through needle
- □ Transarterial
- □ Doppler
- □ Nerve stimulation _____ma
- □ Catheter Placement (depth at skin _____ cm)
- □ Paresthesia; describe quality of paresthesia_____
- □ Ultrasound was used to identify needle positioning in close proximity to the nerve being blocked

Narrative: Injection was made incrementally with constant monitoring and aspiration every _____ ml's

Blood aspirated:	□ No	□ Yes _____
Intravenous test using epinephrine:	□ Negative	□ Positive _____
Pain on injection noted:	□ No	□ Yes _____
Resistance on injection:	□ Normal	□ High _____
Needle(s) removed intact:	□ Yes	□ No_____
Events:	□ None: Easy and well tolerated	□ Difficult _____

Injectate:
- □ Bupivacaine
- □ Ropivacaine
- □ Lidocaine
- □ Decadron 4 mg
- □ Mepivacaine

Sedation Given	
Midazolam	mg
Fentanyl	mcg/cc
Propofol	mg

Concentration (%)	Epinephrine	Volume (ml) Given	Wasted
	□ 1/_____ 00,000		
	□ 1/_____ 00,000		

□ Block performed under spinal / epidural / general anesthesia.

Provider signature _____ Date _____ Time _____

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
ANESTHESIA BLOCK PROCEDURE
Form # 027397 REV 03/26

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

PATIENT'S LABEL

1. Reason for transfusion
My provider has explained that I may need a transfusion of blood or blood products to treat or prevent a serious condition related to blood loss, anemia, or a bleeding problem.

2. Description of treatment
The recommended treatment may include transfusion of one or more of the following: red blood cells, plasma, platelets, cryoprecipitate, or other blood products and derivatives, as clinically indicated by the physician during this hospitalization or procedure.

3. Benefits
The expected benefits of transfusion include improving blood volume or clotting, treating anemia, reducing the risk of serious complications, and possibly preventing disability or death.

4. Risks
Transfusion has risks, including but not limited to fever or allergic reactions, lung injury, circulatory overload, immune reactions, and very small risks of transmitting infections. Serious complications, including disability or death, are rare but possible.

5. Alternatives
Reasonable alternatives may include medications such as iron or drugs that stimulate blood production, fluids, surgical or procedural techniques to reduce blood loss, and other non-blood options, as appropriate for the patient's condition. These alternatives may not work as well or may not be appropriate in every case.

6. Questions and understanding
The patient or legally authorized representative has had the opportunity to ask questions about transfusion, its risks, benefits, and alternatives. Those questions have been answered to their satisfaction, and addition al questions may be asked at any time.

7. Right to change decision
The patient understands that consent or refusal may be withdrawn or changed at any time by informing the physician or care team. If the decision changes, a new consent or refusal form may be required under hospital policy.

8. Decision about blood / blood products
Please check one box and sign below.

- ☐ I CONSENT to receive the blood and/or blood products described above, as the physician believes are needed for diagnosis and treatment during this hospitalization or procedure.
- ☐ I REFUSE to receive the blood and/or blood products described above. I understand that refusing transfusion may result in worsening of condition, permanent injury, or death, and I accept responsibility for this decision.

Optional product-specific selections

If refusing or limiting transfusion, indicate which products are accepted or refused.

BLOOD PRODUCTS & PROCEDURES - PLEASE INITIAL EACH ROW

Blood Product / Procedure	ACCEPT	REFUSE
Whole Blood	☐	☐
Red Blood Cells	☐	☐
White Blood Cells	☐	☐
Plasma (Packed RBCs)	☐	☐
Platelets	☐	☐
Cryoprecipitate / Fibrinogen Concentrate	☐	☐
Clotting Factors (including Factor VIIa)	☐	☐
Albumin	☐	☐
immunoglobulins (IVIG)	☐	☐
Intraoperative Blood Salvage (Ceell Saver)	☐	☐
Acute Normovolemic Hemodilution (ANH)	☐	☐
Plasamapheresis / Apheresis	☐	☐
Hemin (Heme Arginate)	☐	☐
Hemoglobin-based Oxygen Carriers (if available)	☐	☐
Dialysis	☐	☐
Cardiopulmonary Bypass	☐	☐

9. Signatures

Patient or Legally Authorized Representative

By signing below, the signer confirms that they are the patient or legally authorized to make this decision, that they have read or had read to them this information, and that they understand and choose the option checked above.

Signature: _____ Date: _____ Time: _____

Print Name: _____

If signed by representative, relationship to patient: _____

Witness

Date: _____ Time: _____ Signature: _____

Print Name: _____

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

Date: _____ Time: _____ Signature: _____

Provider Obtaining Consent

The provider confirms that the indications, risks, benefits, and alternatives of blood or blood product transfusion and/or refusal were discussed with the patient or representative, and that the practitioner believes the patient or representative understands this information.

Provider Name: _____

Signature: _____ Date: _____ Time: _____

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

PATIENT'S LABEL

1. **Motivo de la transfusión**
   Mi proveedor me ha explicado que podría necesitar una transfusión de sangre o de productos sanguíneos para tratar o prevenir una afección grave relacionada con la pérdida de sangre, la anemia o un problema de sangrado.

2. **Descripción del tratamiento**
   El tratamiento recomendado puede incluir la transfusión de uno o más de los siguientes componentes: glóbulos rojos, plasma, plaquetas, crioprecipitado u otros productos y derivados sanguíneos, según esté clínicamente indicado por el médico durante esta hospitalización o procedimiento.

3. **Beneficios**
   Los beneficios esperados de la transfusión incluyen mejorar el volumen sanguíneo o la coagulación, tratar la anemia, reducir el riesgo de complicaciones graves y, posiblemente, prevenir la discapacidad o la muerte.

4. **Riesgos**
   La transfusión conlleva riesgos, que incluyen, entre otros, fiebre o reacciones alérgicas, lesión pulmonar, sobrecarga circulatoria, reacciones inmunes y riesgos muy reducidos de transmisión de infecciones. Las complicaciones graves, incluida la discapacidad o la muerte, son poco frecuentes, pero posibles.

5. **Alternativas**
   Las alternativas razonables pueden incluir medicamentos, tales como hierro o fármacos que estimulan la producción de sangre; fluidos; técnicas quirúrgicas o procedimientos para reducir la pérdida de sangre; y otras opciones no sanguíneas, según resulte apropiado para la condición del paciente. Es posible que estas alternativas no resulten tan eficaces o que no sean apropiadas en todos los casos.

6. **Preguntas y entendimiento**
   El paciente o su representante legalmente autorizado ha tenido la oportunidad de formular preguntas sobre la transfusión, sus riesgos, beneficios y alternativas. Dichas preguntas han sido respondidas a su entera satisfacción, y podrán formularse preguntas adicionales en cualquier momento.

7. **Derecho a cambiar de decisión**
   El paciente comprende que el consentimiento o el rechazo pueden ser revocados o modificados en cualqui er momento, informando al médico o al equipo de atención. Si la decisión cambia, es posible que se requi era un nuevo formulario de consentimiento o rechazo, de conformidad con la política del hospital.

8. **Decisión sobre sangre / productos sanguíneos**
   Por favor, marque una casilla y firme a continuación.
   - ☐ CONSIENTO en recibir la sangre y/o los productos sanguíneos descritos anteriormente, según el médico considere necesarios para el diagnóstico y el tratamiento durante esta hospitalización o proced- imiento.
   - ☐ NO DOY mi consentimiento para recibir la sangre y/o los productos sanguíneos descritos anterior- mente. Entiendo que rechazar la transfusión puede resultar en un empeoramiento de mi estado, una lesión permanente o la muerte, y asumo la responsabilidad de esta decisión.

Selecciones opcionales específicas del producto.
Si rechaza o limita la transfusión, indique qué productos acepta o rechaza.

BLOOD PRODUCTS & PROCEDURES - PLEASE INITIAL EACH ROW		
Producto sanguíneo/Procedimiento	Aceptar	Rechazar
Sangre total	☐	☐
Glóbulos rojos	☐	☐
Glóbulos blancos	☐	☐
Plasma (Eritrocitos concentrados)	☐	☐
Plaquetas	☐	☐
Crioprecipitado / Concentrado de fibrinógeno	☐	☐
Factores de coagulación (incluido el Factor VIIa)	☐	☐
Albúmina	☐	☐
Inmunoglobulinas (IVIG)	☐	☐
Recuperación intraoperatoria de sangre (Cell Saver)	☐	☐
Hemodilución normovolémica aguda (HNA)	☐	☐
Plasmaféresis / Aféresis	☐	☐
Hemina (Arginato de hemo)	☐	☐
Transportadores de oxígeno basados en hemoglobina (si están disponibles)	☐	☐
Diálisis	☐	☐
Circulación extracorpórea	☐	☐

9. Firmas

Paciente o representante legalmente autorizado

Al firmar a continuación, el firmante confirma que es el paciente o que está legalmente autorizado para tomar esta decisión, que ha leído esta información —o que esta le ha sido leída—, y que comprende y elige la opción marcada anteriormente.

Firma: _____ Fecha: _____ Hora: _____

Nombre impreso: _____

Si está firmado por un representante, se indica la relación con el pacente: _____

Testigo(a)

Fecha: _____ Hora: _____ Firma: _____

Nombre impreso: _____

Si la firma no corresponde al paciente, indique el nombre y la relación: _____

Date: _____ Time: _____ Signature: _____

Obtención del consentimiento por parte del proveedor

El proveedor confirma que se compartieron con el paciente o su representante las indicaciones, los riesgos, los beneficios y las alternativas de la transfusión de sangre o productos sanguíneos, y/o de su rechazo, y que el profesional considera que el paciente o su representante comprende dicha información.

Nombre del Proveedor: _____

Firma: _____ Fecha: _____ Hora: _____

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 **May 26, 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 (Arrived at 5:12 pm)
- 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, Roger Larsen, Interim Chief Financial Officer, Melissa Crippen, Vice President of Quality and Regulatory Affairs, Brandy Irwin, Chief Nursing Officer, Tracy Canales, Vice President of Human Resources and Marketing, Kim Pryor-DeShazo Director of Marketing and Community Services, Silvia Roberts, Director of Care Integration, Terry Villareal, Clerk to the Board, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

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

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Absent

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

Chairman Lomeli arrived to the meeting at 5:12 p.m.

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

1. General Update;
2. Compliance Quarterly Report

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).

Closed Session items were addressed out of order. Items A, B and E were reviewed, and the remaining items, C,D,F, G and H will be 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 5:32 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

2. Compliance Report
Following review and discussion, Vice Chair REDDY made a motion to approve the Compliance Quarterly Report 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

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

IV. Public Comments
None

V. Consent Agenda
The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). Following review and discussion, it was moved by Director FLORES, seconded by Vice Chair REDDY, 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. Motion made by Director FLORES and seconded by Vice Chair REDDY to approve the April 28 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

B. Motion made by Director FLORES and seconded by Director MARTINEZ to approve the May 8, 2026, Minutes of the Special 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. Baker Tilly Entrance Audit Presentation

Representatives from Baker Tilly, including Brian Conner, Justen Gomes, Erick Lucas, and Bradyn Stowe, provided the Board with an audit entrance presentation outlining the scope of services, audit objectives and planned approach for the annual financial statement audit for the fiscal year ending June 30, 2026.

B. April 2026 Financial Report

Roger Larsen, Interim CFO presented the April monthly financial report.

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

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

C. Resolution 05-26-26/01 Ordering Board of Directors Election; Consolidation of Elections; Specifications of the Election Orde; and Specific Services Rendered to the District

Following review and discussion, it was moved by Director FLORES, seconded by Vice Chair REDDY and carried to approve Resolution 05-26-26/01 as presented. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes

REDDY Yes
LOMELI Yes

D. Resolution 05-26-26/02 Appointing CFO as Treasurer of the Board

The Board considered the appointment of Interim Chief Financial Officer, Roger Larsen to serve as Board Treasurer. Following review and discussion, it was moved by Vice Chair REDDY, seconded by Director MARTINEZ and carried to approve Resolution 05-26-26/02 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

Board Chair, Liberty Lomeli, shared that he recently received care at Sierra View Medical Center and commended the staff for their professionalism, attentiveness, and the high level of service he experiences during his visit.

IX. CEO Report

Our CEO shared some highlights on what's happening around our organization.

- The Spring Edition of Health Insights is out and can be found on our website.
- The first class of the SVMC Nursing Education Pathway, powered by Unitek College has graduated. All nine graduates are SVMC employees, we're happy to hear they will continue to serve our community.
- Christine, our Nurse Residency Program Coordinator, was nominated for the Vizient, Inc/American Association of Colleges of Nursing for Nurse Residency Program Coordinator of the Year at a national conference.
- Employee of the month is Monica, our Education Coordinator who supports staff development across Sierra View.
- Staff celebrated Nurses week with an Olympic theme and celebrated the Power of the Nurse.
- Hospital Week gave us a blast from the past with a theme of "Through the Decades"
- Happy Retirement to CNA Teresa Cortez Ruiz. Thank you to her for providing 20 years of dedication and service.
- We had an onsite career event with great attendance.
- Kyle Savage, Field Representative for Senator Shannon Grove, recently visited to present certificates of recognition to the first graduating class of the SVMC Nursing Education Pathway, powered by Unitek.

- I was invited to speak at the Noon Rotary Club of Porterville. A big thank you to them for the opportunity to connect and share updates with the community. 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.*
- Students from the Health Academy Club and HOSA (Health Occupations Students of America) dropped off 20 pediatric activity kits for young patients at Sierra View Medical Center as part of the Golden Hearts Initiative. The project celebrates California HOSA's 40th anniversary and encourages students to give back through service and healthcare outreach.

X. Announcements:

Regular Board of Directors Meeting – June 23, 2026, at 5:00 p.m.

XI. Closed Session: Board adjourned Open Session at 6:30 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.

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).

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).

XII. Open Session: Chairman LOMELI adjourned Closed Session at 7:52 p.m., reconvening in Open Session at 7:53 p.m.

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

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

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

G. Public Employee Annual Performance Evaluation of Hospital CEO
After review and discussion Director FLORES made a motion to approve the completion of CEO's annual performance evaluation as required by employment contract, motion was seconded by Director MARTINEZ. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

H. Conference With Legal Counsel
Information Only; No Action Taken

XIII. Adjournment

The meeting was adjourned at 7.55 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

SIERRA VIEW
MEDICAL CENTER

Business Items

Sierra View Local Health Care District
Balance Sheet
For the Years Ended June 30,

	Annualized 2026	Budgeted 2027	Projected 2028	Projected 2029
Assets				
Current Assets:				
Cash & Cash Equivalents	19,076,750	23,195,033	25,184,743	26,841,757
Short-Term Investments	-			
Assets Limited As To Use	5,222,203	5,222,203	5,222,203	5,222,203
Patient Accounts Receivable	198,141,473	204,149,919	209,253,667	214,485,009
Less Uncollectables	(13,284,452)	(13,687,290)	(14,029,472)	(14,380,209)
Contractual Allowances	(167,707,111)	(172,792,665)	(177,112,482)	(181,540,294)
Other Receivables	28,924,728	28,924,728	28,924,728	28,924,728
Inventories	4,465,655	4,599,625	4,737,613	4,879,742
Prepaid Expenses and Deposits	2,837,553	2,837,553	2,837,553	2,837,553
Less Receivable - Current	301,020	301,020	301,020	301,020
	-			
Total Current Assets	**77,977,819**	**82,750,126**	**85,319,574**	**87,571,509**
Assets Limited as to use, Less				
Current Requirements	32,993,335	32,993,335	32,993,335	32,993,335
Long-Term Investments	142,709,460	142,709,460	142,709,460	142,709,460
Property, Plant and Equipment, Net	69,665,942	64,402,821	62,848,159	62,713,359
Intangible Right of use Assets	156,945	156,945	156,945	156,945
SBITA Right of use Assets	2,228,866	2,251,155	2,273,666	2,296,403
Lease Receivable - LT	431,186	431,186	431,186	431,186
Other Investments	250,000	250,000	250,000	250,000
Prepaid Loss on Bonds	1,028,001	1,028,001	1,028,001	1,028,001
Total Assets	**327,441,554**	**326,973,028**	**328,010,326**	**330,150,199**
Liabilities and Funds Balances				
Current Liabilities				
Bond Interest Payable	507,354	481,986	433,788	390,409
Current Maturities of Bonds Payable	4,235,000	3,811,500	3,430,350	2,744,280
Current Maturities of Long Term Debt	-	-	-	-
Account Payable and Accrued Expenses	6,089,130	6,271,804	6,459,958	6,653,757
Accrued Payroll and Related Costs	8,649,917	8,909,415	9,176,697	9,451,998
Estimated Third-Party Payor Settlements	4,639,895	4,639,895	4,639,895	4,639,895
Lease Liability - Current	129,125	129,125	129,125	129,125
SBITA Liability - Current	1,759,193	1,776,785	1,794,553	1,812,498
Total Current Liabilities	**26,009,614**	**26,020,510**	**26,064,365**	**25,821,962**
Self-Insurance Reserves	1,979,859	1,979,859	1,979,859	1,979,859
Capital Lease Liab LT	0	0	0	0
Bonds Payable, Less Curr Reqt	29,040,000	25,264,800	22,738,320	21,601,404
Bonds Premium Liability - LT	1,577,856	1,498,963	1,468,984	1,439,604
Lease Liability - LT	46,676	23,338	-	-
SBITA Liability - LT	902,979	857,830	840,673	739,793
Other Non Current Liabilities	-	-	-	-
Deferred Inflow - Leases	676,563	642,735	629,880	617,283
Total Liabilities	**60,233,547**	**56,288,035**	**53,722,082**	**52,199,904**
Unresticted Fund	258,350,395	267,208,007	270,684,993	274,288,244
Profit or (Loss)	8,857,612	3,476,986	3,603,251	3,662,050
Total Liabilities and Fund Balance	**$ 327,441,554**	**$ 326,973,028**	**$ 328,010,326**	**$ 330,150,199**

Sierra View Local Health Care District
Statements of Revenues, Expenses and Changes in Net Position
For the Years Ended June 30,

	Annualized 2026	Budgeted 2027	Projected 2028	Projected 2029
Total Patient Revenue	**175,029,355**	**180,336,949**	**184,845,373**	**189,466,507**
Other Operating Revenue	8,669,203	8,361,563	8,612,410	8,870,782
Total Operating Revenue	**183,698,558**	**188,698,512**	**193,457,783**	**198,337,289**
	-	-	-	-
Salaries	82,553,025	87,293,009	89,911,799	92,609,153
Employee Benefits	17,663,311	18,671,481	19,231,625	19,808,574
Professional Fees	18,562,377	21,296,728	21,935,630	22,593,699
Purchased Services	10,914,874	12,184,139	12,427,822	12,676,378
Supplies & Expenses	28,262,163	29,779,657	30,673,047	31,593,238
Maintenance & Repairs	3,442,618	3,588,963	3,660,742	3,733,957
Utilities	3,368,172	3,526,653	3,632,453	3,741,426
Rent/Lease	474,117	463,753	477,666	491,996
Insurance	1,400,677	1,498,787	1,543,751	1,590,063
Depreciation/Amortization	10,340,021	10,057,538	9,554,661	9,076,928
Other Expense	4,953,592	5,244,877	5,349,775	5,456,770
Total Operating Expense	**181,934,947**	**193,605,585**	**198,398,970**	**203,372,183**
Net Gain/(Loss) From Operations	**1,763,611**	**(4,907,073)**	**(4,941,187)**	**(5,034,893)**
	-	-		
District Taxes	1,661,724	1,682,545	1,699,370	1,716,364
Investment Income	5,271,629	5,499,421	5,554,415	5,609,959
Other Non - Operating Income	697,036	487,015	501,625	516,674
Interest Expense	(1,089,973)	(865,362)	(778,826)	(700,943)
Non-Operating Expense	(453,811)	(419,560)	(432,147)	(445,111)
Total Non-Operating Income	**7,094,001**	**8,384,059**	**8,544,439**	**8,696,943**
	-	-	-	-
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt				
Net Incr/(Decr) in the Fair Value Invstmt	1,007,396	2,000,000	2,000,000	2,000,000
Net Gain/(Loss)	**$ 8,857,612**	**$ 3,476,986**	**$ 3,603,251**	**$ 3,662,050**

Sierra View Local Health Care District
Statement of Cash Flows
For the Years Ended June 30,

	Annualized 2026	Budgeted 2027	Projected 2028	Projected 2029
Cash flows from operating activities:				
Operating Income/(Loss)	1,763,611	(4,907,073)	(4,941,187)	(5,034,893)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		-	-	-
Depreciation/Amortization	10,340,021	10,057,538	9,554,661	9,076,928
Provision for bad debts	(936,345)	402,838	342,182	350,737
Change in assets and liabilities:				
Patient accounts receivable, net	3,182,777	(922,892)	(783,931)	(803,530)
Other receivables	(8,699,010)	-	-	-
Inventories	27,256	(133,970)	(137,989)	(142,128)
Prepaid expenses and deposits	(217,635)	-	-	-
Advance refunding of bonds payable, net	230,776	-	-	-
Accounts payable and accrued expenses	1,691,772	182,674	188,154	193,799
Deferred inflows - leases	(269,464)	(33,828)	(12,855)	(12,598)
Accrued payroll and related costs	2,186,359	259,498	267,282	275,301
Estimated third-party payor settlements	231,182	-	-	-
Self-insurance reserves	(149,230)	-	-	-
Total adjustments	7,618,459	9,811,857	9,417,505	8,938,509
Net cash provided by (used in) operating activities	9,382,070	4,904,784	4,476,318	3,903,616
Cash flows from noncapital financing activities:				
District tax revenues	1,661,724	1,682,545	1,699,370	1,716,364
Noncapital grants and contributions, net of other expenses	(846,748)	(797,907)	(709,347)	(629,380)
Net cash provided by (used in) noncapital financing activities	814,976	884,638	990,023	1,086,984
Cash flows from capital and related financing activities:				
Purchase of capital assets	(8,519,732)	(4,794,417)	(8,000,000)	(8,942,128)
Proceeds from sale of assets	-	-	-	-
Proceeds from debt borrowings	-	-	-	-
Proceeds from lease receivable, net	275,449	-	-	-
Principal payments on debt borrowings	-	-	-	-
Interest payments	(186,171)	(25,368)	(48,199)	(43,379)
Issuance of bonds payable and bond premium liability	-	-	-	-
Net change in notes payable and lease liability	(5,724,322)	(4,350,776)	(2,982,848)	(1,958,038)
Net changes in assets limited as to use	(437,415)	-	-	-
Net cash provided by (used in) capital and related financing activities	(14,592,191)	(9,170,561)	(11,031,046)	(10,943,544)
Cash flows from investing activities:				
Net (purchase) or sale of investments	(4,227,926)	2,000,000	2,000,000	2,000,000
Investment income	5,271,629	5,499,421	5,554,415	5,609,959
Net cash provided by (used in) investing activities	1,043,703	7,499,421	7,554,415	7,609,959
Net increase (decrease) in cash and cash equivalents:	(3,351,442)	4,118,283	1,989,710	1,657,014
Cash and cash equivalents at beginning of month/year	22,428,192	19,076,750	23,195,033	25,184,743
Cash and cash equivalents at end of month	$ 19,076,750	$ 23,195,033	$ 25,184,743	$ 26,841,757

Sierra View Local Health Care District
Capital Budget
FY 2027

Project		Estimated Cost
ED Nurse Call	$	522,783
DPSNF Nurse Call		429,085
Sysmex XN3100 Hematology Analyzer		288,701
IR Room Replacement (Design Only)		1,763,611
External Fetal Heart Monitors		266,496
Remote Box Telemetry Monitors		100,527
Telemetry Vital Sign Cardiac Monitor		38,502
MCCLAB/CCW Upgrade		60,512
Scope Replacement		109,158
Pyxis Machine		33,012
Pharmacy Room IV Construction		91,249
Vapotherms		61,231
Ventilator Replacement		107,762
ICU Central Nurses Station		387,834
Windows Upgrade & DR Plate Upgrade MOB X-RAY RM 1,2,3		142,684
Main Hospital X-Ray Room 1		779,357
Nuclear Medicine Replacement		653,427
Total Capital Projects		4,294,417
Contingency		500,000
Total Capital Budget	$	4,794,417

SIERRA VIEW MEDICAL CENTER

FINANCIALS

FINANCIAL REPORTS FROM THE PREVIOUS MONTH

Please Note:

The May Monthly Financials will be provided as a handout at the Board meeting.

Thank you,
Terry Villareal
Clerk of the Board