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

AGENDA
July 28, 2026

OPEN SESSION (5:00 PM)

The Board of Directors will call the meeting to order at 5:00 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 5:05 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. **The public meeting will reconvene in person at 5:30 P.M.** In person attendance by the public during the open session(s) of this meeting is allowed in accordance with the Ralph M. Brown Act, Government Code Sections 54950 et seq. Per California Government Code § 54953, the public may use the following link for remote participation during open session: https://svmc.zoom.us/j/82113731729

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(c): **Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning**. Estimated date of disclosure December 1, 2026.

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

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

A. Chief of Staff Report:

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

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

B. Quality Division Update

Recommended Action: Approve/Disapprove Quality Division Report as Given

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

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

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

VI. Public Comments

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. This is the time for the public to make a request to move any item on the consent agenda to the regular agenda. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for the Public Comment period. Please state your name and address for the record prior to making your comment. Written comments submitted to the Board prior to the Meeting will 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. June 23, 2026 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove June 23, 2026, Minutes of the Regular Meeting of the Board of Directors

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MONTHLY MEETING AGENDA
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IX. Business Items

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

B. Chandler Asset Management Contract Proposal
Recommended Action: Approve/Disapprove Contract Proposal as Presented

C. Resolution07-28-26/01 Rural Health Transformation Grant Submission
Recommended Action: Approve/Disapprove Resolution

X. SVLHCD Board Chair Report

XI. SVMC CEO Report

XII. Announcements:

- Regular Board of Directors Meeting – August 25, 2026, at 5:00 p.m.

XIII. Adjournment

PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Crippen, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 4:30 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

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

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

HOSPITAL POLICIES AND REPORTS FOR REVIEW
APPROVED BY SENIOR LEADERSHIP TEAM

Senior Leadership Team	7/28/2026
Board of Director's Approval	
Liberty Lomeli, Chairman	7/28/2026

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
July 28, 2026
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	Action
		Approve ↓
Forms:		
• 013979 Transfusion Reaction	1	
Policies:		
• Authorized Driver's Program	2-6	
• Centralized Release of Information	7-14	
• Code of Ethics and Conduct for Elected and Appointed Officials	15-23	
• Hiring RN Students and New Graduates	24-28	
• Investigations and Government Search Warrants, Unannounced	29-33	
• Just Culture	34-38	
• Licenses and Permits-Required Governmental	39	
• Medical Records Security During Evacuation Procedures	40	
• Minimum Necessary	41-43	
• Disruptive Behavior, Identification	44-50	
Reports		
• Human Resources Report – Quarter 2	51-88	
• Marketing Report – Quarter 2	89-117	

SIERRA VIEW MEDICAL CENTER

REPORT OF SUSPECTED TRANSFUSION REACTION

NURSING

Steps: Discontinue transfusion, flush line with saline, monitor vs. notify physician & lab, transport blood product to lab, collect U/A & blood specimen

*Date*_____ *Room #* _____ *BBK#*_____ *Unit ID #*_____

Blood Unit Label matches Patient ID band and Transfusion Issue Card YES NO (Circle)

Product: ❑ **PC** ❑ **FFP** ❑ **PLAT**

Diagnosis _____

Patient History

Previous transfusions ❑ Yes ❑ No Date of previous tranfusions _____

Number of pregnancies ❑ N/A # _____ Number of deliveries

Tranfusion Date	Time Started	Temperature	Discontinued	Temperature	Amount Given

Concurrent administration of other intravenous fluids or drugs? ❑ NO ❑ YES (please specify)

Reactions Noted

❑ Chills	❑ Nausea	❑ Anxiety	❑ Pallor	❑ Erythema	❑ Anuria	❑ Shock	❑ Pain_____ (where)
❑ Fever	❑ Vomiting	❑ Restlessness	❑ Urticaria	❑ Hematuria	❑ Jaundice	❑ Cyanosis	❑ Pulmonary Edema
❑ Sweating	❑ Rigor	❑ Headache	❑ Bronchospasm	❑ Oliguria	❑ Dyspnea	❑ Pruritis	❑ Precordial Distress

Time of Onset _____ Signature _____ RN/LVN

LABORATORY

Unit ID# _____ Exp. date _____ Amount of blood returned to lab _____

POST-TRANSFUSION FINDINGS (LAB)

Are there Identification Errors? YES NO (Circle)

Serum appearance: Pre-transfusion: Hemolysis? YES NO (Circle)

Post-transfusion: Hemolysis? YES NO (Circle)

Urine Check: Post-transfusion: Hemglobin? POS NEG (Circle) Note: If positive spin down specimen and check for RBCs.

Compare pre-transfusion urine HBG if available.

DIRECT COOMBS on post-transfusion blood

AHG _____

TYPE _____

Rh _____

CONCLUSION: IF ALL FINDINGS ARE NEGATIVE, NO ADVERSE REACTION.

NOTE: If all findings are negative at this point, notify floor and submit report to pathologist. CLS Signature:_____

If findings are questionable complete the remainder of workup and notify pathologist and patient physician of findings.

RECHECK OF TYPINGS, ANTIBODY SCREEN, AND CROSSMATCH

	ABO Typing DIRECT ANTI			BACK CELLS		**Rho (D) Typing**		
	A	B	A,B	A	B	ANTI D	Du	**CONCLUSION:**
Pt's pre-transfusion blood								TYPE_____ Rh_____
Pt's post-transfusion blood								TYPE_____ Rh_____
Donor blood								TYPE_____ Rh_____

MAJOR CROSSMATCH							**ANTIBODY SCREEN**						
SALINE				ALBUMIN			SALINE				ALBUMIN		
I.S.	R.T.	37	AHG	I.S.	R.T.	AHG	I.S.	R.T.	37	AHG	I.S.	R.T.	AHG

Donor unit gram stain _____ Culture to follow _____

Medical Director's Signature _____ Date _____

Comment: _____

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

REPORT OF SUSPECTED TRANSFUSION REACTION

Form # 013979 REV. 5/26

PATIENT'S LABEL

SUBJECT: **AUTHORIZED DRIVER'S PROGRAM**	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 employees who drive vehicles for District use and ensure drivers are authorized to drive for District business. The District participates in the California Department of Motor Vehicle (DMV) Employer Pull Notice Program (EPN). (The Risk Management Department monitors the Motor Vehicle Records (MVRs) and maintains an "Authorized Driver List.")

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to ensure that employees' who drive District owned and private vehicles for District use are Authorized Drivers.

AFFECTED PERSONNEL/AREAS:

ALL EMPLOYEES WHOM ARE REQUIRED AS PART OF THEIR JOB TO DRIVE A HOSPITAL VEHICLE OR THEIR OWN VEHICLE FOR DISTRICT BUSINESS.

PROCEDURE:

1. An applicant applying for a position which will require driving on behalf of the District on a regular basis (at least once per week) will be required to be an Authorized Driver. The applicant must complete an Authorization for Release of Driver Record Information (Attachment A). Human Resources will forward the release to the Risk Management Department. This policy applies to employees driving District vehicles and their private vehicles for District use.

2. An employee who has excessive motor vehicle infractions shall not be considered for such program. Excessive is defined as:

    a. More than three moving citations during a three year period, or
    b. More than two moving citations and an at-fault accident during a three year period, or
    c. Any serious infraction such as DUI, reckless driving, participation in a speed contest, etc., or loss of driver's license within the last three years.

3. The Authorized Driver is required to abide by all local, state and federal traffic laws and regulations.

4. The Authorized Driver is responsible for maintaining a current valid CA driver's license and shall notify his/her director and the Risk Management Department in the event his/her license is suspended or revoked or has excessive motor vehicle infractions.

5. The Risk Management Department will evaluate the Authorized Driver's MVR's on an on-going basis through notification of incidents and DMV reports for excessive infractions. Sierra View Medical Center reserves the right to deem employees ineligible if they do not qualify for the Authorized Driver's Program.

6. The Risk Management Department will remove the Authorized Driver from the DMV Employer Pull Notice Program upon a job change to a non-driving position or termination of employment.

7. The Authorized Driver's Program is optional for those employees who drive personal vehicles for District business, but not on a regular basis.

Unsafe Drivers:

1. The Risk Management Department will notify the Authorized Driver's director if the Authorized Driver's MVR reflects excessive infractions. An Authorized Driver deemed to be an unsafe driver due to excessive motor vehicle infractions, when possible, will be placed in a position, which does not require driving on behalf of the District. This may result in the employee's termination in the event that no non-driving positions are available for which the employee is qualified.

2. Excessive motor vehicle infractions include both the use of the Authorized Driver's own personal vehicle as well as the District's vehicles.

3. It shall be the responsibility of the Authorized Driver's director, upon notification that an Authorized Driver is considered to be an unsafe driver, to ensure that the Authorized Driver does not drive on behalf of the District under any circumstances.

4. It shall be the responsibility of the Risk Department to:

- Provide the Authorized Driver with written notice that he/she can no longer drive on behalf of the District.

- Send a copy of the written notice to the Human Resource Department.

Personal Vehicles:

1. Authorized Driver's vehicles used on District business shall be maintained in good working order at all times.

2. An Authorized Driver's personal vehicle insurance shall be primary applicable coverage when using their own vehicle on business in the event that an accident occurs. If the Authorized Driver was not at fault, the District will reimburse its driver for his/her out-of-pocket deductible up to $500.00.

3. The District's automobile insurance shall provide excess coverage for third party liability purposes only. The District maintains no coverage for damage to the Authorized Driver's vehicle, therefore it is:

   a. Required that employees using their own personal vehicles maintain at least state mandatory limits of liability insurance.

4. Failure to comply with this policy and procedure shall revoke participation in the Authorized Driver Program.

Rental Vehicles:

1. Refer to Attachment B

Reporting Motor Vehicle Incidents:

1. Authorized Drivers must report all motor vehicle incidents immediately to their director and the Manager of Patient Safety & Risk.

2. Authorized Drivers must provide a copy of a police report when applicable.

3. To submit a claim, an Authorized Driver must complete a claim form and submit to the Office of Risk Management.

4. Determination of eligibility of claims reimbursement will be made upon completion of the investigation conducted by Risk Management.

Transporting Patients:

1. Under no circumstances shall Authorized Drivers transport patients using either the District's, employee's or patient's vehicle.

REFERENCES:

- DMV Employer Pull Notice Program (2021). Retrieved April 24, 2026, from https://www.dmv.ca.gov/portal/vehicle-industry-services/motor-carrier-services-mcs/employer-pull-notice-epn-program/.

Attachment A

Driver's Agreement:

While an employee of Sierra View Medical Center and a participant in the Employer Pull Notice program, I hereby agree to the following:

- Maintain a current, valid California driver's license
- Maintain at least state required limits of liability insurance/evidence of financial responsibility on my vehicles (such limits may not be adequate and I should consider higher limits for my own protection), and
- Drive safely and abide by all local, state and federal traffic laws and regulations.
- Complete and sign the Authorization For Release of Driver Record Information.
- Report any motor vehicle incidents within 48 hours to my department director and the Director of Quality & Patient Safety, as outlined in the policy and procedure.
- Notify my director and the Director of Quality & Patient Safety in the event my license is suspended or revoked or has excessive motor vehicle infractions.

☐ My signature acknowledges I am in receipt of a copy of the Authorized Driver's Program policy and will abide by the terms and conditions.

_____ _____

Print Name Department

_____ _____

Signature Date

Attachment B

Important Information You Should Know When Renting a Car On a Business Trip

1. Always name Sierra View Medical Center in the rental agreement. Some rental agencies may want the name of the person in whose name the credit card is issued and whose personal auto policy may be brought into play. Just make sure Sierra View is named on the rental agreement so the Sierra View commercial policy can respond.

2. Obtain a Certificate of Insurance from the Risk Management Dept. to carry with you. This provides you with the evidence of Sierra View insurance coverages in effect. Should you have an accident, show this certificate and the car rental agreement to the law enforcement officer.

3. Purchase the LDW (loss damage waiver) protection.

4. The Sierra View insurance policy, your credit card, or LDW protection, will not protect you if you allow someone to drive the auto that is not listed on the rental contract. You are 100% responsible for the vehicle's damage and down time.

5. When traveling to foreign countries, local automobile insurance should be purchased.

6. You may be held responsible if the keys are left in the car, or in some cases, seat belts are not worn at the time of the accident. This could void any rental insurance coverage purchased.

7. Driving under the influence can void rental insurance coverage.

8. Do not assume you have automatic protection as long as you rent with a major credit card. Most companies have removed this coverage.

9. Even if your prime insurance protects you for rental cars, your insurance company can deny your claim if the rental agency makes repairs to the auto before your insurance company inspects the auto.

10. Most credit cards companies or private insurance policies will not extend to rented vans or pickups.

SUBJECT:	CENTRALIZED RELEASE OF INFORMATION	SECTION: *Health Information Management* **Page 1 of 8**

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

PURPOSE:

This policy established the centralized release of information (ROI) process for Sierra View Medical Center (SVMC), including its provider-based clinics. The centralized ROI ensures that all requests for patient health information are processed in a consistent, compliant, and timely manner in accordance with applicable federal and California state laws.

Centralization of the ROI function under the Health Information Management (HIM) Department eliminates fragmented, department-level disclosures, reduces compliance risk, and ensures that every release is authorized, documented, and auditable.

DEFINITIONS:

Authorization: A written, signed document granting permission for the disclosure of specific medical information, meeting the requirements of HIPAA (45 CFR § 164.508) and CMIA (Cal. Civil code § 56.11), including identification of the patient, recipient, purpose, scope, and expiration date. Under CMIA, the authorization must be printed in a minimum of 14-point type or handwritten by the signing individual.

Business Associate (BA): A person or entity that performs services on behalf of a covered entity involving the use or disclosure of PHI, as defined under 45 CFR § 160.103, and bound by a Business Associate Agreement (BAA).

Covered Entity: A healthcare provider that transmits health information electronically in connection with a HIPAA-covered transaction (45 CFR § 160.103). SVMC is a covered entity.

Medical Information (CMIA): Any individually identifiable information in electronic or physical form derived from a provider of health care regarding a patient's medical history, mental or physical condition, or treatment (Cal. Civil Code § 56.05(j)).

Minimum Necessary: The standard requiring that disclosures of PHI be limited to the minimum amount needed to accomplish the intended purpose (45 CFR § 164.502(b)).

Protected Health Information (PHI): Individually identifiable health information created, received, maintained, or transmitted by a covered entity or business associate, as defined under 45 CFR 160.103.

Provider-Based Clinic: A facility that meets the requirements of 42 CFR § 413.65, operates as a department of the hospital, and bills as a hospital outpatient department (HOPD). Provider-based clinics are subject to both hospital-level and clinic-level privacy obligations.

Release of Information (ROI): The process of disclosing patient-specific health information to an authorized requestor, whether the patient, a third party, or legal entity, in accordance with applicable law and a valid authorization or recognized exception.

Sensitive Information: A subset of PHI/medical information requiring heightened protection, including: mental health records, substance use disorder (SUD) records, HIV/AIDS status, reproductive health, genetic information, and records related to minors' self-consented care.

AFFECTED PERSONNEL/AREAS:

- *All employees, contractors, vendors, and workforce members of SVMC*
- *All departments within the acute care hospital*
- *All provider-based clinics, including those designated under 42 CFR § 413.65 (e.g., surgery clinic, OB clinic, medical office building)*
- *The Rural Health Clinic (RHC) operated by SVMC*
- *All third-party vendors or business associates involved in processing ROI requests*
- *All media of protected health information (PHI): paper, electronic, diagnostic imaging, video, audio.*

POLICY:

SVMC designates the Health Information Management (HIM) Department as the single, centralized authority responsible for processing all requests for the release of patient health information across the acute care hospital and all provider-based clinics. No employee, department, or clinic shall independently release, copy, fax, email, or otherwise disclose patient records outside of this centralized process without explicit HIM authorization and a valid legal basis.

All releases of patient information shall: (1) have a document legal basis; (2) include patient verification; (3) satisfy the minimum necessary standard; (4) be logged in the ROI tracking system; and (5) be processed in compliance with both HIPAA and the California Confidentiality of Medical Information Act (CMIA), apply whichever standard is more protective of patient privacy.

VALID AUTHORIZATION REQUIREMENTS:

All ROI requests, unless meeting a recognized exception, require a valid patient authorization meeting both HIPAA and CMIA standards simultaneously.

Per 45 CFR § 164.508 (HIPAA) and Cal. Civil Code § 56.11 (CMIA), a valid authorization must include all of the following:

1. Patient name, date of birth, and medical record number or other unique identifier
2. Name or description of the person(s) or class of persons authorized to disclose the information
3. Name or description of the person(s) or class of persons authorized to receive the information
4. Description of the information to be disclosed – specific in the nature, not a blanket release
5. Purpose of the requested disclosure (or statement that patient does not wish to specify)
6. Expiration date or event
7. Statement of the individual's right to revoke the authorization and how to do so
8. Statement that treatment, payment, enrollment, or eligibility may not be conditioned on signing the authorization (where applicable)
9. Signature of the patient or legal representative (with representative's authority stated)
10. Date signed
11. Copy of the authorization provided to the signer

Per Cal. Civil Code § 56.11:

- Printed in a minimum of 14-point type, OR entirely handwritten by the signing individual
- Authorization language must be clearly separated from any other language on the same page
- Patient's signature serves no purpose other than to execute the authorization
- Must specify the uses and limitations on types of medical information to be disclosed
- Must specify the uses and limitations on use by authorized recipients

SENSITIVE RECORD CATEGORIES – ADDITIONAL REQUIREMENTS

The following record types require heightened protections beyond the standard authorization:

Record Type	Additional Requirement	Legal Authority
LPS/Involuntary Psychiatric Hold Records	Strict California confidentiality; limited to specific authorized parties	Cal W&I Code §§ 5150, 5250, 5328
HIV/AIDS Status	Do not disclose without specific written authorization referencing HIV-related information	Cal. Health & Safety Code §§ 121010
Minors' Self-Consented Care	May not disclose to parents/guardians without minor's consent for records involving self-consented services	Cal. Health & Safety Code §§ 123115, 123110a
Genetic Information	Not to be disclosed without explicit specific authorization	GINA; Cal. Civil Code § 56.17
Reproductive Health/Gender-Affirming Care	Segregated access required per CMIA 2024 amendments; do not disclose without specific authorization	Cal. Civil Code § 56.101 (AB-352/SB-345)

REQUESTOR TYPES AND IDENTIFY VERIFICATION

Patient (or Personal Representative):

- Government-issued photo ID required for in-person requests
- For written requests: signed authorization plus identifying information
- For legal representatives: documentation of authority (power of attorney, guardianship order, executor letter)
- Minors: parent/guardian may request records except where minor independently consented to care
- Right of access responses due within 15 calendar days of receipt (Cal. H&S Code § 123110

Third-Party Requestors (Attorneys, Insurance, Employers):

- Valid HIPAA and CMIA compliant authorization required
- Verify authorization has not expired and has not been revoked
- Apply minimum necessary standard – release only information specified
- Document requestor identify, purpose and record released

Healthcare Providers (Treatment purposes):

- PHI may be disclosed for treatment purposes without patient authorization under HIPAA (45 CFR § 164.502(a)(1)(ii))
- CMIA allows treatment disclosures to providers directly involved in patient care
- For provider-based clinics to acute care (and vice versa): internal treatment sharing within the integrated delivery system does not require patient authorization.
- Document treatment disclosures per policy

Law Enforcement:

- Requires valid court order, warrant, or subpoena, OR falls within narrow law enforcement exceptions (45 CFR § 164.512(f))

Subpoenas and Legal Process:

- Attorney subpoena without court order: requires patient authorization OR a qualified protective order (45 CFR § 164.512(e))
- Court-ordered subpoena: may be released per court order scope

Government Agencies and Oversight Bodies:

- Release to DHCS, CMS, OIG, or other regulatory bodies for oversight purposes allowed under 45 CFR § 164.512(d) and CMIA
- Accreditation surveys (The Joint Commission, DNV): allowed under operations
- Workers' Compensation: California law permits release for WC purposes per Cal. Labor Code § 3762

PERMISSIBLE DISCLOSURES WITHOUT PATIENT AUTHORIZATION

The following disclosures may be made without prior patient authorization, subject to applicable conditions and minimum necessary standards. All such disclosures must be documented.

- Treatment, Payment, and Healthcare Operations (TPO) – 45 CFR § 164.506
- Public health activities – 45 CFR § 164.512(b); reporting of communicable disease to CDPH.
- Mandatory state reporting – child abuse (Cal. Penal Code § 11166), elder abuse (Cal. W&I code § 15630), gunshot wounds (Cal. Penal Code § 11160)
- Coroner/medical examiner – CMIA mandatory disclosure; Cal H&S Code § 102850
- Organ and tissue procurement organizations – 45 CFR § 164.512(h)
- Research with IRB-approved waiver of authorization – 45 CFR § 164.512(i)
- Health oversight activities/regulatory audits – 45 CFR § 164.512(d)
- Court orders and lawfully issued subpoenas – per conditions in 45 CFR § 164.512 (e)
- To avert a serious and reasonably foreseeable threat to health and safety – 45 CFR § 164.512(j)
- Workers' compensation – Cal. Labor Code § 3762; 45 CFR § 164.512(l)
- De-identified information meeting HIPAA standards – 45 CFR § 164.514(b)

PROVIDER-BASED CLINIC – SPECIFIC CONSIDERATIONS

All SVMC provider-based clinics (Surgery, OB, AHC, and RHC) are treated as departments of the hospital for billing and operation purposes under 42 CFR § 413.65. The following provisions apply:

Integrated Medical Record:

- Patient records generated at provider-based clinics are part of the patient's integrated hospital record for privacy and ROI purposes
- A single ROI authorization covers the integrated record unless the patient specifically limits scope
- HIM processes all record requests for both the acute care and provider-based clinic components

Notice of Privacy Practices (NPP):

- A single NPP may cover both the acute care hospital and its provider-based clinics, provided the NPP clearly identifies the covered healthcare components.
- The NPP must be provided at first point of service contract, including first clinic visit
- NPPs must meet CMIA requirements in addition to HIPAA, disclosing California-specific patient rights

Rural Health Clinic (RHC) records:

- RHC records are subject to all the same HIPAA and CMIA protections as hospital records
- RHC billing records (UB-04/CMS-1500 components) may be subpoenaed: follow the same legal processes protocols as hospital records
- RHC clinical staff should be trained so that all external records requests must be directed to HIM

PROCEDURE:

Request Intake:

1. All requests are received by HIM via in-person, secure fax, mail, patient portal, or authorized third-party ROI vendor portal
2. Front desk and clinical departments receiving requests must forward them to HIM same day
3. HIM Staff log all requests in the ROI tracking system within one business day of receipt
4. Date of receipt is documented as the start of the response clock

Authorization Review:

1. Verify the authorization meets all HIPAA (45 CFR § 164.508) and CMIA (Cal. Civil Code §56.11) requirements
2. Verify patient identity against the medical record
3. Check for revocation, expiration, or conflicts
4. Identify any sensitive record categories requiring heightened review
5. If authorization is deficient: contact requestor, document deficiency, and restart the response clock upon receipt of the corrected form

Record Retrieval and Preparation

1. Retrieve requested records from Meditech or other relevant systems
2. Apply minimum necessary standard – do not include records outside the authorized scope
3. Segregate and protect sensitive record categories

Delivery and Documentation:

1. Deliver records via the method specified by requestor (secure fax, encrypted email, mail, or patient portal)
2. Document delivery date, method, and recipient in the ROI log
3. For electronic delivery: use encrypted or password-protected transmission
4. Retain copies of all authorizations, request forms, and delivery confirmations per retention schedule

Response Time Requirements:

Request Type	Time Limit	Authority
Patient request for own records (inspection)	5 business days from written request	Cal. H&S Code § 123110(c)
Patient request for copies	15 calendar days from written request	Cal. H&S Code § 123110(b)
Summary of records	10 business days (or as agreed)	Cal. H&S § 123111
Third-party / attorney / insurance requests	Reasonable time; target within 20 business days	HIPAA/CMIA
Law enforcement / court order (emergency)	As expeditiously as possible	45 CFR § 164.512(f)
Public benefit program (no charge copy)	15 calendar days from written request	Cal. H&S Code § 123110(d)

FEES FOR COPIES OF MEDICAL RECORDS

Fees must comply with Cal. Health & Safety Code § 123110 and HIPAA's reasonable cost-based fee standard (45 CFR § 164.524(c)(4)). The more restrictive California Fee limits govern.

- Paper copies: not to exceed $0.25 per page
- Diagnostic films (X-ray, MRI, CT, PET): actual cost of reproduction only
- Reasonable clerical fee: permitted in addition to per-page charges
- Summary of records: reasonable fee based on actual time and cost of preparation
- No charge for records supporting public benefit program claim or appeal (Cal. H&S Code § 123110(d))
- No charge when requested by patient for continuity of care purposes (verify applicability)
- Fees may not be charged to patients exercising their HIPAA right of access electronically when records are maintained in EHR and can be provided in readily producible format (e.g., patient viewing record electronically and printing applicable elements of documentation)

DENIAL OF ACCESS

SVMC may deny access to records in limited circumstances. All denials must be documented, communicated in writing to the requestor, and reviewed by the HIM Director.

Reviewable Grounds for Denial (Patient May Request Review):

- Licensed healthcare professional determines access is reasonably likely to endanger life or safety of the patient or another person (45 CFR § 164.524(a)(3)(i)
- PHI references another person (non-healthcare provider) and access may cause harm to that person
- Patient is an inmate and access would jeopardize health, safety, or security

Unreviewable Grounds for Denial:

- Psychotherapy notes – no right of access under HIPAA (45 CFR § 164.524(a)(1)(i)); must follow specific authorization path
- Information compiled for civil, criminal, or administrative proceedings

- Records subject to the Clinical Laboratory Improvement Amendments (CLIA) laboratory exception

Denial Process:

1. Provide written denial within 15 calendar days
2. State basis for denial in plain language; do not cite only regulatory code numbers
3. Advise patient of rights to submit written request for review of denial (if reviewable grounds)
4. Designate a licensed healthcare professional not involved in the original decision to conduct review
5. Document denial and outcome in the ROI log

ACCOUNTING OF DISCLOSURES

Patients have the right to receive an accounting of certain disclosures of their PHI made without authorization, for the six years prior to the date of the request (45 CFR § 164.528).

Disclosures that must be tracked and including in an accounting:

- Disclosures for public health activities
- Disclosures for health oversight activities
- Disclosures for judicial and administrative proceedings
- Disclosures for law enforcement purposes
- Disclosures about decedents
- Disclosures for research where authorization was waived
- Disclosures to avert a serious threat to health or safety

Disclosures excluded from accounting: disclosures for TPO, disclosures to the individual, disclosures for facility directory, disclosures pursuant to an authorization.

HIM Maintains an accounting of disclosure log. Patient requests for accounting must be fulfilled within 60 days (extended once by 30 days with written notice).

REFERENCES:

- HIPAA Privacy Rule – 45 CFR Part 164: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164
- HIPAA Right of Access Guidance (HHS): https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html
- 42 CFR Part 2 – SUD Records (eCFR): https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2
- 42 CFR Part 2 Final Rule Fact Sheet (HHS, updated Jan. 2026): https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html
- CMS Conditions of Participation – Medical Records (42 CFR § 482.24): https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.24
- CMS Provider-Based Status Rules (42 CFR § 413.65): https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-E/section-413.65
- California CMIA – Civil Code §§ 56–56.16 (Justia): https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=56.&lawCode=CIV

- California H&S Code § 123110 – Patient Access and Fees (Justia): https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=123110.&lawCode=HSC
- California H&S Code §§ 123100–123149.5 – Patient Records Access Act (Medical Board of CA): https://www.mbc.ca.gov/Resources/Medical-Resources/Access-Records.aspx
- California W&I Code § 5328 – Mental Health Record Confidentiality: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=5328.&lawCode=WIC
- 22 CCR § 73543 – Hospital Records Retention Requirements (Cornell): https://www.law.cornell.edu/regulations/california/22-CCR-73543
- CMIA Overview (UCR Health Compliance Corner, 2026): https://www.ucrhealth.org/blog/2026/01/29/compliance-corner-californias-confidentiality-of-information-act/

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

SUBJECT:	SECTION:
CODE OF ETHICS AND CONDUCT FOR ELECTED AND APPOINTED OFFICIALS	***[Enter manual section here]***

PURPOSE:

The Sierra View Local Health Care District (SVLHCD) Board of Directors adopts this Code of Ethics and Conduct to assure that all elected and appointed officials, while exercising their office, conduct themselves in a manner that will instill public confidence and trust in the fair operation and integrity of SVLHCD governance.

This policy shall apply to all elected positions, including the Chairman, Vice Chairman, Secretary, Treasurer, and Directors, whether elected or appointed to serve in that capacity, and to all persons appointed by the Board of Directors to serve in any official capacity on behalf of the Hospital.

POLICY:

A. ETHICS

The community members served by SVLHCD are entitled to have fair, ethical and accountable local government. To this end, the public shall have full confidence that their elected and appointed officials:

- Comply with both the letter and spirit of the laws and policies affecting the operations of government;
- Are independent, impartial, and fair in their judgment and actions
- Use their public office for the public good, not for personal gain; and
- Conduct public deliberations and processes openly, unless required by law to be confidential, in an atmosphere of respect and civility.

Therefore, members of the SVLHCD Board of Directors, Appointees and/or Delegates, Advisory Boards and Committees shall conduct themselves in accordance with the following ethical standards:

Act in the Public lnterest. Recognizing that stewardship of the public interest shall be their primary concern, members will work for the common good of the community and not for any private or personal interest, and they will assure fair and equal treatment of all persons, claims and transactions coming before them.

Comply with both the spirit and the letter of the law and SVLHCD Policy. Members shall comply with the laws and regulations of the nation, the State of California and Local Governments and the Board bylaws and the policies of SVLHCD in the performance of their public duties.

Conduct of Members. The professional and personal conduct of members while exercising their office shall be above reproach and avoid even the appearance of impropriety. Members shall refrain from abusive, bullying ~~,~~conduct, personal charges or verbal attacks upon the character or motives of other members of Council, Boards, Committees, the management team, staff or public. SVLHCD is committed to maintaining an environment which respects the dignity of all individuals. No Board member shall engage in retaliation or discrimination based on a protected class or any other basis protected by federal, state, or local law, ~~oridinance~~ordinance or regulation or engage in harassment to include sexual harassment and hostile work environment in their capacity as a board member.

Respect for Process. Members shall perform their duties in accordance with the processes and rules of order established by the SVLHCD Bylaws.

Conduct at Public Meetings. Members shall prepare themselves for public issues; listen courteously and attentively to all public discussions before the body; and focus on the business at hand.

Decisions Based on Merit. Members shall base their decisions on the merits and substance of the matter at hand, rather than on unrelated considerations. When making adjudicative decisions (those decisions where the member is called upon to determine and apply facts peculiar to an individual case), members shall maintain an open mind until the conclusion of the hearing on the matter and shall base their decisions on the facts presented.

Communication. For adjudicative matters pending before the body, written communication provided to the Board of Directors shall be retained in accordance with SVLHCD Board record retention practices and bylaws and shall be open to inspection and/or copying in accordance with the California Public Records Act, unless the document is privileged or it is otherwise legally in the best interest of the Hospital for that record to remain confidential.

Conflict of lnterest. In order to assure their independence and impartiality on behalf of the common good and compliance with conflict of interest laws, members shall use their best efforts to refrain from creating an appearance of impropriety in their actions and decisions. Members of the SVLHCD Board of Directors, Appointees and/or Delegates, Advisory Boards and Committees shall not use their official positions to influence government decisions in which they have (a) a material financial interest as set forth in the Political Reform Act and applicable regulations promulgated by the Fair Political Practices Commission, or (b) actual bias that would result in the denial of procedural due process.

SVLHCD has adopted a Conflict of Interest Code approved by the Tulare County Board of Supervisors and it has adopted a Conflict of Interest Code policy that is intended to assist those on which it applies in understanding their duties and obligations under the Political Reform Act.

It is the responsibility of any individual on whom the Conflict of Interest Code and Policy apply to understand all obligations thereunder.

Gifts and Favors. Members of the SVLHCD Board of Directors, Appointees and/or Delegates, Advisory Boards and Committees shall not take any special advantage of services or opportunities for personal gain, by virtue of their public office that is not available to the public in general. They shall refrain from accepting any gifts, favors, or promises of future benefits which might compromise their independence of judgment or action, or give the appearance of being compromised. Disqualification of an individual from participating in a government decision based on the acceptance of a gift shall be determined in accordance with legal requirements of the Political Reform Act, applicable regulations and case law.

Confidential Information. Members of the SVLHCD Board of Directors, Appointees and/or Delegates, Advisory Boards and Committees shall maintain the confidentiality of all written materials and verbal information provided which is confidential or privileged and shall neither disclose confidential information without proper legal authorization, nor use such information to advance their personal, financial or other private interests. SVLHCD has adopted a formal policy to assist those impacted by these obligations in understanding their duties and obligations.

Use of Public Resources. Members of the SVLHCD Board of Directors, Appointees and/or Delegates, Advisory Boards and Committees shall not use public resources which are not available to the public in general (e.g., hospital staff time, equipment, supplies or facilities) for private gain or for personal purposes. If an individual board member requests SVLHCD information and/or records outside of a noticed meeting, such request will be processed in the manner set forth in the Board's bylaws, specifically section 4.16.2.

Representation of Private Interests. In keeping with their role as stewards of the public interest, members of the SVLHCD Board of Directors, Appointees and/or Delegates, Advisory Boards and Committees shall not appear on behalf of the private interests of third parties before the Board nor any committee or ~~subcomittee~~subcommittee acting on behalf of the Board.

Advocacy. Members of the SVLHCD Board of Directors, Appointees and/or Delegates, Advisory Boards and Committees shall represent the official policies or positions of SVLHCD to the best of their ability when designated as delegates for this purpose. When representing their individual opinions and positions, each shall explicitly state they do not represent the official position of the board or SVLHCD, nor will they allow the inference that they do. Board members, have the right to endorse candidates for all Board seats. It is inappropriate to mention or display endorsements during Board meetings, Committee, or other official SVLHCD meetings.

Policy Role of Members. Board Members shall respect and adhere to the structure of SVLHCD governance as outlined in the SVLHCD Bylaws. In this structure, the Board determines the

policies of the Board of Directors with the advice, information and analysis provided by Hospital management, Boards, Committees, and the public. Except as provided by the SVLHCD Code and applicable policies, Board Members shall not interfere with the administrative functions of the Hospital management or the professional duties of Hospital staff; nor shall they impair the ability of staff to implement policy decisions.

Positive Work Place Environment. Board Members shall support the maintenance of a positive and constructive work place environment for SVLHCD employees and for citizens and businesses dealing with the District. Members shall recognize their special role in dealings with District employees to in no way create the perception of inappropriate direction to staff.

B. CONDUCT GUIDELINES

The Conduct Guidelines are designed to describe the manner in which elected and appointed officials shall treat one another, SVLHCD constituents, and others they come into contact with while representing SVLHCD.

Elected and Appointed Officials' Conduct with each Other in Public Meetings

Elected and appointed officials are individuals with a wide variety of backgrounds, personalities, values, opinions, and goals. Despite this diversity, all have chosen to serve in public office in order to preserve and protect the present and the future of the community. ln all cases, this common goal shall be acknowledged even though individuals may not agree on every issue.

(a) Honor the role of the chair in maintaining order

It is the responsibility of the chair to keep the comments of members on track during public meetings. Members shall honor efforts by the chair to focus discussion on current agenda items. If there is disagreement about the agenda or the chair's actions, those objections shall be voiced politely and with reason, following procedures outlined in parliamentary procedure.

(b) Practice civility and decorum in discussions and debate

Difficult questions, tough challenges to a particular point of view, and criticism of ideas and information are legitimate elements of debate by a free democracy in action. Free debate does not require nor justify, however, public officials to make belligerent, personal, impertinent, slanderous, threatening, abusive, or disparaging comments.

(c) Avoid personal comments that could offend other members

If a member is personally offended by the remarks of another member, the offended member shall make notes of the actual words used and call for a "point of personal privilege" that challenges the

other member to justify or apologize for the language used. The chair will maintain control of this discussion.

(d) Demonstrate effective problem-solving approaches

Members have a public stage and have the responsibility to show how individuals with disparate points of view can find common ground and seek a compromise that benefits the community as a whole.

Elected and Appointed Officials' Conduct with the Pubic in Public Meetings

Making the public feel welcome is an important part of the democratic process. No signs of partiality, prejudice, or disrespect shall be evident on the part of individual members toward an individual participating in a public forum. Every effort shall be made to be fair and impartial in listening to public testimony.

(a) Be welcoming to speakers and treat them with care and respect.

While questions of clarification may be asked, the official's primary role during public testimony is to listen.

(b) Be fair and equitable in allocating public hearing time to individual speakers.

The chair will determine limits on speakers at the start of the public comment portion of open session, if different than standard time limits.

(c) Practice active listening

It is disconcerting to speakers to have members not look at them when they are speaking. lt is fine to look down at documents or to make notes, but reading for a long period of time or gazing around the room gives the appearance of disinterest. Members shall try to be conscious of facial expressions, and avoid those that could be interpreted as "smirking," disbelief, anger, or boredom. There should be no side bar conversations among members or others.

(d) Maintain an open mind

Members of the public deserve an opportunity to influence the thinking of elected and appointed officials.

(e) Ask for clarification, but avoid debate and argument with the public

Only the chair - not individual members - can interrupt a speaker during a presentation. However, a member can ask the chair for a point of order if the speaker is off the topic or exhibiting behavior or language the member finds disturbing.

(f) Use of Electronic Devices during Public Comment Time

While the board meeting is in session, to satisfy due process requirements, Board Members shall give their sole attention to the proceedings and shall refrain from using electronic devices such as computers, cell phones, pagers, PDAs, and other electronic devices for the purpose of sending or receiving external communication unless an emergency or extraordinary circumstance exists.

Elected and Appointed Officials' Conduct with SVLHCD employees

Governance of a Healthcare District relies on the cooperative efforts of elected officials, who set policy, appoint members of boards, and ~~commitees~~committees who advise the elected, and SVLHCD management delegated by the Board who implement and administer the policies. Therefore, every effort shall be made to be cooperative and show mutual respect for the contributions made by each individual for the good of the community.

(a) Treat all staff as professionals

Clear, honest communication that respects the abilities, experience, and dignity of each individual is expected. Poor behavior towards staff is not acceptable.

(b) Do not disrupt SVLHCD staff from their jobs

Elected and appointed officials shall not disrupt SVLHCD staff while they are in meetings, on the phone, or performing their job functions in order to have their individual needs met. Attendance by elected officials at any meeting attended by SVLHCD staff shall be in accordance with the SVLHCD Bylaws.

(c) Never publicly criticize an individual employee

Elected and appointed officials shall never express concerns about the performance of a SVLHCD employee under the supervision of the CEO or management team in public, to the employee directly, or to the employee's manager. Comments about staff performance shall only be made to the CEO or Senior Leader, as applicable, through private correspondence or conversation. Appointed members of Committee shall make their comments regarding staff to the CEO or appropriate Senior Leader.

(d) Do not get involved in administrative functions

Elected and appointed officials acting in their individual capacity shall not attempt to influence SVLHCD staff on the making of appointments, awarding of contracts or selecting of consultants.

(e) Do not solicit political support from staff

Elected and appointed officials shall not solicit any type of political support (financial contributions, display of posters or lawn signs, name on support list, etc.) from SVLHCD staff. SVLHCD staff may, as private citizens with constitutional rights, support political candidates but all such activities shall be done away from the workplace.

(f) No Attorney-Client Relationship

The SVLHCD Attorney represents SVLHCD and not elected or appointed officlals acting in their individual capacity.

Conduct with the Media

Board Members may be contacted by the media for background and quotes. Board members are not authorized to represent SVLHCD outside of official District Board meetings unless specifically authorized to do so by the Board. Official SVLHCD responses will be given by the CEO, or designee or the Director of Marketing or designee. When conveying opinions to the Media, Board Members shall use their best efforts to make clear that the opinion being expressed is that of the individual Board Member, not that of the entire Board.

Social Media Use

When using social media, members of the SVLHCD Board of Directors, Appointees and/or Delegates, Advisory Boards and Committees must clearly disclose that they are expressing their own personal opinion and not an official position of SVLHCD or, if applicable, the body on which they serve. Where appropriate, posting a disclaimer to this effect is advised. Board members must also use caution when communicating on social media in that it does not become a conduit to communicate with their fellow Board members in violation of the Brown Act.

Outside Emplovment

No member of the SVLHCD Board of Directors, Appointee and/or Delegate, Advisory Board member and/or Committee member shall engage in or accept private employment or render services for private interests when such employment or service is incompatible with the proper discharge of their official duties in violation of Government Code section 1099 and applicable case law, or would tend to impair their independence of judgment or action in the performance of their official duties.

C. SANCTIONS

Upon a finding by a majority of the Board of Directors that any public official violated any provision of the Prohibited Conduct section of this policy, the Board may impose any of the following sanctions:

Elected Officials

(a) Public censure, in accordance with the Board's Bylaws and policy for censure.

Appointed Officials/Elected Officers of Advisory Boards and Committees

(a) Referral to the Board, or Committee of which the appointed official is a member for public censure, in accordance with the Board's Bylaws and policy for censure.
(b) Public censure by the SVLHCD Board; or
(c) Removal from office by a majority of the SVLHCD Board

Whistle Blower Protections

To the extent not otherwise prohibited by State law, SVLHCD Board members and employees shall not use or threaten to use any official authority or influence to discourage, restrain or interfere with or to effect a reprisal against any person, including, but not limited to, another Board member or District employee, for the purpose or with the intent of preventing such person from acting in good faith to report or otherwise bring to the attention of the District or other appropriate agency, office or department, any information that, if true, would constitute a gross waste of District funds, a gross abuse of authority, a specific and substantial danger to public health or safety due to any act or omission of a Board member or employee, or the use of a SVLHCD office or position or of SVLHCD resources for personal gain.

D. IMPLEMENTATION

The Code of Ethics and Conduct is intended to be self-enforcing and is an expression of the standards of conduct for members expected by SVLHCD. It therefore becomes most effective when members are thoroughly familiar with it and embrace its provisions.

For this reason, this document shall be included in orientation for members of the SVLHCD Board of Directors, New Appointees and/or Delegates, and new members of Advisory Boards and/or Committees. Each **individual to whom this policy applies shall sign a statement (below) acknowledging they have read, understand and will comply with the Code of Ethics and Conduct.** In addition, the Code of Ethics and Conduct shall be periodically reviewed by the Board and updated as necessary.

I affirm that I have read, understand and will comply with the SVLHCD Board of Directors Code of Ethics and Conduct for Elected and Appointed Officials.

Name:_____

Signature:_____Date:_____

AFFECTED PERSONNEL/AREAS: SVLHCD Board Members

CROSS REFERENCES:

Anti-Discrimination, Harassment & Non-Retaliation Policy

Board Procedures for Hearing to Censure a Board Member

Bylaws of the Board of Directors of Sierra View Local Health Care District

Code of Conduct

Conflict of Interest Code

Conflict of Interest Policy

Personal Conduct

Public Records Request

Unauthorized Disclosure of Privileged Information

SUBJECT: **HIRING NEWLY LICENSED RNs AND RNIPs**	SECTION: ***Human Resources*** **Page 1 of 5**

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

PURPOSE:

- To define the hiring requirements for newly licensed Registered Nurses (RN) and newly graduated RN students with an Interim Permit (RNIP).

- To delineate timeline requirements for taking the California State National Council Licensure Exam (NCLEX) and the consequences if the NCLEX is not passed on the first or second attempt.

POLICY:

Sierra View Medical Center (SVMC) believes in and supports the hiring of recent graduates of accredited RN Programs to attract recent graduates to the facility. Hiring recent graduates of an accredited RN Program also provides a greater opportunity for the systematic transition to practice.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS*

PROCEDURE:

HIRING NEWLY LICENSED RNs AND RNIPs

A. *Current Employees:*

1. Must have graduated from an accredited Registered Nursing Program.

2. Must either have a California (CA) RN license or must have an Interim Permit (IP) from the CA Board of Registered Nursing (BRN). If the New Grad RN has an IP from the CA BRN, the IP must be valid for a period of no less than 2 months after the transfer date into the New Grad/Novice RN Program. RNIPs must take and successfully pass the NCLEX within 2 months of transfer date.

3. Current employees must apply to the New Grad/Novice RN Program through the internal job board on the SVMC website, complete the interview process, and be offered and accept a position in the New Grad/Novice RN Program.

*** Current employees who obtain their RN license at a time that does not coincide with the start date of a New Grad/Novice RN program will have two options:

1. If the employee has enough Vacation/Holiday leave to carry them through until the start date of the next New Grad/Novice RN program (no longer than 2 months), the employee will be allowed to remain employed with SVMC during the interim. This will allow the employee to apply and interview for a New Grad/Novice RN position without a break in employment. If the employee is not offered the position, he/she will be placed on a 2-week Administrative Leave of Absence to allow them to apply for another position within the District for which they are qualified. If after two weeks they are unable to find such a position, they will be terminated from employment.

2. If the employee does not have enough Vacation/Holiday leave to carry them through until the start date of the next New Grad/Novice RN program or the employee does not wish to use his/her Vacation Holiday leave, he/she will have the option of going on an Administrative Leave of Absence for a period no longer than 2 months. During the time the employee is on the Administrative Leave, he/she will be required to pay the full cost of their medical/dental/vision insurance. This will allow the employee to apply and interview for a New Grad/Novice RN position without a break in employment. If the employee is not offered the position or does not apply for another position within the District for which they are qualified during the specified time period, they will be terminated from employment.

B. *Non-Employees:*

1. Must have graduated from an accredited Registered Nursing Program.

2. Must either have a CA RN license or must have an IP from the CA BRN. If the New Grad RN has an IP from the CA BRN, the IP must be valid for a period of no less than 2 months after their hire date into the New Grad/Novice RN Program. RNIPs must take and successfully pass the NCLEX within 2 months of hire date.

3. External candidates must apply to the New Grad/Novice RN Program through the job board on the SVMC website, complete the interview process, and be offered and accept a position in the New Grad/Novice RN Program.

CONSEQUENCES OF FAILURE TO MEET THE TIMELINE REQUIREMENTS FOR TAKING THE NCLEX AND CONSEQUENCES OF FAILURE TO PASS THE NCLEX

A. *RNIPs who fail to take the NCLEX within 2 months of transfer or hire into the New Grad/Novice RN program:*

All RNIPs in the New Grad/Novice RN Program must take and successfully pass their NCLEX within 2 months of transfer or hire into the New Grad/Novice RN Program, or must submit evidence supporting a delay of scheduling the exam to the Education Department. The RNIP will only be allowed to stay in the New Grad/Novice RN Program if the Education Department can verify the evidence supporting the delay and the New Grad RN's IP is still valid. If the IP expires before the NCLEX can be taken, the New Grad RN will be offered a position as an RN Aide. If the Education Department cannot verify the evidence supporting the delay, the RNIP will be immediately placed on a 2-week Administrative Leave of Absence to allow them to apply for another position within the District for which they are qualified. If after two weeks they are unable to find such a position, they will be terminated from employment.

B. *RNIPs who fail to pass the NCLEX on the first attempt:*

If the RNIP takes the NCLEX for the first time (within the required 2-month period of time) but fails to pass, he/she will be offered a position as an RN Aide. He/she must apply for and successfully pass their second NCLEX within 60 days of failure of first exam or submit evidence

supporting a delay of scheduling the second exam to the Education Department. If the Education Department can verify the evidence supporting the delay, the RN Aide will be granted an extension for a period no greater than an additional 30 days. RN Aides who fail to pass the NCLEX for the second time or fail to take the second NCLEX within the allotted time, will be immediately placed on a 2-week Administrative Leave of Absence to allow them to apply for another position within the District for which they are qualified. If after two weeks they are unable to find such a position, they will be terminated from employment.

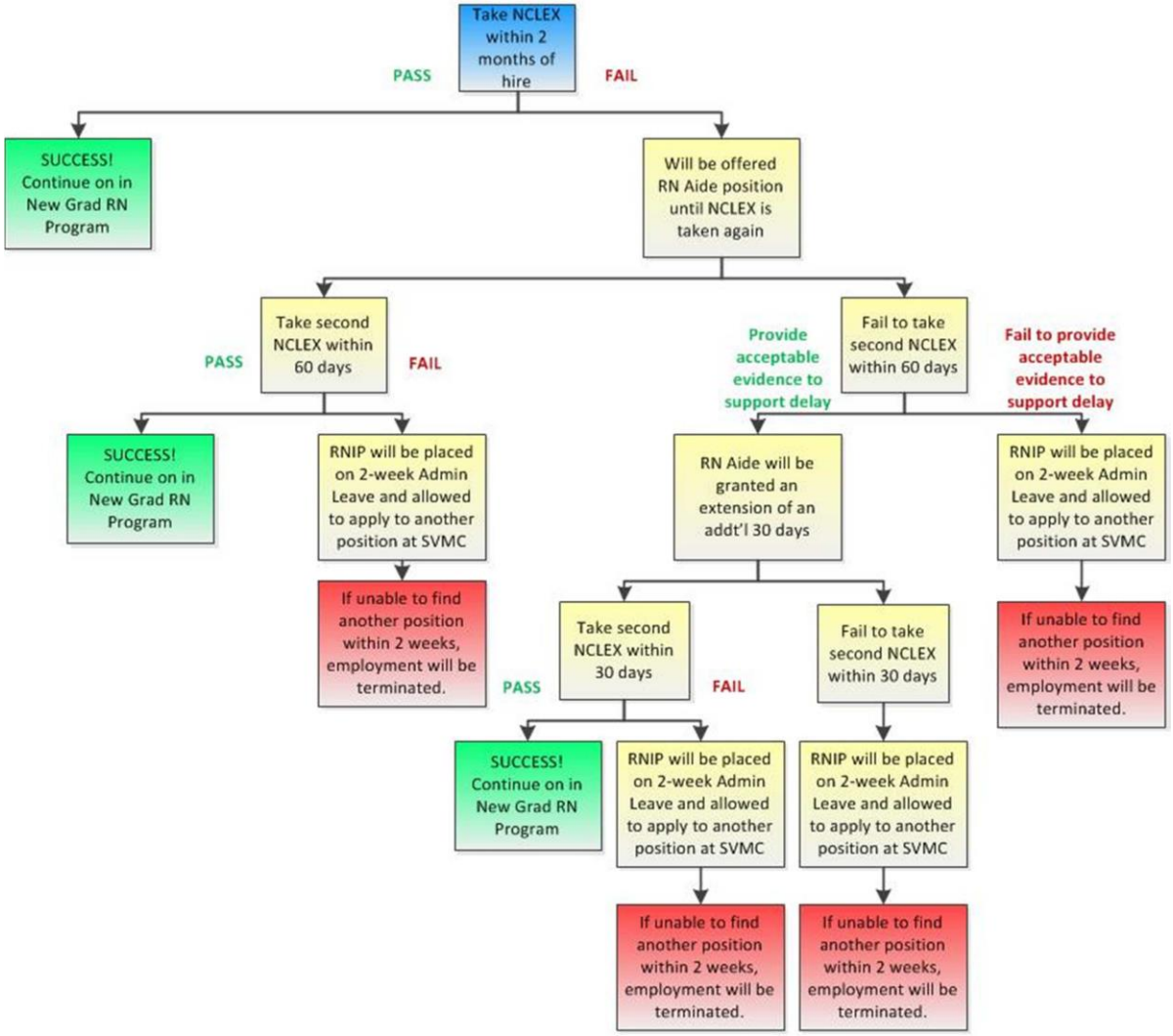
C. *RN Aides who fail to pass the NCLEX on their first or second attempt:*

If the New Grad RN has transferred to the RN Aide position and the NCLEX is not passed on the first attempt, he/she must apply for and successfully pass their second NCLEX within 60 days of failure of first exam or submit evidence supporting a delay of scheduling the second exam to the Education Department. If the Education Department can verify the evidence supporting the delay, the RN Aide will be granted an extension for a period no greater than an additional 30 days. RN Aides who fail to pass the NCLEX for the second time or fail to take the second NCLEX within the allotted time, will be immediately placed on a 2-week Administrative Leave of Absence to allow them to apply for another position within the District for which they are qualified. If after two weeks they are unable to find such a position, they will be terminated from employment.

**New Grad RNs who accept a position as an RN Aide will be paid as commensurate with the RN Aide position's pay grade.

SUBJECT: **HIRING NEWLY LICENSED RNs AND RNIPs**	SECTION: *Human Resources* **Page 4 of 5**

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



SUBJECT: **HIRING NEWLY LICENSED RNs AND RNIPs**	SECTION: *Human Resources* **Page 5 of 5**

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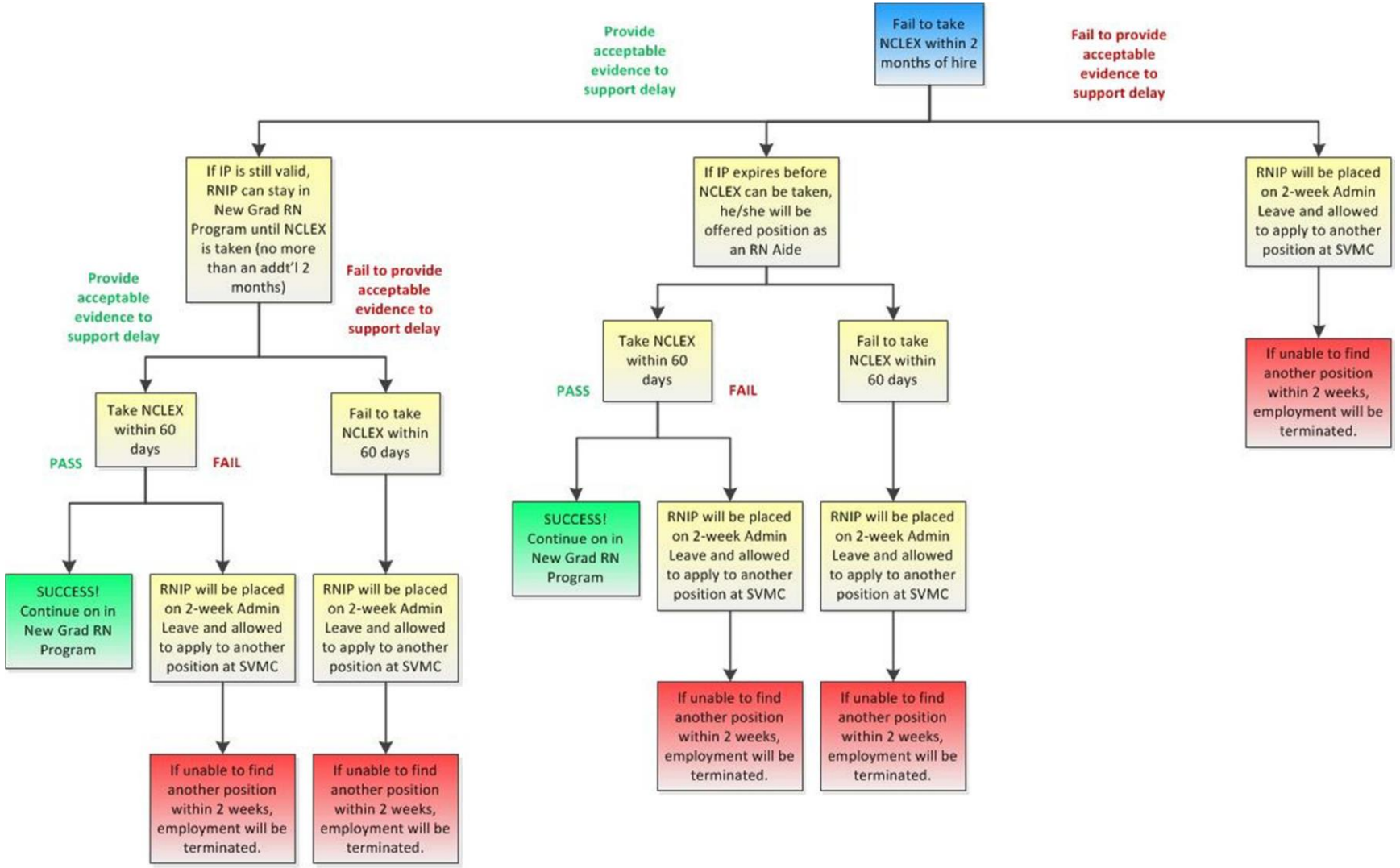

SUBJECT: **INVESTIGATIONS AND GOVERNMENT SEARCH WARRANTS, UNANNOUNCED**	SECTION: **Page 1 of 5**

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

PURPOSE:

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

POLICY:

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

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

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

DEFINITION:

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

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

PROCEDURE:

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

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

2. Identify the agent in charge.

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

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

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

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

IN THE CASE OF A SEARCH WARRANT

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

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

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

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

a. Contact the hospital's general counsel.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REFERENCES:

- HCCA Health Care Compliance Professional's Manual, 2025. ePublication, Chapter 4: During an Investigation.,.

- United States Sentencing Commission Guidelines Manual 2025: Appendix B (2025). Retrieved from https://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2025/APPENDIX_B_PART_II.pdf

SUBJECT: **JUST CULTURE**	SECTION: ***Human Resources*** **Page 1 of 5**

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

PURPOSE:

Sierra View Medical Center's (SVMC) philosophy for building and supporting the culture of patient safety includes promoting a fair, just and supportive environment for those employees that self-report potential or actual safety risk or hazard events as described in this policy. The Just Culture model provides a mechanism to:

1. Encourage an open environment of reporting all potential or actual safety risk or hazard events without fear of reprisal;

2. Increase knowledge regarding types of recurring potential or actual safety risk or hazard events that take place at SVMC.

3. Focus attention on systems and processes, rather than individual blame, in an effort to continuously improve patient safety; and identify precursors to errors in order to fix system issues.

4. Retain competent staff.

SVMC staff is encouraged to bring patient-safety and patient-care issues to the attention of their director or supervisor. Staff may also report patient-safety and care issues by completing an online occurrence report. Our employees also have the right to report concerns about the safety or quality of patient care to The Joint Commission. The hospital will not retaliate against an employee for bringing patient safety and patient-care issues forward via the event reporting system, The Joint Commission, or any other regulatory agency. Appropriate actions will be taken by the hospital depending on the facts and circumstances of any reported issues, concerns, or errors.

Nothing in this policy provides any contractual rights regarding employee discipline or counseling nor should anything in this policy be read or construed as modifying or altering the employment-at-will relationship between SVMC and its employees.

DEFINITIONS:

Potential or actual safety risk or hazard events are defined as follows:

1. Hazard: A source of danger that is potentially harmful to patients, visitors, hospital staff, physician staff, or is disrupting the orderly operation of the hospital.

2. Risk: An occurrence or incident that has the potential or actual effect of exposing a patient and/or others in the hospital to the chance of loss or danger.

3. Event or incident is: a) an unexpected, unintended, undesirable occurrence transpiring in or on the premises of the hospital facility or b) an unexpected, unintended, undesirable departure from the policies or standards of patient care or behavior required by the hospital.

4. Ongoing threat to safety: An incident in which there is ongoing exposure to the risk or hazard unless immediate action is taken to resolve the risk or hazard. Examples include:

   - Water on the floor associated with an electrical hazard that could lead to electrical shock
   - Staff member or physician who arrives at the hospital to engage in care who may be under the influence of drugs or alcohol
   - A visitor who exhibits disruptive behavior that impairs quality patient care.

Human Error (Blameless Act): An unintentional act either of omission or commission in which blame against an individual is not assigned. A human error occurs when either a correct action is not executed properly or an incorrect action is executed. Error is then managed through process, system, or environmental changes. Discipline is not warranted or productive since the staff member did not intend the action or the risk of harm that resulted. However, if after the staff member has been educated and no improvement is noted which is supported by a pattern of successive human errors, they will be subject to disciplinary action. Inadvertent actions associated with human error include: situations in which organizational processes contributed to the event. Situations that involve gross negligence and/or disregard for policies and procedures are not to be defined as a blameless act.

Slips: Occurs in situations that are so routine that there is no conscious awareness of them.

Lapses: Missed actions and omissions. For example: when somebody has failed to do something due to lack of attention or because they have forgotten something.

Mistakes: Judgment failures that are more subtle and complex than slips; can go unnoticed for a period of time and when detected may generate differences of opinion.

At-Risk Behavior: A behavioral choice that increases the risk where risk is not recognized or is mistakenly believed to be justified. Examples: drifting into unsafe habits and behaviors which are often rooted in the system. At-risk behavior should be managed by:

1. Uncovering, addressing and removing incentives for unsafe behaviors including identifying the system-based reason for the behavior (Example: perception of saved time.)

2. Decreasing staff tolerance for risk-taking by creating incentives for healthy behaviors.

3. Staff members should be coached and educated on making better behavioral choices (once the incentives for their at-risk behaviors have been addressed.) If, after the staff member has been educated, no improvement is noted which is supported by a pattern of successive at-risk behaviors, they will be subject to disciplinary action.

Intentional Act (Reckless Behavior): An act knowingly committed with the intent to harm or deceive. SVMC has a zero tolerance for reckless behavior. Examples: Person knows that others are engaging in unsafe behavior and fails to report it while understanding the risk is substantial, making a conscious choice to disregard the substantial and unjustifiable risk, and falsification or purposeful omission of

known information that can result in a harm event. Reckless behavior is "blameworthy" behavior and should be managed through remedial or disciplinary actions according to the District's progressive disciplinary process.

Non-Punitive: No punishment or disciplinary action will be imposed for any specific error for those staff who report a human error (blameless act) that has resulted in a potential or actual safety risk or hazard event.

POLICY:

The Just Culture Model embraces three duties for all employees to fulfill:

1. The duty to avoid causing unjustifiable risk or causing harm;

2. The duty to follow a procedural rule/policy; and

3. The duty to produce an outcome.

Potential or actual safety risk or hazard events are tracked in an attempt to establish trends and patterns, to learn from them, and to prevent recurrence. Staff involved in potential or actual safety risk or hazard events are encouraged to participate in analyzing the event and in developing the action plans for improved processes.

Crisis intervention will be made available to staff involved and/or affected by a potential or actual safety risk or hazard event.

Human error occurs when an employee inadvertently performs a task or an action other than what should have been done (a slip, a lapse, or a mistake). Individual performance may be affected by fatigue, stress, or interruptions. A human error may have been caused by a fault in the system or the process, by the characteristics of equipment being used, or by environmental factors such as noise or poor lighting. When a system fault or process error occurs, the matter will be referred to the appropriate parties for process improvement review and planning to correct the deficiency. If the event is determined to be human error (blameless act) disciplinary action is not taken until event is investigated. In cases of reckless behavior, blatant disregard for safety, or purposefully not following established policies, disciplinary action will be considered.

In the event that it becomes clear that staff competency is the root cause for a pattern of errors, management makes every effort to ensure that staff is provided with the education and resources needed to reliably deliver safe care. If it becomes clear that a staff member cannot practice in a reliably safe manner in spite of education and counseling, this situation is treated as a staff performance issue through normal disciplinary procedures.

AFFECTED PERSONNEL/AREAS: *SVMC STAFF MEMBERS & PHYSICIANS*

PROCEDURE:

Staff members are subject to disciplinary action if they:

1. Intentionally fail to report a potential or actual safety risk or hazard event;

2. Knowingly violate established operating procedures;

3. Violate established operating procedures despite documented education and counseling;

4. Make successive slips, lapses, mistakes, and/or continue to demonstrate at-risk behavior after receiving remedial education/training and coaching;

5. Operate outside of the employee's scope of practice, licensure, certification, registration, training, and/or job description

6. Intentionally cause harm.

Prior to taking any disciplinary action for suspension or termination related to a safety risk or hazard event, Human Resources arranges for a Just Culture review panel consisting of an Employee Relations staff member, the staff member's Director and/or Manager, the Manager of Risk and/or Administrative Director of Quality and Care, and another director (preferably one who is familiar with the systems and processes involved in the type of incident/error reported and/or duty that may not have been fulfilled). This panel reviews the information and circumstances of the alleged policy violation and makes a recommendation for appropriate action to the Director of Human Resources and the Senior Team member.

Taking into consideration the heightened requirements for compliance of confidentiality and privacy of patient information, the Just Culture algorithm and review panel do not apply to violations of the hospital's patient privacy policies and federal and state laws. Depending on the facts and circumstances of a policy or privacy violation, even a first offense may result in a written warning or other disciplinary action, up to and including termination of employment.

REFERENCES:

- Marx, D. (2014). *Whack-a-mole: The Price We Pay for Expecting Perfection*. Plano, TX: By Your Side Studios.

- Miller, V. B., & Jones, T. L. (2011). *Creating a Just Culture: A Nurse Leader's Guide*. Danvers, MA: HCPro.

- Reason, J.T. (2016). *Managing the Risks of Organizational Accidents*. London: Routledge.

CROSS REFERENCES:

- PERFORMANCE ACCOUNTABILITY AND COMMITMENT
- PERSONAL CONDUCT

SUBJECT:	SECTION:
LICENSES AND PERMITS-REQUIRED GOVERNMENTAL	***Leadership (LD)*** **Page 1 of 1**

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

PURPOSE:

To establish and define Sierra View Medical Center (SVMC)'s compliance with maintaining the appropriate licenses and permits as mandated by applicable governmental agencies.

POLICY:

In accordance with applicable law and regulation, SVMC has and will maintain current and compliant those licenses and permits required for the provision of care and treatment specific to the services offered at SVMC as established by Federal, State, County and City entities. SVMC will comply with all the requirements for maintenance and posting of such documents as set forth by the authority having said jurisdiction.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

REFERENCES:

- 42 CFR § 482.11(b)(1) & 482.11(b)(2)- Condition of participation: Compliance with Federal, State and local laws. Retrieved from https://www.law.cornell.edu/cfr/text/42/482.11.

SUBJECT: **MEDICAL RECORDS SECURITY DURING EVACUATION PROCEDURES**	SECTION: **Page 1 of 1**

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

PURPOSE:

To ensure the confidentiality and safety of the medical record during an evacuation.

POLICY:

Sierra View Medical Center (SVMC) shall safeguard the confidentiality and integrity of medical records at all times.

PROCEDURE:

1. In the event of an emergency or disaster requiring evacuation of hospital building(s), medical records shall be given to the appropriate, individual patient for protection and removal during the evacuation process.

2. Patients will be instructed as to the importance of protecting these records from loss, for privacy as well as continuity of care.

    a. If the patient is bedridden, his/her medical record shall be placed under the head of the bed for transport.

REFERENCES:

- The Joint Commission (2026). Hospital accreditation standards. IM.01.01.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **MINIMUM NECESSARY**	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 regarding each workforce member's responsibility related to using and disclosing only the minimum amount of identifiable patient information to fulfill the purpose of the use or disclosure, regardless of the extent of access provided. This policy covers uses and disclosures of protected health information (PHI) in any form including oral, written and/or electronic mediums. Each individual is responsible for adhering to this policy by using only the minimum information necessary to perform his or her responsibilities, regardless of the extent of access provided or available.

To establish the requirements to protect patients' privacy rights and their individually identifiable health information as required by the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Part 164 and all Federal regulations and interpretative guidelines.

POLICY:

Only workforce members with a legitimate "need to know" may access, use or disclose patient information. This includes all activities related to treatment, payment and health care operations of the facility. Each workforce member may only access, use or disclose the minimum information necessary to perform his or her designated role regardless of the extent of access provided to him or her.

The minimum necessary requirement does not apply to the following:

- Requests by another covered entity;
- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual who is the subject of the PHI;
- Uses or disclosures made pursuant to HIPAA compliant authorizations;
- Disclosures to the Secretary of the Department of Health and Human Services (the "Secretary") when required by the Secretary to investigate or determine the facility's compliance with the HIPAA Privacy Standards;
- Uses and disclosures required by law as described in §164.512(a); and
- Limited data sets and de-identified information.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

1. Workforce members acting on behalf of the facility must always use only the minimum amount of information necessary to accomplish the intended purpose of the access, use, and/or disclosure of PHI.

2. With respect to system access, minimum necessary will be supported through authorization, access, and audit controls (e.g., role-based access) and should be implemented for all systems that contain identifiable patient information. Within the permitted access, an individual system user is only to access what they need to perform his or her job functions.

    a. The facility must identity workforce members or classes of workforce members who need access to PHI to carry out their job functions.

    b. For each workforce member or class of workforce members, the category or categories of PHI to which access is needed and any conditions appropriate to such access. Reasonable efforts must be made to limit the access of the workforce member or classes of workforce members to the category or categories of PHI to which access is needed.

3. The Compliance/Privacy Officer (PO) has the responsibility of facilitating compliance with these principles ~~in conjunction with the Compliance Officer (CO)~~.

4. The facility may rely on a requested disclosure as being the minimum necessary when:

    a. Making disclosures to public officials as permitted in §164.512 if the public official represents the information requested as the minimum necessary;

    b. The information requested is requested by a professional who is a member of the facility's workforce or is a business associate of the facility for the purpose of providing professional services to the facility, and the professional represents the information requested as the minimum necessary; and

    c. Documentation or representations that comply with the applicable requirements of §164.512(i) have been provided by a person requesting the information for research purposes.

5. For disclosures and requests made on a non-routine basis, criteria must be developed and maintained to limit PHI to the information reasonably necessary to accomplish the purpose of the disclosure and each request must be reviewed on an individual basis in accordance with such criteria.

6. For disclosures and requests made on a routine and recurring basis, the facility must create, implement and maintain policies and procedures or standard protocols that limit the PHI to the amount reasonably necessary to achieve the purpose of the disclosure.

7. The facility must limit any requests for PHI to the amount reasonably necessary to accomplish the purpose of the request.

REFERENCES:

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

CROSS-REFERENCES:

Patient Privacy - Program Requirements policy

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SUBJECT: **DISRUPTIVE BEHAVIOR, IDENTIFICATION & MANAGEMENT OF**	SECTION: ***Leadership (LD)*** **Page 1 of 7**

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

PURPOSE:

To establish an environment that requires all individuals, employees, physicians, allied health practitioners and other independent practitioners to conduct themselves in a professional and cooperative manner within the facility and to define the behaviors that:

- Interfere with high quality patient care.
- Disrupt the orderly administration of Sierra View Medical Center, herein known as "Hospital."
- Disrupt the orderly administration of the independent Medical Staff, herein known as "Medical Staff."
- Affects the abilities of others to do their jobs.
- Creates a hostile work environment for Hospital or Medical Staff members.
- Adversely affects or impacts the community's confidence in the Hospital's ability to provide exemplary patient care.

POLICY:

Workplace violence is not merely the heinous, violent events that make the news; it is also the everyday occurrences, such as verbal abuse, that are often overlooked (TJC, 2018).

It is the intention of the Hospital organizational and Medical Staff Leadership that this policy is enforced in a consistent, fair, equitable manner. The policy delineates the process for dealing with a disruptive environment, and will be interpreted and enforced by the Board of Directors or Board appointed designees. The Board of Directors believes that:

- A culture of safety exists when all who work at the Hospital are focused on excellent performance.
- Safety thrives in an environment that supports teamwork, collegial relations, and respect for others.
- The Hospital and Medical Staff leaders are responsible for setting expectations and creating a structure that allows a culture of quality and safety to flourish.

The Board of Directors furthermore delegates the Medical Executive Committee to resolve physician to physician concerns, Senior Management, Human Resources and Risk Management to resolve Hospital employee and contractor issues, and to work together in a collegial forum to resolve physician-to-hospital employee issues in an ad hoc or Joint Forum environment.

Definition:

"Disruptive Behavior" is aberrant behavior manifested through personal interaction with practitioners, Hospital personnel, healthcare professionals, patients, family members or others which:

1. interferes with patient care or tends to interfere with the delivery of high quality patient care or the orderly administration of the Hospital or the Medical Staff; or

2. includes abusive behavior toward authority, intimidating or harassing behavior and threats (TJC, 2019 & US Department of Labor, n.d.); or

3. creates a hostile work environment; or

4. is directed at a specific person or persons, causing substantial emotional distress among other staff and affects overall morale within the work environment, undermining productivity and possibly leading to high staff turnover; or

5. even resulting in ineffective or substandard care.

Examples of disruptive conduct may include, but is not limited to:

1. Any offensive striking, pushing, or touching of others;

2. Any conduct that would violate Medical Staff and/or Hospital policies relating to discrimination and /or sexual harassment;

3. Throwing, hitting, pushing, or slamming objects in an expression of anger/frustration;

4. Destroying any Board of Director approved form or note from a patient's legal medical record;

5. Yelling, screaming, or using an unduly loud voice directed at another;

6. Use of racial, ethnic, epithetic, socio-economic derogatory comments, or profanity directed at another;

7. Refusing to respond to a request by any caregiver for orders, instructions, or assistance with the care of a patient or responding inappropriately to request i.e., pain medication;

8. Unreasonable or unprofessional criticism of Hospital or Medical Staff personnel (including other practitioners), policies, or equipment, and making public derogatory comments about quality of care being provided by others, or any negative comments that undermines patient trust in the Hospital or Medical Staff heard by patients, patient families, visitors, Hospital employees, Medical Staff or others;

9. Use of medical record entries to criticize Hospital or Medical Staff personnel, policies, or equipment, or others;

10. Threatening to get someone fired, making belittling or berating statements and tirades anywhere on the hospital campus;

11. Intentional filing of a false complaint or accusation;

12. Persisting attempts to contact a Hospital employee(s) or other person(s) to discuss personal or performance matters after the person(s) or a supervisory person, the Director or Administrator or designated Medical Staff leader has requested that such conduct be discontinued;

13. Imposing idiosyncratic requirements on hospital staff that have no legitimate purpose to improve patient care, and only serve to burden the staff with "special" techniques and procedures;

14. Any form of retaliation against a person who has filed a complaint against another alleging violation of the Standards of Performance and Personal Conduct;

15. Use of physical or verbal threats, including threatening or offensive gestures;

16. Unauthorized use and/or disclosure of confidential or personal information related to another employee, patient, Practitioner or other person.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL EMPLOYEES; MEDICAL STAFF MEMBERS; ADMINISTRATION AND BOARDMEMBERS*

PROCEDURE:

ALLEGATIONS AND REPORTING

A. All allegations of disruptive behavior by Practitioners, Medical or Professional Students or Hospital employees shall be reported as follows:

1. All allegations of disruptive or prohibited behavior involving

a. A Physician directed toward a physician resident will be reviewed and investigated in a coordinated manner by the GMEC Leadership and the Medical Staff Service Department in consultation with the Chief of Staff and/or the Human Resources Department. ~~Practitioner directed toward a hospital employee, patient, visitor or other non-practitioner will be screened in a coordinated effort by Risk Management and the Medical Staff Service Department in consultation with the Chief of Staff.~~

b. Medical Students on clinical rotation will be reported to the Chief of Staff or his/her designee through the Medical Staff Office, who will also be in contact with the appropriate program director or school facilitator. A report on what actions were taken will then be forwarded to the Director of Medical Staff Office and reviewed by the Chief of Staff and/or Medical Executive Committee. Information will also be reported back to the Vice President of Patient Care Services on actions taken.

c. All allegations must be documented on the Hospital "Event Reporting System" form and sent to Risk Management. *(Refer to the Hospital Policy located in the House-Wide Policy & Procedure Manual titled* ***Occurrence Report (Quality of Care Events.)***

2. All allegations of disruptive or prohibited behavior involving nursing or other professional/technical students will be reported to the Vice President of Patient Care Services who will contact the student's school. The school will provide a report of follow up action to the Vice President of Patient Care Services.

3. All allegations of disruptive or prohibited behavior involving Hospital employee to hospital employee will be reported by appropriate Department Directors/Managers or Supervisors to the Human Resources Department for investigation and follow-up.

4. Initial complaints of disruptive behavior shall be documented on the facility's "Event Reporting System" form.

   a. Name(s) of individual(s) involved;

   b. Date, time, and place of incident;

   c. A factual description and detailing of the incident;

   d. All witnesses to the incident including any patient or patient family member or visitor;

   e. The immediate effects or consequences of the incident; and

   f. Any action taken by anyone to intervene or remedy the incident.

INITIAL INVESTIGATION AND MEDIATION

Allegations of disruptive/prohibited behavior will be handled as follows:

A. ***Physician/ Employee Allegation*** –

1. The Chief of Staff and applicable Department Chair shall promptly review and investigate, and when appropriate, establish an Ad Hoc Committee to investigate the complaint.

2. When required and/or appropriate, the Ad Hoc Committee shall take written statements from the complaining party and from the witnesses. **Human Resources will be present and co-lead the investigation of employees for the hospital with the medical staff designee.

3. All witness statements and investigation documents shall be maintained as confidential, peer review documents.

4. The Ad Hoc Committee and Hospital Administration shall take appropriate steps to assure that employees, witnesses and others are protected from discrimination, harassment or retaliation.

B. ***Employee/Employee of the District Allegation***

Allegations of disruptive behavior where two employees of the Hospital District are involved will be handled by the Human Resources Department and Hospital Leadership.

ACTION BY THE BOARD OF TRUSTEES OR DESIGNEE

A. If the Board of Directors determines that the Medical Executive Committee's or Human Resources' action/s are inadequate, or if the Medical Executive Committee or Hospital takes no action after the investigation, the Board of Directors may do or recommend any one or more of the Formal Actions as allowed by the Board of Directors Bylaws.

REFERENCES:

- The Joint Commission (2019). Hospital accreditation standards. LD.03.01.01 and MS.06.01.05. Joint Commission Resources. Oak Brook, IL.

EVIDENCE-BASED RESEARCH SUPPORTING:

- The Joint Commission Sentinel Event Alert #40 (Issued 7/9/08). (Behaviors that undermine a culture of safety.)
- The Joint Commission Sentinel Event Alert. (2018). *Physical and verbal violence against health care workers*, 59. The Joint Commission.
- The Joint Commission. (2019). Hospital Accreditation Standards (LD.01.01.01 – LD.01.05.01)
- Diaz, A.L. & McMillan, D.J. (1991). A definition and description of nurse abuse. *Western Journal of Nursing Research. 13*(1). 97-109.
- Institute for Safe Medication Practices (ISMP). Results from ISMP survey on workplace intimidation.
- Porto, G., & Lave, R. (2006, July-August). Disruptive clinician behavior: A persistent threat to patient safety. *Patient Safe Quality Healthcare.*
- Rosenstein, A.H. (2002). Nurse-Physician Journal Relationship: Impact on nurse satisfaction and retention. *American Journal of Nursing*. 102(6). 26-34.
- Rosenstein, A., & O'Donnell, M. (2005, January). Disruptive behavior and clinical outcomes: Perceptions of nurses and physicians: nurses, physicians and administrators say that clinicians' disruptive behavior has negative effects on clinical outcomes. *Nurse Manage, 36*(1). 18-29.
- Rosenstein, A., & O'Donnell, M., (2008, August). A survey of the impact of disruptive behaviors and communication defects of patient safety. *Joint Commission Journal Quality Patient Safety, 34*(8). 464-471.
- Rosenstein, A., Russell, H., & Lauve, R. (2002, November-December). Disruptive physician behavior contributes to nursing shortage; Study links bad behavior by doctors to nurses leaving the profession. *Physician Exec. 28*(6). 8-11.

CROSS REFERENCES:

- Anti-Discrimination, Harassment & Non-Retaliation Policy
- Non-Discrimination Policy
- Personal Conduct Policy
- Performance Accountability and Commitment Policy
- Introductory Periods Policy

SIERRA VIEW
MEDICAL CENTER

HR Report 2026 QTR 2
April –June 2026

Dashboard

Measurement	QTR 1	QTR 2	YTD	Annualized	Goal	Variance
EE Referral Rate	14.0%	11.0%	12.0%	12.0%	—	—
Geofencing Rate	0.0%	0.0%	0.0%	0.0%	—	—
Turnover	2.9%	3.4%	**6.3%**	**12.6%**	**10.2%**	-2.4%
RN Turnover	3.7%	1.0%	**4.7%**	**9.3%**	**9.9%**	+0.6%
Employee Retention > 5 Years	45.0%	44.0%	**44.0%**	**44.0%**	**50.0%**	-6.0%

CY 2026 Year-to-Date Turnover Report (Through QTR 2)

SVMC Total: 813 Employees | 51 Terms
Turnover Rate: 6.3%

Department	Employees	Terms	Turnover Rate	Department	Employees	Terms	Turnover Rate
ACADEMIC HEALTH CLINIC	2	-	0.0%	MARKETING	4	-	0.0%
ACCOUNTING	7	-	0.0%	MATERIALS MANAGEMENT	10	2	20.3%
ACS	6	-	0.0%	MATERNAL CHILD HEALTH	44	-	0.0%
ADMINISTRATION	7	2	27.3%	MED SURG	57	5	8.8%
CARE INTEGRATION	11	-	0.0%	NURSING ADMIN	6	-	0.0%
CATH LAB/INTERV ANGIO	10	1	10.3%	OB-GYN CLINIC	8	-	0.0%
CHAPLAINCY	1	-	0.0%	PATIENT ACCESS	24	5	21.3%
COMMUNICATIONS	8	1	12.0%	PFS/CC	26	-	0.0%
CTC	19	-	0.0%	PHARMACY	18	1	5.7%
DIETARY	26	-	0.0%	PHYSICAL THERAPY/SPEECH	9	-	0.0%
DPSNF	49	4	8.2%	PLANT OP/MAINTENANCE	12	-	0.0%
EDUCATION	4	-	0.0%	QUALITY	9	-	0.0%
ER	45	5	11.2%	RADIOLOGY	40	1	2.5%
EVS/LAUNDRY	33	3	9.0%	RECOVERY/ENDO	20	-	0.0%
FACILITY/GROUNDS	7	3	45.0%	RENAL DIALYSIS	4	-	0.0%
FINANCIAL PLANNING	4	-	0.0%	RESPIRATORY	20	3	14.9%
FLOAT POOL	20	4	19.7%	RURAL HEALTH CLINIC	7	-	0.0%
GME	42	1	2.4%	SURGERY/CENTRAL SUPPLY	32	2	6.3%
HIM	25	1	3.9%	SURGERY CLINIC	6	-	0.0%
HUMAN RESOURCES	8	-	0.0%	UROLOGY	5	1	20.7%
ICU/TELE	52	3	5.7%	UTILIZATION MANAGEMENT	5	-	0.0%
IT	14	-	0.0%	WOUND CARE	5	-	0.0%
LAB	31	3	9.7%	*OTHER	13	-	0.0%

*Other includes: Compliance, Infection Control, Contracts, Medical Staff, Projects, Security

SVMC RECRUITMENT

Recruitment Update – Q2

52

Full Time Positions Filled

*Includes all positions

44

Per Diem Positions Filled

*Includes 9 internal transfers for all positions

26

RN Positions Filled

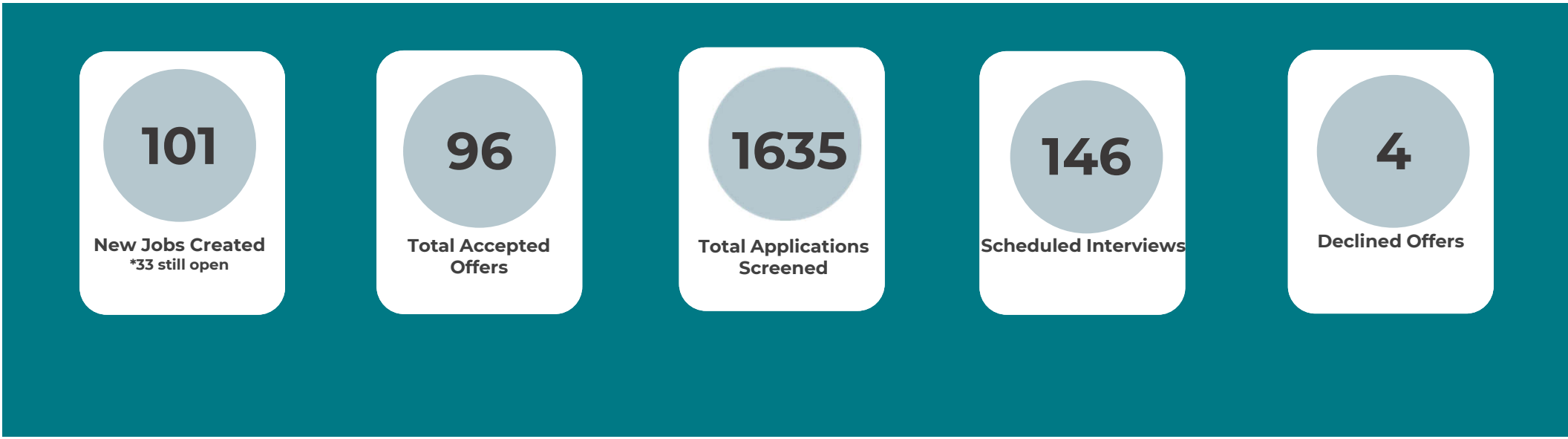
*Includes 8 internal transfers to a different/new RN role including New Grad/Interim Permittee

96

Total positions filled **including transfers**

Candidate Activity Metrics

Recruitment Metrics



Quarter 2

Recruitment Events/Projects

- 4/10/26 – Lemoore College Nursing Career Fair
- 4/13/26 – Tulare Adult School Interview Event
- 4/14/26 – Visalia Adult School Career Fair
- 4/30/26 – SVMC Career Fair, Admin Hallway
- 5/13/26 – Tulare County WIB Healthcare Career Fair

Quarter 3

Upcoming Recruitment Events

- August New Grad Recruitment
- New Grad Interviews
- Porterville Adult School Meet N Greet
- Fresno State Dietitian Students Meet N Greet
- Visalia/Tulare Adult School Career Fairs

ONBOARDING UPDATE

Onboarding Stats

56	6	0	3	0	0
Total # of New Hires Onboarded	Total # of SPD / Travelers Onboarded	% of rescheduled onboarding appointments	# of cancelled employment – withdrew interest in job	# of cancelled employment – inability to pass EH Screening	# of cancelled employment – failed to clear background

EMPLOYEE RELATIONS

Employee Relations Activity

Human Resources

Performance Management Activities

INVESTIGATIONS CONDUCTED

24

PACPs SUPPORTED

2

EXIT INTERVIEWS CONDUCTED

21

GRIEVANCES MANAGED

2

Progressive Disciplinary Action

33
Attendance NOCAs

14
Performance NOCAs

48
Terminations Processed

1
Suspension Letters Pending Investigation

Employee Relations

Unemployment Insurance Activity

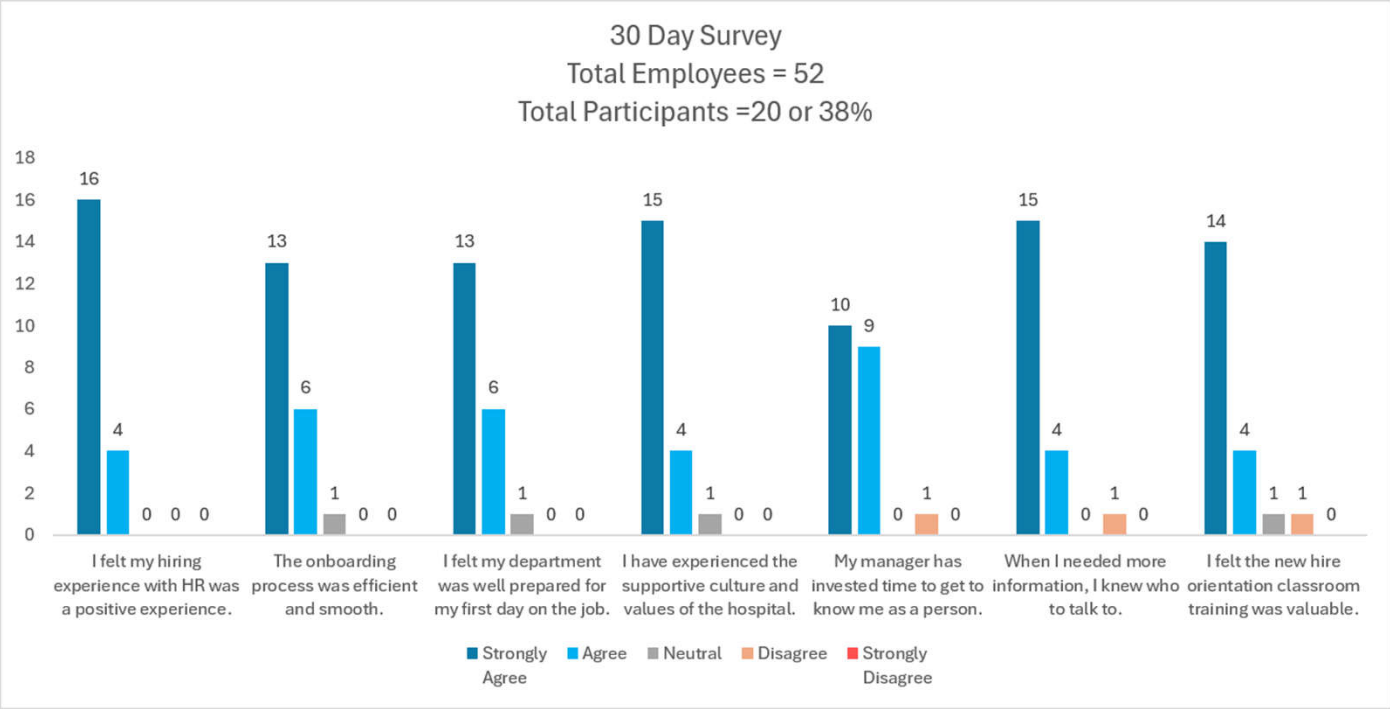
21	Submitted UI Claims/Additional Claims
25%	Initial Claims Win Ratio
$5,962	Savings
0	Appeal Hearing Attended
0	Hearings Won
0	Hearings Pending

Training & Development

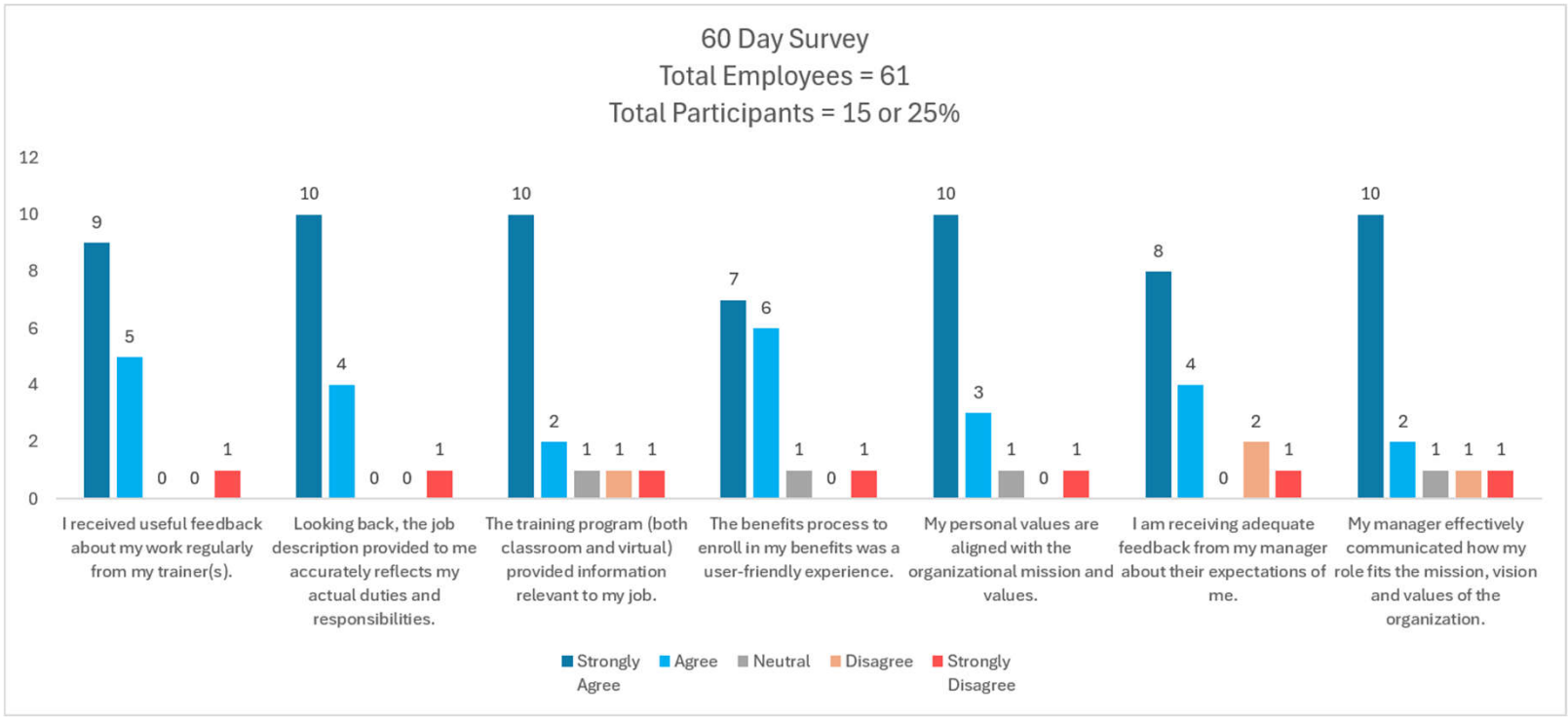
- ✓4 NHO Sessions Facilitated
- ✓54 New Hires Trained

EMPLOYEE ENGAGEMENT

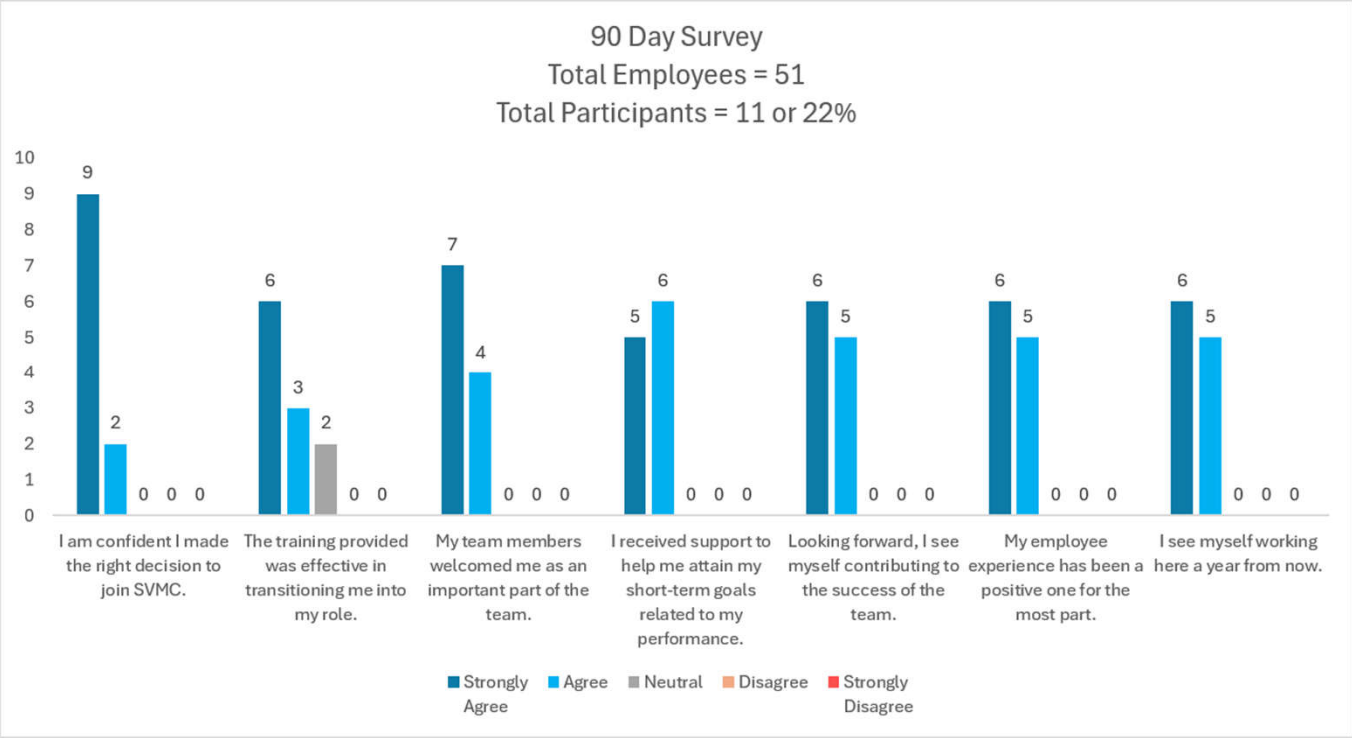
New Hire Survey



New Hire Survey

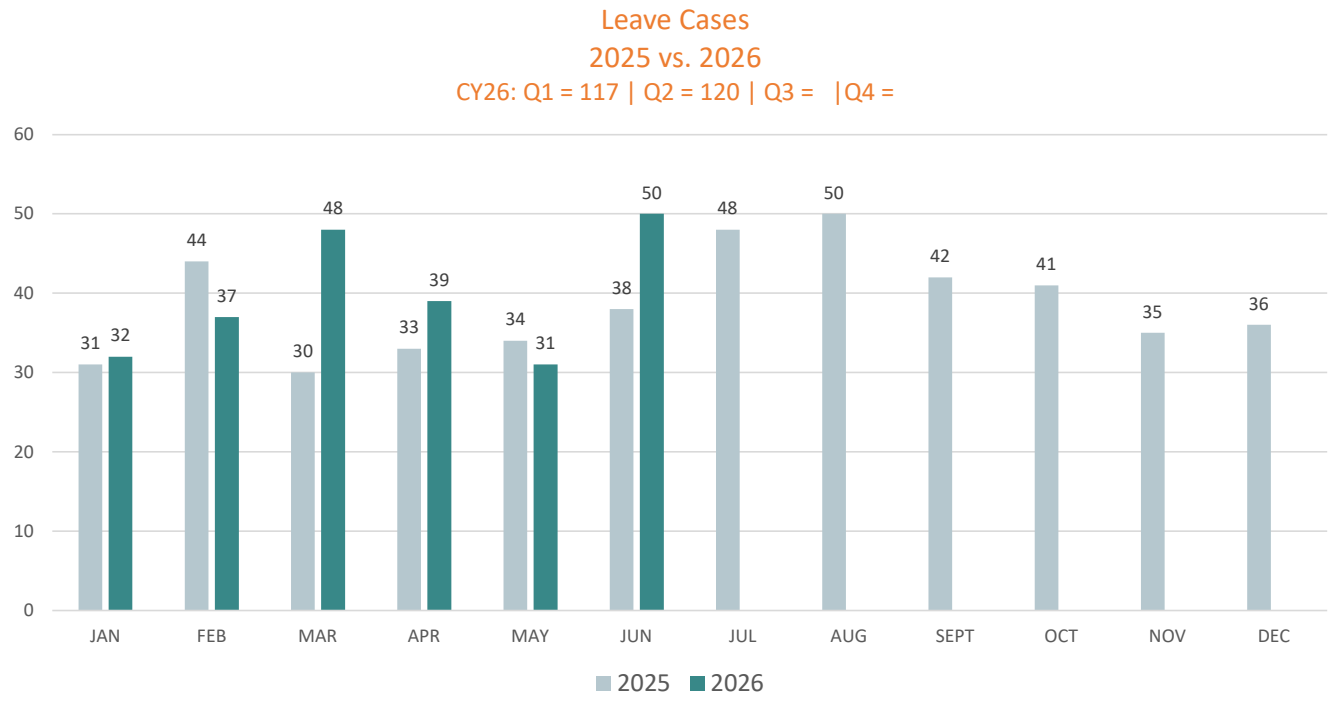


New Hire Survey

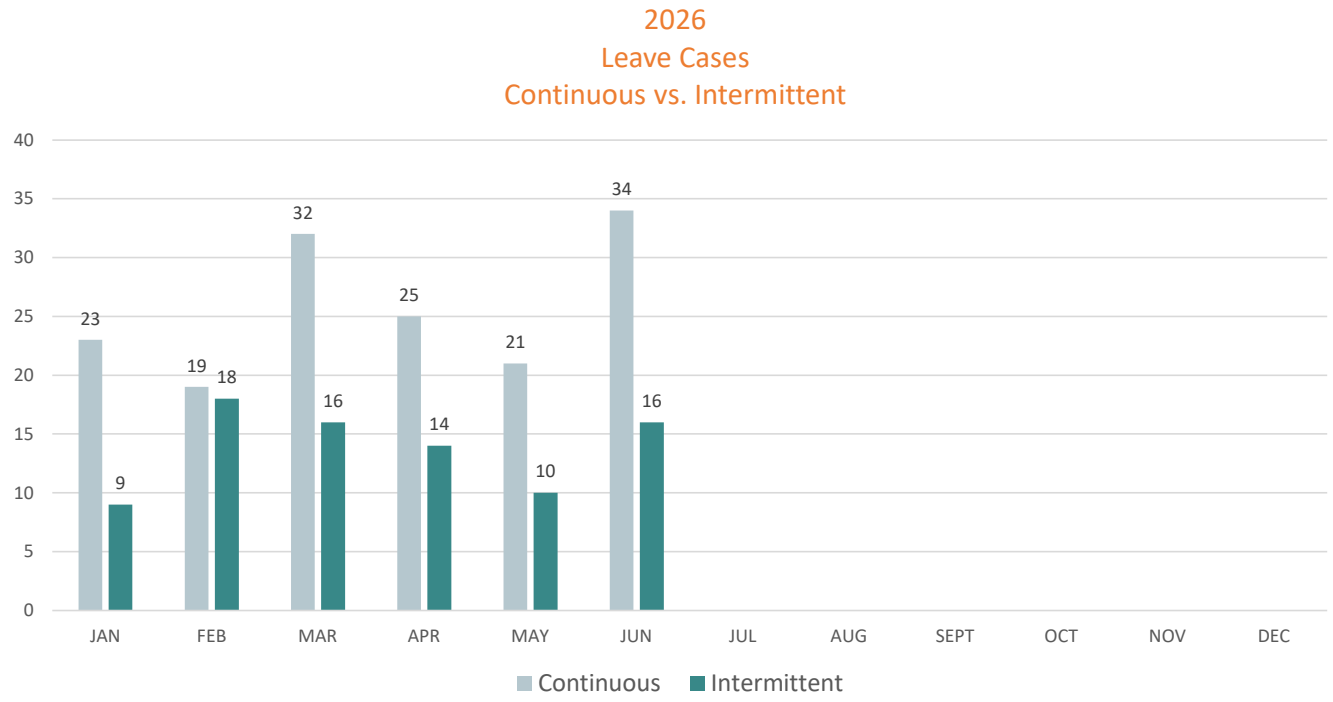


LEAVE OF ABSENCE UPDATE

Leave of Absence Update



Leave of Absence Update



Leave of Absence & Accommodations

Leave Designation & Totals

- FMLA- 55
- FMLA Intermittent- 40
- ADA Accommodation- 21
- Administrative- 4
  - Licensure/Certification
    - New Licensure-2
    - Expired licensure/certification- 1
    - Expired I-9 documentation- 1

- Workers Compensation- 3
- Extensions- 61
- Return to Work- 67
- Total of ALL Leaves- 120

Accommodations Requests

- Light Duty/Modified Duty- 6

Consultations with Benefits/Leave Coordinator

Q2 Total= 517

84

Benefits

357

Leave of Absence & Accommodations

22

Policy

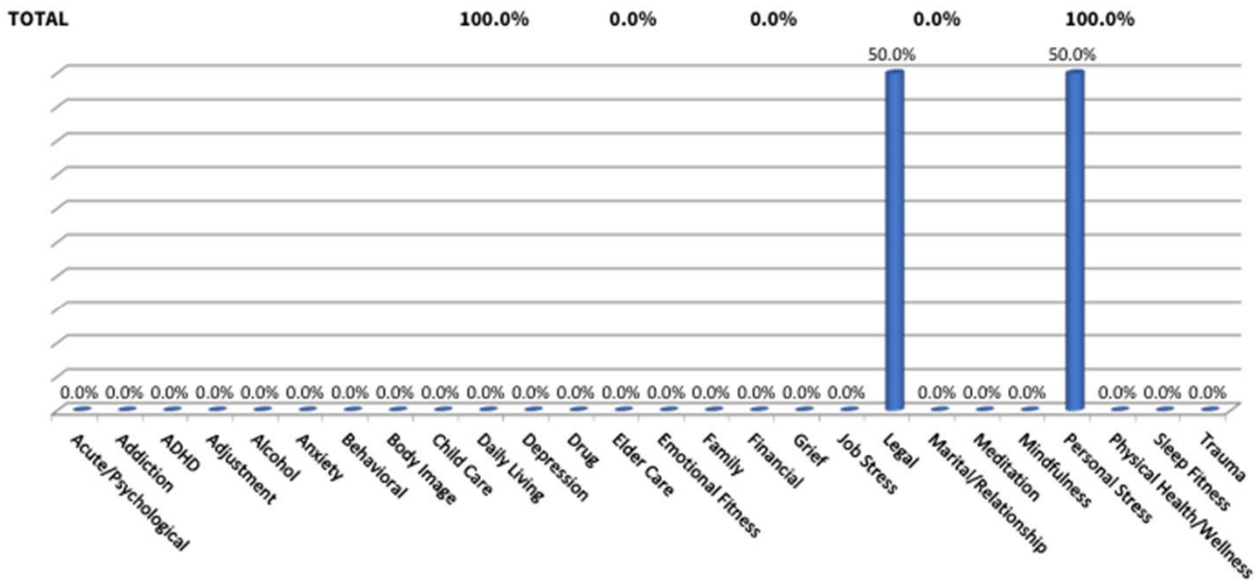
54

Miscellaneous
Ex: UKG, Access, VOE, Lic/Cert

BENEFITS UPDATES

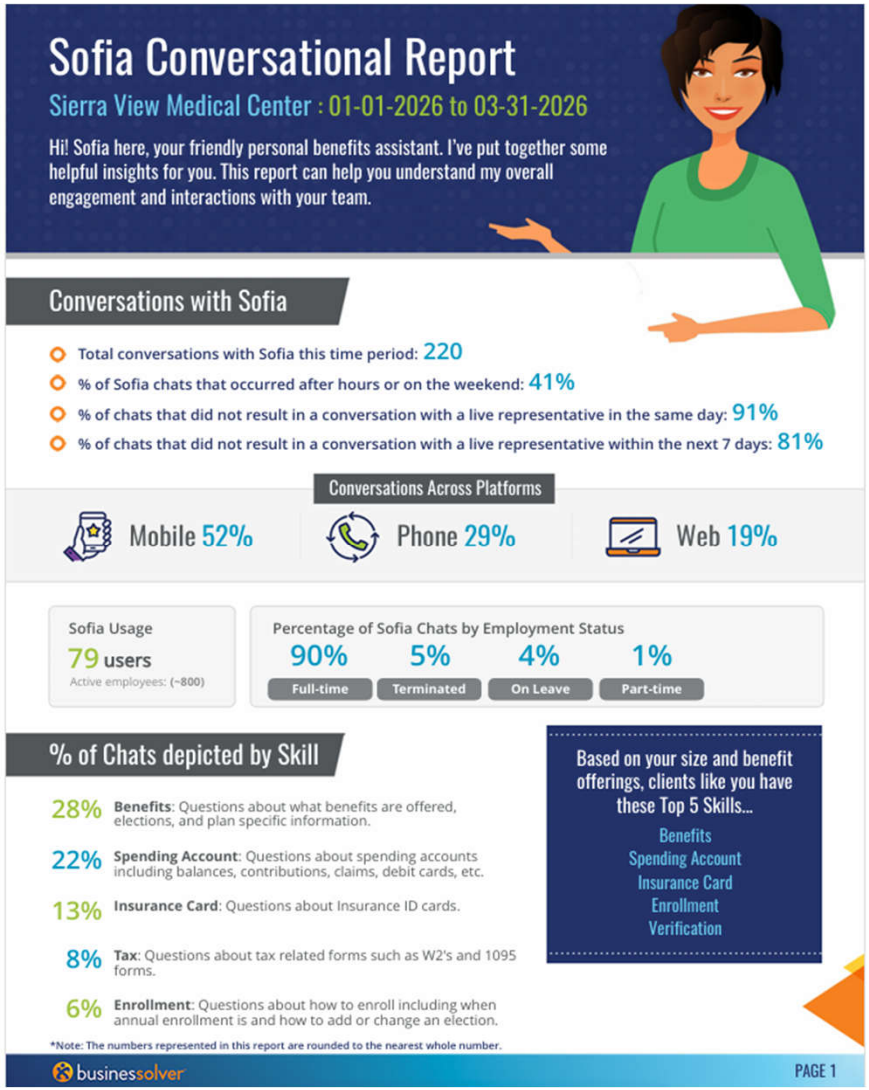
* Always a QTR behind

Simple Therapy- EAP



Benefits Conversational Report

* Always a QTR behind



Sofia Conversational Report

Sierra View Medical Center : 01-01-2026 to 03-31-2026

Hi! Sofia here, your friendly personal benefits assistant. I've put together some helpful insights for you. This report can help you understand my overall engagement and interactions with your team.

Conversations with Sofia

- Total conversations with Sofia this time period: 220
- % of Sofia chats that occurred after hours or on the weekend: 41%
- % of chats that did not result in a conversation with a live representative in the same day: 91%
- % of chats that did not result in a conversation with a live representative within the next 7 days: 81%

Conversations Across Platforms

Mobile 52% | Phone 29% | Web 19%

Sofia Usage

79 users

Active employees: (~800)

Percentage of Sofia Chats by Employment Status

90%	5%	4%	1%
Full-time	Terminated	On Leave	Part-time

% of Chats depicted by Skill

28% **Benefits**: Questions about what benefits are offered, elections, and plan specific information.

22% **Spending Account**: Questions about spending accounts including balances, contributions, claims, debit cards, etc.

13% **Insurance Card**: Questions about Insurance ID cards.

8% **Tax**: Questions about tax related forms such as W2's and 1095 forms.

6% **Enrollment**: Questions about how to enroll including when annual enrollment is and how to add or change an election.

*Note: The numbers represented in this report are rounded to the nearest whole number.

Based on your size and benefit offerings, clients like you have these Top 5 Skills...

Benefits
Spending Account
Insurance Card
Enrollment
Verification

businessolver

PAGE 1

HR POLICY REVIEW

HR Policies

APRIL BOARD APPROVALS

- None

MAY BOARD APPROVALS

- Participation Input of the Retirement Policy
- Paychecks and Paydays

JUNE BOARD APPROVALS

- Introductory Period
- Performance Review Process

REGULATORY COMPLIANCE AUDIT UPDATES

Regulatory Audits/Internal Audits

Below is a glimpse into our department's participation in regulatory surveys along with Internal Audits to ensure data is accurate.

QUARTERLY INTERNAL CONTROL AUDITS

- ✓ Employee Demographic
- ✓ HR Personnel User Changes
- ✓ Rate Variance from Pay Grade
- ✓ User Access and Security Roles

REGULATORY SURVEYS CONDUCTED

- CDPH – 3.23.26 Pt Complaint visit

Regulatory Compliance

233

License and Certification Renewals Processed

100

Employee Change Notices


HR PROJECT
UPDATES

HRIS Project Update

- **UKG Performance Review**
  - **In Progress** – Leaders are completing annual performance reviews, with all reviews due by **July 31, 2026**.
- **ACA Hours Integration**
  - **In Progress** – Integration activities are underway.
- **Job Description Transition**
  - **In Progress** – Leader meeting invitations will be sent by **July 31, 2026**. Department review meetings will occur **August–September 2026**, with all revised job descriptions finalized and implemented by **January 1, 2027**.
- **The Work Number – Employment and Income Verifications**
  - **Complete** – Implementation is complete and the service is now live.
- **Salary administration**
  - **Complete** – Salary administration updates have been finalized.
- **Discretionary Merit Increase**
  - **Complete** – Salary adjustments has been updated and reconciled.

REPORT REQUESTS

24

Total Report Requests

8

Total Analyses

16

Total staff support reports

HR KEY ACCOMPLISHMENTS

- Audited FMLA Leaves for timeframe accuracy
- Created and implemented new LOA intake forms for staff and leadership
- Updated and prepared launch for 2026 EE and Volunteer Annual Orientation
- Facilitated 3 Critical Incident Stress Debriefings & Grief Counseling for staff
- Completed Benefits Enrollment discovery for 2026-2027
- Edited and updated Employee Handbook for 2026 launch
- Provided Gap Analysis for Hospital Telework Program
- Completed TB noncompliance
- Coordinated and scheduled 2026 Biometric Screening for staff
- Revamped process for Physical Functions on new JD
- Started the transfer of job descriptions to the new templates
- Celebrated National Volunteer Month
- Participated and supported SCORE Survey Program and subsequent staff and leadership surveys
- Partnered with Payroll to complete wage and hour audit and payout of shift diff practices
- Presented attendance, timekeeping and monetary rewards education session at depart head

Marketing Report

Quarter 2

SIERRA VIEW
MEDICAL CENTER

Social Media

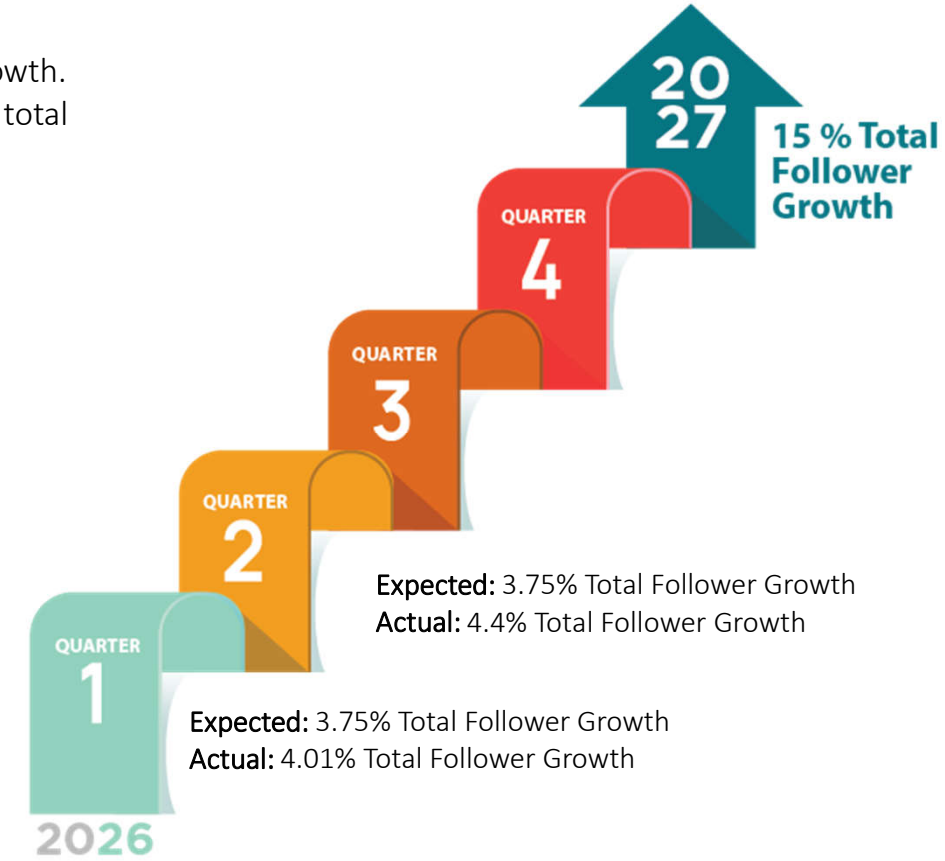
SIERRA VIEW
MEDICAL CENTER

Quarter 2

Social Media Growth

SVMC social media platforms continue to experience steady growth. Average growth for Q1 was 4.4% in overall audience net gain. A total of 498 new followers was gained across the three platforms.

Followers by Platform				
Platform	**2026 Q1**	2026 Q2	Followers Gained	Growth Percentage
Facebook	**5,952**	6,164	212	3.56%
Instagram	**2,439**	2,546	107	4.39%
LinkedIn	**2,939**	3,118	179	6.09%



Quarter 2

Social Media Analytics

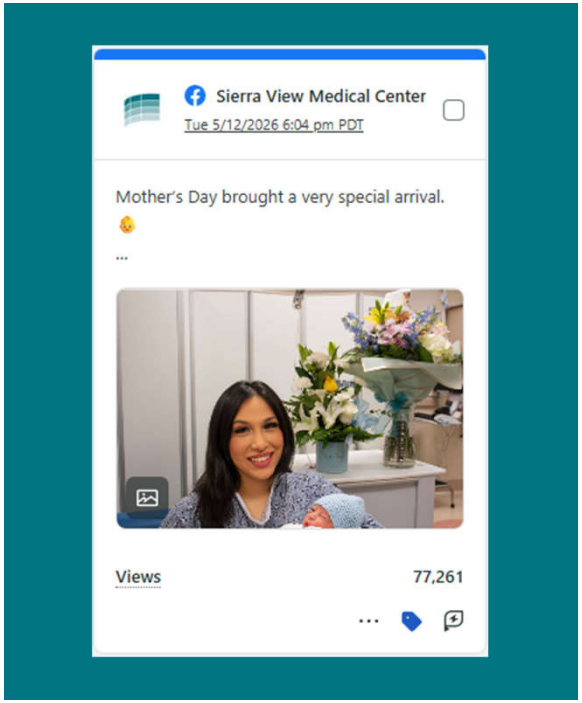
	Facebook	Instagram (Including Stories)	LinkedIn	Overall Total for Q2	Social Media Quarterly Goals
# of Posts	92	106	56	245 ↓	250 per quarter
Impressions	1,113,983	405,510	27,545	1,547,038 ↑	625,603
Engagements	127,234	6,098	7,564	140,896 ↑	48,587
Engagement Rate	11.4%	1.5%	27.5%	9.1% ↑	8.4%

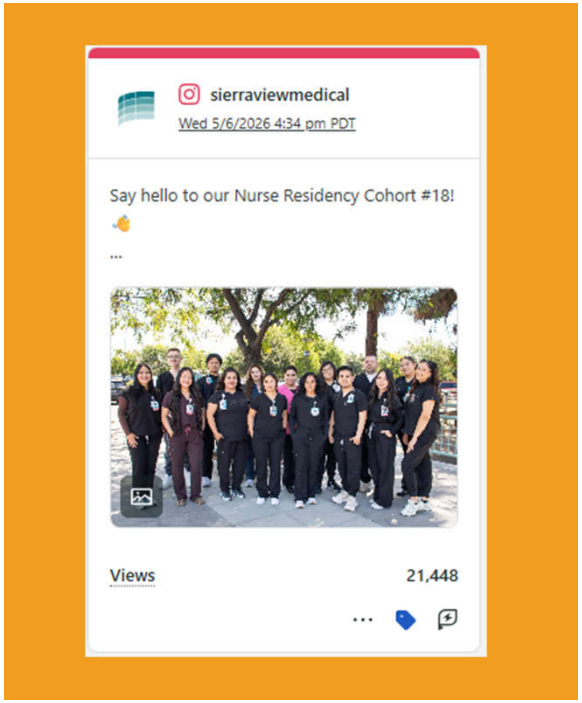
Social Media Quarterly Goals Explained:

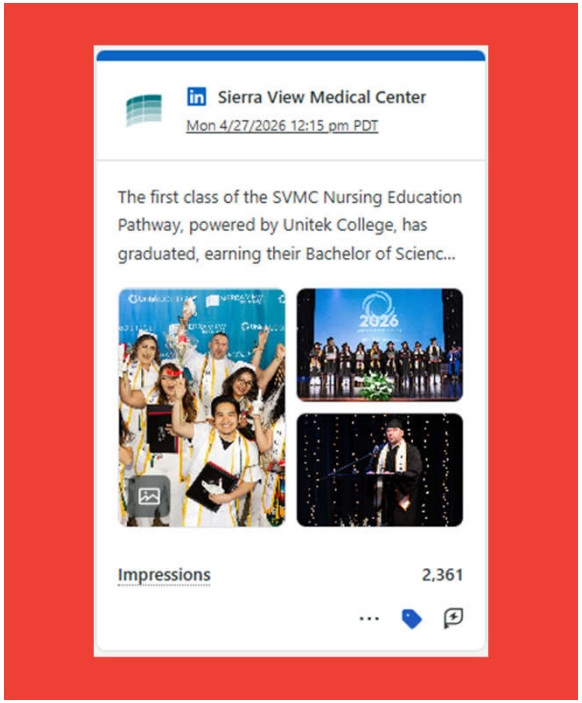
- **# of Posts (250 per quarter):** Realistic goal for SVMC that keeps up with industry standards
- **Impressions Goal (625,603 per quarter):** 10% growth from previous year-to-date
- **Engagements Goal (48,587 per quarter):** 10% growth from previous year-to-date
- **Engagement Rate Goal (8.4%):** 7.5%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

Quarter 2

Top Three Stories By Platform (Impressions)

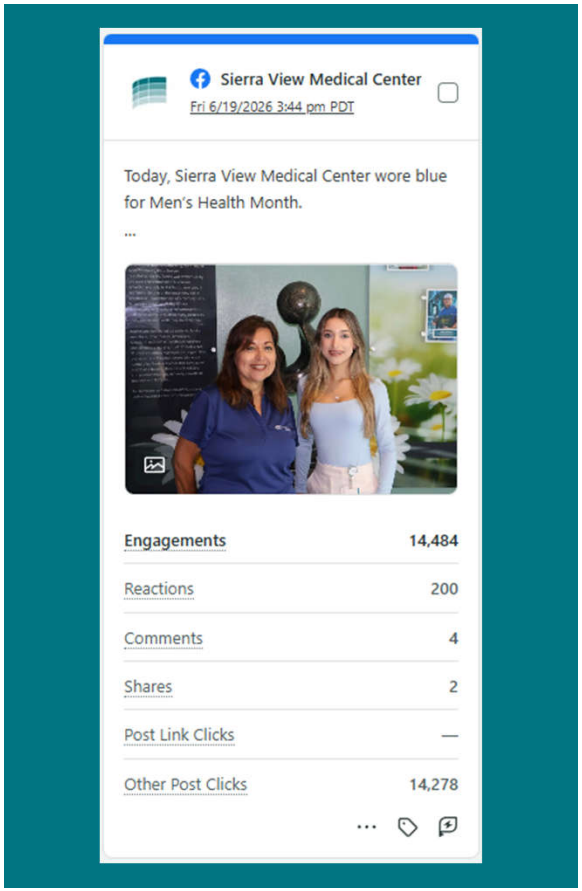


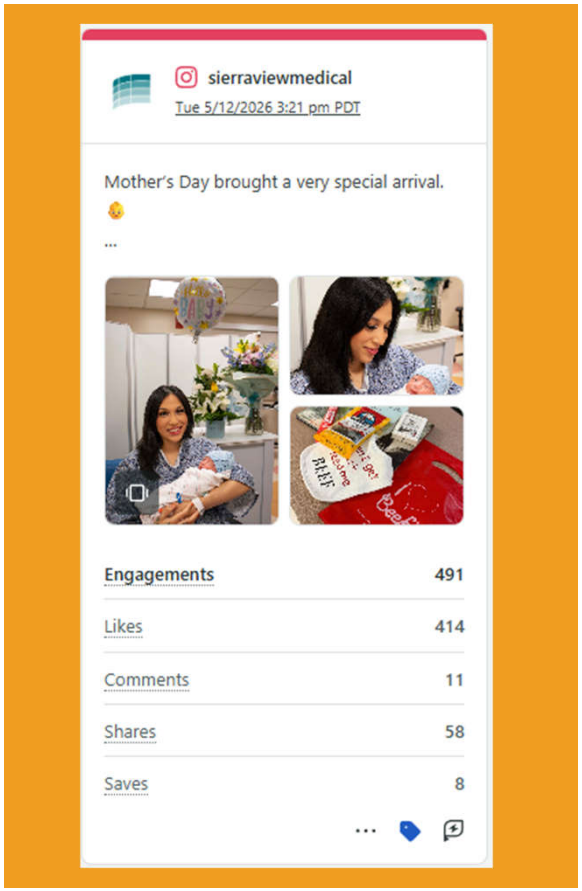


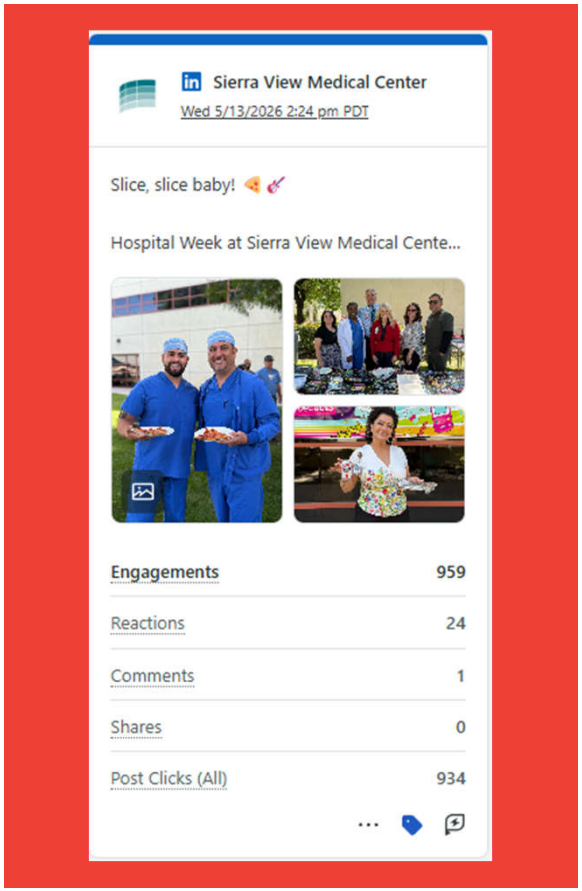


Quarter 2

Top Three Stories By Platform (Engagements)







Quarter 2

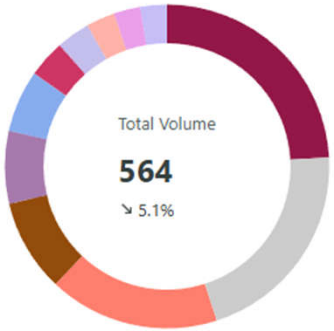
Top Paid Advertisement

Platform	Post	Date	Landing Page Views	Views
Facebook	Emergency Department Careers	Started June 17 for 30 Days	325	16,401

Quarter 2

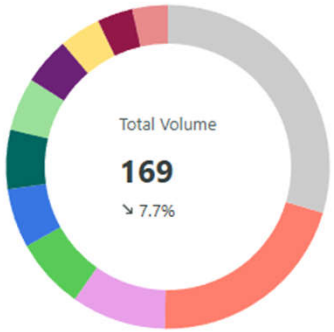
Category Breakdown for Social Media Posts

All Tags



Employees	24.1%
Holiday & Observances	17%
events	9.2%
Senior Team	7.3%
Nursing Services	6.2%
Awards	3.7%
Updates	3.4%
SV Foundation	2.8%
partnerships	2.7%
recruitment	2.7%
All Other Tags	20.9%

Service Lines Only



Nursing Services	20.7%
SV Foundation	9.5%
Emergency Services	7.1%
CTC	5.9%
GME	5.9%
SVLHCD Board	5.3%
Maternal Child Health	4.7%
Stroke Center	4.1%
ICU/Tele	3.6%
Unitek	3.6%
All Other Tags	29.6%

Quarter 2

Competitive Analysis

Facebook	Kaweah Health	Sierra View Medical Center
Followers Gained	+114	+212
Growth Rate Based on Audience Size	0.43% Growth	3.56% Growth
# of Posts	61	92
Public Engagements	4,448 (72.92 per post)	7,812 (84.91 per post)

Instagram	Kaweah Health	Sierra View Medical Center
Followers Gained	+193	+107
Growth Rate Based on Audience Size	2.37% Growth	4.39% Growth
# of Posts (Not including stories)	56	106
Public Engagements	6,373 (113.8 per post)	5,438 (51.3 per post)

Analytics Explained:

- **Followers Gained:** New followers added during the reporting period.
- **Growth Rate:** % increase relative to total audience. Enables fair comparison across different-sized accounts (Kaweah: ~26K FB / ~8K IG; Sierra View: ~6K FB / ~2.5K IG).
- **Posts:** Total content published during the reporting period.
- **Public Engagements:** Total interactions (likes, comments, shares, etc.).

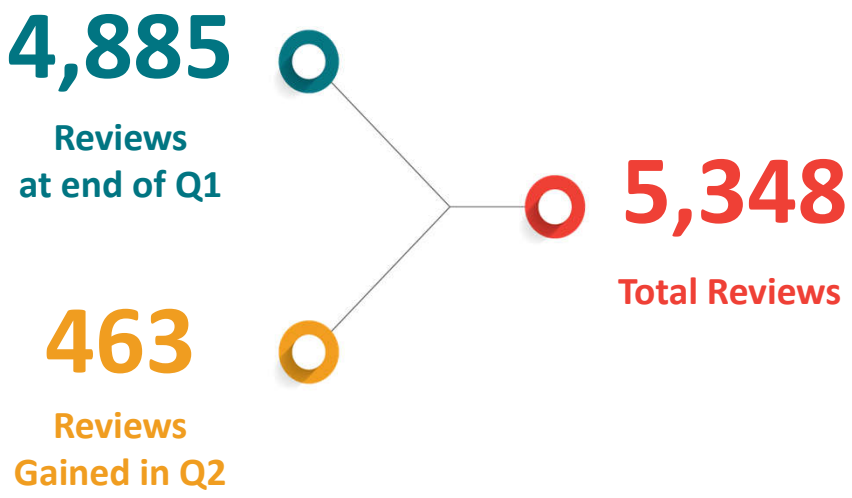
Reputation Management

SIERRA VIEW
MEDICAL CENTER

Quarter 2

Reputation Management

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



Google Star Rating by Location	
Sierra View Medical Center	3.8 Stars
SVMC Urology Clinic	4.3 Stars
SVMC Medical Office Building	4.6 Stars
SVMC Physical Therapy	4.7 Stars
SVMC Roger S. Good Cancer Treatment Center	4.7 Stars
SVMC Women's Services Clinic	4.7 Stars
Sierra View Community Health Center – Terra Bella	4.8 Stars
Sierra View Hip & Knee Center	4.8 Stars
SVMC Wound Healing Center	4.9 Stars
SVMC Ambulatory Surgery Center	4.9 Stars

SIERRA VIEW MEDICAL CENTER

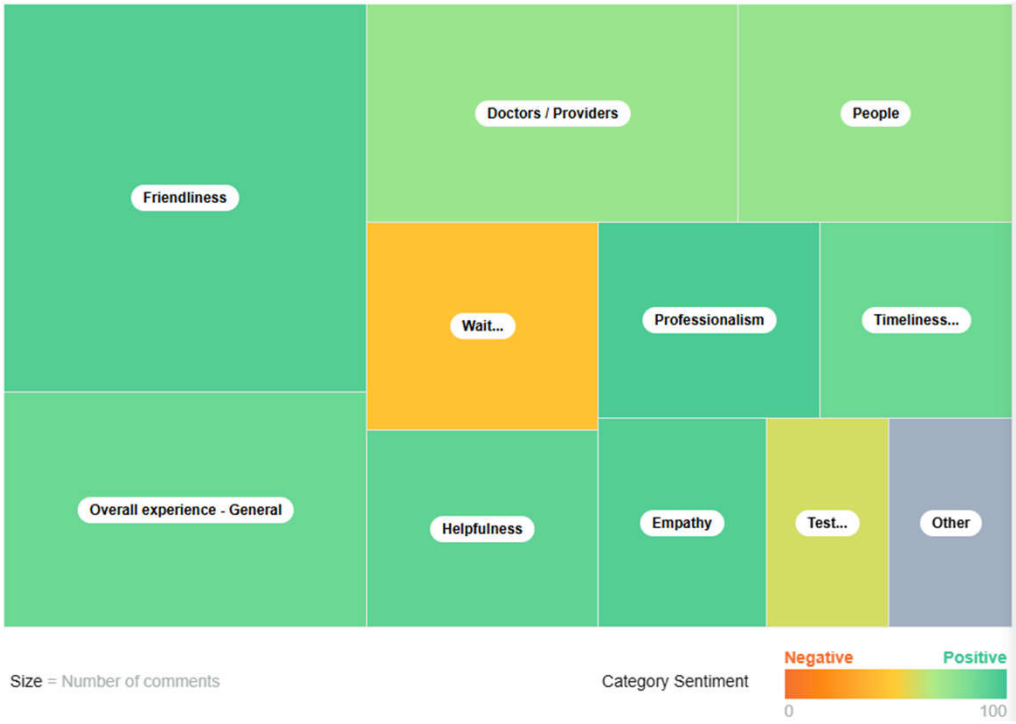
Quarter 2

What Our Patients Are Saying

Word Cloud

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

Sentiment Map



Quarter 2

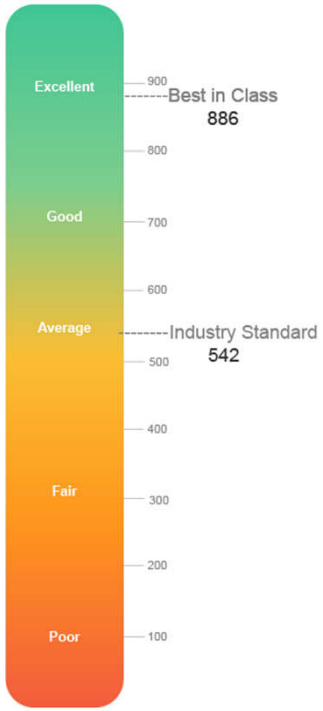
Reviews & Average Ratings

Location (10)	Total Reviews	Average Rating
SVMC Wound Healing Center (SVMC_Wound_Healing)	10 0% | 0% | 100%	5 /5
Sierra View Community Health Center – Terra Bella (SVMC_Terra_Bella_Clinic)	4 0% | 0% | 100%	5 /5
SVMC Ambulatory Surgery Center (SVMC_ASC)	35 0% | 0% | 100%	5 /5
Sierra View Hip & Knee Center (SVMC_Hip_Knee)	27 0% | 0% | 100%	4.9 /5
SVMC Roger S. Good Cancer Treatment Center (SVMC_CTC)	41 5% | 0% | 95%	4.8 /5
Sierra View Physical Therapy (SVMC_PT)	17 6% | 6% | 88%	4.6 /5
SVMC Women's Services Clinic	18 6% | 6% | 88%	4.6 /5
SVMC Medical Office Building (SVMC_MOB)	291 8% | 3% | 89%	4.5 /5
Sierra View Medical Center (SVMC)	256 18% | 2% | 80%	4.1 /5
Sierra View Medical Center Urology Clinic in alliance with Keck Medicine of USC (SVMC_Urology_Clinic)	8 38% | 0% | 62%	3.5 /5

SIERRA VIEW MEDICAL CENTER

Quarter 2

Reputation Scores



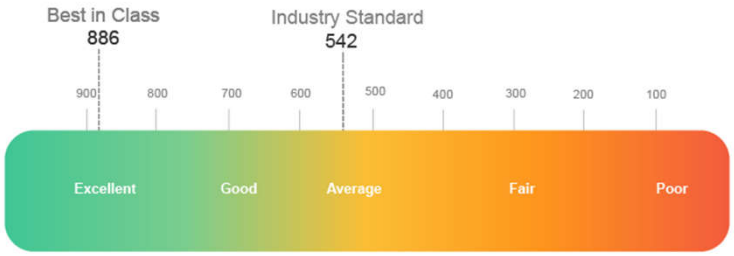
Location (10)	Reputation Score	Review Sentiment	Review Volume	Review Recency	Review Quality	Review Spread	Review Response	Search Impressions	Listing Completeness
Sierra View Medical Center Urology Clinic in alliance with Keck Medicine of USC (SVMC_Urology_Clinic)	541	38%	57%	100%	17%	57%	100%	31%	93%
Sierra View Medical Center (SVMC)	703	55%	57%	100%	68%	57%	100%	98%	93%
SVMC Medical Office Building (SVMC_MOB)	776	81%	57%	100%	62%	57%	100%	74%	81%
SVMC Roger S. Good Cancer Treatment Center (SVMC_CTC)	784	80%	57%	100%	60%	57%	100%	74%	93%
Sierra View Community Health Center – Terra Bella (SVMC_Terra_Bella_Clinic)	826	95%	57%	100%	11%	57%	100%	59%	93%
Sierra View Physical Therapy (SVMC_PT)	841	94%	57%	100%	59%	57%	90%	74%	93%
SVMC Women's Services Clinic	855	94%	57%	100%	48%	57%	97%	90%	95%
SVMC Wound Healing Center (SVMC_Wound_Healing)	858	97%	57%	97%	54%	57%	100%	74%	93%
Sierra View Hip & Knee Center (SVMC_Hip_Knee)	872	96%	57%	100%	67%	57%	100%	91%	95%
SVMC Ambulatory Surgery Center (SVMC_ASC)	872	99%	57%	100%	59%	57%	100%	74%	93%

SIERRA VIEW MEDICAL CENTER

Quarter 2

Competitive Analysis of Patient Reviews

Location (4)	Total Reviews	Average Rating	Reputation Score
Kaweah Health Medical Center	36 44% | 3% | 53%	3.1 /5	612
Sierra View Medical Center (SVMC)	256 18% | 2% | 80%	4.1 /5	706
Dignity Health - Memorial Hospital	258 10% | 3% | 87%	4.5 /5	868
Adventist Health Hanford	306 10% | 3% | 87%	4.5 /5	834



Website

SIERRA VIEW
MEDICAL CENTER

Quarter 2

Session Durations

110,946 Sessions

(Up 814)

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

1.5 Pages Per Session

(No Change)

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

2M 49S Average Engaged Duration

(Up 7S)

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

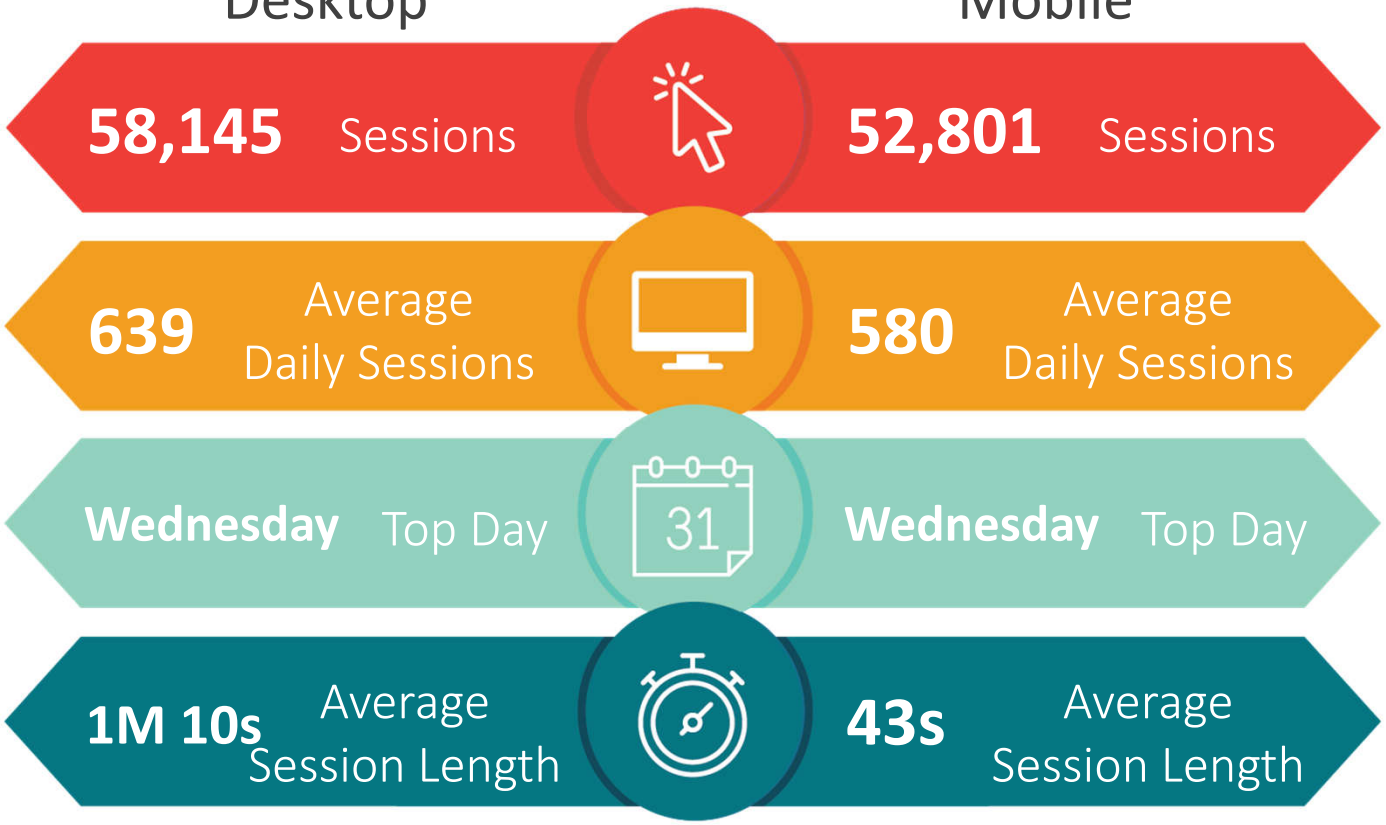
57S Average Session Duration

(No Change)

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

Quarter 2

A Snapshot of Our Users



Quarter 2

Top Pages

Page	Sessions	Bounce Rate
Home page	33,003	59.4%
Welcome	23,335	99.6%
Careers	16,828	13.6%
Patient Portal	9,367	10%
Locations: Sierra View Medical Center	5,876	18%
Remote Access	5,313	17%
Physician Directory	2,600	20.2%
Locations	2,147	16%
Women's Services Clinic	1,685	47.8%
Pay My Bill	1,630	46.3%

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

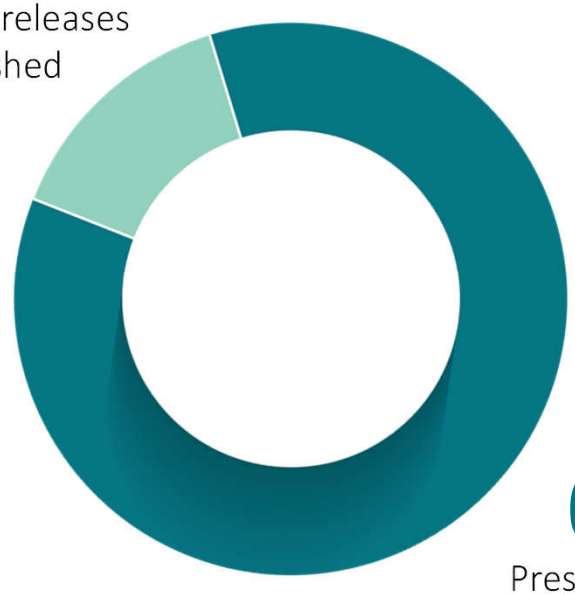
Bounce Rate: The percentage of website sessions where a user leaves after viewing only one page, without taking further action. A high bounce rate isn't always bad—it can mean the visitor quickly found the information they needed.

Public & Media Relations

SIERRA VIEW MEDICAL CENTER

Quarter 2

SVMC In the Headlines



Top Articles

1. Third Class graduates from SVMC Internal Medicine Residency Program
2. Sierra View recognized in Best of Central California Awards
3. San Joaquin Valley Hospitals Earn Top Safety Grades
4. Sierra View in Solid Financial Position
5. Chief Financial Officer leaves Sierra View
6. Sierra View celebrates first graduating class of SVMC Nursing Education Pathway, powered by Unitek College
7. Central CA detective shot and killed

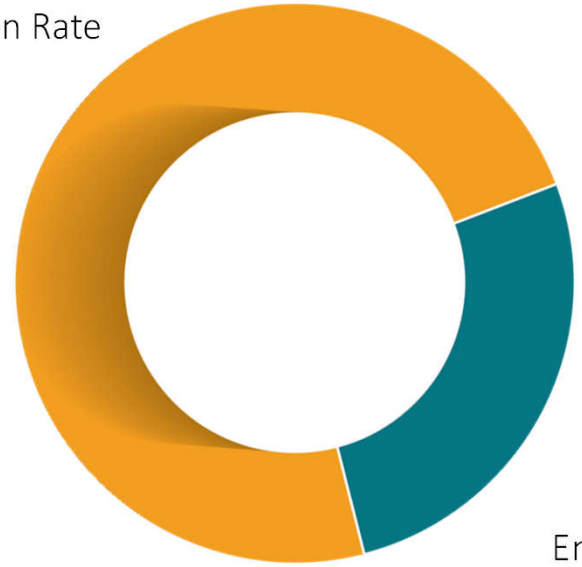
Quarter 3

SIERRA VIEW MEDICAL CENTER

INSIDE View

SIERRA VIEW MEDICAL CENTER

52%
Open Rate



3
Emails Sent

Sierra View Medical Center delivered 3 installments of our digital newsletter, Inside View. This publication gives an Inside View of everything happening at and around our hospital such as news, events, career openings, and more.

Email Subscribers			
2026 Q1	2026 Q2	Subscribers Gained	Growth Percentage
704	902	198	28.13%

Community Relations, Events, & Fundraising

SIERRA VIEW MEDICAL CENTER

Quarter 2

Community Engagement and Impact

April

5 Engagements

- Sierra View Foundation Golf Classic
- Read Across America with Porterville Schools
- Cancer Connection
- National Donate Life
- Green & Blue Day

Focus Area

- Community Education / Fundraising

Breakdown

- Community fundraising event
- Youth literacy partnership
- Cancer support outreach
- Organ donation awareness

Impact

- Strengthened community partnerships
- Increased awareness of lifesaving health initiatives

May

3 Engagements

- Cinco de Mayo Parade
- Community Blood Drive
- Cancer Connection

Focus Areas

- Community Health / Outreach

Breakdown

- Community Celebration
- Blood donation initiative
- Cancer support program

Impact

- Expanded community outreach
- Supported patient care through blood donation efforts

June

4 Engagements

- National Cancer Survivors Day Celebration
- Cancer Connection
- Wear Blue Day – Men's Health
- GME Graduation

Focus Areas

- Health Awareness / Community Engagement

Breakdown

- Cancer survivorship celebration
- Men's health awareness
- Graduate medical education

Impact

- Promoted preventive health and wellness
- Celebrated patient and physician milestones

Summary

11 Total Engagements | **1** Golf Tournament - **$60,000** raised for local healthcare

Primary Focus Areas: Community Education | Community Health | Fundraising | Health Awareness

Quarter 2

Community Relations Outreach

Meetings by Month

April – 3 Meetings

- ABC 30 Advisory Council Meeting
- MTA Pathway Advisory Board Meeting
- Access To Care Meeting

May – 4 Meetings

- Access To Care Meeting (Tulare County)
- MTA Pathway Advisory Board Meeting
- CHIP TAME Bi Monthly Meeting
- Foundation Monthly Meeting

June – 2 Meetings

- MTA Pathway Advisory Board Meeting
- Access To Care Meeting (Tulare County)

9 Total Meetings Attended **5** Unique Organizations Engaged **3** Recurring Partnerships

Strategic Impact

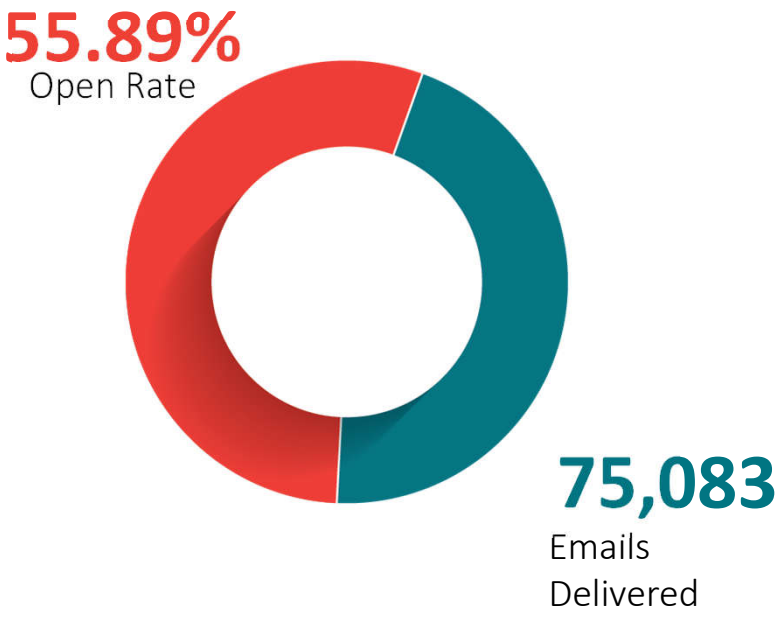
- Maintained Sierra View Medical Center's presence in key regional planning and advisory groups.
- Strengthened partnerships with education, healthcare, media, and community organizations.
- Supported workforce development and access to care initiatives through ongoing collaboration.
- Fostered relationships that create future opportunities for community outreach and strategic partnerships.

Internal Communication Strategy

SIERRA VIEW MEDICAL CENTER

Quarter 2

Internal Communications



Email	Open Rate
4/30 Bi-Weekly Leadership Email	95.92 % Open Rate
Leadership Update from the CEO	93.88% Open Rate

Types of Internal Communication:

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

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

Get In Touch With Marketing

Address

444 West Putnam Avenue

Porterville, CA 93257

General Email

Marketing@sierra-view.com

General Line

(559)791-3922

Thank You

SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	07/01/2026
BOARD OF DIRECTORS APPROVAL	
	0728/2026
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
July 28, 2026 BOARD APPROVAL

The following Policies/Procedures/Protocols/Plans/Forms have been reviewed by the Medical Executive Committee and are being submitted to the Board of Directors for approval:

	Pages	Action
I. Policies:		**APPROVE**
• Accessibility of the Medical Record	1	
• Administration of Pneumococcal Vaccine to Inpatients	2-7	
• AMA Discharge Request (Against Medical Advice)	8-9	
• Autopsy - Securing of	10-11	
• Change of Physician	12	
• Consent and HIV (HTLV III/LAV) Antibody Testing for AIDS	13-15	
• Discharge of Homeless Patients	16-18	
• Discharge Planning – Assessment and Reassessment	19-22	
• Drug Withdrawal: Newborn	23-31	
• Ebola Virus Disease	32-42	
• Endotracheal Intubation: Newborn	43-45	
• Formula – Infant Formula Preparation and Storage	46-47	
• Gavage Feeding	48-51	
• Maternal Child Health Scope of Services	52-66	
• Operating Room Cleaning	67-70	
• Pediatric Blood Transfusion	71-75	
• Seasonal Influenza Plan	76-80	
• Seeing/Hearing/Companion Dog (Service Animals)	81-83	

SUBJECT: **ACCESSIBILITY OF THE MEDICAL RECORD**	SECTION: **Page 1 of 1**

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

POLICY:

Sierra View Medical Center (SVMC) shall have all patient medical records accessible on a 24-hour per day basis.

PROCEDURE:

1. The electronic medical record is available to all SVMC staff members based on their access role 24/7.

2. From the hours of 5:00 PM through 7:00 AM, seven days per week, any appropriate individual requesting an old paper medical record must contact the Nursing Supervisor and provide the patient's name and medical record number, if the number is known.

    a. The Nursing Supervisor will unlock the Health Information Management (HIM) Department and obtain the requested medical record. The medical record will be logged out of the department by the Nursing Supervisor, listing the patient's name, medical record number, most recent discharge date (if multiple volumes in one [1] jacket) and destination of the medical record.

3. Should the record requested be located off campus, the Jack and Jeff Storage Company will be contacted and provided with the requested medical record number and patient name, if this is known. The Jack and Jeff Storage Company will courier the medical record to the HIM Department during normal business hours. They do not have 24 hour service.

REFERENCES:

- California Code of Regulations (2023). Title 22. § 70751,

  Retrieved from https://govt.westlaw.com/calregs/Document/IB47D04195B6111EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)&bhcp=1

- Code of Federal Regulations (2020). §482.24,

  Retrieved from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.24

/

SUBJECT:	SECTION:
ADMINISTRATION OF PNEUMOCOCCAL VACCINE TO INPATIENTS	***Surveillance, Prevention, Control of Infection (IC)***

POLICY

PURPOSE

To provide guidelines for the administration of pneumococcal vaccine to all inpatients who meet the criteria established by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

BACKGROUND

Streptococcus pneumoniae (*S. pneumoniae*) is a gram-positive facultative anaerobe with more than 100 known serotypes. Although most serotypes cause serious disease only a few cause pneumococcal infections such as meningitis, bacteremia and pneumococcal pneumonia. Vaccination opportunities for those with an increased risk of pneumococcal disease are often missed during two critical times – regular office visits and during hospitalization. Screening followed by immunization of at-risk hospital patients (see Table 1) would significantly reduce the complications associated with pneumococcal disease, up to and including death.

A. PREREQUISITES

a. Offer to any inpatient who meets the criteria in Table 1, especially:

   i. Patients age 65 years or older

   ii. Immunocompromised patients including, but not limited to, patients with chronic heart, pulmonary renal, metabolic or liver disease; cancer, anemia, alcoholism, HIV/AIDS, etc. (See Table 1, from Epidemiology and Prevention of Vaccine-Preventable Diseases, CDC)

   iii. Any vaccine recipients with more than 5 years since the last vaccination

   iv. In 2021, ACIP recommended use of PCV20 or PCV15 for all adults aged ≥65 years who have not previously received a pneumococcal vaccine or whose previous vaccination history is unknown

B. PRECAUTIONS

a. The following should be taken into consideration before administering pneumococcal vaccination:

   i. The patient should wait to be vaccinated if moderately or severely ill

   ii. The patient should wait to be vaccinated if the health care provider decides to postpone vaccination

C. CONTRAINDICATIONS AND RISKS

a. The patient should tell the vaccination provider if any of the following conditions exist:

   i. The patient has received two pneumococcal vaccine doses

   ii. The patient received the vaccine less than 5 years ago

   iii. The patient is allergic to the vaccine or any component of the vaccine

   iv. The patient is pregnant – women who are at increased risk of pneumococcal disease and who are candidates for pneumococcal vaccine should be vaccinated before pregnancy, if possible

   v. The patient has had any neurological reaction(s) to the vaccine

   vi. The patient is at risk for having less than 50,000 platelets per microliter of blood

   vii. The patient has a fever greater than 38°C/100.4°F at the time of vaccination

   viii. The patient refused vaccination (notify the physician)

   ix. Physician provides orders that the patient not be given the vaccine

   x. Lesser known risks or reactions include pain, redness or swelling at the injection site, mild fever, headache, feeling tired, etc. (Consult product insert for additional lesser known risks)

D. RESPONSIBILITIES

a. Any of the following health care professionals with current California licenses may administer the vaccine: Licensed Vocational Nurse (LVN), Registered Nurse (RN), Family Nurse Practitioner (FNP), Physician's Assistant (PA), or a physician (MD or DO)

b. Prior to administering vaccines for the first time at SVMC, the health care professional must conduct an initial review of the CDC immunization criteria and the SVMC Standardized Procedures for Immunizations

c. The Nursing Staff will review the SVMC Standardized Procedures for Immunizations annually during the Annual Competency Fair

d. A copy of the most current Vaccine Information Statement (VIS) in the appropriate language must be provided to the vaccine recipient and recorded in the EMR or office log, along with the publication date of the VIS (See References for link to the VIS)

E. PROCEDURE

a. Treatment

i. Assess the inpatient for the need of pneumococcal vaccination.

ii. Screen all adult inpatients for contraindications and precautions associated with the administration of pneumococcal vaccine.

iii. If inpatient gives consent provide a copy of the most current Pneumococcal Vaccine Information Statement (VIS) in the language appropriate for the recipient.

TABLE 1

Recommendations for use of PCV15 or PCV20 in pneumococcal conjugate vaccine – naïve adults aged ≥ 19 years. Advisory Committee on Immunization Practices, United States, 2023

		Age group, yrs	
Medical indication group	**Specific underlying medical condition**	**19–64**	**≥65**
None	None	None	1 dose of PCV20 alone, or 1 dose of PCV15 followed by a dose of PPSV23 ≥1 year later*
Underlying medical conditions or other risk factors	Alcoholism Chronic heart disease† Chronic liver disease Chronic lung disease§ Chronic renal failure¶ Cigarette smoking Cochlear implant Congenital or acquired asplenia¶ Congenital or acquired immunodeficiencies¶,** CSF leak Diabetes mellitus Generalized malignancy¶ HIV infection Hodgkin disease¶ Iatrogenic immunosuppression¶,†† Leukemia¶ Lymphoma¶ Multiple myeloma¶ Nephrotic syndrome¶ Sickle cell disease or other hemoglobinopathies¶ Solid organ transplant¶	1 dose of PCV20 alone or 1 dose of PCV15 followed by a dose of PPSV23 ≥1 year later*	1 dose of PCV20 alone or 1 dose of PCV15 followed by a dose of PPSV23 ≥1 year later*

Abbreviations: CSF = cerebrospinal fluid; PCV15 = 15-valent pneumococcal conjugate vaccine; PCV20 = 20-valent pneumococcal conjugate vaccine; PPSV23 = 23-valent pneumococcal polysaccharide vaccine.
* Adults with immunocompromising conditions, a CSF leak, or a cochlear implant might benefit from shorter intervals (e.g., ≥8 weeks). These vaccine doses do not need to be repeated at age ≥65 years if administered at age <65 years.
† Includes congestive heart failure and cardiomyopathies.
§ Includes chronic obstructive pulmonary disease, emphysema, and asthma.
¶ Indicates immunocompromising conditions
** Includes B- (humoral) or T-lymphocyte deficiency, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), and phagocytic disorders (excluding chronic granulomatous disease).
†† Diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids and radiation therapy.

From: https://www.cdc.gov/mmwr/volumes/72/rr/rr7203a1.htm

iv. Administer the manufacturer's recommended dose of the pneumococcal vaccine

b. Education

i. As stated in the treatment section above, provide a copy of the most current VIS. Document in the inpatient's medical record or office log that the VIS was provided, the publication date of the VIS and the date the education was provided (see below for more information on documentation). Provide non-English speakers with a copy of the VIS in their native language if it is available. These may be obtained through the link in the cross-reference below or at the website www.immunize.org/vis

c. Follow-up

i. Reassess the inpatient within 15 to 30 minutes to make sure that there are no immediate adverse side effects such as anaphylaxis, to any component of the vaccine

ii. Be prepared to manage any medical emergency related to the administration of the vaccine

1. Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). VAERS is a reporting system only and does not provide advice or clinical management. Contact VAERS at **www.vaers.hhs.gov** or call **1-800- 822-7967** (verified on 04-30-26)

2. The following items should be available at the time of vaccination:

a. A written emergency protocol specifically for vaccination reactions

b. Equipment and/or medication described in the written emergency protocol

d. Documentation

i. The following items should be documented in the electronic medical record

1. Date of vaccination
2. The manufacturer and lot number
3. The vaccination site and route
4. The name and title of the person administering the vaccine
5. Note that the VIS was provided (see above in Education)
6. If the vaccine was not administered, record the reason(s) (e.g. medical contraindication, refusal, etc.)

F. DEVELOPMENT & APPROVAL OF THE STANDARDIZED PROCEDURE

a. The Infection Prevention Committee, the Infection Prevention Manager and the Medical Director of Infection Prevention will participate in the development and approval of the standardized procedure for the administration of pneumococcal vaccine to inpatients

b. The review is to be done on a yearly basis to incorporate any updated or new information on pneumococcal vaccines

REFERENCES:

CDC: Advisory Committee on Immunization Practices (ACIP). GRADE: 20-valent pneumococcal conjugate vaccine (PCV20) for adults aged ≥65 years. (2021) Page last reviewed September 9, 2024, Accessed April 24, 2026 from: https://www.cdc.gov/acip/grade/pneumo-pcv20-age-based.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/acip/recs/grade/pneumo-PCV20-age-based.html

CDC: Advisory Committee on Immunization Practices (ACIP). Pneumococcal ACIP Vaccine Recommendations. Page last reviewed January 8, 2025, Accessed April 24, 2026 from: https://www.cdc.gov/acip-recs/hcp/vaccine-specific/pneumococcal.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html

CDC: Epidemiology and Prevention of Vaccine-Preventable Diseases – Chapter 17: Pneumococcal Disease (The Pink Book). Hall E., Wodi A.P., Hamborsky J., et al., eds. 14th ed. Washington, D.C. Public Health Foundation, 2021. Updated May 1, 2024, Accessed April 24, 2026 from https://www.cdc.gov/pinkbook/hcp/table-of-contents/?CDC_AAref_Val=https://www.cdc.gov/vaccines/pubs/pinkbook/index.html

CDC: Pneumococcal Vaccine Timing for Adults, Informational Sheet. Last reviewed March 2025, accessed April 24, 2026 from https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf

CDC: Vaccine Information Statements (VISs). Pneumococcal Conjugate VIS (Interim). Last reviewed May 29, 2025. Accessed April 24, 2026 from https://www.cdc.gov/vaccines/hcp/current-vis/downloads/pcv.pdf

SUBJECT:	SECTION:
AMA DISCHARGE REQUEST (AGAINST MEDICAL ADVICE)	***Ethics, Rights and Responsibilities (RI)*** **Page 1 of 2**

PURPOSE:

To specify the appropriate actions to be followed by the facility when a patient requests to leave the facility Against Medical Advice (AMA) or when a patient refuses/declines specific medical management by the attending physician or mid-level clinical provider.

POLICY:

All patients have the right to refuse any and all healthcare being offered to them.

AFFECTED AREAS/PERSONNEL: *ALL NURSING PERSONNEL*

PROCEDURE:

1. When the patient or his representative demands to be discharged from the hospital before the completion of treatment or contrary to the advice of the physician, the Charge Nurse or designee will take the following steps:

   a. Notify the patient's physician, the Department Director, Clinical Supervisor, or the House Supervisor, and the patient's family.

   b. Request that the patient sign the Leaving the Hospital against Medical Advice Form, providing patient education regarding the risks of departing against Medical Advice. If the patient refuses to sign, document the refusal on the form. If the patient or legal representative refuses to sign, the notation "patient refuses to sign" should be made at the place for the signature and the witness or employee who received the refusal to sign should sign the form.

   c. Give the patient instructions for follow-up.

   d. Ensure that the patient leaves the hospital in a safe manner.

DOCUMENTATION

1. Nursing shall document in the Nursing Progress Notes the following:

   a. The exact date and time of the patient's request to leave AMA, the patient's stated reasons, document patient education provided to the patient regarding the risks of departing against Medical Advice.

   b. The date, time, and physician notified of the patient's request.

   c. If the patient refuses to sign the AMA form, document the refusal and the reason for refusal, if known, in the Nursing Notes.

2. Complete an Occurrence Report Form and forward as per hospital policy.

a. The report should include a brief description of the nature of the refusal.
b. The fact that the physician discussed with the patient or legal representative information about the proposed treatment and the potential consequences of refusing the recommended treatment, the alternatives to the treatment (if any), and the fact the patient still decided to refuse.

c. The report should record whether the patient was cautioned not to drive and any actions that were taken to assure the patient's safety in leaving the hospital.

3. Complete the Medical Record documentation as per established policy and procedure.

REFERENCES:

California Hospital Association. (2024). *Refusal of Treatment and End of Life Issues.* Consent Manual. Sacramento, CA: CHA Publications.

SUBJECT: **AUTOPSY – SECURING OF**	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 provide guidelines for when an autopsy is ordered or the request for an autopsy is made.

POLICY:

For those cases that do not meet the coroner's criteria for an autopsy, the hospital or physician and patient's family legally consenting party may seek to secure an autopsy.

AFFECTED PERSONNEL/AREAS: *HOSPITAL STAFF AND PHYSICIANS*

PROCEDURE:

PHYSICIAN OR HOSPTIAL REQUEST FOR AUTOPSY

1. When a patient has expired and the cause of death or associated circumstances of such are indeterminate, collaboration between the physician, Senior Administration or designee of Risk Management/Patient Safety determine whether an autopsy is appropriate.

2. Care is taken to communicate with family and legally consenting party in a considerate manner respectful of their grief, values and spiritual beliefs.

3. The legally consenting party should not be made to feel obligated to consent to autopsy.

4. In the event that the legally consenting party is agreeable to an autopsy, the physician obtains and documents consent and writes an order for the autopsy.

5. The original signed consent form and a copy of the order is scanned into the patient's electronic medical record. Both copies will then be sent with the decedent to the mortuary. The department director or manager ensures the order and consent form is faxed to Premier Pathology.

6. Once the consent form and order have been faxed to Premier Pathology, the department director or manager is to notify Risk Management.

FAMILY REQUEST FOR AUTOPSY

1. In the event that the legally consenting party requests an autopsy independent of the hospital, the arrangements can be made by the family and pathologist of choice. Consent does not need to be obtained by the hospital but hospital staff can assist the family in doing so.

2. The family should be made aware that they are responsible for the cost of the autopsy.

3. Notify Risk Management of the request for autopsy.

QUALITY MONITORING

The occurrence of autopsies, requested by SVMC, will be monitored by the Risk/Patient Safety Department and findings will be reported to the appropriate Medical Staff Department Committee Chair, , usually within forth-five (45) working days. Information obtained from the autopsy will be reviewed by the medical staff during the department's peer review session, as deemed appropriate by the Department Chair

REFERENCES:

- Joint Commission on Accreditation of Healthcare Organizations. (2026). The Joint Commission Comprehensive Accreditation Manual. Oakbrook Terrace, IL: Joint Commission Resources
- Government Code §27491
- California Health & Safety Code §10250

CROSS REFERENCES:

- Patient Care Services Policy & Procedure Manual: Deaths Reportable to the Coroner

SUBJECT: **CHANGE OF PHYSICIAN**	SECTION: **Page 1 of 1**

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

PURPOSE:

To define the process to be followed in assisting the patient to change physicians.

POLICY:

Sierra View Medical Center supports the patient's or the designated decision-makers right to participate in making decisions about their healthcare to include which physician they want to handle their care. While hospital staff may not be directly involved with the decision as to which physician the care is to be transferred to, staff may offer guidance as listed below.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS*

PROCEDURE

1. Once the patient or their designated decision-maker makes the decision to change physicians, they can do so by the following:
    a. The patient / designated decision-maker must make their selection of a new physician either from a list of physicians, or one of their choosing;
    b. They must first approach the new physician to determine whether he/she will take over their care. If agreed upon, then the patient / designated decision-maker must speak with the current physician letting him/her know of their wishes to change physicians and who has agreed to take over the case.
2. The current physician must sign off the case in the medical record noting which physician he/she is turning the case over to, and the accepting physician then takes over the care.
3. Once the transition is complete, nursing will notify the Admissions office of the change so that the information in the computer and in the medical record can remain current.
4. Hospital personnel must remain neutral and may not suggest nor promote one physician over another.

REFERENCE

- The Joint Commission (2025). Oakbrook Terrace, IL. Rights and Responsibilities of the Patient chapter.

SUBJECT:	SECTION:
CONSENT AND HIV (HTLV III/LAV) ANTIBODY TESTING FOR AIDS	***Ethics, Rights & Responsibilities (RI)*** **Page 1 of 3**

PURPOSE:

To specify how consent procedures are related to testing for HIV at Sierra View Medical Center.

POLICY:

1. No person shall test a person's blood for antibodies to the HTLV III virus without written consent of the person being tested, unless the law expressly permits otherwise. The patient's consent must be obtained by the physician ordering the test before testing for the antibody.

2. In the event of incompetency, a health care provider may obtain written consent for testing from the patient's parents (if a minor), guardians, conservators, or other person lawfully authorized to make health care decisions for the patient.

    a. This consent is only appropriate when the test is necessary to aid in caring for the patient or in preventing the spread of the HIV virus.

    b. A person's agent appointed under a Durable Power of Attorney for Health Care may authorize a test.

3. The legal capacity of children twelve years of age or older to consent to diagnosis and treatment for certain infectious, contagious/communicable or sexually transmitted diseases shall be recognized in the case of HIV antibody testing. [Family Code Section 6926] However, the involvement of the child's parents or guardian is generally recommended unless the child expressly objects thereto.

    a. Under state law, children twelve years of age or older have the legal capacity to consent to HIV antibody testing. Given the implications of such testing, however, the involvement of the parents or legal guardian is generally recommended. The request of a child twelve years or older to have the HIV test without the knowledge or participation of parents or a guardian **shall** be respected unless there are serious doubts concerning the child's competence. (i.e. the child's capacity to appreciate the meaning of the test results and the implications of his/her decision.)

    b. Children twelve years of age or older have the right to refuse testing for the HIV antibody even if the child's parent or legal guardian is willing to consent to the testing. The patient must be informed of the consequences of this refusal.

    c. Other unique considerations involving minors including self-sufficient minors and emancipated minors should be based on applicable state laws. (See CAHHS Consent Manual)

4. Sierra View Medical Center retains the right to refuse to perform antibody testing for patients unwilling or unable to pay for such services.

5. Testing in Instances of Occupational Exposure

   a. California law provides a "narrow exposure notification and information mechanism" to permit heal care personnel and other "first responders" who have experienced a significant exposure to a patient's blood or other potentially infectious materials, to learn of the patient's HIV status *[Health and Safety Code Sections 121130-121140]*

   b. An "exposed individual" may have a "source patient's" blood, tissue or other material tested for HIV even though the patient refuses to be tested – provided the blood, tissue or other material was obtained prior to the exposure. The law does not permit a health care provider to draw blood or other bodily fluids except as otherwise permitted by law.

6. Deceased patients may be tested for the HIV antibody if:

   a. consent has been given to perform an autopsy or organ donation in accordance with the Uniform Anatomical Gift Act;

   b. the death falls under the jurisdiction of the Coroner's office and a medical examiner is involved;

   c. The relative authorized to control disposition of the remains has given consent. Relatives authorized to control disposition of remains are as follows in descending order of priority:

      - an "Attorney-in-Fact" appointed under Durable Power of Attorney for Health Care;
      - the spouse;
      - an adult son or daughter;
      - either parent;
      - an adult brother or sister;
      - a guardian or conservator of the decedent at the time of death;
      - any other person authorized or under obligation to dispose of the body.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL AREAS, LABORATORY, MEDICAL RECORD*

REFERENCES:

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

California Hospital Association (CHA) Consent Manual (2024). https://powerdms.com/link/sierraview/document/?id=3237988

California Legislature (2014, January 1). California Health & Safety Code Section 121020. Retrieved June 8, 2026. https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=121020.

SUBJECT: **DISCHARGE OF HOMELESS PATIENTS**	SECTION: **Page 1 of 3**

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

PURPOSE:

To describe the steps taken to ensure that homeless patients are managed with the same care received by other patients.

DEFINITIONS:

Homeless: The United States Department of Housing and Urban Development defines homeless as:

1. An individual who lacks a fixed, regular, and adequate nighttime residence or
2. An individual who has a primary nighttime residence that is:
   a. A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
   b. An institution that provides a temporary residence for individuals intended to be institutionalized; or
   c. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including but not limited to a street, Skid Row or other similar location (a "Street Location").

POLICY:

In recognition that homeless patients face particular barriers to ongoing medical care and have complex medical and social service needs, the discharge planning process will begin as soon as possible after hospital admission. All patients identified as homeless will receive a consultation and evaluation by a Care Integration staff, with the creation of a discharge plan that addresses the following:

A. Assistive Care Needs

B. Referrals to appropriate service providers and governmental agencies

C. Need for weather appropriate clothing at discharge

D. Shelter referrals

E. Transportation needs for follow-up medical care.

F. Transportation at time of discharge to patient discharge location up to 30 miles or 30 minutes travel.

G. A meal within two hours of discharge

H. Provide resources/transportation to obtain discharge medications

For shelter referrals, the discharge plan must include documentation that the patient meets the shelter's criteria for acceptance, is appropriate for the patient, and that the patient agrees to the referral. Whenever possible, community organizations will be contacted to explore alternatives to shelter referrals. No homeless patient will be discharged to a "street location" unless they have expressly indicated that this is their discharge preference; no appropriate resource is available; or the patient refuses to accept resources that are available; and the patient can safely be discharged to that location.

AFFECTED AREAS/PERSONNEL: *SOCIAL SERVICES, CASE MANAGEMENT, NURSING*

PROCEDURE:

1. A social service consult will be requested for every homeless patient admitted to the hospital and a complete assessment will be performed by a member of the social service department no later than the second day after referral, or prior to discharge, whichever comes first. The assessment will include evaluation of the patient's cognitive functioning.

2. It is the responsibility of the nurse caring for the patient at admission to place the order in Meditech for a Social Services / Case Management consult based on identifying the patient as homeless.

3. The Care Integration staff will initiate a plan for post hospital transition to the community with the participation and agreement of the patient or surrogate decision-maker. The discharge plan will include:

    a. Assistive care needs

    b. Arrangements for patient to obtain ongoing medical care

    c. Referrals to appropriate service providers and government agencies such as Adult Protective Services, Mental Health, Food Stamps, Medi-cal, County Health Department and similar programs

    d. Clothing needs for discharge

    e. If shelter referral is made, documentation will include contact of the shelter to confirm criteria, and patient's acceptance of the referral

4. Shelter referrals: If the patient requests or accepts a shelter referral, the social service staff will:

    a. Identify patient's preferred geographic residence

b. Identify local shelter criteria to determine if patient is a match for that shelter

c. Verify availability of a shelter bed

d. Thoroughly document placement and patient acceptance

5. Discharge to other than a shelter or residence:

a. If a patient requests to be discharged to a "street location", staff will document the patient's request in the electronic medical record, and indicate whether the patient requires follow-up care that would prevent a safe discharge to such location.

b. If a patient refuses to accept the proposed placement or services, and no longer requires acute medical care, the patient will be discharged to his/her own resources and this will be documented in the electronic medical record. The patient will be offered such basics as a sack lunch and a bus token. The patient will also be given written referrals for any recommended aftercare.

REFERENCES:

- Bill Information Text SB1152. (2018, October 1). Retrieved from California Legislative Information: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1152.

SUBJECT: **DISCHARGE PLANNING-- ASSESSMENT AND REASSESSMENT**	SECTION: **Page 1 of 4**

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

PURPOSE:

To describe the process of discharge planning, assessment and reassessment of the patient by the interdisciplinary healthcare team during their hospital stay. It is the responsibility of each discipline assessing discharge planning needs to document associated assessment findings within the medical record and make appropriate referrals to discharge planning.

POLICY:

A. Continuity of care requires thoughtful preparation by the entire healthcare team. Each patient's needs for continuing care are assessed in an ongoing fashion by all members of the healthcare team, as dictated by their presenting condition(s). This assessment may begin prior to admission, but in no event later than at the time of the Nursing Admission Assessment. Appropriate disciplines are involved in the assessment, referral and planning for after discharge healthcare needs of the patient and/or family may include , but are not limited to:

1. Members of the medical staff
2. Nursing staff members
3. Rehabilitation services professionals
4. Social workers
5. Respiratory care practitioners
6. Pharmacists
7. Discharge Planners
8. Dieticians

B. The Registered Nurse caring for the patient is ultimately responsible/accountable for the discharge planning needs of the patient.

C. The discharge planning function focuses on meeting the patient's continuing healthcare needs after discharge. These needs may have necessitated the admission to the facility or may occur as an expected outcome to medical or surgical intervention, such as cast care following open reduction of a fracture. The purpose of discharge planning is to identify a patient's unique needs for continuing physical, emotional, safety, transportation, social and other needs and to arrange services to meet those needs. Needed discharge services may include:

1. Long-term care
2. Home health services

3. Palliative services
4. Hospice services
5. Ambulatory care services
6. Rehabilitation services
7. Durable Medical Equipment
8. Support groups
9. Community agency services
10. Community mental health
11. Adult foster care

D. Patient education is a major focus of discharge planning activities for all patients. Many patients' after care needs are met through education provided by members of the healthcare team.

E. A list of available post-hospital extended services identified in the discharge plan will be provided to the patient or designated caregiver and documented in the patient's medical chart. If the patient or designated caregiver does not have a preference, referral will be given to any available agency that can provide the requested service.

AFFECTED AREAS/PERSONNEL:

UTILIZATION MANAGEMENT / SOCIAL SERVICES / NURSING STAFF/CASE MANAGEMENT

PROCEDURE:

A. The initial screening assessment for discharge planning needs is conducted during the Nursing Admission Assessment using "high risk screening criteria" that triggers a referral to the Social Services department for discharge planning. .

B. In addition, disciplines involved in the care of the patient, assesses needs for aftercare as part of their ongoing assessment and reassessment processes. It is the responsibility of each discipline assessing discharge planning needs to document associated assessment findings within the medical record and make appropriate referrals to discharge planning. For Social Services, specifically, an initial discharge screening assessment is to be completed after admission to

identify needs early in the admission, then a re-evaluation is to be done every 3 business days after to assess for any ongoing needs or changes in the original plan of care. In addition, each patient will be provided the opportunity to identify one family caregiver, who may assist in post-hospital care, and record the designated caregiver's information in the patient's medical record. Additionally, each patient is also offered the opportunity to name a support person, who would be in charge of determining who may or may not visit the patient if the patient is no longer able to decide that for themselves. If the patient or legal guardian declines to designate a caregiver or support person, the hospital must document the declination in the patient's medical record. In the event that the patient is unconscious or otherwise incapacitated upon admittance, the hospital must provide the patient with the opportunity to identify the caregiver and support person after the patient recovers consciousness or capacity. If patient permits, this person identified as the family caregiver is to be notified of discharge or transfer as soon as possible, but no later than at the time a discharge order is written by the physician. The family caregiver, if named, will also receive information pertaining to the continuing health care needs after discharge and providing the caregiver an opportunity to engage in and ask questions during the discharge planning process. This should include providing information and instruction on a patient's post hospital care needs, and when applicable, include education and counseling about the patient's medications, including proper dosing and proper use of medication delivery devices. Additionally, information and instruction must be provided in a culturally competent manner and in a language that is comprehensible to the patient and caregiver. If the named family caregiver is not available, the inability to provide this information will not delay the discharge, but attempts must be noted in the chart.

C. Patients in the following high-risk category receive initial assessment by social services staff within two (2) business days of referral. The Patient/Family/Guardian will be given the opportunity to be involved in formulating the discharge plan, upon patient consent to do so.

D. High-risk patients include:

1. 70 or older, living alone or with a non-capable caregiver
2. Admissions from nursing homes or residential care homes
3. Re-admissions within 30 days
4. No identification, i.e. John/Jane Doe
5. Multiple trauma
6. Substance Abuse issues or presenting mental health issues
7. Patients with cognitive deficiencies
8. Patients requiring transportation needs

9. Requires assistance with ADL's (Activities of Daily Living)

E. Reassessment of patients is an ongoing process and will be documented on a minimum of every three (3) business days, in the Discharge Planning/Social Service progress notes. Physician Orders for follow up care will be incorporated into the plan.

REFERENCE:

- The Joint Commission (2025). Oakbrook Terrace, IL. Provision of Care chapter.
- Centers for Medicare & Medicaid Services Conditions of Participation, Subpart C, Discharge Planning, §482.43

SUBJECT:	SECTION:
DRUG WITHDRAWAL: NEWBORN	*MCH Patient Care (Other) Policy* Page 1 of 10

9

PURPOSE:

To set nursing guidelines in the management of a newborn experiencing withdrawal symptoms after exposure to drugs or alcohol.

POLICY:

1. Physician provider and/or registered nurse will assess all newborns for signs of withdrawal and will manage symptoms of withdrawal according to policy.

2. Infants with positive urine drug screen or signs of abstinence will have Neonatal Abstinence scoring every 2 hours for 48 hours. Score per guidelines as attached appendix.

3. Physician will be notified if any 3 successive scores are greater than 8 for possible medication intervention.

4. Infants experiencing withdrawal will receive appropriate interventions.

5. Neonatal urine will be screened for drugs if any of the following criteria are met by the mother:

    a. Maternal or paternal history, signs or symptoms of illicit drug use or alcohol abuse, oral history of intrauterine drug exposure in a sibling

    b. Maternal or paternal HIV, recent gonococcal or chlamydial infections, hepatitis B or syphilitic infection. Previous positive toxicology screen(s) in prenatal period

    c. Skin lesions, such as abscesses or track marks consistent with IV drug abuse

    d. Withdrawal symptoms

    e. Current enrollment in drug/alcohol treatment program

    f. Presence of drug paraphernalia in the mother's belongings or hospital room

    g. Altered mental status consistent with drug/alcohol intoxication

    h. Inconsistent or inadequate prenatal care (less than 3 visits) or no prenatal care

    i. Precipitous labor and delivery

    j. Poor maternal weight gain

    k. Premature onset of labor

    l. Unexplained changes in mental status

    m. Intrauterine growth retardation or oligohydramnios in the absence of other identifiable causes

    n. Intrauterine fetal demise or stillbirth in absence of other identifiable causes

    o. Placental abruption in the absence of other identifiable causes

    p. Unexplainable severe hypertension

q. Violence and substance abuse in the home

r. History of incarceration, probation and parole

AFFECTED PERSONNEL/AREAS: *MCH STAFF-RNs and physicians.*

EQUIPMENT:

Neonatal Abstinence Scoring Form

PROCEDURE:

1. Assess infant for risk factors.

2. Assess infant for signs/symptoms of drug/alcohol use (true onset of abstinence can vary from shortly after birth to two weeks of age. Symptoms usually appear within 72 hours):

   a. Central Nervous System

   - Irritability
   - High pitched crying
   - Tremors
   - Increased musle tone
   - Frequent yawning and sneezing
   - Occasional seizures
   - Hyperactive deep tendon reflex
   - Exaggerated Moro reflex

   b. Gastrointestinal dysfunction

   - Vomiting
   - Diarrhea
   - Uncoordinated and constant sucking
   - Poor feeding
   - Dehydration

- Poor weight gain

c. Respiratory distress

- Tachypnea
- Stuffy nose
- Flaring
- Retractions
- Apnea

d. Other

- Yawning
- Sneezing
- Mottled color
- Fever
- Cyanosis

3. Notify physician if the average of any three (3) successive scores is greater than eight (8) for possible medication intervention.

4. Pharmacologic treatment will be initiated according to the provider orders when non-pharmacologic interventions are insufficient

5. Once medication has been started, scoring may be done according to attached scoring guidelines.

6. Be certain there has been a maternal referral to Social Services.

7. Upon confirmation of newborn positive drug screen, notify CPS and Social Services.

8. Rooming-in and parental participation in care should be encouraged whenever clinically appropriate and safe. Encourage parental interaction with the newborn under nursing supervision.

   Note: Maternal use of methadone does not eliminate the need for scoring, as methadone withdrawal is more severe than any other narcotic alone or cocaine alone.

9. Interventions to support the newborn experiencing withdrawal:

   a. Swaddling

   b. Rocking

   c. Decrease tactile stimulation

d. Dark room

e. Decrease environmental noise and stimulation

f. Small frequent feedings

g. Use of a pacifier

DOCUMENTATION:

1. Document reason for Neonatal Abstinence Scoring (i.e., maternal history of drug use).
2. Use Neonatal Abstinence Scoring Form (see attached):
   a. Record time of scoring.
   b. Give points for all behaviors seen during the scoring interval even if they are not present at the time of scoring.
   c. Wake the newborn to test reflexes. Calm before assessing muscle tone, respirations, or Moro reflex.
   d. A startle reflex should not be mistaken for the Moro reflex.
   e. Many of the signs of hunger can appear the same as withdrawal. The appearance after feeding gives a good idea of muscle activity.
   f. Count respirations for a full minute.
   g. Always take the temperature at the same site. Temperatures listed on the scoring sheet are rectal, an axillary temperature that is 2 degrees lower may indicate withdrawal.
   h. Do not give points for perspiration if it is due to swaddling.
   i. Record daily weight.
3. Social Services and CPS referrals.
4. Document interventions (i.e., swaddling, rocking) that are effective.
5. Document parental interaction.

REFERENCES:

- American Academy of Pediatrics. (2020). Neonatal opioid withdrawal syndrome. Pediatrics, 146(5), e2020029074. https://doi.org/10.1542/peds.2020-029074
- American Academy of Pediatrics. (2024). Neonatal opioid withdrawal syndrome treatment guidelines and birth hospital utilization. Pediatrics, 154(1). https://doi.org/10.1542/peds.2023-063635

NEONATAL ABSTINENCE SCORING FORM

CENTRAL NERVOUS SYSTEM DISTURBANCES														
SIGNS AND SYMPTOMS	SCORE	AM							PM					
Excessive High-pitched Cry	2													
Continuous High-Pitched Cry	3													
Sleeps <1 Hour After Feeding Sleeps <2 Hours After Feeding Sleeps <3 Hours After Feeding	3 2 1													
Hyperactive Moro Reflex Markedly Hyperactive Moro Reflex	2 3													
Mild Tremors Disturbed Moderate-Severe Tremors Disturbed	1 2													
Mild Tremors Undisturbed Moderate-Severe Tremors Undisturbed	1 4													
Increased Muscle Tone	2													
Excoriation (Specify Area):	1													
Myoclonic Jerks	3													
Generalized Convulsions	5													
METABOLIC/VASOMOTOR /RESPIRATORY DISTURBANCES														
Sweating														
Fever <101(99-100.8°F/37.2-38.2°	1													
Fever >101(38.2°C and Higher) Frequent Yawning (>3-4 times/ interval)	2 1													
Mottling	1													
Nasal Stuffiness	1													
Sneezing (>3-4 times/interval)	1													
Nasal Flaring	2													
Respiratory Rate >60/Min. Respiratory Rate >50/Min. with Retractions	1 2													
GASTROINTESTINAL DISTURBANCES														
Excessive Sucking	1													
Poor Feeding	2													
Regurgitation Projectile Vomiting	2 3													
Loose Stools Watery Stools	2 3													
TOTAL SCORE														
Initials														

Modified Finnegan Neonatal Abstinence Score Sheet1

System	Signs and Symptoms	Score	AM	PM	Comments
Central Nervous System Disturbances	Excessive high-pitched (or other) cry < 5 mins	2			
		3			
	Sleeps < 1 hour after feeding	3			
	Sleeps < 2 hours after feeding	2			
	Sleeps < 3 hours after feeding	1			
	Hyperactive Moro reflex	2			
	Markedly hyperactive Moro reflex	3			
	Mild tremors when disturbed	1			
	Moderate-severe tremors when disturbed Mild tremors when undisturbed	2			
		3			
		4			
	Increased muscle tone	1			
	Excoriation (chin, knees, elbow,	1			
	Myoclonic jerks (twitching/jerking	3			
	Generalized convulsions	5			
Metabolic/ Vasomotor/ Respiratory Disturbances	Sweating	1			
	Hyperthermia 37.2-38.3C	1			
	Hyperthermia > 38.4C	2			
	Frequent yawning (> 3-4 times/	1			
	Mottling	1			
	Nasal stuffiness	1			
	Sneezing (> 3-4 times/scoring	1			
	Nasal flaring	2			
	Respiratory rate > 60/min	1			
	Respiratory rate > 60/min with	2			
Gastrointestinal Disturbances	Excessive sucking	1			
	Poor feeding	2			
	Regurgitation (≥ 2 times	2			
	during/post feeding)	3			
	Loose stools (curds/seedy	2			
	Watery stools (water ring on nappy around stool)	3			
	Total Score				
	Date/Time				
	Initials of Scorer				

1. Finnegan LP. Neonatal abstinence syndrome: assessment and pharmacotherapy. In: Nelson N, editor. Current therapy in neonatal-perinatal medicine. 2 ed. Ontario: BC Decker; 1990.

The NAS score sheet lists 21 symptoms that are most frequently observed in opiate-exposed infants. Each symptom and its associated degree of severity are assigned a score and the total abstinence score is determined by totalling the score assigned to each symptom over the scoring period.

Key points

- The first abstinence score should be recorded approximately two hours after birth or admission to the nursery (baseline score). This score reflects all infant behaviour up to the first scoring interval time point.
- Following the baseline score all infants should be scored at 4-hourly intervals, except when high scores indicate more frequent scoring.
- The score sheet allows for 2-hourly scoring over the 24-hour period.
- A new sheet should be started at the beginning of each day.
- Scoring is dynamic. All signs and symptoms observed during the scoring interval are included in the point-total for that period.
- If the infant's score at any scoring interval is ≥ 8, scoring is increased to 2-hourly and continued for 24 hours from the last total score of 8 or higher.
- If the 2-hourly score is ≤ 7 for 24 hours then 4-hourly scoring intervals may be resumed.
- If pharmacotherapy is not needed the infant is scored for the first 4 days of life at 4-hourly intervals.
- If pharmacotherapy is required the infant is scored at 2- or 4-hourly intervals, depending on whether the abstinence score is less than or greater than 8 throughout the duration of therapeutic period.
- If after cessation of pharmacotherapy the score is less than 8 for the following 3 days, then scoring may be discontinued.
- If after cessation of pharmacotherapy the score is consistently 8 or more, then scoring should be continued for the following 4 days (minimum) to ensure that the infant is not likely to develop late onset of withdrawal symptoms at home following discharge.

Guide to assessment and scoring2, 3

1. The neonatal abstinence syndrome scoring system was designed for term babies on four-hourly feeds and may therefore need modification for preterm infants. In a term infant scoring should be performed 30 minutes to one hour after a feed, before the baby falls asleep.
2. If necessary the infant should be awakened to elicit reflexes and behaviour, but if the infant is woken to be scored then diminished sleep after scoring should not be recorded. A crying infant should be soothed and quietened before assessing muscle tone, Moro reflex and respiratory rate.

High-pitched cry	Score 2 if high-pitched at its peak, 3 if high-pitched throughout. Infant is scored if crying is prolonged, even if it is not high-pitched.2
Sleep	This is a scale of increasing severity and a term infant should receive only one score from the three levels of severity. A premature infant on 3 hourly feeds can sleep for 2½ hours at most. Scoring should thus be 1 if the baby sleeps less than 2 hours, 2 if less than 1 hour and 3 if the baby does not sleep between feeds.2
Moro reflex	The Moro or startle reflex is a normal reflex of young infants and occurs when a sudden loud noise causes the child to stretch out the arms and flex the legs. Score if the infant exhibits pronounced jitteriness (rhythmic tremors that are symmetrical and involuntary) of the hands during or at the end of a Moro reflex. Score 3 if jitteriness and clonus (repetitive involuntary jerks) of the hands and/or arms are present during or after the initiation of the reflex.

Tremors	This is a scale of increasing severity and an infant should only receive one score from the four levels of severity. Undisturbed refers to the baby being asleep or at rest in the cot.2
Increased muscle tone	Score if excessive or above-normal muscle tone or tension is observed - muscles become "stiff" or rigid and the infant shows marked resistance to passive movements, e.g. if the infant does not experience any head lag when being pulled to the sitting position; or if there is tight flexion of the infant's arms and legs (unable to slightly extend these when an attempt is made to
Excoriation	Excoriations (skin abrasions resulting from constant rubbing against a surface that is covered with fabric such as bed linen). Score only when excoriations first appear, increase or appear in a new area.2
Myoclonic jerks	Score if involuntary muscular contractions which are irregular and exceedingly abrupt (usually involving a single group of muscles) are observed.4
Generalized convulsions	In the newborn infant generalized seizures or convulsions are often referred to as tonic seizures. They are most commonly seen as generalized activity involving tonic extensions of all limbs, but are sometimes limited to one or both limbs on one side. Unusual limb movements may accompany a seizure. In the upper limbs these often resemble "swimming" or "rowing". In the lower limbs, they resemble "pedalling" or "bicycling." Other subtle signs may include eye staring, rapid involuntary movements of the eyes, chewing, back arching,
Sweating	Score if sweating is spontaneous and is not due to excessive clothing or high room temperature4
Hyperthermia	Temperature should be taken per axilla. Mild pyrexia (37.2-38.3ºC) is an early indication of heat produced by increased muscle tone and tremors.
Yawning	Score if more than 3 yawns observed within the scoring interval.2, 4
Mottling	Score if mottling (marbled appearance of pink and pale or white areas) is present on the infant's chest, trunk, arms, or legs.4
Nasal stuffiness	Score if the infant sounds congested; mucous may be visible.4
Sneezing	Score if more than 3 sneezes observed within the scoring interval.2, 4
Nasal flaring	Score only if repeated dilation of the nostrils is observed without other evidence of lung or airways disease.4
Respiratory rate	Respirations are counted for one full minute. Score only if >60 per minute without other evidence of lung or airways disease.2 Score 2 if respiration involves drawing in of the intercostal muscles (retractions).
Excessive sucking	Score if hyperactive/disorganized sucking, increased rooting reflex, or attempts to suck fists or thumbs (more than that of an average hungry infant) are observed.3, 4
Poor feeding	Score if the infant demonstrates excessive sucking prior to feeding, yet sucks infrequently during a feeding taking a small amount of breast milk or formula, and / or demonstrates an uncoordinated sucking reflex (difficulty sucking and swallowing).3 Premature infants may require tube feeding and should not be scored for poor feeding if tube feeding is expected at their gestation.2
Regurgitation	Score if at least one episode of regurgitation is observed even if vomit is contained in the mouth.4

Loose/watery stools	Score if loose (curds/seedy appearance) or watery stools (water ring on nappy around stool) are observed. Check the nappy after the examination is completed if not apparent during the examination.[4]
Scale References:	1. Finnegan LP. Neonatal abstinence syndrome: assessment and pharmacotherapy. In: Nelson N, editor. Current therapy in neonatal-perinatal medicine. 2 ed. Ontario: BC Decker; 1990. 2. Royal Women's Hospital Drug Information Centre. Newborn Emergency Transport Service (Victoria). Neonatal handbook. Carlton, Vic: Royal Women's Hospital; 2004. 3. Finnegan LP, Kaltenbach K. Neonatal abstinence syndrome. In: Hoekelman RA, Friedman SB, Nelson N, Seidel HM, editors. Primary pediatric care. 2 ed. St Louis: C V Mosby; 1992. p. 1367-78. 4. Lester BM, Tronick EZ, Brazelton TB. The Neonatal Intensive Care Unit Network Neurobehavioral Scale Procedures. Pediatrics. 2004;113(3 Pt 2):641-67

SUBJECT:	SECTION:
EBOLA VIRUS DISEASE	***Infection Prevention***

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

PURPOSE:

The purpose and intent of this document is to provide for the use of Sierra View Medical Center (SVMC) administration and planning personnel to identify and communicate key elements of this policy and procedure for screening, identification and initial management of a suspected Ebola patient. This policy is to be considered guidance and is intended to be used as a tool for hospital administration and planning personnel to assist in the effective preparation for, implementation and execution of facility Ebola response plans.

***As information related to recognizing, diagnosing, treating, and prevention of Ebola is updated at the federal, state and local levels, this response plan will be modified accordingly.**

DEFINITIONS:

The Ebola virus, previously known as Ebola hemorrhagic fever, is a rare and sometimes deadly disease. It is caused by infection with a virus of the family *Filoviridae* (https://www.cdc.gov/viral-hemorrhagic-fevers/about/?CDC_AAref_Val=https://www.cdc.gov/vhf/virus-families/filoviridae.html), genus *Ebolavirus.*

Many of the signs and symptoms of Ebola are non-specific and similar to those of many common infectious diseases, as well as other infectious diseases with high mortality rates.
Symptoms may include:

- Temperature >101.5°F
- Myalgia
- Severe Headache
- Muscle Pain
- Vomiting
- Diarrhea
- Abdominal Pain
- Bleeding

POLICY:

A. The hospital monitors infectious diseases that are occurring locally, nationally, or worldwide that could potentially affect our local community. SVMC has developed an Ebola Preparedness Program that includes, but is not limited to, education and training in the following areas:

- Infectious Disease Screening Process
  - Inpatient and Outpatient
- Personal Protective Equipment (PPE)
  - Donning (placing on) and Doffing (removing)
- Equipment (PPE Cart)
- Education of Disease Process
- Patient Movement
- Environmental Safety

B. SVMC will utilize CDC's guidelines for screening and preparedness to handle an Ebola patient: https://www.cdc.gov/ebola/hcp/clinical-guidance/index.html

C. The list of Ebola-affected countries is subject to change. For up-to-date information regarding the Ebola virus disease (EVD), refer to the CDC Ebola Virus Disease webpage at https://www.cdc.gov/ebola/situation-summary/index.html

AFFECTED PERSONNEL/AREAS: *EMERGENCY DEPARTMENT, INTENSIVE CARE UNIT, NURSING, RESPIRATORY THERAPY, ENVIRONMENTAL SERVICES, INFECTION PREVENTION & CONTROL, FACILITIES, EMERGENCY MANAGEMENT, LABORATORY, RADIOLOGY, PHYSICIANS, SURGICAL SERVICES, CENTRAL PROCESSING SERVICES, LABOR & DELIVERY, AND OUTPATIENT SERVICES.*

PROCEDURE:

INFECTIOUS DISEASE SCREENING

1. An "Infectious Disease Screening" tool will be utilized for all **Newly Admitted** patients and also for all **Outpatients** who have traveled to West Africa in in the last 3 weeks or have come into contact with anyone who has traveled outside the U.S in the last 3 weeks. (See **ADDENDUM A**)

PERSONAL PROTECTIVE EQUIPMENT (PPE)—Donning & Doffing

1. Ebola is spread through direct contact with blood or body fluids of a person who is sick with Ebola or with objects that have been contaminated with infectious blood or body fluids. PPE that fully covers skin and clothing and prevents any exposure of the eyes, nose, and mouth is recommended by CDC. The recommended PPE equipment and steps of applying (donning) and removing (doffing) are found in: (See **ADDENDUM B**)

EQUIPMENT: EBOLA PATIENT CARE CART

1. There will be 1 Ebola PPE Cart stocked with items needed to care for this type of patient. The cart will be stored in the RME storage room, in the Emergency Department. (See **ADDENDUM C**)

EDUCATION

1. Competency Verification of Personal Protective Equipment (PPE)

   - All PPE Super Users will complete hands-on training for proper donning and doffing of PPE according to Center for Disease Control (CDC) recommendations. (Training to be done as needed)
   - A return demonstration is required for proper sequence of application and removal of PPE.
   - Advanced PPE (PAPR) will be provided to direct care providers in high-risk areas (ED).

2. **Identify.** Prompt isolation of patients. Place infection control measures to minimize the spread of infectious diseases to other patients or healthcare providers

PATIENT MOVEMENT AFTER PRESENTING TO THE EMERGENCY DEPARTMENT:

1. Ebola screening tool is used initially with the patient that presents to the Emergency Room and outpatient care departments. If patient presents with elevated temperature and one or more additional symptoms along with

answering "Yes" to ANY of the questions under the section "Questions to Ask Patient or Family" patient must be isolated and masked immediately:

- Outpatient departments:
  1. Clinical Licensed staff: Immediately notify the provider in the department, Clinical Manager and Clinical Supervisor and the Infection Prevention Department (IP)
  2. Patient must be kept in private room with door closed
  3. Implement Enhanced Droplet and Contact Precautions
  4. Call EMS and notify of Suspected Ebola Virus patient and location. Copy all records pertaining to work up of patient (vital signs, history provided, symptoms, etc.) for the EMS to take in transport
- Emergency Department:
  1. When possible, the patient should remain outside, in their vehicle, until the designated EBOLA isolation room (RP Pending room) has been prepared and the designated RN has donned the appropriate PPE. Once the room is ready, the RN will escort the patient in a wheelchair, staying on the outside of the ED, directly to the designated RP Pending room.
     If the patient is unable to remain outside the ED, in their vehicle, the patient will be placed in the old triage room with all doors closed. Droplet and Contract Precautions signage will be posted on each door. Once the RP pending room is prepared, the designated RN, wearing the appropriate PPE, will escort the patient by wheelchair from the triage room, through the designated exit route from the ED, directly to the RP Pending room.
  2. The process would be for designated Engineering Supervisor to call COAST IAQ & Life Safety Services and request the need for the "Containment" to be set up.
  3. The Ebola patient would remain in the isolated RP Pending room. "Containment" is set up and prepared for the patient. (See **ADDENDUM D** for floor plan of patient flow). IP&C should be contacted immediately and the process to transfer the patient to appropriate facility as instructed by Tulare County will begin.

ENVIRONMENTAL CLEANING

1. SVMC will follow CDC's recommendations/guidelines for environmental cleaning of a room, equipment, or other surfaces that have been exposed to an Ebola patient.

2. Environmental services staff that perform cleaning after an Ebola patient will only be staff that has been trained with donning/doffing personal protective equipment (PPE) specific for Ebola patients.

3. SVMC follows CDC's recommendation to use a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (norovirus, rotavirus, adenovirus, poliovirus) to disinfect environmental surfaces. EPA-registered hospital disinfectants with label claims against non-enveloped viruses are broadly antiviral and capable of inactivating both enveloped and non-enveloped viruses.
   Including but not limited to:
   - Micro-Kill Bleach Germicidal Bleach wipes
   - Ecolab QC #40
   - Ecolab QC #42
   - Virasept Ready to Use

4. SVMC will handle and dispose of contaminated or suspected to be contaminated materials (e.g., any single-use PPE, cleaning cloths, wipes, single-use microfiber cloths, linens, food service) and linens, privacy curtains, and other textiles in the patient room per CDC recommendations

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Clinical Guidance for Ebola Disease. (26 May 2026). Accessed 3 June 2026 from Centers for Disease Control and Prevention: https://www.cdc.gov/ebola/hcp/clinical-guidance/index.html

Donning and Doffing PPE During Management of Patients with Selected VHF in U.S. Hospitals (2024, May 2). Accessed 3 June 2026 *from Centers for Disease Control and Prevention*: https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/guidance/index.html#cdc_listing_intro-donning-and-doffing-ppe-during-management-of-patients-with-selected-vhf-in-u-s-hospitals

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How Ebola Disease Spreads. (2 June 2026). Accessed 3 June 2026 from Centers for Disease Control and Prevention: https://www.cdc.gov/ebola/causes/

PPE: Confirmed Patients and Clinically Unstable Patients Suspected to have VHF. (2024, May 9). Accessed 3 June 2026 from Centers for Disease Control and Infection https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/guidance/ppe-clinically-unstable.html

ADDENDUM A

Travel Infection History

- Travel
  - Hx Recent Travel: ○ Yes ○ No Comment:
  - Travel Start Date
  - Travel End Date
  - Travel Locations
    For example: *Africa, Uganda, South America, Carribean, Capa Verde, Central America, Mexico, Puerto Rico, El Salvador, Barbados, US Virgin Islands, Samoa, China, Iran, Italy, Japan, Korea
  - Exposure to anyone with the following diseases? ☐ Ebola ☐ Covid ☐ Zika ☐ Monkeypox ☐ None ☐ Other
- Covid Screening
  - Covid Signs/Symptoms: ○ Yes ○ No Comment:
    Lower resp illness (cough, diff breathing) or chills, repeated shaking with chills, muscle pain, HA, sore throat, new loss of taste or smell, persistent pain or pressure in chest, new confusion or inability to arouse, bluish lips or face?
  - Symptoms Upon Arrival to Unit: ☐ Temp > 100.4 ☐ Chills ☐ Headache ☐ Bluish Lips or Face ☐ Cough ☐ Repeated Shaking with Chills ☐ Sore Throat ☐ New Confusion or Unable to Arouse ☐ Difficulty Breathing ☐ Muscle Pain ☐ New Loss of Taste or Smell ☐ Persistent Chest Pain or Pressure
  - Have you had a fever with severe acute lower resp illness (e.g., PNA, ARDS) requiring a previous hospitalization and without an identified source of exposure (e.g.Influenza)? ○ Yes ○ No Comment:
- Isolation Implementation
  - Patient Isolated? ○ Yes ○ No
  - Charge Nurse Notified ○ Yes ○ No Comment:
    *Enter name of charge nurse notified in comment field

ADDENDUM B

EQUIPMENT: Personal Protective Equipment (PPE)

- Impermeable garment:
  - Single-use (disposable) impermeable fluid-resistant gown extending to at least mid-calf
  - Single-use (disposable) impermeable fluid-resistant coveralls
- Authorized Undergarment (hospital scrubs)
- Authorized Shoes (closed toe and back, without holes or perforations, made of material that will not be compromised by use of disinfectants)

- Respiratory Protection:
  - PAPR (full face shield, helmet or headpiece) covered with a single-use shroud that extends the shoulders and fully covers the neck
- 2 pairs of gloves. Inner standard gloves and single-use (disposable) examination gloves with extended cuffs
- Single-use (disposable) boot covers that extend to at least mid-calf
- EPA-registered disinfectant wipes
- EPA-registered bleach wipes

PROCEDURE: Donning (placing PPE) Competency Assessment Tool

8. PREPARE PAPR HELMET AND SHROUD AND PUT ON HELMET: • Remove the original helmet if it is in place. Make sure the Max Air sticker faces the helmet. • Clip the inside of the face shield to the front of the helmet by clipping the middle first and the sides after. • Place helmet cord over right shoulder. Plug cord into the battery pack and insure indicator lights are functioning and all turn green. • Don helmet and tighten as needed. • Flip the shroud over and pull down over shoulder. Make sure the Max Air logo shows in the front. • Place Ebola helmet over and make sure it snaps into place. • Adjust face cuff under chin. • Ensure helmet is straight and positioned ½ an inch above the eyebrow.		
9. SECURE PAPR SHROUD: • Bring shroud neckties forward and tie at front of neck, leaving a 2-finger space between neck and shroud. • Pull body ties under arms and lace through shroud slits. Tie snugly around waist.		
10. PUT ON OUTER GLOVES-EXTENDED CUFF GLOVES: Observer assists while HCW dons each glove. Hold gown cuff while donning gloves. Observer pulls the cuffs over the sleeves of the gown as far up the arm as possible.		
11. INSPECT: Verify integrity of the PPE ensemble by having the HCW go through a range of motion.		

Employee's Signature:		**Date:**
Trainer Name:		**Date:**
Trainer Signature:		

Doffing (removing PPE) Competency Assessment Tool

SIERRA VIEW MEDICAL CENTER

Skill/Competency: DOFFING PPE for an Ebola Patient

Employee: _____ **Date:** _____

Trained observer must be present:	Healthcare Worker Doffing of PPE:
• Provide guidance and supervision • Confirms PPE is visually intact prior to removal and doffed successfully • May not assist in doffing process	• Notifies trained observer when ready to doff • Acknowledges each command given by observer

Precautions:

A. Assume HCW hands are contaminated throughout the doffing process
B. Outside of HCW PPE is contaminated; avoid contact
C. Avoid reflexive actions that put HCW at risk, such as touching one's hair or face during doffing.
D. Contain and dispose of PPE in biohazard waste container
E. Observer prepares supplies prior to initiating doffing procedure

Supplies Needed:

- Standard gloves- 1 pair
- 2 Alcohol-based hand rub
- 2 Chairs
- 2 cases of Bleach wipes
- Medical Chuck
- Biohazard waste container
- PAPR collection container
- Extra pair of scrubs

Observer Reads Aloud	OBS.	HCW
1. **PREPARATION:** Place two chairs and a medical chuck in front of each in the area. The observer ensures doffing area is clear, signals a thumbs up and states *"All is clear"* for HCW to enter doffing area		
2. **WIPE GLOVES:** Wipe gloves using bleach wipe on the outer gloves. Start at the forearm and work down to hands. Use separate wipes for each hand. Allow gloves to dry		
3. **INSPECT PPE:** Ensure there are no visible signs of contamination present. If contamination is identified, HCW uses additional bleach wipe to neutralize the contamination.		
4. **REMOVE OUTER GLOVES:** Hold one of your wrist so that your thumb points up, punch that glove and lift at the wrist. Roll it down until the glove is completely off your hand in a ball in the palm of the other hand. Then slide a finger down inside the outer glove on the other hand, and pull it off until it is balled around the first glove. Discard. Avoid contaminating inner gloves during removal.		
5. **INSPECT AND CLEAN GLOVES:** If gloves are intact and do not appear contaminated, use hand sanitizer on the inner gloves. Allow gloves to dry. *If gloves are not intact or are visibly soiled, disinfect gloves with bleach wipes, remove gloves as described in Step 4, perform hand hygiene with hand sanitizer and don a new pair of gloves. Use hand sanitizer on your gloves*		
6. **REMOVE SHROUD:** • Release PAPR shroud neckties. Re-tie at distal end of ties. • Release body ties, unlace from shroud, pull tie all the way off, and discard. • Clean gloves with hand sanitizer. • Press black button and disconnect the battery cord from the battery pack.		

• Roll back of shroud up to top of helmet. Grasp shroud above ears, pull away from side posts, pull forward and slightly upward away from face. • Remove helmet from shroud and dispose shroud and helmet cover. • Place helmet on "dirty table." • Remove belt and battery pack; place them on the "dirty table."		
7. **CLEAN GLOVES:** Using hand sanitizer on gloves. Allow gloves to dry.		
8. **REMOVE GOWN:** Unfasten ties. Grasp the outside of gown at the back of the shoulders and pull the gown down over the arms. Turn the gown inside out, away from clothing and fold or roll into a bundle as you remove the gown. Discard.		
9. **CLEAN GLOVES:** Using hand sanitizer on gloves. Allow gloves to dry.		
10. **REMOVE BOOT COVERS** Be careful not to touch one leg with the other. Remove the shoe cover of the leg closest to the other chair. Grasp the outside of the boot cover and pull down toward your ankle. Then lift the boot cover over your heel. Pull it off your foot and dispose. Repeat for the other boot cover. When both boot covers are off sit on the other chair.		
11. **CLEAN GLOVES:** Using hand sanitizer on gloves. Allow to dry.		
12. **DISINFECT SHOES:** Sit down in the clean chair. Wipe all external surfaces of shoes with bleach wipe, moving from top to bottom and including the soles. Allow to dry.		
13. **CLEAN GLOVES:** Using hand sanitizer on gloves. Allow to dry.		
14. **REMOVE GLOVES:** Hold one of your wrist so that your thumb points up, punch that glove and lift at the wrist. Roll it down until the glove is completely off your hand, in a ball in the palm of the other hand. Then slide a finger down inside the outer glove on the other hand, and pull it off until it is balled around the first glove. Discard. Avoid contaminating inner gloves during removal.		
15. **PERFORM HAND HYGIENE:** Using hand sanitizer. Allow hand to dry.		
16. **INSPECT:** The Observer and HCW inspect clothing for contamination. ***If contamination is identified, remove scrubs carefully change into new clean scrubs.***		
17. **EXIT THE DOFFING AREA:** Go to closest designated shower. Remove scrubs and shower with soap and water.		

Employee's Signature:		**Date:**
Trainer Name:		**Date:**
Trainer Signature:		

ADDENDUM C—Ebola PPE Cart

Drawer #1
Gowns

Drawer #2
Face Shields

DRAWER #3
Surgeon Caps

DRAWER #4
Extended Cuff Gloves

DRAWER #5
Gloves

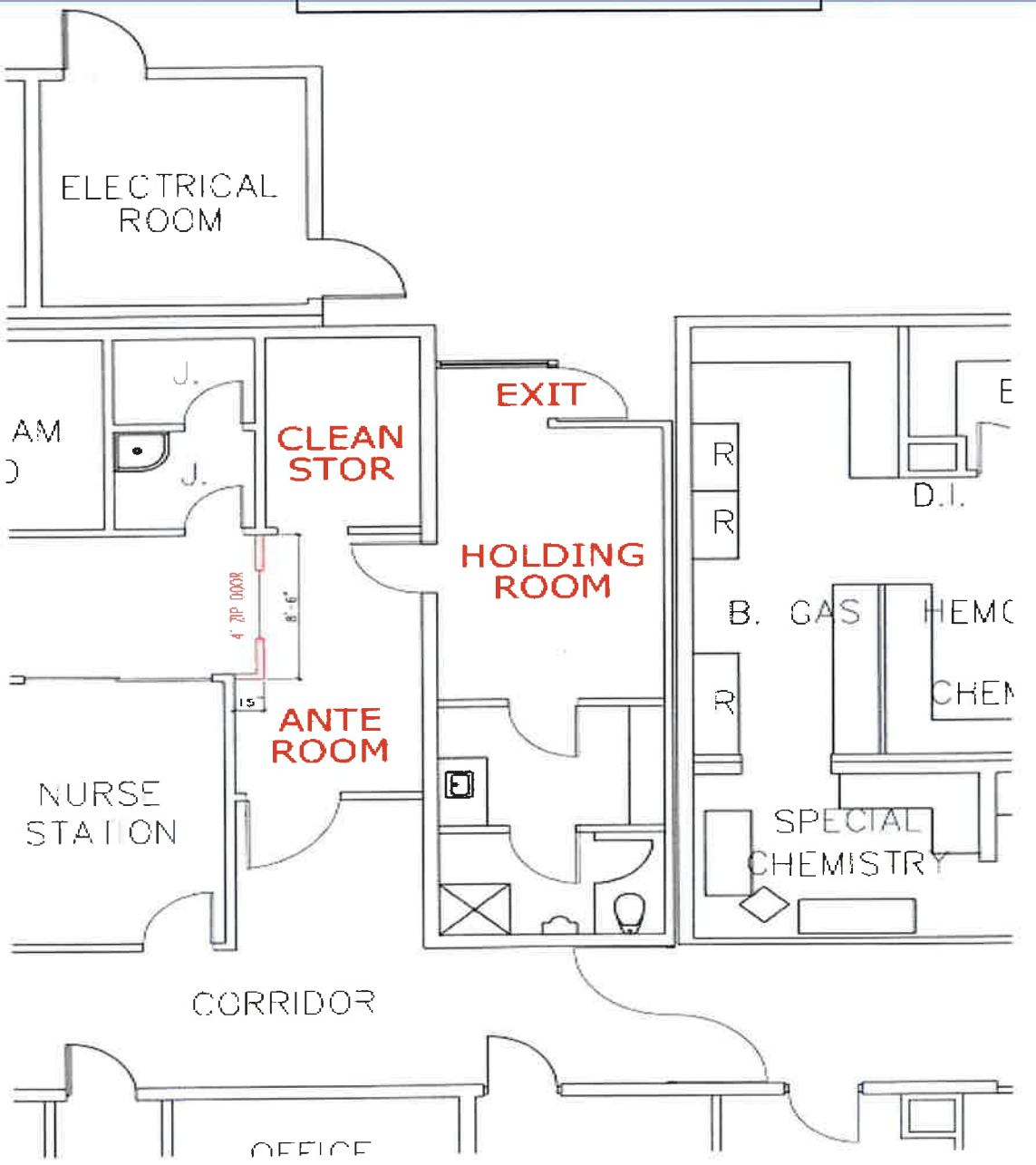
DRAWER #6
Gowns (Bunny suits)

DRAWER #7
Boot Covers

SUBJECT: **EBOLA VIRUS DISEASE**	SECTION: ***Infection Prevention*** **Page 11 of 11**

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

ADDENDUM D



SUBJECT: **ENDOTRACHEAL INTUBATION; NEWBORN**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide guidelines for airway management for infants who require ventilator support when bag/mask ventilation is not advisable or sufficient.

POLICY:

1. Endotracheal intubation shall be performed only by healthcare professionals who have documented training, demonstrated competency, and ongoing proficiency in neonatal airway management consistent with current NRP standards and facility credentialing requirements.

2. Nurses and Respiratory Therapists who have completed NRP may assist with the procedure.

3. Infants requiring ongoing invasive mechanical ventilation, advanced respiratory support, or care beyond the capabilities of the birth facility shall be evaluated for transfer to an appropriate level NICU in consultation with the neonatologist and neonatal transport team.

AFFECTED AREAS/ PERSONNEL: *Maternal Child Health (MCH) Department (RNs & LVNs), Respiratory Therapists.*

EQUIPMENT:

1. ET tube size:
   a. 2.5 for infant less than 1000 grams
   b. 3.0 for infant 1000-2000 grams
   c. 3.5 for infant 2000- 3000 grams
   d. 4.0 for infant over 3000 grams or more
2. Stylet (optional)
3. Laryngoscope – handles for term and premature infants:
   a. #00 blade for preterm infants weighing less than 1000 grams
   b. #0 blade for infants weighing 2000 gm- 3000 grams
   c. #1 blade for very large infant (4000 gm-5000 grams)
4. Suction apparatus, suction catheter (5 to 10 Fr), suction canister
5. Scissors

6. Tape and device for securing ET tube (latex free preferred)

7. Anesthesia bag with pressure valve connected with O2 outlet

8. CO_2 Detector

9. Extra batteries and bulb for laryngoscope

10. Meconium aspirator (when clinically indicated)

11. Gloves

12. Pulse oximeter with heart rate monitor

PROCEDURE:

1. Notify Respiratory Therapy for assistance and to set up O_2.

2. Use radiant warmer to ensure heated environment. Hypo/hyperthermia alters metabolic rate and increases oxygen consumption.

3. Throughout the intubation procedure, observation of the patient is mandatory:

   a. Cardio-respiratory monitors – with an audible pulse rate.

   b. Pulse oximeter should be used (with heart rate monitor).

   c. If bradycardia is observed, especially with hypoxia, the procedure should be stopped ventilated with bag/mask.

4. Provide respiratory support and oxygen concentration according to NRP oxygen saturation targets and clinical condition. Supplemental oxygen should be titrated using pulse oximetry. Routine preoxygenation with 100% oxygen is not recommended.

5. The baby's head should be slightly lifted anteriorly with chin, shoulders slightly elevated and with the baby's body aligned straight. Do not hyperextend. The "sniffing" position will assist displacing the tongue from the posterior pharyngeal wall. Hyperextension may occlude the trachea.

6. Intubation attempts should be limited to approximately 30 seconds or less. If the infant develops bradycardia, desaturation, or clinical instability, the attempt should be stopped and effective positive-pressure ventilation resumed.

7. The primary method to confirm ET tube placement are detecting exhaled CO2 through a CO2 detector (color change from blue or purple to yellow), and rapidly rising heart rate. ET tube

should be taped/secured from "tip to lip" applying rule of 6. For oral intubation, add 6 cm to infant's weight in kilograms.

a. If air entry is poor over the left side of the chest, the tube should be pulled back until it becomes equal to the right side.

b. Orogastric tube placement to decompress stomach, secure in place and leave open to air.

8. Attach anesthesia bag and apply positive pressure.

9. Once correct position is ascertained, the tube should be held against the palate with one finger, until it can be taped securely in place.

10. Obtain chest x-ray to confirm tube placement.

11. Decompress stomach with #5-10 French feeding tube especially if PPV with bag/mask.

DOCUMENTATION:

- Intubation, time, and confirmation method(s) used
- Name of person placing the tube
- Size of tube, and tube depth
- How infant tolerated the procedure
- Quality of breath sounds
- Time x-ray was taken and read
- Amount of positive pressure exerted.
- Complications/adverse events

REFERENCES:

- American Academy of Pediatrics. (2021). *Textbook of neonatal resuscitation (NRP) (8th ed.)*. American Academy of Pediatrics. https://doi.org/10.1542/9781610025256
- American Heart Association. (2025). *Neonatal resuscitation*. https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/neonatal-resuscitation
- California Perinatal Quality Care Collaborative. (n.d.). *Neonatal transport*. California Perinatal Quality Care Collaborative. https://cpqcc.org/nicu/nicu-data/neonatal-transport

SUBJECT: **FORMULA – INFANT FORMULA PREPARATION AND STORAGE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide standardized prepared commercial formulas to meet the nutritional needs of infants in a manner that meets infection control standards and promotes safe feeding practies.

POLICY:

1. Formulas to be used are to be pre-sterilized, ready to feed formulas in individual units.
2. Formula will be kept in nursery or on exchange cart at room temperature in accordance with manufacturer recommendations.
3. Once opened, ready to feed formula will be discarded within two (2) hours.
4. Central Supply Clerk will be responsible for monitoring expiration dates and rotating deliveries from the back to the front using the first-expire first out method.
5. Cases and/or units that reach their expiration dates will be removed from the department by Central Supply Clerk.

AFFECTED AREAS/PERSONNEL: *MATERNAL CHILD HEALTH (MCH) STAFF, REGISTERED NURSES (RN)s, UNIT CLERKS*

EQUIPMENT:

- Ready to feed formula

PROCEDURE:

1. Parents will be instructed to discard remainder of formula at end of feeding.
2. Staff will verify the correct formula type prior to distribution and feeding.

DOCUMENTATION:

- Maintain documentation of newborn feedings.
- Document any feeding related concerns in the medical record and report to physician per unit standard.

REFERENCES:

Centers for Disease Control and Prevention. (2024, December 19). Infant formula preparation and storage. U.S. Department of Health and Human Services. https://www.cdc.gov/infant-toddler-nutrition/formula-feeding/preparation-and-storage.html

Centers for Disease Control and Prevention. (2025, March 19). How to clean, sanitize, and store infant feeding items. U.S. Department of Health and Human Services. https://www.cdc.gov/hygiene/about/clean-sanitize-store-infant-feeding-items.html

Centers for Disease Control and Prevention. (2026, May 4). Tips for infant formula feeding. U.S. Department of Health and Human Services. https://www.cdc.gov/infant-toddler-nutrition/formula-feeding/

World Health Organization. (2023). WHO guideline for complementary feeding of infants and young children 6–23 months of age. World Health Organization. https://www.who.int/publications/i/item/9789240081864

World Health Organization. (2023, December 20). Infant and young child feeding. https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding

SUBJECT: **GAVAGE FEEDING**	SECTION: **Page 1 of 4**

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

PURPOSE:

To set nursing guidelines for meeting the nutritional needs of infants unable to take adequate nutrition for growth orally. Infants less than 34 weeks gestation typically do not have the ability to coordinate suck-swallow-breathe patterns.

POLICY:

1. A physician's order is required for gavage feedings. It should include:
    a. Type or formula
    b. Volume of feeding
    c. Frequency of feeding
2. Only trained licensed personnel will perform gavage feedings.
3. Infants will be provided a pacifier for non-nutritive sucking during intermittent gavage feedings.

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

EQUIPMENT:

- 5 to 10 mL Sterile syringes
- Appropriate size of feeding tube (# 8 Fr for orogastric, # 5 Fr for nasogastric)
    - For infants less than 1000 grams use No. 5 French Gastric tube. For infants equal to or greater than 1000 grams use No. 6 to 8 French gastric tube.
- Formula/breast milk or sterile water for Gavage
- Tape/Tegaderm™ (Hypoallergic Preferred)
- Stethoscope
- Gloves
- Pacifier

PROCEDURE:

Preparatory Phase:

1. Check physician's order.
2. Explain procedure to parents before starting.
3. Assemble gavage equipment at crib side or warmer.
4. Wash hands and check crib card and ID bands, then place baby on his/her back with the head slightly hyper-flexed or semi-recumbent position unless an alternate position is medically indicated.

Measure the distance from the nares to ear lobe and from ear to xiphoid process. Then mark the length on feeding tube with tape.

Performed Phase:

1. Lubricate catheter with sterile water, NSS, or with soluble lubricant
2. Stabilize the patients head with one hand, use the other hand to insert catheter
    a. **Insertion through naris**: Slip the catheter into the patients nostril and direct it toward the occiput in a horizontal plane along the floor of nasal cavity. Do not direct the catheter upward. Observe for respiratory distress.
    b. **Insertion through the mouth**: Pass the catheter through the patients mouth toward the back of the throat with his/her head tilted slightly forward.
3. Pass the feeding tube along the base of the tongue, advancing into the esophagus as infant swallows. Do not push against resistance. Gently try rotating the tube if resistance is met. If there is no swallowing insert the catheter smoothly and quickly.
4. Test for tube placement as follows:
    a. Aspirate gastric contents with 10 mL syringe (Note: there may not be aspirate if stomach is empty or catheter tip is not in contact with fluid).
    b. Listening to the stomach with stethoscope while injecting 2 to 3 mL of air. Air should be heard entering the stomach. Withdraw air that was injected.
    c. If unsure of placement at any time, obtain order for abdominal x-ray
5. Pause and observe for apnea or bradycardia due to vagal stimulation.
6. Secure the tube by taping or using Tegaderm™.

7. Assess gastric residuals when clinically indicated or ordered by the provider. Clinical signs of feeding intolerance should be considered in conjunction with residual findings

8. Position infant to facilitate the stomach emptying and to prevent aspiration:
   a. Side-lying (preferably right side)
   b. Head and chest slightly elevated

9. Pour formula/breast milk into syringe.

10. Insert plunger gently to start gravity feeding.

11. Remove plunger.

12. Allow the contents of the syringe barrel to flow slowly by gravity, elevating the syringe 6 to 8 inches (15 to 20 cm) above the baby.

13. Provide pacifier for non-nutritive sucking.

14. Regulate rate of flow by raising or lowering feeding syringe (Feeding too rapidly may cause distension, regurgitation and possible aspiration).

15. While the fluid is running, watch the baby closely for any indications of distress. Stop the feeding immediately if signs of distress, cyanosis, bradycardia, apnea or coughing appear.

16. Do not force the baby to take more than he/she can tolerate. If the baby tolerates a specified amount, wait a few moments for the catheter to empty, pinch the tube tightly and remove gently but quickly.

17. Burp the baby and place him/her in a position according to current neonatal safe sleep and clinical condition guidelines. Supine positioning is preferred unless an alternate position is medically indicated.

DOCUMENTATION:

1. Size of feeding tube used

2. Time, gavage method

3. Amount, type of formula or breast milk

4. Amount of residual

5. Amount retained

6. How the infant tolerated the procedure and condition afterwards

7. Parent/family education

REFERENCE:

- American Academy of Pediatrics. (2026). *Nutrition for VLBW infants and newborns*. https://www.aap.org/en/patient-care/newborn-infant-and-early-childhood-nutrition/nutrition-for-vlbw-infants-and-newborns/

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SUBJECT: **MATERNAL CHILD HEALTH SCOPE OF SERVICES**	SECTION: **Page 1 of 15**

PURPOSE

EXECUTIVE SUMMARY

ABSTRACT

The purpose of the Maternal Child Health Scope of Service Policy is to describe how comprehensive nursing and medical care is provided to obstetrical and neonatal patients.
This includes educational programs for staff and parents. The services are provided in the following clinical settings at Sierra View District Hospital: Labor and Delivery (L & D), Postpartum Unit, Well Baby Nursery, Neonatal Intensive Care Unit (NICU), and Antepartum Testing.
The organization of the professional staff that provides care is described in detail, particularly noting how the service meets the requirements of external regulatory bodies. The role of the Medical Directors for each of the clinical practice areas is clearly explained.

TABLE OF CONTENTS

Abbreviations:

AAP - American Academy of Pediatrics

ACOG - American College of Obstetricians and Gynecologists

ANA - American Nurses Association

AWHONN - Association of Women's Health, Obstetric and Neonatal Nurses

TJC- The Joint Commission

L & D - Labor and Delivery

NANN - National Association of Neonatal Nurses

NICU - Neonatal Intensive Care Unit

PP/FBC - Postpartum Unit/Family Birth Center

WBN - Well Baby Nursery

CMQCC – California Maternal Quality Care Collaborative

STATEMENT OF POLICY

I. PURPOSE

A. To provide comprehensive nursing and medical care for the following:

1. Obstetrical patients (Antepartum, Intrapartum and Postpartum)

2. Well newborns

3. Neonates requiring continuing care services

B. To provide educational programs:

1. Education for nursing and medical staff encompassing orientation and continuing education to develop, improve and maintain patient care skills.

2. Education for parents with special emphasis on family-centered care. Instruction includes the details of Antepartum, Intrapartum, postpartum, and newborn care. Prenatal classes are offered.

3. Breastfeeding is encouraged and supported by a knowledgeable staff and supportive policies and procedures.

4. Parents of infants in the nursery are instructed on how to care for their infant at home. Prior to discharge parents are encouraged to participate in the infant's care to facilitate family adjustment and continuity of care following discharge.

5. Infant rooming-in is encouraged when clinically appropriate and consistent with safe sleep practices.

II. ORGANIZATION

A. Committee Structures

1. OB/Gyn

2. Pediatric

B. Medical Directors

1. Maternal Child Health Medical Director:

a. Qualifications:

- Is a member of Sierra View District Hospital Medical Staff as a licensed independent practitioner with clinical privileges appropriate to Obstetrics and Gynecology.

- Must be a physician with current obstetrical privileges and experience in maternal-child health services. Board certification or board eligibility in Obstetrics and Gynecology is preferred.

- Must be able to provide consultation regarding the activities of the Maternal Child Health Department.

b. Duties and responsibilities:

- The Medical Director will work in collaboration with the Clinical Leadership of Women's Services.
- Continuing surveillance of the professional performance of all individuals in MCH department who have delineated clinical privileges.
- Recommending to the Medical Staff the criteria for clinical privileges that are prevalent to the care provided in the MCH Department.
- Recommending clinical privileges for each member of MCH Department.
- Participating in Medical Staff and Hospital activities, i.e., meetings.
- Knowledge in and complying with Hospital and Department policies, procedures, and standards of care.
- Assisting with integrating the MCH Department into the overall functioning of the hospital.
- Planning, implementing, monitoring, evaluating, and documenting patient care activities provided by the medical staff.
- Assuring that the individuals in the department who are responsible for the assessment, treatment and care of patients are competent to deliver care appropriate to the ages of the patients served.
- Assuring that all patients are cared for appropriately, safely and quality is maintained.
- Acting as a liaison between Medical, Nursing and Administrative Staff.
- Providing consultation to the clinical and medical staff.
- Supporting the hospital's mission and values.
- Staying abreast of the advances in the Obstetrical and Gynecological fields.
- Acting as a role model for practices and behaviors.

- Responsible for appointing a qualified designee to act in his/her absence.

c. Authority of the Medical Director

- To represent MCH Services in the hospital and medical staff decision-making process through direct participation or formal submission of recommendations.
- Full authority for emergency medical decisions in the absence or unavailability of the responsible physician.
- Has the final decision regarding admission and discharge of patients from the Labor and Delivery and Postpartum units.

2. Neonatal/Pediatric Intensivist

a. Qualifications

b. Duties and Responsibilities

- Responsible for enforcing hospital policies and supervising the professional neonatal services
- Responsible for providing appropriate pediatric coverage for the Labor and Delivery Unit.
- Supervises all newborn services and is responsible through the Chair of Pediatric Service for the quality of medical care given in the Newborn Nursery.

c. Authority

- Has final decision regarding admission and discharge of patients from the nursery.
- Is responsible for appointing a qualified designee to act in his/her absence.

3. Obstetrical Anesthesia Medical Director

a. Qualifications

b. Duties and Responsibilities

c. Authority

4. Attending Physicians

a. Practice privileges

b. Responsibilities

5. Certified Nurse Midwives

a. Practice privileges

b. Responsibilities

6. Certified Nurse Anesthetist

a. Practice privileges

b. Responsibilities

C. Hospital Administration

Hospital Administration provides, with the advice of the Medical Directors and Nursing Service the personnel and facilities (beds, equipment, space, and supplies) required for the efficient and effective operation of Maternal Child Health Department at Sierra View Medical Center, include but not limited to: Case Management, Social Service, Interpreter Service and Chaplain Service.

D. Nursing Administration

1. Patient Care Services directs nursing administration, and is responsible for defining, establishing, maintaining, and evaluating standards for nursing practice.

2. Each unit has clinical leadership who supervises the nursing care and staff. Leadership is a registered nurse with appropriate training and experience relevant to that particular unit. Leadership will work in collaboration with the clinical educator to define, establish, maintain, and evaluate the unit standards for nursing practice.

3. The delegation of medical function to registered nurses requires "Standardized Procedures" approved by the Nursing Practice Committee, Medical and Hospital Boards.

4. Unit staff is based on an acuity system or per Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Standards, Title 22, American Academy of Pediatrics (AAP), and National Association of Neonatal Nurses (NANN).

E. Nursing Staffing

F. Staff Education and Training

G. Relationship to Other Hospital Units

III. POLICIES AND PROCEDURES

Define services provided by Maternal Child Health Services. Maternal Child Health Department services are provided 24-hours a day, 7 days a week. The department employees include Registered Nurses specially trained to assist in all aspects of care of the Obstetrical patient, neonate, pre- and post-operative GYN surgical cases and non-infectious medical patients. OR Techs that assist surgical cases preformed in the OB Surgical suite, and a Unit Clerk. The staff provides patient and family psychosocial support, education, and discharge planning to assist in the transition of an infant and the postpartum mother into the family setting. Additionally, the department will provide pre- and post-operative care for GYN surgical patients.

AFFECTED AREAS/PERSONNEL:

MCH/LABORATORY/RADIOLOGY/SOCIAL SERVICES, SURGICAL SERVICES, MATERNAL CHILD HEALTH STAFF

PATIENTS SERVED:

PATIENT POPULATION

Generally, patients are considered candidates for admission if they are pregnant or having pregnancy related problems, newborn infants or GYN surgical patients. The department adheres to a mother –baby couplet care model, but does provide services to newborns through a Level I and Level II Nursery for continuous care, or immediate stabilization for transfer (temporary ventilatory stabilization may be initiated pending transfer to a higher level neonatal center). Patients seen in the unit other than post-partum includes women from adolescent through adult, who are pregnant with a gestational age of 20 weeks or greater, in need of pregnancy- related hospitalization. The service is designed to provide routine obstetrical care to include the performance of Caesarean Sections and post-partum tubal ligations in the

department's Operating Room. There is a working referral process for Perinatology and Neonatology consultation, referral and/or transfer to neighboring tertiary centers as needed.

A. Common candidates for admission to L&D and PP include:

1. Laboring obstetrical patients
2. Patients with premature labor
3. Patients with PIH
4. Antepartum medical problems
5. Mother/newborn units
6. Candidates for GYN surgical intervention, both pre and postoperative.
    a. A&P repair
    b. Hysterectomy
    c. Bladder Suspension
    d. Laparoscopic Cholecystectomy
7. Non-infectious medical patients

B. Common candidates for admission to NICU include:

1. Significant hyperbilirubinemia requiring intensive phototherapy or monitoring
2. Infants greater than 32 weeks gestation or greater than 1500 grams
3. Administration of antibiotics
4. Infants requiring resuscitation
5. Infants requiring assessment of vital signs, blood glucose or pulse oximetry
6. Infants requiring a transitional period
7. Infants requiring stabilization for transfer to a higher level of care, which includes temporary vent support until transfer.

AGE OF PATIENTS

The MCH Department serves the age specific needs of the following patients:

- Neonates
- Pediatric
- Adolescent
- Adult
- Geriatric

SERVICES/PROCEDURES

Included in the services of the MCH Unit are:

- Nursing
- Emergency and routine lab work availability
- Blood bank service availability
- Diagnostic radiology availability
- Surgical Services
- Social Services

HOURS OF OPERATION

MCH operates 24 hours a day 7 days a week.

Departmental Goals

- To provide safe, effective, and appropriate nursing care using the ongoing Nursing Process.
- To provide an environment which will be conductive to laboring or healing through detecting and coping with emergency situations and preventing complications associated with the various stages of labor or surgical interventions. Provide care to newborn infants and promote the baby friendly unit.

- To provide high-level medical and nursing management with the focus on collaborative, multi-disciplinary approach, minimizing negative physical and psychological effects through patient/family education, restoring the patient/family to a high level of self-care.

- To utilize CMQCC maternal safety bundles and evidence-based perinatal practices regarding but no limited to obstetric hemorrhage, hypertension, sepsis, and emergency response.

Staffing Plan

The MCH Unit is committed to provide one level of care and will have adequate staff for the provision of that care. In addition to maintaining Title 22 regulations, MCH will strive to staff according to the guidelines set forth by the American Academy of Pediatrics, the American College of Obstetrics and Gynecology and staffing is based on patient acuity using Association of Women's Health, Obstetrics and Neonatal Nursing (AWHONN) standards, and National Association of Neonatal Nurses (NANN). Acuity levels (patient classification) shall be determined each shift by the Charge Nurse and reported to the Nursing Supervisor. A set of staffing guidelines will be provided to the Nursing Supervisor to use to assist the Charge Nurse in determining the correct number of staff.

- Director
- Clinical Managers
- Charge Nurse (RN)
- Staff RN
- OB Technician

Staffing will be maintained according to ACOG guidelines: (see attached)

Nursing Supervisor/Manager based on the guidelines makes staffing adjustments:

1. Whenever a scheduled person is not required in the unit due to low census, this individual is placed on call, floated, or called off.

2. Whenever additional staff is needed, staff that is placed on call will be called in or staff from other units will be floated if available.

3. Perinatal staff working additional hours adjusts increasing variances.

Qualifications of Staff

The staff in the unit will maintain the following skills and competency:

- RN
  1. Fetal monitoring in L&D
  2. NRP
  3. ACLS
  4. BLS
  5. STABLE (NICU and Charge Nurses)
- OB Tech
- Lactation Consultants
  1. BLS

* Staff members are encouraged to seek educational opportunities at this facility and through outside sources, in order to enhance the level of care delivery to our patients.

ADDENDUM A

ACOG GUIDELINES FOR PERINATAL CARE STAFFING

	Nurse to Patient Ratio	Care Provided
Antepartum	1:2-3	Women During Nonstress Tests
	1:3	Women in Antepartum with complications but stable
Intrapartum	1:1	Patients with complications
	1:2	Laboring patients
	1:1	Patients in the second stage of labor
	1:1-2	Woman receiving oxytocin during labor
	1:1	Coverage of Epidural Anesthesia –first 30 minutes after initial dose
	1:1	Circulation during Cesarean delivery
	2:1	Birth: one nurse for the mother and one nurse for the baby
Postpartum	1:1-2	Immediate post-operative recovery period (at least 2 hours)
	1:3	Women in postpartum with complications, but stable
	1:5-6	Women in postpartum without complications
	1:3-4	Mother-newborn care
Nursery	1:5-6	Newborns needing only routine care
	1:3-4	Newborns requiring continuing care
	1:2-3	Newborns needing intermediate care
	1:1-2	Newborns needing intensive care
	1:1	Newborns requiring multisystem support
	1:1 or greater	Unstable newborns needing complex medical care

Acuity Based Staffing

PURPOSE:

1. To provide an objective measurement for staffing based on patient acuity.

2. To provide a method of distributing patient assignments among the staff to ensure both patient and nurse satisfaction.

3. To document productivity by ongoing comparison of required hours and actual hours worked.

4. To project staffing requirements for annual budget planning.

5. To document minimum staff requirements for each shift and assist in ongoing scheduling.

Acuity Implementation Guidelines

1. All patients will be classified as to the category and number that they belong in based on specific criteria in the acuity indicators tool.

2. The nurse responsible for the patient care will classify the patient four hours before the next shift. The online acuity tool, Optilink, will be used. The patient acuity system is embedded in the program and will automatically be configured based on the patient condition.

3. Patient classification should reflect the anticipated need for the next 12-hour shift.

4. All anticipated admissions and outpatients should be classified per appropriate acuity indicators.

5. If actual patient hours currently needed differ from those projected by the acuity indicators, actual hours should be projected and the House Manager or Department Manager be made aware of needs. Justification should be documented at the bottom of the Staffing sheet with a corresponding asterisk.

6. Appropriate staffing will be determined, by the oncoming charge nurse with the following considerations:

   a. Number of oncoming staff with labor and delivery skills.

   b. Number of deliveries on the present shift that may necessitate increased cleaning and restocking activities for the oncoming shift.

   c. On call staff available.

   d. Oncoming staff who desire to take On Call, while still maintaining an appropriate experience level for emergencies.

   e. Projected hours needed to cover scheduled meetings, inservice or special project assignments.

   f. Acuity hours will be used by the charge nurse on the oncoming shift to make appropriate patient assignments.

   g. Completed forms are to be left on the clipboard for 48 hours. They are then transferred to a notebook on the unit for reference as needed.

MATERNAL CHILD HEALTH, ACUITY TOOL, DESCRIPTION OF INDICATORS

High Risk Labor: Category IV

1. Medical conditions such as pregnancy induced hypertension receiving magnesium sulfate infusion, insulin dependent diabetic on insulin drip.

2. Fetal Complications: Indications of fetal distress as evidenced by decelerations of FHR that do not recover during labor, or expected advanced resuscitation after delivery as with preterm infants or known neonatal anomaly.

3. Multiple Gestation: Twins or triplets monitoring during entire labor.

Mid Risk Labor: Category III

4. Epidural anesthesia during labor, continuous infusion requiring cardiac monitoring and assessment q 15 minutes.

5. Delivery expected 1st 4 hours of shift, during the pushing phase the patient becomes a 1:1 ratio and the initial recovery phase is also 1:1

6. Pitocin augmentation is IV titration of a drug to enhance uterine contractions. It required maternal/fetal assessments every 15 minutes.

7. TOLAC/VBAC is when the patient has had a previous cesarean section and is attempting to deliver vaginally. TOLAC = Trial of Labor after Cesarean Section; VBAC – Vaginal Birth after Cesarean Section. The patient is at risk for a repeat C/S and possible rupture of previous uterine scar.

8. Fetal Demise: The baby has died in utero and the patient requires a lot of emotional support. Also there is increased risk for DIC.

Normal Labor: Category II

9. Normal labor is spontaneous labor without medical interventions, requires maternal fetal assessment every 30 minutes and nurse to patient ratio of 1:2.

10. Scheduled C/S delivery, the patient is a planned surgical delivery and the nurse must admit the patient, accompany to surgery, catch the baby and recover both the mother and the baby.

Antenatal Complications: Category I

11. Antenatal complications requiring monitoring: Patient is not delivered but is hospitalized due to conditions such as hyperemesis, or preterm labor that can be treated with oral medication. Assessment required every 1-2 hours.

12. Antenatal complication requiring education before discharge would include preterm labor, diabetes, placenta previa, and PIH. Education would include Sign and Symptoms

13. Report, management of condition, medication regime and specific physician instructions. Family education would also be included.

REFERENCE:

- American Academy of Pediatrics & American College of Obstetricians and Gynecologists American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2022). *Guidelines for perinatal care* (9th ed.). American Academy of Pediatrics.
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- California Maternal Quality Care Collaborative. (2024). *CMQCC maternal safety quality improvement toolkits and patient safety bundles*. https://www.cmqcc.org
- Weiner, G. M., Zaichkin, J., & American Academy of Pediatrics. (2021). *Textbook of neonatal resuscitation (NRP)* (8th ed.). American Academy of Pediatrics.

CROSS-REFERENCE:

- Maternal Child Health Policy & Procedure Manual: Labor & Delivery Standards of Care; Postpartum/Newborn Standard of Care; Nursery Standards of Care; MCH Education Plan

SUBJECT: **OPERATING ROOM CLEANING**	SECTION: **Page 1 of 4**

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

PURPOSE:

This document provides guidance on cleaning procedures, personnel education, competency verification, and monitoring cleanliness through performance improvement processes. All perioperative team members have a responsibility to provide a **clean** and safe environment for patients. Perioperative and environmental services leaders can cultivate an environment in which perioperative and environmental services personnel work collaboratively to accomplish cleanliness in a culture of safety and mutual support.

POLICY:

All employees will follow consistent cleaning, according to established routine.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR), MATERNAL CHILD HEALTH (MCH) OR, AMBULATORY SURGERY DEPARTMENT (ASD), CATH LAB, INTERVENTIONAL RADIOLOGY OR / ALL SCRUB PERSONNEL, CARDIAC CATH LAB PERSONNEL*

PROCEDURE:

1. Patients will be provided with a safe, clean environment, free from dust and organic debris.
    a. Performing terminal cleaning or closing the OR after a contaminated or dirty/infected procedure
    b. Furniture, surgical lights and equipment will be damp-dusted before the first scheduled procedure of the day. Damp dusting will be done with a clean, lint free material moistened with a hospital grade chemical germicide.
    c. Preparation of the surgical suites will include a visual inspection of the room for cleanliness before the case carts, supplies, and instrument sets are brought into the room.
    d. Operating and procedure rooms must be cleaned and disinfected after each patient procedure.

2. During the surgical procedure, activities will be directed to confine and contain contamination.
    a. Identify high-touch objects and surfaces to be cleaned and disinfected
    b. Contaminated disposable items will be discarded into leak proof containers.
    c. Items contaminated with potentially infectious waste will be handled using protective barriers.

d. All blood, body fluids and tissue specimens will be placed in a clean, leak proof container for transport.

e. All items that come in contact with the patient and/or sterile field during a procedure will be considered contaminated.

f. Disposable items will be disposed of according to policy and procedure of medical waste disposal.

g. Reusable items will be processed according to the established policy and procedure.

h. Disposable items contaminated with blood and body fluids are placed in closable, leak proof containers or red biohazard bags.

i. Gowns and gloves will be removed (inside out) and placed into the appropriate receptacle before leaving the surgical suite.

j. Contaminated linen will be handled as little as possible and with minimal agitation.

k. All disposable sharps will be placed in puncture resistant containers.

l. Contaminated instruments, basins, trays and other items shall be handled only by personnel wearing personal protective equipment/attire, until the items are decontaminated.

m. After each surgical procedure, equipment and furniture used during the surgical procedure will be cleaned with tuberculocidal, hospital-grade chemical germicide.
- Clean and disinfect high touch surfaces
- Clean any visibly contaminated walls or floors immediately.
- **Mop/clean floor areas in and around the procedural field when soiled and according to facility policy.**

n.

o. Patient transport vehicles will be cleaned with a hospital-grade disinfectant/detergent.

p. Floors will be cleaned using hospital-grade disinfectant/detergent.

3. At the conclusion of the day's schedule, operating rooms, scrub/utility areas, corridors, furnishings and equipment shall be terminally cleaned with mechanical friction and a hospital-grade disinfectant/detergent which will include:

a. Surgical lights and tracks

b. Fixed ceiling-mounted equipment

c. All furniture, including wheels and casters

d. Face plates of vents

e. Horizontal surfaces (e.g., tops of counters, autoclaves, fixed shelving)

f. Entire floor

g. Scrub sinks

4. All of the following areas and equipment in the surgical area shall be cleaned on a routine scheduled basis:

a. Air conditioning grills and/or filters

b. Cabinets

c. Shelves

d. Walls

e. Ceiling

f. Offices

g. Lounges

h. Locker Rooms

5.

REFERENCE:

- AORN Standards and Recommended Practices (Jan 2025). Retrieved from https://aornguidelines.org/guidelines/content?sectionid=173715702&view=book#236401528

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

CROSS REFERENCE:

- Surgery Between Case Cleaning
- Surgery End of Day Terminal Cleaning

SUBJECT: **PEDIATRIC BLOOD TRANSFUSION**	SECTION: **Page 1 of 5**

PURPOSE:

To assist in maintaining equilibrium in the hemodynamically stable child and ensure the safe preparation, verification, administration, monitoring, and documentation of blood and blood component transfusions in pediatric patients.

POLICY:

1. To obtain, safely administer, and document blood/blood products.
2. Proper identification of the patient and blood unit.
3. Check for informed consent.
4. A consent for the transfusion must be signed by the child's parent or guardian before the infusion.
5. Do not add medications or IV solutions to blood products. Administer medications through a separate IV access site whenever possible. If interruption is unavoidable, follow blood bank and manufacturer recommendations regarding product hang time and completion limits.
6. Flush the IV line with normal saline before and after administering blood products.
7. 1:1 monitoring of the patient during the transfusion process.
8. If a reaction occurs, stop the blood transfusion immediately and notify the physician.

AFFECTED PERSONNEL/AREAS: *Medical Surgical Pediatric RNs*

EQUIPMENT:

- Nonsterile gloves
- Y-tubing with blood filter
- Blood/blood product
- Normal saline
- Thermometer
- Blood pressure equipment
- Stethoscope

- IV infusion pump/syringe pump
- Oximetry monitoring

PROCEDURE:

1. Prepare the child and family.
   a. Obtain Type & Cross as ordered.
   b. Check for informed consent.
   c. Determine if the child has received a previous transfusion and has had a transfusion reaction.
   d. Consult the physician if the child has had a previous reaction.
   e. Administer premedication per physician's order if child has had a previous reaction during administration.
2. Assemble the equipment.
3. Obtain the blood/blood product.
   a. Obtain blood from Lab Technician.
   b. With Technologist, check unit number, group and Rh type, expiration date, patient's name and medical record number, BBK number and sign blood bank slips.
   c. First, verification of accuracy is confirmed by the Lab Technician and employee picking up blood at the time that the blood is obtained. Both signatures are required on designated space on blood bank slips.
   d. ** There must be exact correspondence of the information before the unit leaves the blood bank. Only licensed nursing staff may go to the blood bank to pick up the unit(s) of blood.
4. Verify that the blood/blood product is correct.
   a. Check the blood product, amount to be infused, and rate against the physician's order.
   b. Verify appropriate volume/rate for patient weight and clinical condition, correlate with maintenance fluid requirement. Dose and rate is physician ordered; suggested doses and rates may be: (see attached table).

c. The blood product will be verified by the transfusionist and scanned as the second verification. Scanning should include all indicators: Patient name, date of birth (DOB), patient account number, BBK number, blood unit number, donor blood group and Rh type in order to qualify as the second verification. If unable to scan, the blood product can be verified with two (2) qualified licensed staff against the "Transfusion Administration Record" at the bedside. The one individual conducting the identification verification must be the qualified transfusionist who will administer the blood or blood component to the patient. At least two unique identifiers are used in the verification process and will be conducted after the blood or blood component matches the order has been issued or dispensed. If two licensed staff are verifying, a **signature is required of the nurse who administers blood and signature of licensed witness should appear next to RN.** The transfusion shall not begin until electronic verification or independent double-check procedures confirm compatibility between the patient, physician order, and blood component.

d. Hand hygiene needs to be performed.

e. Using the Y-tubing, connect the 250 ml bag of normal saline to one port and flush the line. Connect IV tubing to the child's venous access.

f. Inspect catheter insertion site for signs of infiltration or infection prior to starting the blood transfusion. A 23 gauge needle is the smallest size to be used for transfusion. Vascular access shall be appropriate for the prescribed blood product, infusion rate, and patient size.

g. Put on gloves and prime the appropriate blood administration set with the blood/blood product.

h. Take baseline vital signs (temperature, pulse, respiration, blood pressure and oxygen saturation).

i. Using an infusion pump/syringe pump to regulate flow, stop the normal saline and: Begin infusion with 0.5ml/kg/hr over the first 15 minutes, and then advance to the ordered rate after the 15 minute vitals if no adverse reactions are seen.

5. Identify possible transfusion reactions promptly and intervene immediately.

a. Watch for increased, shallow, or labored respirations; stridor or wheezing; tachycardia; decreased blood pressure.

b. Remain with child at bedside during entire transfusion.

c. Rate changes in skin color or mentation.

d. Auscultate lungs for rales, rhonchi or muffled breath sounds.

e. Fever—Temperature rise from baseline vitals >2 degrees C (3.5 degrees F) for blood components

f. Itching

g. Chills

h. Rash

i. Flank pain

j. Hematuria

k. Urticaria

2. Take vital signs at start of infusion, 15 minutes after start, 30 minutes after start and post transfusion. Document in the electronic medical record and on the blood transfusion form.

3. Discontinue blood if untoward effects occur and call physician.

a. Notify lab of reaction. Lab will draw blood specimens as required.

b. Complete upper part of Transfusion Reaction form in duplicate.

c. Obtain urine and remaining blood in bag/syringe, blood tubing and saline to Lab.

4. Discontinue when blood absorbed or as ordered. Blood components shall be completed within the time frame specified by the blood bank, generally not exceeding 4 hours from spike time unless otherwise specified.

5. Resume primary IV fluid as ordered.

6. Attach chart copy of Blood Transfusion Slip to Laboratory Record Sheet in the patient's chart when completed.

7. Care of Equipment Return of empty transfusion bag to lab.

d. Remove patient information/identification from bag/syringe.

e. Place transfusion empty pack in red bag.

f. Discard in red bag bin.

8. Documentation

   g. Document pertinent observations in the electronic medical record.

   h. Document in I & Os

   i. Transfusion Administration Record

REFERENCES:

1* Association for the Advancement of Blood & Biotherapies. (2026). *Standards for blood banks and transfusion services* (35th ed.). AABB. https://www.aabb.org/standards-accreditation/standards/blood-banks-and-transfusion-services

2* Association for the Advancement of Blood & Biotherapies. (2026, March 2). *AABB releases 35th edition of blood banks and transfusion services standards*. https://www.aabb.org/news-resources/news/article/2026/03/02/aabb-releases-35th-edition-of-bb-ts-standards

3* Association for the Advancement of Blood & Biotherapies. (2026). *Guidance for standards for blood banks and transfusion services* (35th ed.). AABB. https://www.aabb.org/aabb-store/product/bundle-standards-for-blood-banks-and-transfusion-services-35th-edition-print-and-guidance-20540919

4* The Joint Commission National Patient Safety Goals. (2026). *National Patient Safety Goals® for hospitals*. The Joint Commission.

5* Infusion Nurses Society. (2024). *Infusion therapy standards of practice* (9th ed.). *Journal of Infusion Nursing, 47*(1S), S1–S285. https://doi.org/10.1097/NAN.0000000000000532

6* Wong's Nursing Care of Infants and Children. (2024). Elsevier.

7* Policies and Procedures for Infusion Therapy: Neonate to Adolescent. (2024). Wolters Kluwer. https://shop.lww.com/Policies-and-Procedures-for-Infusion-Therapy--Neonate-to-Adolescent/p/9781975213824

CROSS REFERENCES:

- Blood and Blood Components, Administration of
- Blood and Blood Components, Transfusion Reaction

SUBJECT: **SEASONAL INFLUENZA PLAN**	SECTION: **Page 1 of 5**

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

PURPOSE:

The purpose of the SVMC Seasonal Influenza Plan is:

1. To implement prevention control measures to address seasonal influenza. Anticipated outcomes include a decrease in the number of seasonal influenza cases, accompanied by a less severe illness course for those who do become infected.
2. To describe the processes that will ensure the safety of patients, visitors, volunteers and healthcare personnel in the event of severe seasonal influenza.

INTRODUCTION:

- Influenza (the 'flu') is a contagious viral respiratory illness. Influenza virus strains perennially circulate throughout the world. In this geographical region, the influenza season can begin as early as October and continue through late May.
- The influenza virus can cause mild to severe illness, which may sometimes lead to death. The elderly, young children and individuals with specific health conditions such as metabolic diseases or a weakened immune system, etc., are at higher risk for serious complications from influenza. Research shows that the best way to prevent influenza is through yearly vaccination.
- Influenza is a disease that is transmitted by droplets expelled when an infected person coughs, sneezes or speaks. Less often, a person may contract influenza via fomite (surfaces that harbor viral particles) followed by touching their own face, especially the mouth, eyes or nose.
- Most individuals are able to transmit the influenza virus to others one day before symptoms appear and up to and through the 7th day after the appearance of symptoms.

POLICY:

- Sierra View Medical Center (SVMC) will monitor guidance and recommendations from the Centers for Disease Control (CDC), as well as state and local health officials, and may revise this flu season policy as more information becomes available.
- SVMC seeks to minimize the risk of influenza infection in patients, staff, students and visitors.
- The seasonal influenza plan and respiratory isolation precautions shall be implemented in the event of signs/symptoms of influenza.

AFFECTED AREAS/PERSONNEL: *ALL PATIENTS/VISITORS/STAFF*

PROCEDURE:

1. Visual alerts in Spanish and English will be posted in all appropriate entrances to the facility instructing all persons with signs/symptoms of infectious disease, especially respiratory, to:

    a. Inform reception and healthcare personnel when they first register for care that they may

be infectious.

b. Practice respiratory hygiene/cough etiquette: covering mouth and nose when coughing or sneezing, using tissues and disposing of them correctly.

2. The waiting area will be set up to enable patients with respiratory symptoms to sit at least 3 feet away from other patients and visitors; if feasible.

3. Signs promoting respiratory hygiene/cough etiquette will be placed in areas such as patient rooms to serve as reminders to all persons in the facility. The signs will instruct persons to:

   a. Cover the nose/mouth when coughing or sneezing.

   b. Use tissues to contain respiratory secretions.

   c. Dispose of tissues in the nearest waste receptacle after use.

   d. Patients with respiratory signs/symptoms will be given masks upon entry to the facility with instructions to wear them until evaluated, admitted or discharged.

   e. Perform hand hygiene after contact with respiratory secretions.

4. Personal protective measures:

   a. Early self-isolation of those feeling ill, feverish and having other symptoms of influenza (e.g., coughing, sneezing)

   b. Avoid close contact with sick people

   c. Avoid touching one's eyes, nose or mouth

5. SVMC will provide appropriate materials in waiting areas for patients and visitors:

   a. Surgical Masks

   b. Tissues and waste receptacles for used tissue disposals.

   c. Conveniently located dispensers of hospital-approved alcohol-based hand sanitizers.

   d. Soap and disposable towels for hand washing where sinks are available.

   e. If the condition is respiratory in nature and infectious, family members accompanying the patient will be asked to wear masks.

   f. Visitors will be limited to those necessary for patient's emotional well-being and care.

g. Visitors will be required to wear surgical mask while visiting an infected patient.

h. Visitors will be instructed on hand hygiene practices (washing hands with soap and water or using alcohol-based hand sanitizer for at least 20 seconds).

6. SVMC staff, volunteers, healthcare personnel and students are required NOT to report to work if they have a fever greater than 100.4° Fahrenheit (38° Celsius), combined with one or more of the following symptoms:

- Cough
- Sore throat
- Runny or stuffy nose
- Body aches
- Headache
- Chills
- Fatigue
- Diarrhea
- Vomiting

7. Influenza-related complications may affect people age 65 years and older, people with chronic medical conditions, pregnant women and young children and include:

- Bacterial pneumonia
- Otitis media
- Bronchitis and more

8. Prevention of illness:

a. SVMC endorses and encourages all healthcare personnel, staff, volunteer, and students to adhere to the guidance of the CDC to minimize the risk of becoming sick with seasonal flu, such as:

- Get the influenza vaccination
- Practice good hand hygiene by washing hands often with soap and water or by using alcohol-based hand sanitizer, especially after coughing or sneezing.
- Practice good respiratory etiquette by covering the mouth and nose with tissue when coughing or sneezing. If a tissue is not available, the cough or sneeze should be directed into a sleeve, elbow, or shoulder, but **not into hands**. Avoid touching eyes, nose or mouth.
- Individuals who are sick with influenza-like illnesses (ILI) should stay home.
- Individuals who declined the Influenza vaccine must wear a mask for the duration of Influenza season

Health Care System and Provider Actions

- Vaccinate health care workers.
- Review plans and prevention strategies for seasonal influenza in the health care setting, including implementation of respiratory hygiene, appropriate management of ill staff, and infection control precautions.
- Coordinate with the CDC to identify likely influenza strains that could affect California during the next influenza season:

    1. CDC guidance can be found at: http://www.cdc.gov/flu/professionals/index.htm.

- Monitor any disease outbreaks with patients exhibiting upper-respiratory infections or symptoms of ILI.
- Monitor ILI-activity in hospital emergency departments for statistically significant warnings and threats.
- Conduct laboratory testing to identify and confirm any influenza cases prior to the beginning of influenza season or early influenza activity phase.
- Monitor and report adverse reactions to vaccine by accessing the VAERS website at: https://vaers.hhs.gov/reportevent.html

REFERENCES:

- Centers for Disease Control and Prevention. 2026-2027 Flu Season. April 13, 2026. Accessed June 4, 2026 at https://www.cdc.gov/flu/season/2026-2027.html
- Centers for Disease Control and Prevention. Chapter 12: Influenza, in Epidemiology and Prevention of Vaccine-Preventable Diseases (The Pink Book). Hall E., Wodi A.P., Hamborsky J., et al., eds. 14th ed. Washington, D.C. Public Health Foundation, 2021. April 1, 2024. Accessed June 4, 2026 at https://www.cdc.gov/pinkbook/hcp/table-of-contents/chapter-12-influenza.html
- Centers for Disease Control and Prevention. Influenza (Flu) Vaccine (Inactivated or Recombinant): What You Need to Know. Updated February 28, 2025. Accessed June 4, 2026 at https://www.cdc.gov/vaccines/hcp/current-vis/influenza-inactivated.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html
- Influenza (Flu), California Department of Public Health. Updated March 3, 2026. Accessed June 4, 2026 at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Influenza.aspx
- Influenza (Flu), Centers for Disease Control and Prevention. Accessed June 4, 2026 at https://www.cdc.gov/flu/index.htm

SUBJECT:	SECTION:
SEEING/HEARING/COMPANION DOG (SERVICE ANIMALS)	***Ethics, Rights & Responsibilities (RI)*** **Page 1 of 3**

PURPOSE:

The purpose of this policy is to establish ADA-based guidelines for accommodating patients, visitors and/or employees the use of seeing/hearing/guide service dogs as an auxiliary aid within the confines of SVMC facilities.

DEFINITIONS:

ADA – American with Disabilities Act

AOC – Administrator-on-call

PACU – Post-Anesthesia Care Unit

Service Animal – ADA regulations narrowly define a "service animal" as any dog that is specially and individually trained to do work or perform tasks for the benefit of a disabled individual. Emotional support animals are expressly excluded from qualifying as a service animal under the ADA.

SVMC – Sierra View Medical Center

AFFECTED AREAS/PERSONNEL:

This policy covers all SVMC personnel, medical staff, patients and visitors.

POLICY:

SVMC will allow any patient, visitor, or employee the use of a service dog(s) as an auxiliary aide. The dog may be used in all situations *except* where it is clearly demonstrated that the presence or use of a service dog would pose a significant health risk (see "Exceptions" section on page 2), or when a dog's behavior is uncontrollable and/or disruptive.

PROCEDURE:

Hand Hygiene

1. Anyone handling or touching a Seeing/Hearing/Companion Service Dog(s) must perform hand hygiene after each and every contact.

Outpatient Areas

1. Service dogs will be allowed to work in any outpatient setting where the public and patients are routinely allowed to go.

Inpatient Areas

1. Any patient with a disability will be allowed to keep their service dog in a private room for the duration of their hospital stay. The patient is responsible for all service animal care, including grooming, feeding, and toileting the dog. If the patient is unable to care for the service dog, the patient can make arrangements for a family member or friend to come to the hospital to provide this care.
2. If the patient is unable to care for the service animal or is unable to arrange for someone else to care for the service dog, the hospital may place the dog in a boarding facility until the patient is released, or make other appropriate arrangements. However, the hospital must give the patient the opportunity to make arrangements for the dog's care before taking such steps.
3. Hospital staff is not obligated to supervise or otherwise care for a service animal. In an extreme emergency, the House Supervisor will be notified to assist with toileting.

Visitors

1. Visitors may make use of a service dog in accordance with the Hospital's Visitor Guidelines Policy.

Employees

1. Any disabled individual offered employment at SVMC will be allowed the use of a service dog while at work.
2. If at any time a current employee or a member of the medical staff needs accommodations, employees must make a request through Human Resources and medical staff must make a request through the Medical Staff Office.

EXCEPTIONS:

1. Areas where service dogs will not be allowed may include, but are not limited to: the operating room, the labor and delivery room, the newborn nursery, sterile processing and sterile processing storage areas, PACU, and the kitchen.
2. A case-by-case assessment will be made with medically qualified personnel, and the AOC in situations not covered by this list.
3. Proof of immunizations and training of the service animal may be requested in *specialized* cases or as needed in conjunction with ADA regulations.

REFERENCES:

ADA.gov – ADA requirements: Service Animals. Accessed June 5, 2026, last updated on February 28, 2020. https://www.ada.gov/resources/service-animals-2010-requirements/

ADA.gov – Service Animals. Accessed June 5, 2026. https://www.ada.gov/topics/service-animals/ https://www.ada.gov/topics/service-animals/

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 **June 23, 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 5:04 p.m.

Board Attendance:

- Liberty Lomeli, Chair - Present (Arrived at 5:06 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, Ron Wheaton, Vice President of Professional Services and Physician Recruitment, Tracy Canales, Vice President of Human Resources and Marketing, Val Reyes-Chavez, Marketing, Foundation & Events Specialist, 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 5:05 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 5:06 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

Closed Session items, C,D,E, and F 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 5:34 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	Abstain

B. Quality Division Update

1. 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

IV. Public Comments

None

V. Consent Agenda

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

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

VI. Approval of Minutes:

A. Motion made by Vice Chair REDDY and seconded by Director FLORES to approve the May 26, 2026, Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

VII. Business Items

A. May 2026 Financial Report

Roger Larsen, Interim CFO presented the May monthly financial report.

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

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

B. SVLHCD Fiscal Year 2027 Operating Budget
Item Deferred to the End of the Meeting

C. SVLHCD Fiscal Year 2027 Capital Budget
Item Deferred to the End of the Meeting

VIII. SVLHCD Board Chair Report
No Report Given

IX. CEO Report
The CEO provided an overview of June performance highlights, organizational accomplishments, community engagement, and upcoming initiatives.

- June dashboard highlights included:
  - 37,000 website sessions.
  - 3 community events attended or hosted.
  - 11,000 social media followers.
  - 5,297 total Google reviews, including 238 received in June.
  - Google reputation rating of 709, compared to an industry average of 484.
  - 35 accepted recruitment offers, including 15 in June.
- Sierra View Medical Center received recognition in the 2026 Best of Central California People's Choice Awards, including:
  - Gold Awards for Best Hospital, Best Surgery Center, and Best Cancer Treatment Center.
  - Silver Awards for Best Place to Have a Baby, Best Orthopedic Surgery, Best Women's Clinic, and Best Nonprofit Organization.
  - Bronze Award for Best Medical Facility.
- The Roger S. Good Cancer Treatment Center hosted its annual Survivor's Day Celebration, providing patients and guests an evening of connection, activities, and recognition.
- Staff had the opportunity to ask questions, share feedback, and connect with nursing leadership at Coffee & Cocoa with the CNO.
- Following the annual SCORE Survey, SVMC launched a SCORE Debrief Survey to gather additional employee feedback related to communication and recognition efforts. Results will help guide future organizational improvement initiatives.
- Community outreach efforts included participation in:
  - Porterville City Firefighters Association Golf Tournament.
  - United Way of Tulare County's Power of the Purse event.
- Upcoming events and initiatives highlighted included:
  - Freedom Fest community event sponsored by SVMC (July 3).
  - Coffee & Coworkers event (July 30).
  - Blood Drive partnership with Central California Blood Center (August 6).
  - BOCC Fiesta employee celebration (August 27).
  - Scrub Fair (September 8–10).
  - Midnight in Manhattan fundraiser benefiting SVF (September 18).
  - Unitek Graduation for Cohort #2 (September 25).

X. Announcements:

Regular Board of Directors Meeting – July 28, 2026, at 5:00 p.m.

XI. Closed Session: Board adjourned Open Session at 5:51 p.m., reconvening in Closed Session at 6:01 p.m. to discuss the following items:

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).

XII. Open Session: Chairman LOMELI adjourned Closed Session at 6:54 p.m., reconvening in Open Session at 7:53 p.m.

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

F. Conference with Legal Counsel

Board revisited Open Session Business Items B and C.

B. SVLHCD Fiscal Year 2027 Operating Budget
Following review and discussion, it was moved by Director FLORES, seconded by Vice Chair REDDY and carried to approve the 2027 Operating Budget as presented. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes

REDDY	Yes
LOMELI	Yes

C. SVLHCD Fiscal Year 2027 Capital Budget

Following review and discussion, it was moved by Director FLORES, seconded by Vice Chair REDDY, and carried to approve the modified 2027 Capital Budget as presented in the Board Room. The budget differed from the version published in the Board packet, as an Echo Machine Replacement was added, resulting in a change to the contingency amount. The Vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

XIII. Adjournment

The meeting was adjourned at 6:55 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

SIERRA VIEW
MEDICAL CENTER

Business Items

CHANDLER ASSET MANAGEMENT

INVESTMENT MANAGEMENT AGREEMENT
(Institutional Client, Non-ERISA)

Sierra View Local Health Care District (Client) hereby retains Chandler Asset Management, Inc. (Chandler) as Investment Adviser on the terms and conditions set forth herein.

1. Term. The term of this Agreement shall commence effective upon the funding of assets to the Client's existing managed account~~upon the execution of this Agreement~~ and shall continue until this Agreement is terminated effective upon receipt of notice of termination in writing delivered by the terminating party.

2. Fees. Client shall compensate Chandler monthly an amount calculated on the average market value of Client's portfolio, including accrued interest, in accordance with the following schedule:

Assets Under Management	Annual Investment Management Fee
First $50 million	0.09 of 1% (9 basis points)
Next $50 million	0.06 of 1% (6 basis points)
Assets in excess of $100 million	0.04 of 1% (4 basis points)

The fees expressed above do not include any custody fees that may be charged by Client's bank or other third party custodian.

Fees shall be prorated to the effective date of termination on the basis of actual days elapsed, and any unearned portion of prepaid fees shall be refunded. Client is not required to pay any start-up or closing fees; there are no penalty fees.

Chandler charges 1 basis point (0.01%) to report on assets that are not under our direct management.

Fees shall be deducted monthly in arrears from Client's custody account.

3. Client Representative. In its capacity as investment manager, Chandler shall receive all instructions, directions and other communications on Client's behalf respecting Client's account from _____ (Representative). Chandler is hereby authorized to rely and act upon all such instructions, directions and communications from such Representative or any agent of such Representative.

4. Investment Policy. In investing and reinvesting Client's assets, Chandler shall comply with Client's Investment Policy, which is attached hereto as Exhibit A.

5. Authority of Chandler. Chandler is hereby granted full discretion to invest and reinvest all assets under its management in any type of security it deems appropriate, subject to the instructions given or guidelines set by Representative.

6. Notices. All reports and other communications required hereunder to be in writing shall be delivered in person, or sent by first-class mail postage prepaid, by overnight courier, by confirmed facsimile

with original to follow or by confirmed electronic mail with proof of receipt to the addresses set forth below. Either party to this Agreement may, by written notice given at any time, designate a different address for the receipt of reports and other communications due hereunder.

Chandler Asset Management
Attn: Nicole Dragoo
9255 Towne Centre Dr., Suite 600
San Diego, CA 92121

CLIENT
Attn:
Address:
City, ST ZIP
Email

7. Electronic Delivery. From time to time, Chandler may be required to deliver certain documents to Client such as account information, notices and required disclosures. Client hereby consents to Chandler's use of electronic means, such as email, to make such delivery. This delivery may include notification of the availability of such document(s) on a website, and Client agrees that such notification will constitute "delivery". Client further agrees to provide Chandler with Client's email address(s) and to keep this information current at all times by promptly notifying Chandler of any change in email address(s).

   Client email address:_____

8. Proxy Voting. Chandler will vote proxies on behalf of client unless otherwise instructed. Chandler has adopted and implemented written policies and procedures and will provide client with a description of the proxy voting procedures upon request. Chandler will provide information regarding how clients' proxies were voted upon request. To request proxy policies or other information, please contact us by mail at the address provided, by calling 800-317-4747 or by emailing your request to info@chandlerasset.com.

9. Custody of Securities and Funds. Chandler shall not have custody or possession of the funds or securities that Client has placed under its management. Client shall appoint a custodian to take and have possession of its assets. Client recognizes the importance of comparing statements received from the appointed custodian to statement received from Chandler. Client recognizes that the fees expressed above do not include fees Client will incur for custodial services.

10. Valuation. Chandler will value securities held in portfolios managed by Chandler no less than monthly. Securities or investments in the portfolio will be valued in a manner determined in good faith by Chandler to reflect fair market value.

11. Investment Advice. Client recognizes that the opinions, recommendations and actions of Chandler will be based on information deemed by it to be reliable, but not guaranteed to or by it. Provided that Chandler acts in good faith, Client agrees that Chandler will not in any way be liable for any error in judgment or for any act or omission, except as may otherwise be provided for under the Federal Securities laws or other applicable laws.

12. Payment of Commissions. Chandler may place buy and sell orders with or through such brokers or dealers as it may select. It is the policy and practice of Chandler to strive for the best price and execution and for commission and discounts which are competitive in relation to the value of the transaction and which comply with Section 28(e) of the Securities and Exchange Act. Nevertheless, it is understood that Chandler may pay a commission on transactions in excess of the amount another broker or dealer may charge, and that Chandler makes no warranty or representation regarding commissions paid on transactions hereunder.

13. Other Clients. It is further understood that Chandler may be acting in a similar capacity for other institutional and individual clients, and that investments and reinvestments for client's portfolio may differ from those made or recommended with respect to other accounts and clients even though the investment objectives may be the same or similar. Accordingly, it is agreed that Chandler will have no obligation to purchase or sell for Client's account any securities which it may purchase or sell for other clients.

14. Confidential Relationship. The terms and conditions of this Agreement, and all information and advice furnished by either party to the other shall be treated as confidential and shall not be disclosed to third parties except (i) as required by law, rule, or regulation, (ii) as requested by a regulatory authority, (iii) for disclosures by either party of information that has become public by means other than wrongful conduct by such party or its officers, employees, or other personnel, (iv) for disclosures by either party to its legal counsel, accountants, or other professional advisers, (v) as necessary for Chandler to carry out its responsibilities hereunder, or (vi) as otherwise expressly agreed by the parties.

15. No Assignment & Amendments. Neither party may assign, directly or indirectly, all or part of its rights or obligations under this Agreement without the prior written consent of the other party, which consent shall not be unreasonably withheld or delayed. This Agreement may be amended at any time by mutual agreement in writing.

16. Governing Law. It is understood that this Agreement shall be governed by and construed under and in accordance with the laws of the State of California.

17. Severability. Any provision of this Agreement which is prohibited or unenforceable shall be ineffective only to the extent of such prohibition or unenforceability without invalidating the remaining provisions hereof.

18. Receipt of Brochure and Privacy Policy. Client hereby acknowledges receipt of the disclosure statement or "brochure" and “brochure supplement” also known as Part 2A and Part 2B of Form ADV, required to be delivered pursuant to Rule 204-3 of the Investment Advisers Act of 1940 (Brochure). Client further acknowledges receipt of Chandler’s Privacy Policy, as required by Regulation S-P.

19. Arbitration. It is agreed that any controversy between Chandler and the Client arising out of Chandler business or this Agreement, shall be submitted to arbitration conducted under the provisions of the commercial arbitration rules of the American Arbitration Association. Arbitration must be commenced by service upon the other party of a written demand for arbitration or a written

notice of intention to arbitrate, therein electing the arbitration tribunal. In the event the Client does not make such election within five (5) days of such demand or notice, then the Client authorizes Chandler to do so on the Client's behalf. Judgment upon any award rendered by the arbitrators shall be final and may be entered in any court having jurisdiction thereof. This clause does not constitute a waiver of any right including the right to choose the forum, whether arbitration or adjudication, in which to seek resolution of disputes.

Sierra View Local Health Care District

By:_____
Date

Chandler Asset Management, Inc.,
a California Corporation

By:_____
Nicole Dragoo Date
Chief Executive Officer

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS' RESOLUTION NO: 07-28-2026/01
AUTHORIZING THE PURSUIT OF FUNDING THROUGH THE CALIFORNIA RURAL HEALTH TRANSFORMATION (CalRHT) PROGRAM AND AUTHORIZING THE CHIEF EXECUTIVE OFFICER OR DESIGNEE TO PREPARE, EXECUTE, AND SUBMIT APPLICATIONS AND RELATED DOCUMENTS

WHEREAS, the Sierra View Local Health Care District ("District") is committed to providing high-quality, accessible, and patient-centered healthcare services to the residents of Porterville and the surrounding rural communities; and

WHEREAS, the California Department of Health Care Access and Information (HCAI), in partnership with the Centers for Medicare & Medicaid Services (CMS), administers the California Rural Health Transformation (CalRHT) Program to strengthen healthcare delivery systems in rural communities by improving access to care, supporting workforce development, enhancing operational sustainability, and expanding care coordination; and

WHEREAS, the CalRHT Transformative Payments Program provides financial resources to rural hospitals to support strategic initiatives that improve healthcare access, operational resilience, workforce stability, technology, care coordination, and long-term sustainability while advancing measurable improvements in patient care;

WHEREAS, participation in the CalRHT Program aligns with the District's strategic priorities by strengthening healthcare infrastructure, improving care delivery, expanding access to essential services, enhancing operational efficiency, and ensuring the long-term sustainability of healthcare services for the communities served by Sierra View Medical Center;

WHEREAS, the District wishes to streamline the application process and communication between the District, HCAI, CMS and CalRHT by designating an authorized agent to prepare, execute and submit applications and any supporting documents on behalf of the District;

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Sierra View Local Health Care District hereby:

Authorizes the Chief Executive Officer, or the CEO's designated representative(s), to identify, pursue, prepare, execute, and submit applications for funding available through the California Rural Health Transformation (CalRHT) Program.

CONSIDERED, PASSED AND ADOPTED, by the Board of Directors of Sierra View Local Health Care District, Tulare County, State of California at the regular meeting of the Board on July 28, 2026.

The vote of the Board is as follows:

Yes: ___

No: ___

Absent/Abstain: ___

By: _____
Liberty Lomeli, Chairman

Attest: _____
Areli Martinez, Secretary (Official Seal)

SIERRA VIEW MEDICAL CENTER

FINANCIALS

FINANCIAL REPORTS FROM THE PREVIOUS MONTH

FINANCIAL PACKAGE
Jun-26

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
June 2026

Statistic	Jun-26 Actual	Jun-26 Budget	Jun-26 Over/ (Under)	Jun-26 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 25 YTD	Increase/ (Decrease) Jun-25	% Change
Utilization											
SNF Patient Days											
Total	30	-	30	0.0%	178	-	178	0.0%	143	35	24.5%
Medi-Cal	30	-	30	0.0%	178	-	178	0.0%	143	35	24.5%
Sub-Acute Patient Days											
Total	1,004	1,051	(47)	-4.5%	12,333	12,410	(77)	-0.6%	11,881	452	3.8%
Medi-Cal	443	536	(93)	-17.3%	5,669	6,188	(519)	-8.4%	5,925	(256)	-4.3%
Acute Patient Days	1,266	1,679	(413)	-24.6%	18,685	19,935	(1,250)	-6.3%	19,833	(1,148)	-5.8%
Acute Discharges	370	445	(75)	-16.9%	5,351	5,285	66	1.2%	5,306	45	0.8%
Medicare	142	173	(31)	-18.0%	2,016	2,139	(123)	-5.7%	2,149	(133)	-6.2%
Medi-Cal	164	212	(48)	-22.7%	2,563	2,465	98	4.0%	2,476	87	3.5%
Contract	56	58	(2)	-3.0%	716	648	68	10.6%	648	68	10.5%
Other	8	1	7	704%	56	33	23	70.4%	33	23	69.7%
Average Length of Stay	3.42	3.77	(0.35)	-9.3%	3.49	3.77	(0.28)	-7.4%	3.74	(0.25)	-6.6%
Newborn Patient Days											
Medi-Cal	129	145	(16)	-11.0%	1,919	1,839	80	4.3%	1,808	111	6.1%
Other	39	28	11	39.2%	468	368	100	27.3%	397	71	17.9%
Total	168	173	(5)	-2.9%	2,387	2,207	180	8.2%	2,205	182	8.3%
Total Deliveries	94	94	-	0.0%	1,299	1,152	147	12.8%	1,155	144	12.5%
Medi-Cal %	73.40%	83.43%	-10.03%	-12.0%	79.49%	83.43%	-3.94%	-4.7%	82.54%	-3.05%	-3.7%
Case Mix Index											
Medicare	1.4820	1.6368	(0.1548)	-9.5%	1.5453	1.6368	(0.0915)	-5.6%	1.5924	(0.0471)	-3.0%
Medi-Cal	1.0562	1.1975	(0.1413)	-11.8%	1.1405	1.1975	(0.0570)	-4.8%	1.1882	(0.0477)	-4.0%
Overall	1.2417	1.3724	(0.1307)	-9.5%	1.2947	1.3724	(0.0777)	-5.7%	1.3599	(0.0652)	-4.8%
Ancillary Services											
Inpatient											
Surgery Minutes	5,063	7,863	(2,800)	-35.6%	82,654	93,626	(10,972)	-11.7%	88,168	(5,514)	-6.3%
Surgery Cases	65	86	(21)	-24.7%	994	1,095	(101)	-9.2%	1,053	(59)	-5.6%
Imaging Procedures	1,058	1,506	(448)	-29.7%	17,608	17,865	(257)	-1.4%	18,197	(589)	-3.2%
Outpatient											
Surgery Minutes	14,309	14,118	191	1.4%	177,878	167,493	10,385	6.2%	169,199	8,679	5.1%
Surgery Cases	201	196	5	2.7%	2,333	2,321	12	0.5%	2,280	53	2.3%
Endoscopy Procedures	168	187	(19)	-9.9%	2,059	2,213	(154)	-7.0%	2,224	(165)	-7.4%
Imaging Procedures	4,439	4,194	245	5.8%	50,435	49,758	677	1.4%	49,601	834	1.7%
MRI Procedures	317	304	13	4.4%	3,844	3,603	241	6.7%	3,585	259	7.2%
CT Procedures	1,376	1,262	114	9.1%	16,798	14,969	1,829	12.2%	15,070	1,728	11.5%
Ultrasound Procedures	1,562	1,360	202	14.9%	18,051	16,130	1,921	11.9%	15,747	2,304	14.6%
Lab Tests	35,604	32,307	3,297	10.2%	414,024	383,283	30,741	8.0%	390,419	23,605	6.0%
Dialysis	5	3	2	48.3%	78	40	38	95.0%	47	31	66.0%

Sierra View Medical Center
Financial Statistics Summary Report
June 2026

	Jun-26				YTD					Increase/	
Statistic	**Actual**	**Budget**	**Over/ (Under)**	**% Var.**	**Actual**	**Budget**	**Over/ (Under)**	**% Var.**	**Fiscal 25 YTD**	**(Decrease) Jun-25**	**% Change**
Cancer Treatment Center											
Chemo Treatments	2,081	2,014	67	3.3%	23,621	23,889	(268)	-1.1%	23,666	(45)	-0.2%
Radiation Treatments	1,606	1,920	(314)	-16.4%	19,920	22,778	(2,858)	-12.5%	21,901	(1,981)	-9.0%
Cardiac Cath Lab											
Cath Lab IP Procedures	18	14	4	28.6%	189	166	23	13.9%	152	37	24.3%
Cath Lab OP Procedures	43	33	10	29.1%	450	395	55	13.9%	413	37	9.0%
Total Cardiac Cath Lab	61	47	14	29.0%	639	561	78	13.9%	565	74	13.1%
Outpatient Visits											
Emergency	3,510	3,442	68	2.0%	42,710	41,661	1,049	2.5%	41,655	1,055	2.5%
Total Outpatient	15,631	14,313	1,318	9.2%	179,083	169,808	9,275	5.5%	171,162	7,921	4.6%
Staffing											
Paid FTE's	896.67	900.16	(3.49)	-0.4%	882.51	900.16	(17.65)	-2.0%	878.01	4.50	0.5%
Productive FTE's	755.47	772.13	(16.66)	-2.2%	760.53	772.13	(11.60)	-1.5%	752	8.44	1.1%
Paid FTE's/AOB	5.22	5.04	0.18	3.6%	5.01	5.21	(0.20)	-3.8%	5.12	(0.10)	-2.0%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,967	10,965	1,002	9.1%	11,293	11,167	126	1.1%	11,239	54	0.5%
Cost/Adj.Patient Day	3,314	2,811	503	17.9%	2,890	2,898	(8)	-0.3%	2,860	30	1.1%
Revenue/Adj. Discharge	57,273	54,307	2,966	5.5%	52,419	55,234	(2,815)	-5.1%	54,478	(2,059)	-3.8%
Cost/Adj. Discharge	15,860	13,924	1,937	13.9%	13,415	14,333	(919)	-6.4%	13,862	(447)	-3.2%
Adj. Discharge	1,076	1,082	(5)	-0.5%	13,838	12,739	1,100	8.6%	12,916	923	7.1%
Net Op. Gain/(Loss) %	2.47%	-0.57%	3.03%	-536.2%	0.89%	-0.57%	1.46%	-257.4%	-0.45%	1.34%	-298.0%
Net Op. Gain/(Loss) $	432,095	(84,766)	516,861	-609.8%	1,668,367	(2,848,703)	4,517,070	-158.6%	(801,850)	2,470,217	-308.1%
Gross Days in Accts Rec.	98.40	95.03	3.38	3.6%	98.40	95.03	3.38	3.6%	86.70	11.70	13.5%
Net Days in Accts. Rec.	35.59	57.75	(22.16)	-38.4%	35.59	57.75	(22.16)	-38.4%	37.21	(1.62)	-4.4%

Sierra View Local Health Care District
Balance Sheet

	Jun-26	May-26
Assets		
Current Assets:		
Cash & Cash Equivalents	15,210,198	17,145,283
Short-Term Investments	351,176	279,356
Assets Limited As To Use	5,700,629	5,222,203
Patient Accounts Receivable	194,851,268	198,141,473
Less Uncollectables	(13,395,833)	(13,284,452)
Contractual Allowances	(164,760,231)	(167,707,111)
Other Receivables	29,675,933	28,924,728
Inventories	4,594,966	4,465,655
Prepaid Expenses and Deposits	2,801,744	2,837,553
Less Receivable - Current	301,020	301,020
Total Current Assets	**75,330,870**	**76,325,709**
Assets Limited as to use, Less		
Current Requirements	33,070,246	32,993,335
Long-Term Investments	142,836,282	142,709,460
Property, Plant and Equipment, Net	69,433,844	69,665,942
Intangible Right of use Assets	146,618	156,945
SBITA Right of use Assets	2,087,195	2,228,866
Lease Receivable - LT	405,614	431,186
Other Investments	250,000	250,000
Prepaid Loss on Bonds	1,007,021	1,028,001
Total Assets	**324,567,691**	**325,789,445**
Liabilities and Funds Balances		
Current Liabilities		
Bond Interest Payable	608,825	507,354
Current Maturities of Bonds Payable	4,235,000	4,235,000
Current Maturities of Long Term Debt	0	0
Account Payable and Accrued Expenses	4,744,978	6,089,130
Accrued Payroll and Related Costs	10,070,787	8,649,917
Estimated Third-Party Payor Settlements	2,517,030	4,639,895
Lease Liability - Current	129,125	129,125
SBITA Liability - Current	1,759,193	1,759,193
Total Current Liabilities	**24,064,938**	**26,009,613**
Self-Insurance Reserves	1,941,663	1,979,859
Capital Lease Liab LT	0	0
Bonds Payable, Less Curr Reqt	29,040,000	29,040,000
Bonds Premium Liability - LT	1,532,336	1,577,856
Lease Liability - LT	35,605	46,676
SBITA Liability - LT	741,708	902,979
Other Non Current Liabilities	-	-
Deferred Inflow - Leases	652,066	676,563
Total Liabilities	**58,008,317**	**60,233,546**
Unresticted Fund	258,350,395	258,350,395
Profit or (Loss)	8,208,979	7,205,503
Total Liabilities and Fund Balance	**324,567,691**	**325,789,445**

Sierra View Local Health Care District
Income Statement

For Period **Jun-26**

	ACTUAL	BUDGET	VARIANCE	% VARIANCE	ACTUAL YTD	BUDGET YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	4,604,504	5,096,409	(491,905)	(10%)	64,196,178	64,977,448	(781,270)	(1%)
Inpatient - Ancillary	16,643,788	19,070,222	(2,426,434)	(13%)	216,966,507	226,936,200	(9,969,693)	(4%)
Total Inpatient Revenue	**21,248,292**	**24,166,631**	**(2,918,339)**	(12%)	**281,162,685**	**291,913,648**	**(10,750,963)**	(4%)
Outpatient - Ancillary	40,390,651	34,569,353	5,821,298	17%	444,231,614	411,698,211	32,533,403	8%
Total Patient Revenue	**61,638,943**	**58,735,984**	**2,902,959**	5%	**725,394,299**	**703,611,859**	**21,782,440**	3%
Medicare	(17,676,795)	(19,389,419)	1,712,624	(9%)	(222,375,931)	(231,804,696)	9,428,765	(4%)
Medi-Cal	(17,209,692)	(18,021,982)	812,290	(5%)	(239,034,461)	(216,362,793)	(22,671,668)	10%
Other/Charity	(8,542,263)	(6,914,670)	(1,627,593)	24%	(76,924,637)	(82,557,165)	5,632,528	(7%)
Discounts & Allowances	(808,429)	(18,380)	(790,049)	4,298%	(3,830,452)	(220,193)	(3,610,259)	1,640%
Bad Debts	(461,813)	(234,944)	(226,869)	97%	(5,273,386)	(2,814,447)	(2,458,939)	87%
Total Deductions	**(44,698,992)**	**(44,579,395)**	**(119,597)**	0%	**(547,438,868)**	**(533,759,294)**	**(13,679,574)**	3%
Net Service Revenue	**16,939,950**	**14,156,589**	**2,783,361**	20%	**177,955,431**	**169,852,565**	**8,102,866**	5%
Other Operating Revenue	561,638	818,039	(256,401)	(31%)	9,349,786	9,888,043	(538,257)	(5%)
Total Operating Revenue	**17,501,588**	**14,974,628**	**2,526,960**	17%	**187,305,216**	**179,740,608**	**7,564,608**	4%
Salaries	6,332,983	5,855,600	(477,383)	(8%)	72,675,903	71,934,323	(741,580)	(1%)
S&W PTO	1,077,509	695,813	(381,696)	(55%)	8,355,546	8,532,469	176,923	2%
Employee Benefits	1,875,319	1,460,162	(415,157)	(28%)	18,513,837	17,522,406	(991,431)	(6%)
Professional Fees	2,182,432	1,884,733	(297,699)	(16%)	22,911,273	22,655,479	(255,794)	(1%)
Purchased Services	961,018	908,326	(52,692)	(6%)	11,084,236	10,886,273	(197,963)	(2%)
Supplies & Expenses	2,518,648	2,287,295	(231,353)	(10%)	29,032,501	27,365,478	(1,667,023)	(6%)
Maintenance & Repairs	299,857	303,754	3,897	1%	3,299,652	3,645,048	345,396	9%
Utilities	354,790	306,217	(48,573)	(16%)	3,423,465	3,674,604	251,139	7%
Rent/Lease	45,524	30,041	(15,483)	(52%)	443,865	360,492	(83,373)	(23%)
Insurance	119,809	122,727	2,918	2%	1,410,173	1,472,724	62,551	4%
Depreciation/Amortization	920,256	811,079	(109,177)	(13%)	10,181,736	9,732,948	(448,788)	(5%)
Other Expense	381,349	393,647	12,298	3%	4,304,664	4,807,067	502,403	10%
Impaired Costs	-	-	-	0%	-	-	-	0%
Total Operating Expense	**17,069,493**	**15,059,394**	**(2,010,099)**	(13%)	**185,636,851**	**182,589,311**	**(3,047,540)**	(2%)
Net Gain/(Loss) From Operations	**432,095**	**(84,766)**	**516,861**	**(610%)**	**1,668,365**	**(2,848,703)**	**4,517,068**	**(159%)**
District Taxes	319,177	138,478	(180,699)	(130%)	1,922,742	1,661,725	(261,017)	(16%)
Investment Income	682,939	488,226	194,713	40%	6,698,988	5,858,712	840,276	14%
Other Non - Operating Income	29,141	40,308	(11,167)	(28%)	347,184	483,696	(136,512)	(28%)
Interest Expense	(67,366)	(70,643)	3,277	5%	(863,016)	(847,782)	(15,234)	(2%)
Non-Operating Expense	(21,105)	(39,853)	18,748	47%	(421,668)	(478,239)	56,571	12%
Total Non-Operating Income	**942,786**	**556,516**	**386,270**	69%	**7,684,231**	**6,678,112**	**1,006,119**	15%
			-				-	
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	**1,374,881**	**471,750**	**903,131**	**191%**	**9,352,596**	**3,829,409**	**5,523,187**	**144%**
Net Incr/(Decr) in the Fair Value Invstmt	(371,405)	162,500	(533,905)	(329%)	(1,143,617)	1,950,000	(3,093,617)	(159%)
Net Gain/(Loss)	**1,003,475**	**634,250**	**369,225**	58%	**8,208,979**	**5,779,409**	**2,429,570**	42%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
June-26

	Current Month	YTD
Cash flows from operating activities:		
Operating Income/(Loss)	432,095	1,668,365
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation/Amortization	920,256	10,181,736
Provision for bad debts	111,381	(824,964)
		-
Change in assets and liabilities:		-
Patient accounts receivable, net	343,324	3,526,102
Other receivables	(751,205)	(9,407,478)
Inventories	(129,310)	(102,055)
Prepaid expenses and deposits	35,809	(181,826)
Advance refunding of bonds payable, net	20,980	251,755
Accounts payable and accrued expenses	(1,344,151)	(752,970)
Deferred inflows - leases	(24,497)	(293,964)
Accrued payroll and related costs	1,420,871	875,353
Estimated third-party payor settlements	(2,122,864)	(1,891,683)
Self-insurance reserves	(38,196)	(187,426)
Total adjustments	(1,557,603)	1,192,581
Net cash provided by (used in) operating activities	(1,125,508)	2,860,946
Cash flows from noncapital financing activities:		
District tax revenues	319,177	1,922,742
Noncapital grants and contributions, net of other expenses	(3,379)	(265,301)
Net cash provided by (used in) noncapital financing activities	315,797	1,657,441
Cash flows from capital and related financing activities:		
Purchase of capital assets	(677,831)	(8,035,617)
Proceeds from sale of assets	-	5,000
Proceeds from debt borrowings	-	-
Proceeds from lease receivable, net	25,572	301,021
Principal payments on debt borrowings	-	(4,235,000)
Interest payments	(0)	(1,308,139)
Issuance of bonds payable and bond premium liability	-	-
Net change in notes payable and lease liability	(30,670)	(1,015,539)
Net changes in assets limited as to use	(555,337)	(992,752)
Net cash provided by (used in) capital and related financing activities	(1,238,266)	(15,281,025)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(498,227)	(4,924,171)
Investment income	682,939	6,698,988
Net cash provided by (used in) investing activities	184,712	1,774,817
Net increase (decrease) in cash and cash equivalents:	(1,863,265)	(8,987,821)
Cash and cash equivalents at beginning of month/year	17,424,640	24,549,196
Cash and cash equivalents at end of month	15,561,375	15,561,375
	15,561,375	15,561,375
	(0.00)	0.00

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
June 2026

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Jul-25	13,219,919	932,239	14,152,158
Aug-25	9,922,993	1,161,531	11,084,524
Sep-25	12,323,268	233,998	12,557,266
Oct-25	12,181,755	7,001,985	19,183,740
Nov-25	10,154,998	601,439	10,756,437
Dec-25	13,361,348	2,861,896	16,223,244
Jan-26	10,470,878	6,040,603	16,511,481
Feb-26	12,005,852	5,418,366	17,424,218
Mar-26	16,266,557	2,876,805	19,143,362
Apr-26	13,143,789	7,283,225	20,427,014
May-26	12,237,289	6,326,173	18,563,462
Jun-26	**12,077,436**	**4,017,650**	**16,095,086**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - Receipts for Café, rebates, refunds, and miscellaneous funding sources

- Non-Operating Revenues - rental income, property tax revenues, sale of assets

- Medi-Cal OP Supplemental and DSH Funds
- Medi-Cal and Medi-Care Tentative Cost Settlements
- Grants, IGT, HQAF, & QIP Supplemental Funds
- Medicare interim payments

June 2026 Summary of Other Activity:

100,381	Property Taxes
24,808	Kaiser Permanente(Health Net) DHDP CY24 Phase 1
2,336,455	M-Cal NDPH IGT AB113 FY26
221,872	M-Care interim payments
143,090	M-Care Temporary Allowance Cost Report FY00
718,219	M-Cal IP DSH 04/26 - 05/26
64,276	M-Cal RHC Cost Report FY25
408,549	Miscellaneous
4,017,650	06/26 Total Other Activity