



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

**AGENDA
SEPTEMBER 22, 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/85362939221?pwd=2My0bWK2DXKiCYbhbDxGLUlQRUK3Z.1>

Call to Order

I. Approval of Agendas

Recommended Action: Approve/Disapprove the Agenda as Presented/Amended

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

Bindusagar Reddy
Zone 1

Martha A. Flores
Zone 2

Hans Kashyap
Zone 3

Liberty Lomeli
Zone 4

Areli Martinez
Zone 5



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- 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 54956.9(d)(2), Significant Exposure to Litigation; Anticipated Litigation; and Pending Litigation: **Conference with Legal Counsel.** Estimated Disclosure: 3 years after completion of the matter.
- 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, 2027
- E. Pursuant to Gov. Code Section 54957(b): **Discussion Regarding Confidential Personnel Matter** – One (1) Item. Estimated Date of Disclosure January 1, 2028, for materials that are not part of an individual's private personnel file
- F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): **Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning.** Estimated date of disclosure December 1, 2026.
- G. Pursuant To Gov. Code Section 54956.9(D)(2), **Conference With Legal Counsel** About Recent Work Product (B)(1) And (B)(3)(F): Significant Exposure To Litigation; Privileged Communication (1 Items).

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

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Bindusagar Reddy
Zone 1

Martha A. Flores
Zone 2

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Zone 3

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Zone 4

Areli Martinez
Zone 5



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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. Conference with Legal Counsel

Recommended Action: Information Only; No Action Taken

D. Discussion Regarding Trade Secrets Pertaining to Services

Recommended Action: Information Only; No Action Taken

E. Discussion Regarding Personnel Matter

Recommended Action: Information Only; No Action Taken

F. Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning

Recommended Action: Information Only; No Action Taken

G. Conference with Legal Counsel

Recommended Action: Information Only; No Action Taken

VI. Presentation

A. Proclamation by Sheriff Boudreaux

VII. 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



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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.

VIII. Consent Agenda

Recommended Action: Approve/Disapprove Consent Agenda Policies and Accept Reports therein as presented

Background information has been provided to the Board on all matters listed under the Consent Agenda, covering Medical Staff, Hospital policies and Informational Reports, these items are considered to be routine by the Board. All items under the Consent Agenda covering Medical Staff, Hospital policies and Informational Reports 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.

IX. Approval of Minutes

A. August 25, 2026 Minutes of the Regular Meeting of the Board of Directors

Recommended Action: Approve/Disapprove August 25, 2026, Minutes of the Regular Meeting of the Board of Directors

X. Business Items

A. Graduate Medical Education (GME) Annual Institution Review

Approve/Disapprove Report as Given

B. August 2026 Financials

Recommended Action: Approve/Disapprove August Report as Presented

C. Investment Policy

Recommended Action: Approve/Disapprove Investment Policy

XI. SVLHCD Board Chair Report

XII. SVMC CEO Report

XIII. Announcements:



**SIERRA VIEW LOCAL HEALTH CARE DISTRICT
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- Regular Board of Directors Meeting – October 27, 2026, at 5:00 p.m.

XIV. 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.

CONSENT AGENDA

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

Senior Leadership Team	9/25/2026
Board of Director's Approval	
Liberty Lomeli, Chairman	<u>9/25/2026</u>

SIERRA VIEW MEDICAL CENTER CONSENT AGENDA September 22, 2026 BOARD OF DIRECTOR'S APPROVAL		
The following Policies/Procedures/Protocols/Plans/Informational Reports have been reviewed by Senior Leadership Team and are being submitted to the Board of Director's for approval:		
	Pages	Action
Policies: • Patient Privacy – Accounting of Disclosure • Board Procedures for Hearing to Censure a Board Member • Code of Conduct • Compliance Auditing and Monitoring • Compliance Office Confidentiality Agreement • Disinfectants: Their Selection and Use • Emergency Operations Plan • Employee Code of Conduct Training • Facsimile Machine, Utilization of • Hazardous Materials and Waste Management Plan • Life Safety Management Plan • Marketing Under the HIPAA Privacy Standards/HITECH • Medical Equipment Management Plan • Patient Identity Theft Prevention, Detection and Mitigation (Red Flag Rules) • Public Records Request • Patient Privacy – Right to Request Privacy Restrictions • Safety Management Plan • Security Management Plan • Service Excellence Teams • Utility Systems Management Plan	1-12 13-17 18-38 39-46 47-48 49-50 51-67 68 69-70 71-82 83-92 93-94 95-105 106-114 115-122 123-125 126-136 137-147 148-149 150-160	Approve ↓

SUBJECT: PATIENT PRIVACY – ACCOUNTING OF DISCLOSURE	SECTION: Page 1 of 12
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PURPOSE:

To ensure that each Sierra View Medical Center (SVMC)-affiliated facility, and their respective departments, understands the requirement to provide an Accounting of Disclosures of Protected Health Information to all patients as required by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and any and all other Federal regulations and interpretive guidelines.

POLICY:

Each SVMC-affiliated facility must provide a written accounting of disclosures (AOD) of protected health information (PHI) to authorized individuals that a facility has made during the six years prior to the date on which the accounting was requested. AODs do not need to be provided for any disclosures on or prior to April 13, 2003. Requests for an AOD must be made in writing or the verbal request must be documented.

A system must be in place for all departments (including but not limited to: Radiology, Quality, Emergency Room, and Health Information Management) within the facility to accurately and completely track all disclosures and have such information available for a minimum for six (6) years as required by HIPAA Privacy Standards and this policy.

The right to request an AOD and the process for making a request must be outlined in the Notice of Privacy Practices.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

An individual has the right to receive an accounting of disclosures of PHI made by a facility in the six (6) years prior to the date on which the accounting is requested; **except for the following disclosures** (the HIPAA Privacy Standards Section is included after each exception):

1. To carry out treatment, payment and health care operations (§164.506);
2. To individuals of PHI about them (§164.502);
3. Pursuant to an authorization (§ 164.508);
4. For the facility's directory or to persons involved in the individual's care or other notification purposes (§ 164.510);
5. For national security or intelligence purposes (§ 164.512 (K)(2));
6. To correctional institutions or law enforcement agencies that have lawful custody of an inmate (§ 164.512 (K)(2))

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7. As part of a limited data set (§ 164.514 (e));
8. That occurred prior to the compliance date for the covered entity; or
9. Incident to a use or disclosure otherwise permitted or required (§ 164.502).

The accounting must include the following for each disclosure:

1. The date of the disclosure;
2. The name of the entity or person who received the PHI and, if known, the address of such entity or person;
3. A brief description of the PHI disclosed; and
4. A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure; or, in lieu of such statement, a copy of a written request for a disclosure.

Research -Waiver of Authorization

If the covered entity has made disclosures of PHI for a particular research purpose in accordance with HIPAA Privacy Standards § 164.512 (i) for 50 or more individuals, the accounting may provide:

1. The name of the protocol or other research activity;
2. A description, in plain language, of the research protocol or other research activity, including the purpose of the research and the criteria for selecting particular records;
3. A brief description of the type of PHI that was disclosed;
4. The date or period of time during which such disclosure occurred, or may have occurred, including the date of the last such disclosure during the accounting period;
5. The name, address, and telephone number of the entity that sponsored the research and of the researcher to whom the information was disclosed; and
6. A statement that the PHI of the individual may or may not have been disclosed for a particular research protocol or other research activity.

If the covered entity provides an accounting for research disclosures in accordance with the Research section noted above and at the request of the individual, the covered entity may assist in contacting the entity that sponsored the research and the researcher if it is reasonably likely that the PHI of the individual was disclosed for research protocol or activity.

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If the covered entity has made disclosures of PHI for a particular research purpose in accordance with the HIPAA Privacy Standards §164.512(i) for less than 50 individuals, an AOD is required for each patient that includes the date of the disclosure; the name of the entity or person who received the PHI and, if known, the address of such entity or person; a brief description of the PHI disclosed; and a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure; or, in lieu of such statement, a copy of a written request for a disclosure.

Provision of the accounting

1. The facility must act on the individual's request for an accounting, no later than 60 days after receipt of such a request, as follows:
 - a. The facility must provide the individual with the accounting requested; or
 - b. If the facility is unable to provide the accounting within the time required, then the facility may extend the time to provide the accounting by no more than 30 days, provided that:
 - The facility, within the time limit set, provides the individual with a written statement of the reasons for the delay and the date by which the facility will provide the accounting; and
 - The facility may have only one such extension of time for action on a request for an accounting.
2. The facility must provide the first accounting in any 12-month period to an individual free of charge. The facility may impose a reasonable, cost-based fee for each subsequent request for an accounting by the same individual within the 12 month period, provided that the facility informs the individual in advance of the fee and provides the individual with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

Documentation

A facility must document the following and retain the documentation for six years:

1. The information required to be included in an accounting;
2. The written accounting that is provided to the individual which should be stored with the permanent record; and
3. The titles of the persons or offices responsible for receiving and processing requests for an accounting by individuals.

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Suspend right of accounting to health oversight or law enforcement

The facility must temporarily suspend an individual's right to receive an accounting of disclosures to a health oversight agency or law enforcement for the time specified by such agency or official, if such agency or official provides the facility with a written statement that such an accounting to the individual would be reasonably likely to impede the agency's activities and specifying the time for which such a suspension is required.

If the agency or official statement is made orally, the facility must:

1. Document the statement, including the identity of the agency or official making the statement;
2. Temporarily suspend the individual's right to an accounting of disclosures subject to the statement; **and**
3. Limit the temporary suspension to no longer than 30 days from the date of the oral statement, unless a written statement pursuant to above paragraph is submitted during that time.

List of Types of Uses and Disclosures that must be tracked for the purposes of accounting:

1. Required by law
2. Public health activities
3. Victims of abuse, neglect, or domestic violence unless the Covered Entity (CE), in exercising professional judgment, believes informing the individual may cause serious harm or if the CE believes the individual is responsible for the abuse, neglect, or injury.
4. Health oversight activities
5. Judicial and administrative proceedings
6. Law enforcement purposes
7. Decedents:
 - a. Coroners and medical examiners
 - b. Funeral directors
8. Cadaveric organ, eye, or tissue donation purposes
9. Research purposes where a waiver of authorization was provided by the Institutional Review Board or preparatory reviews for research purposes

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10. In order to avert a serious threat to health or safety
11. Specialized government functions:
 - a. Military and veterans activities
 - b. Protective services for the President and others
12. Worker's compensation disclosures necessary to comply with laws relating to worker's compensation programs (**not** including disclosures related to payment).

Attachments:

- Attachment A is a list of examples of the type of disclosures that must be tracked in the Accounting of Disclosures.
- Attachment B is a list of examples of the type of disclosures that do NOT need to be tracked in the Accounting of Disclosures.
- Attachment C is a sample Patient Request for Accounting of Disclosures form.
- Attachment D is a sample cover letter to include when providing the patient with the Accounting of Disclosures.

REFERENCE:

- Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164)

CROSS REFERENCES:

- [PATIENT PRIVACY – PROGRAM REQUIREMENTS](#) Policy
- [RECORDS MANAGEMENT](#) Policy

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Accounting of Disclosure (AOD) Examples – Attachment A

A. Disclosures to be included/tracked in the AOD:

Type of Disclosure	Tracked in AOD	Clarification (if needed)	Examples (not an inclusive list)
1. Required by Law	Yes	“Required by law” means: “A mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.”	The following types of disclosures are often required by state or federal law: ☐ Cancer registry state reporting ☐ State reporting ☐ Court Orders and Subpoenas ☐ Organ donor services chart review ☐ Peer review organizations- DRG/Utilization chart reviews
2. Public Health Activities	Yes	To a “public health authority”* that is authorized by federal, state, local law to collect or receive such information for the purpose of ☐ preventing or controlling disease; ☐ reporting of disease or injury; ☐ vital events such as birth or death; ☐ the conduct of public health surveillance, public health investigations, and public health interventions; ☐ at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority. *“public health authority” is defined as: “an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including The employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority that is responsible for	☐ Child abuse, neglect, or domestic violence reporting to Social Services or Protective Services agencies--unless the covered entity (CE) professional judgment believes informing the individual may cause serious harm or if the CE believes he/she is responsible for the abuse, neglect, or injury. ☐ Communicable/infectious disease ☐ Head Injury/Trauma reporting ☐ Medical Device reporting ☐ Birth certificate and death certificate tracking ☐ Sentinel event chart reviews - FDA-regulated product or activities (adverse

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Type of Disclosure	Tracked in AOD	Clarification (if needed)	Examples (not an inclusive list)
		public health matters as part of its official mandate.”	events, product defects, etc.)
3. Health oversight activities	Yes	“Health oversight agency” is defined as: “An agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.”	☐ State health professional licensure agencies ☐ HHS Office of Inspector General ☐ U.S. Dept. of Justice ☐ State Medicaid Fraud Units ☐ HHS Office For Civil Rights ☐ Food and Drug Administration ☐ CMS – Medicare surveyor chart reviews ☐ State surveyor chart reviews ☐ Licensure and disciplinary actions (e.g., disclosures to state licensing boards)
4. Judicial and administrative proceedings	Yes		☐ Court orders ☐ Subpoenas (<i>i.e.</i> , for copies of bills and medical records)
5. Law enforcement (unless a request has been made to temporarily suspend an accounting of disclosure)	Yes		☐ Court order or court-ordered warrant ☐ Grand jury subpoenas ☐ Victims of a crime ☐ Crime on premises ☐ Reporting crime in emergencies
6. Decedents	Yes		☐ Coroners or medical examiners to ID a deceased person, determine cause of death, or other duties by law. ☐ Funeral directors to carry out lawful duties.
7. Cadaveric organ, eye or tissue donation	Yes		☐ Organ procurement organizations or other entities engaged in procurement, banking, or transplantation.
8. Research purposes	Yes		☐ IRB or Privacy Board issues a waiver of authorization for research studies with 50 or more individuals.
9. To avert a serious threat to health or safety	Yes		☐ FDA inquiries ☐ Terrorism alerts-medical or safety

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Type of Disclosure	Tracked in AOD	Clarification (if needed)	Examples (not an inclusive list)
			☐ threats. ☐ Communicable disease organizations
10. Specialized government functions	Yes	*See Attachment B, item 7. Disclosures for National Security/Intelligence activities exempted from the AOD requirements	☐ Military and veterans activities. ☐ Protective Services for the President and Others.
11. Workers' Compensation	Yes		☐ Worker's compensation ☐ Disclosures necessary to comply with the law (not including disclosures related to payment).

Abbreviations:

ACOS - American College of Surgeons
 AHCA - Agency for Healthcare Administration
 CMS - Centers for Medicare and Medicaid Services
 FDA – Food and Drug Administration
 JCAHO – Joint Commission of Accreditations of Healthcare Organizations

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DO NOT Include These Examples on the AOD – Attachment B

B. Disclosures that DO NOT need to be included/tracked in the AOD:

Type of Disclosure	Tracked in AOD	Clarification (if needed)	Examples (not an inclusive list)
1. Treatment	No	As the provision, coordination, or management of health care by a health care provider.	☐ Consultants and referrals between healthcare providers. ☐ Verbal, written, and electronic communication between health care providers, ancillary staff, and allied health staff to treat the patient.
2. Payment	No	Efforts to get premium and financial reimbursements for providing health care-related products or services.	☐ Claims Management to obtain payment for facility services. ☐ Utilization Review to follow up on a utilization letter from the PRO. ☐ Determination of insurance eligibility Health plans review for medical necessity. ☐ Disclosures to worker's compensation carriers for claims processing/payment activities.
3. Health Care Operations	No	General administrative and business functions necessary for a health care organization to remain a viable business.	☐ Case Management/UR chart reviews performed by internal facility department and external agencies to facilitate home care and/or treatment after patient discharge. Medical and billing chart reviews for internal facility operations such as: Quality Assessment/Improvement, revenue recovery auditing, supply chain auditing, CPCS auditing. ☐ Training, reviewing ☐ Competency, and peer review of health care providers. ☐ Arranging legal services ☐ Business Planning ☐ Performing Customer Service ☐ Marketing – communication regarding new hospital services, hospital newsletters ☐ Accreditation organizations (ex: TJC, CARF, ACOS, AHCA) ☐ Facility licensing and certificate of

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Type of Disclosure	Tracked in AOD	Clarification (if needed)	Examples (not an inclusive list)
4. Individual Authorization	No		☐ need activities ☐ A patient signs an authorization form to obtain copies of his/her medical records to take them to another physician.
5. Incidental Disclosure	No		☐ PHI overheard by another patient in Emergency Department registration area. (Provided reasonable safeguards had been made by facility).
6. Facility Directory	No		☐ PBX operator communicates with family regarding patients' location, including Clergy listings.
7. National Security Intelligence	No		☐ PHI information was requested by the FBI, CIA, Homeland Security, or other official governmental intelligence agency to track possible terrorists.
8. Correctional Institutions or Law Enforcement Officials	No		☐ PHI disclosed to a correctional facility for an inmate who had surgery at a medical facility.
9. Limited data set	No		☐ De-identified information for health care operations, including Business Associates, public health, and research activities (Data may include zip codes, date of birth, dates of service. Data may NOT include patient identifiers, patient address, medical record numbers and the like.)
10. Occurrence prior to HIPAA Privacy compliance date	No		☐ Request for an AOD received April 20, 2003. The facility only needs to provide an AOD for disclosures made since April 14, 2003, which is the HIPAA-Privacy compliance date.

Abbreviations:

AOD - Accounting of Disclosures
 CIA – Central Intelligence Agency
 FBI – Federal Bureau of Investigation

PHI - Protected Health Information
 PRO - Peer Review Organization
 UR – Utilization Review

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Attachment C
SIERRA VIEW MEDICAL CENTER
REQUEST FOR AN ACCOUNTING OF DISCLOSURES

1. PATIENT INFORMATION

Date of Request:	Unit #:
Name:	DOB:
SSN#:	Telephone #:
Address:	
City, State, Zip:	

2. DATES REQUESTED

I would like an accounting of all disclosures for the following time frame. *Please note:* the maximum time frame that can be requested is six years prior to the date of your request, and we are not required to account for disclosures that occurred before April 14, 2003.

From: _____ To: _____

3. FEES

There is no charge for the first request for an accounting in a 12-month period. For subsequent requests in the same 12-month period, the charge will be based on the current California Fee Schedule.

I understand that there is (check one):

☐

No fee for this request.

☐

A fee for this request will be based on the current California Fee Schedule and I wish to proceed.

4. RESPONSE TIME

I understand that the accounting I have requested will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

Signature of patient/legal representative: _____ Date: _____

THIS SECTION FOR HEALTH CARE ORGANIZATION USE ONLY

Date request received: _____ Date accounting sent: _____

Requestor verified by which method? _____

Extension requested: ☐ No ☐ Yes

If yes, give reason: _____

Patient notified in writing on this date: _____

Staff member processing request: _____

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****This completed form will be permanently maintained with the permanent medical record****

Attachment D

<Patient Name>

<Patient Address>

RE: Requested Accounting of Disclosure

Dear (patient name):

At SVMC we are committed to providing quality patient care that is sensitive, compassionate, promptly delivered, and cost effective, as reflected in the HCA Commitment to Our Patients. The privacy of patient information is second only in importance to patient care itself. We are committed to complying with the Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 1654 (HIPAA Standards of Privacy).

At SVMC each patient is provided the right to an Accounting of Disclosures of his/her protected health information. Please find attached your Accounting of Disclosure. Please note the maximum time frame that can be requested is six years prior to the date of your request, and we are not required to account for disclosures that occurred before April 14, 2003.

There is no charge for the first request for an accounting in a 12-month period. For subsequent requests in the same 12-month period, the charge will be based on the current California Fee Schedule.

Please contact me at 559-784-1110 extension 2240 with questions or concerns.

Sincerely,

Facility Privacy Official
(Facility Name)

SUBJECT: BOARD PROCEDURES FOR HEARING TO CENSURE A BOARD MEMBER	SECTION: <i>[Enter manual section here]</i> Page 1 of 5
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PURPOSE:

The Sierra View Local Health Care District (“District”) is committed to the ethical practice of government in service of the residents and community. This commitment is reflected in the Code of Ethics and Conduct for Elected and Appointed Officials Policy, which every elected and appointed Board Member acknowledges and agrees to abide by. While the Ethics and Conduct Policy shows a voluntary commitment to abide by the highest ethical standards, from time to time situations may arise that require affirmative action by the Board making clear the Board’s position on certain ethical issues. This Censure Policy includes the standards and procedures for the Board to take a clear stand on certain ethical issues.

If a member of the Board is found guilty or liable by any court of law, enforcement agency, administrative hearing officer, or public agency investigation, of violating a Law or Regulation, as that term is defined in this policy, he or she may also be subject to potential censure pursuant to the procedures of this Censure Policy.

The following constitute the Laws and Regulations which may give rise to a request for censure, though additional laws and regulations not listed herein may also give rise to Censure:

- California Political Reform Act of 1974 (Gov. Code § 81000 et seq.)
- Regulations of the Fair Political Practices Commission (2 CCR § 18109 et seq.)
- Statutes concerning conflicts in government contracts (Gov. Code § 1090 et seq.)
- Statutes concerning political activity of District officers (Gov. Code § 3201 et seq.)
- Statutes concerning unlawful use of government resources (Gov. Code § 8314)
- Title 7 of the Civil Rights Act or the Fair Employment and Housing Act (finding of harassment or abuse of a District employee by an independent investigator)
- Unauthorized Disclosures of Confidential Information (Gov. Code § 54963)

- a. ~~Censure may be initiated for any breach of the Board’s Policies or rules, Hospital Policies or rules, OR violation of any law or regulation, or both. Censure may also be initiated for any acts to impede the carrying out of any lawful administrative action of the Hospital CEO undertaken to carry out any approved policy or rule of the Board.~~

~~Censure may be initiated for any breach of the Board’s Ethic’s Policy OR violation of any law or regulation, or both.~~

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POLICY:

1. Grounds for Censure. ~~Grounds for Censure are referenced above. It shall be a violation of this section for any sitting Board Member to violate any general law or regulation, and any rule, law, ordinance or resolution of the District. It shall also be a violation of this section for any sitting Board Member to~~

~~violate an administrative policy of the Board which has been adopted following a vote of the Board on the matter, or~~

~~a. act to impede the carrying out of any lawful administrative action of the Hospital CEO undertaken to carry out any approved policy or rule of the Board.~~

SUBJECT: BOARD PROCEDURES FOR HEARING TO CENSURE A BOARD MEMBER	SECTION: <i>[Enter manual section here]</i> Page 2 of 5
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2. Censure Defined. Any violation of Section 1 by a Board member may be reprimanded through the administration of a public censure of the member by the Board. Such censure may be in addition to any other lawful action or punishment applicable to the violation. For purposes of this section, “censure” shall mean the adoption of a motion setting forth a formal statement of disapproval of a Board Member conduct.

~~2. Censure Considered in Indemnification. When evaluating a request for defense or indemnification made by the censured member in litigation arising from the censured conduct, the record of the censure shall be considered by the Board. Such record shall not be determinative. Failure of the Board to censure the conduct of a member does not constitute a waiver of the body’s right to refuse to indemnify or defend the member in an action.~~

3. Notice and Opportunity to Cure. A Board Member may not be made the subject of a motion for censure without first being given notice of the alleged violation and an opportunity to correct the violation, if it can reasonably be corrected. Notice shall be in writing and delivered by the Board Secretary or the Chair of the Board to the offending Board Member, and all members of the Board will receive a copy.

4. Initiation of Proceedings. Upon a continued violation or failure to correct, ~~the charged Board Member shall be given notice and an opportunity to be heard as follows: or if the Grounds for Censure cannot reasonably be corrected, censure proceedings shall be initiated as follows:~~

- a. Initiated by Member. Only a sitting Board Member may initiate proceedings for the censure of one of its members.
- b. Statement of Charges. Proceedings shall be commenced by the presentation of a written Statement of Charges to the subject Board Member with a copy delivered concurrently to the District Clerk by the member initiating the charge. The Statement of Charges shall be given at least ten (10) days prior to the meeting at which the censure motion is proposed to be brought, unless failure to censure sooner may result in serious harm or disruption to the Board or the District, or if the urgency of the circumstances necessitates a motion for censure be made immediately. The Board has the ability to extend this time frame an additional (5) days in the event of an emergent/urgent issue arises. The Statement of Charges shall contain, at a minimum, the designation of the specific Grounds for Censure which the member is claimed to have violated and a statement of the date, place and time at which such violation occurred. The Statement shall further contain a description of the conduct of the member which is alleged to constitute the violation. A copy of the Statement of Charges shall be delivered to all other Board Members.~~Proceedings shall be commenced by the presentation of a written statement of charges to the subject Board Member with a copy delivered concurrently to the District Clerk by the member initiating the charge. Initiation shall not require the prior approval of the Board. The statement of charges shall be given at least ten (10) days prior to the meeting at which the censure motion is proposed to be brought. The notice shall contain, at a minimum, the designation of the specific rule, law, regulation, etc., which the member is claimed to have violated and a statement of the date, place and time at which such violation occurred. The statement shall further contain a description of the conduct of the member which is alleged to constitute the violation. A copy of the statement of charges shall be delivered to all other Board Members.~~

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- c. Response. Within seven (7) days after delivery of the statement of charges, the charged Board Member may, but is not required, to deliver a written response to the other members of the Board. ~~should deliver a written response to the other members of the Board unless the charged Board Member chooses to defer the response to the hearing.~~

5. ~~Hearing~~ Censure Proceeding.

- a. Generally. The motion for censure shall be agendized and considered at the first regular meeting occurring at least ten (10) days following the delivery of the statement of charges to the charged Board Member and District Clerk unless good cause exists to schedule the proceeding sooner (i.e. failure to hear the matter sooner may result in serious harm or disruption to the Board or the District, or if the urgency of the circumstances necessitates a motion for censure be made immediately) or later (i.e. for good cause as set forth in subsection 6(b)). ~~The motion for censure shall be agendized and considered at the first regular meeting occurring at least ten (10) days following the delivery of the statement of charges to the charged Board Member and District Clerk.~~
- b. The ~~hearing proceeding~~ may not be continued except for good cause within the discretion of the Board. Examples of good cause include, but are not limited to, the excused absence from the meeting of a member of the Board, a material change in circumstances that without continuance would detrimentally impact censure procedure, or a Board vote for a continuance of the hearing at a later session. An excused absence is when a Board member notifies the Chair of the Board prior to the meeting of inability to attend for valid reasons (e.g. illness, work schedule, or family emergency). ~~except upon the absence from the meeting of a member of the Board other than the initiating Board Member or the charged Board Member.~~
- c. ~~Open Hearing. The hearing shall be conducted in an open session by the Chair of the Board unless the Chair of the Board is a party to the action, in which case the Vice Chair or some other member shall conduct the proceedings.~~ Proceeding Setting. The hearing shall be conducted in an open session unless required by law to be held in Closed Session, upon vote by the Board, or upon determination of Closed Session being in the best interests of the District.
- d. ~~Procedure. The hearing shall generally proceed by a reading of the charges by the initiating Board Member. The charging Board Member may present witnesses; the charged Board Member may answer in rebuttal; members of the public may speak in favor of or in opposition to the charges; and the remaining Board Members may speak to the charges in that order.~~ Conducting the Proceeding. The proceeding shall be conducted either by the Chair of the Board or by another qualified Proceeding Officer selected by the Board. The Proceeding Officer shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote. The charged Board Member shall have the right to a reasonable opportunity to challenge the impartiality of the Proceeding Officer.
- e. Open Session Procedure: The proceeding shall generally proceed by a reading of the charges by the initiating Board Member. During the proceeding, both the charging Board member and the charged Board member shall have the right to speak to the charges as determined by the Chair of

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the Board or Proceeding Officer to be relevant, and to allow witnesses to present oral or written statements. No cross examination of witnesses will be allowed. However, Board members may speak and ask questions of witnesses. Members of the public shall also have the right to speak during the proceeding in favor or in opposition to the charges only to the extent relevant to the charges as determined by the Chair of the Board or Proceeding Officer.

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- f. Closed Session Procedure: The proceeding shall generally proceed by a reading of the charges by the initiating Board Member. During the proceeding, both the charging Board member and the charged Board member shall have the right to speak to the charges as determined by the Chair of the Board or Proceeding Officer to be relevant, and to allow oral or written witnesses statements. No cross examination of witnesses will be allowed. However, Board members may speak and ask questions of witnesses. All witnesses who are not Board members must be excluded from the proceedings other than for the purposes of making their statements and will be required to maintain strict confidentiality of the proceeding. Members of the public are not permitted to attend a Closed Session Censure Proceeding.

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~~e.g. Voting. Passage of the motion for censure shall require a majority vote of the Board. The voting Board Members shall not recess to closed session for deliberation. Voting and deliberations. Passage of the motion for censure shall require a majority vote of the Board. The charging Board member and the charged Board member will be excused from the process of deliberations and voting.~~

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6. Failure to Censure. If the motion for censure does not pass, the proceedings shall be concluded. Either party may request reconsideration as set forth in paragraph 9 within sixty (60) days of the conclusion of the vote for censure. If the motion for censure does not pass, the proceedings shall be concluded. A new motion for censure on the same grounds of violation may not thereafter be commenced against the same Board Member for a period of one (1) calendar year from date of the vote. However, new proceedings may be commenced on the same charges within the one (1) year period on the affirmative or unanimous vote of the non-charged Board Members.

7. Sanctions. If the motion for censure does pass, such motion shall become a part of the public record, a copy of which shall be made available upon demand to any member of the public, subject to the District's Procedures, and notice of same shall be placed in the administrative file of the Board Member. The Board may impose any sanctions authorized by law in conjunction with the censure of a Board Member. Additional sanctions may be imposed if the initial sanctions are ineffective.

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8. Reconsideration. Censure reconsideration procedures shall be initiated by a passing motion from the majority of the Board for censure reconsideration. A censure reconsideration shall be agendized for the next Meeting subsequent to the meeting within which the motion was made except for good cause. No Notice and Opportunity to Cure or Statement of Charges is required for a censure reconsideration. The procedures for censure reconsideration shall otherwise follow the procedures established *supra* at Section 6. Once the reconsideration process concludes, the results will be deemed final.

7.

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**BOARD PROCEDURES FOR HEARING TO
CENSURE A BOARD MEMBER**

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AFFECTED PERSONNEL/AREAS: *SVLHCD Board Members*

CROSS REFERENCES:

Ethics and Conduct of Elected and Appointed Officials

Sierra View Local Health Care District Bylaws

Unauthorized Disclosure of Privileged Information

[Conflict of Interest Policy](#)

[Code of Conduct](#)

[Anti-Discrimination, Harassment & Non-retaliation Policy](#)



Sierra View Medical Center

Code of Conduct

PURPOSE:

To ensure Sierra View Medical Center (SVMC) fulfills its ethical responsibility to patients, staff, Medical Staff, contingent work force, third party payors, subcontractors, independent contractors, vendors, consultants, students, volunteers, one another and the community. This Code of Conduct was developed to meet our ethical standards and comply with applicable laws and regulations.

DEFINITIONS:

SVMC: For the purposes of this Code of Conduct, SVMC refers to Sierra View Medical Center, which includes all Medical Center departments, services, and clinics maintained and supported under the California Department of Public Health hospital license.

SVMC Staff: For the purposes of this Code of Conduct, SVMC Staff refers to SVMC employees.

SVMC Contingent Work Force: For the purposes of this Code of Conduct, SVMC Contingent Work Force refers to; Travelers, registry, contractors and subcontractors.

SVMC Medical Staff: For the purposes of this Code of Conduct, SVMC Medical Staff refers to Physicians and credentialed allied health practitioners.

SVMC Board of Directors: For the purposes of this Code of Conduct, the Board of Directors refers to the SVMC Governing Board.

POLICY:

It is the responsibility of every SVMC staff member, contingent work force member, Medical Staff member and Board member to act in a manner that is consistent with SVMC's policies and procedures, Values, and this Code of Conduct. Additionally, SVMC Medical Staff are governed by specific conduct rules outlined in their Bylaws.

MISSION, VISION, AND VALUES STATEMENT:

Sierra View Medical Center is committed to upholding the highest standards of ethical behavior in improving the quality of life and health of our community. We are driven by our Mission and Vision.

Our Mission:

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

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

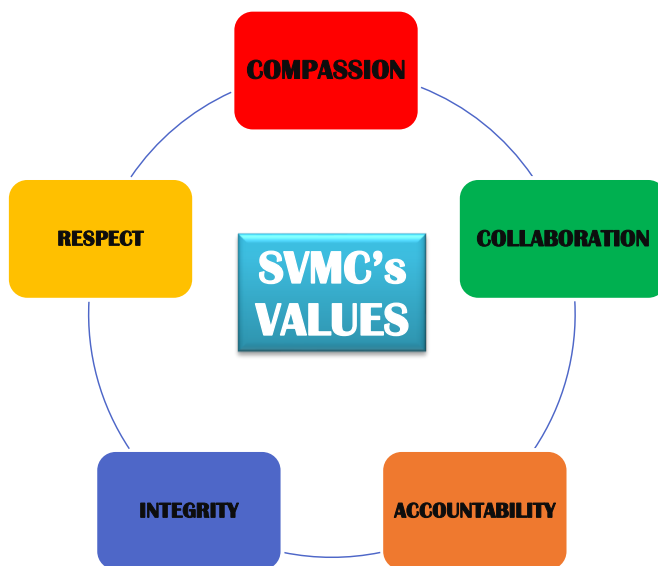
Our Vision:

Strengthen the quality of life through the delivery of integrated health care programs and services that promotes access, care coordination, and patient care experience.

Our Values:

SVMC is committed to our core values:

- **Compassion:** Caring from the heart
- **Collaboration:** Partnering for a common purpose
- **Accountability:** Accepting ownership of our actions
- **Integrity:** Inspiring trust and honesty
- **Respect:** Embracing and appreciating others



A MESSAGE FROM THE CEO

Dear Sierra View Medical Center Colleagues,

We are committed to providing quality health care in an environment that promotes compliance with applicable laws, regulations, and ethical standards. To assist in fulfilling this commitment, Sierra View Medical Center (SVMC) is supported by a Compliance Program managed by the Compliance/Privacy Officer and assisted by the Compliance Committee, which includes directors and members of senior leadership.

Our Code of Conduct is our most important policy, presented as a basic set of guidelines which reflects SVMC's culture, ethics, mission, vision, and values. It defines our organizational and individual responsibilities and describes SVMC's expectations regarding your conduct, and the conduct of all employees, ranging from Senior Leadership to entry level positions. The Code of Conduct also combines with our individual judgment and personal accountability in forming the foundation of our professional behavior.

If you believe you have witnessed a potential or suspected violation of SVMC's Code of Conduct, SVMC policy, or applicable law(s) or violation(s), please follow the reporting instructions on page 8 of this Code of Conduct, which includes details on our anonymous Compliance Reporting Hotline at (559) 791-4777 or ext. 4777. Retaliation against any employee, whom in good faith reports potential or suspected violations, will not be tolerated.

I appreciate your commitment to our mission, vision and values, and thank you for serving our patients, colleagues and hospital with integrity and for truly making a difference.

Sincerely,

Donna J. Hefner
President and Chief Executive Officer



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PURPOSE OF OUR CODE OF CONDUCT:

The Code of Conduct is a primary component of the Sierra View Medical Center (SVMC) Compliance Program, and has been developed to assist SVMC in complying with federal, state and local law, and to promote ethical conduct consistent with the mission, vision and strategic goals of SVMC.

The Code of Conduct is intended to:

- Describe the basic legal and ethical responsibilities expected of SVMC Staff, Contingent Work Force, Medical Staff, Students, Volunteers, Independent Contractors and Vendors.
- Inform SVMC Staff, Contingent Work Force, Medical Staff, Students, Volunteers, Independent Contractors and Vendors about existing SVMC policies and procedures.
- Explain the duty to report instances of suspected misconduct.
- Explain how to report suspected misconduct without fear of retaliation.

SVMC's expectation is that you follow the Code of Conduct and Values, as well comply with all other applicable laws, regulations, and SVMC policies and procedures, whether or not specifically addressed in this Code of Conduct.

Everyone at SVMC shall receive the Code of Conduct upon initial orientation and when significant updates occur. Staff shall acknowledge receipt of the Code of Conduct by electronic signature through the online Learning Management System or by signing and submitting an Attestation form to Human Resources.

Our ability to succeed depends on integrity, knowledge, diversity, respect and teamwork. While it is impossible to portray every situation one might encounter, or every detail of the policies, the Code of Conduct should serve as a guide for how we are expected to conduct ourselves while performing our professional duties on behalf of SVMC. Additional information and specific guidance on many of the topics covered in this Code of Conduct can be found in our Policy Library via the SVMC Intranet (<http://home/>).



PERSONAL CONDUCT:

SVMC's reputation for the highest standards of conduct is reliant on the high level of mutual trust and responsibility that exists between Staff and the Organization. You, as an individual, are essential to the Organization's success. SVMC's integrity and reputation are in your hands and validated by those who exercise good judgment and act in accordance with this Code of Conduct and the law.

This means you are held accountable for:

- Reading the Code of Conduct and understanding how it applies to you.
- Referring to the Code of Conduct and SVMC policies to guide your daily work activities.
- Asking questions when you need clarification or help.
- Reporting all suspected misconduct to the appropriate SVMC personnel.
- Completion of assigned training.

If you have questions or concerns not fully addressed in the Code of Conduct or found in a SVMC policy, your next step should be to discuss the issue with your Manager. Other resources are also available, such as Compliance, Human Resources, Security, Employee Health, Information Technology, Health Information Management, and Financial Services. For current contact information, refer to the most recent phone directory located on the SVMC intranet home page.

DUTY TO REPORT:

There may come a time when you are made aware of a known or suspected violation of law, the Code of Conduct, or a SVMC policy. If you become aware of any questionable activities made by staff, contingent work force, Medical Staff, students, volunteers, independent contractors or vendors that appear to violate applicable laws, rules, regulations, conditions of participation,

policy, or this Code of Conduct, you have a duty to report the incident. You should always report suspicious or questionable behavior even if you are not sure there is a problem. Failure to report a violation is a serious violation in itself and may result in disciplinary action.

You can report incidents via:

- Your ~~Leader~~^{Supervisor}
- The Compliance/Privacy Officer at (559)791-3838, ext. 3838 or Compliance Analyst at (559)791-3917
- Human Resources
- The Compliance Hotline (**see Compliance Hotline below**)
- A Compliance Incident Report form (Found on the Compliance page on the Intranet and submit in the lock box in SVMC's mail room)
- Email to ComplianceOfficeinbox@sierra-view.com
- The electronic event reporting program

COMPLIANCE HOTLINE (559)791-4777 or ext. 4777:

The Hotline is a confidential means of reporting ethical and compliance violations or concerns, or to ask Compliance-related questions. The Hotline is answered during normal business hours by Compliance staff and after hours by a recorded greeting which prompts you to leave a message. When reporting a concern, you can remain anonymous, although you are encouraged to identify yourself as it increases the exchange of vital communication and the ability to request additional information related to the incident being reported, should the need arise. If you disclose your name, but request confidentiality, the Compliance/Privacy Officer will keep this information confidential to the extent permitted by law. See the [Compliance Hotline policy](#).

INTERNAL INVESTIGATIONS:

Violations of the Code of Conduct, failure to comply with applicable federal or state laws, and other types of misconduct threaten SVMC's status as a reliable and honest provider of health care services. Detected but uncorrected misconduct can seriously endanger SVMC's business and reputation, and can lead to serious sanctions against the Medical Center. Consequently, upon reports or reasonable indications of suspected noncompliance, prompt steps to investigate the conduct in question will be initiated under the direction and control of the Compliance/Privacy Officer to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred.

You are strongly encouraged to cooperate with investigations into potential misconduct. Any attempt to obstruct an investigation or the reporting of misconduct is subject to disciplinary

action, up to and including, termination of employment.

If such a violation has occurred, prompt steps will be taken to correct the problem, taking into account the root cause of the problem. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the Office of Inspector General (OIG) or any other appropriate government organization, and/or submission of any overpayments. The specific steps that are appropriate in any given case will be determined after consultation with legal counsel.

Depending upon the nature of the alleged violations, the Compliance/Privacy Officer or designee will conduct a thorough and complete internal investigation, which could include interviews with relevant personnel and a review of relevant documents and may enlist experts from external resources, such as legal counsel, auditors or health care experts.

All interactions and information related to the investigation is kept confidential to the extent possible. To help ensure integrity of the investigation process, staff is also asked to practice discretion by refraining from discussing the information of the Compliance/Privacy Office consultation with colleagues or coworkers.

RETALIATION:

SVMC strives to uphold a culture where you feel comfortable in your work environment and can report known or suspected inappropriate conduct, activities or unethical behavior without fear of retaliation. All levels of leadership have a responsibility to create an atmosphere that facilitates open and honest discussion around issues that may negatively impact the organization. Retaliation against someone who files such a report will not be tolerated. Employees who participate in retaliation will be subject to disciplinary action.

Retaliation is defined as any action, statement, or behavior that is designed to punish an individual for filing a compliance report, cooperating with a compliance investigation, seeking guidance regarding a compliance concern, or to deter one from taking such action. Retaliation includes, but is not limited to intimidation, adverse action against an employee regarding the terms and conditions of employment, such as termination, demotion, or suspension.

Protection is extended to *anyone* filing a Compliance report or inquiry or providing information in relation to an investigation. If you or others have been retaliated against, report this behavior to your supervisor, Compliance or Human Resources. All reports made in “good faith” are protected from retaliation, retribution, or harassment.

Good faith is defined as reasonably believing or perceiving the information reported to be true.

Please note that SVMC reserves the right to discipline employees who knowingly make a false accusation, provide false information to the Organization, or have acted improperly.

For further information on Retaliation, see SVMC [Non-Retaliation-Compliance Issue Reporting and Harassment](#) policies.

WORK ENVIRONMENT:

SVMC strives to provide a safe and productive work environment. The work environment must be free from discrimination and harassment based on race, color, religion, sex, sexual orientation, age, national origin, disability, veteran status, medical condition, marital status or registered domestic status or other factors that are unrelated to the organization's legitimate business interests. SVMC does not tolerate sexual advances, actions, comments or any other conduct in the workplace that creates an intimidating or otherwise offensive environment. Similarly, the use of racial or religious slurs — or any other remarks, jokes or conduct that encourages or permits an offensive work environment — will not be tolerated.

If you believe that you are subject to such conduct, bring such activity to the attention of the Organization, either by informing your supervisor, Compliance or Human Resources. SVMC considers all complaints of such conduct to be serious matters, and all complaints will be investigated promptly.

Some other activities that are prohibited because they clearly are not appropriate are:

- Threats;
- Violent behavior;
- The possession of weapons of any type;
- The distribution of offensive jokes or other offensive materials via e-mail or any other manner; and
- The use, distribution, sale or possession of illegal drugs or any other controlled substance, except to the extent permitted by law for approved medical purposes.

In addition, staff, contingent work force, Medical Staff, students, volunteers, independent contractors, and vendors may not be on the premises or in SVMC work environment if under the influence of or affected by illegal drugs, alcohol or controlled substances used other than as prescribed. Please refer to SVMC policy: [*Drugs and Alcohol in the Workplace*](#) for additional information and further guidance on using medications in the workplace.

EMPLOYEE PRIVACY:

SVMC collects and maintains personal information that relates to staff's employment, including medical and benefit information. Access to personal information is restricted solely to people with a business need to know this information. Personal information is released outside the Medical Center or to its agents only with employee approval, except in response to appropriate investigatory or legal requirements, or in accordance with other applicable law. Employees who are responsible for maintaining personal information and those who are provided access to such information must ensure that the information is not disclosed in violation of the organization's [*Employee's Right to Privacy*](#) policy or other applicable laws or regulations.

PATIENT'S RIGHTS (HIPAA) & SAFETY:

SVMC is committed to providing safe and compassionate treatment and care where patients and their families understand his/her individual condition or illness, as well as the recovery process. Collectively with Medical Staff we will provide the patient or patient's representative with information regarding the diagnosis and anticipated treatment plan. We will provide a clear explanation of the right to refuse or accept care and to make an advance directive, and the risks and benefits associated with available treatment options, organ donation or procurement, as well as financial and insurance information. Discharge planning begins at the time of admission and continues throughout the admission. The patient, the patient's representative or guardian, designated family members, and the clinical team will be involved in the discharge planning process.

SVMC provides each patient with a written statement of patient rights and a notice of privacy practices. These statements conform to all applicable state and federal laws, including but not limited to the Health Insurance Portability and Accountability act of 1996 (hereinafter referred to as HIPAA). Each patient has the right to copy and inspect much of the PHI that we retain on their behalf. All requests for access to PHI must be submitted in writing and signed by the patient or the patient's representative. If a patient believes that the PHI we maintain on their behalf is incorrect or incomplete, they have the right to request in writing that their PHI be amended or corrected. SVMC is not obligated to make all requested amendments, but will give each request careful consideration. Patients have the right to submit written request restrictions of our uses and disclosures of their PHI for treatment, payment, or health care operations.

SVMC supports and facilitates patients' rights to access guardianship, advocacy, conservatorship, child and/or adult protective services by providing information as requested and referrals. The Social Services Department is responsible for ensuring that the proper protective agencies are notified as required by county, state and federal laws.

SVMC treats all patients with compassion and respect. SVMC makes no distinction in the availability of services; the admission, transfer or discharge of patients; or in the care we provide based on age, race, sex, economic status, educational background, color, religion, ancestry, national origin, sexual orientation, gender identity/expression, disability, medical condition, marital status, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by Federal Law). SVMC recognizes and respects the diverse backgrounds and cultures of its patients and makes every effort to equip its caregivers with the knowledge and resources to respect each patient's cultural heritage and needs. SVMC maintains an ongoing, proactive patient safety program for the identification of risk to patient safety and the prevention, reporting and reduction of healthcare errors. The hospital addresses the resolution of grievances from patients and their families through a formal process which includes informing patients of whom to contact regarding the grievance resolution. Please refer to the following SVMC policies for further guidance related to Patient Safety and Patient's Rights: *Patient's Right to Privacy*, *Patient's Rights and Responsibility*, *Patient Safety Plan*, and *Reporting Suspected Child Abuse & Neglect*. All policies are located in the policy library via the Intranet.

PATIENT INFORMATION:

SVMC is committed to ensuring confidentiality of records and related information for all patients. In the course of providing care, SVMC may collect information about a patient's medical condition, financial information, and family or medication history. SVMC will be sensitive to the personal nature of this information, and will maintain its confidentiality at all times. Patient information will not be released or discussed unless it is necessary to serve the patient or required by law.

In accordance with SVMC privacy and security policies and procedures, which reflect HIPAA requirements, no SVMC Staff has a right to any patient information other than that necessary to perform his or her job or responsibilities. Any breach of confidentiality represents a failure to meet the professional and ethical standards expected, and constitutes a violation of this Code of Conduct. A full confidentiality statement is received and accepted by each employee as part of the Employee New Hire process. SVMC also expects its vendors involved in patient care to perform and provide services consistent with all applicable HIPAA laws.

Policies for reference include the following: *[Patient Identity Theft Prevention, Detection, And Mitigation Program \(Red Flags Rule\)](#)*, *[Patient Privacy – Program Requirements](#)*, *[Patient Privacy– Patient's Right to Access, Release of Patient Information, and Confidentiality](#)*, *[Protection of Patient Privacy](#)*.

REGULATORY COMPLIANCE:

SVMC provides many types of healthcare services. These services are provided pursuant to appropriate federal, state, and local laws and regulations, and federal conditions of participation. Such laws, regulations, and conditions of participation may include, but are not limited to, subjects such as certificates of need, licenses, permits, accreditations, access to treatment, consent to treatment, medical record-keeping, access to medical records and confidentiality, patients' rights, clinical research, end of life care decision making, and Medicare and Medicaid program requirements. The organization is subject to other numerous laws in addition to these healthcare laws, regulations, and the conditions of participation.

SVMC has developed policies and procedures to address many legal, accreditation, certification and regulatory requirements. However, it is impractical to develop policies and procedures that encompass the full body of applicable law, standards, conditions and regulations. Such laws, standards, conditions and regulations not covered in organizational policies and procedures must still be followed. There is a range of expertise within SVMC, including operations counsel and numerous functional experts, who should be consulted for advice concerning human resources, legal regulations and statutes, established standards and applicable conditions of participation.

Accreditation and Surveys:

From time to time, government agencies and other entities conduct surveys at SVMC. Accreditation or external agency surveys are extremely significant and broader than the scope of this Code of

Conduct. In preparation for, during, and after surveys, SVMC staff must comply with all accrediting and external agency surveyors in a direct, open and honest manner, and with accurate information.

In preparation for, or during a survey or inspection, SVMC staff must never conceal, destroy, or alter any documents, lie; or make misleading statements to the agency representative. Also, SVMC staff must never attempt to cause another staff member to fail to provide accurate information or obstruct, mislead, or delay the communication of information or records relating to a possible violation of law. No action should ever be taken, directly or indirectly, to mislead the accrediting or external agency survey teams.

EMTALA:

SVMC complies with the Emergency Medical Treatment and Active Labor Act (EMTALA) in providing emergency medical screening examination and necessary stabilization to all patients – including pregnant women and their unborn children – regardless of their ability to pay. A Medical Screening Exam (MSE) shall be performed on all patients presenting to the SVMC Emergency Department with a medical emergency or requesting treatment for an emergency medical condition. If a patient elsewhere on hospital grounds requests treatment for an emergency medical condition, SVMC will expedite that patient to the Emergency Department for care. If, based on a MSE, it is determined the patient suffers from an emergency medical condition, SVMC is obligated to provide services within its capabilities to stabilize the patient. This must all be accomplished prior to requesting financial information from the patient.

SVMC does not admit, discharge, or transfer a patient with an emergency medical condition simply based on their ability or inability to pay or any other discriminatory factor. A patient with an emergency medical condition is only transferred to another facility at the patient's request or if the patient's medical needs cannot be met at SVMC and appropriate care is knowingly available at another facility. Patients are only transferred in strict compliance with state and federal EMTALA regulatory and statutory requirements.

Please refer to the *Intra-facility Transfers* and *EMTALA – Inter-facility Transfers, MSE, Emergency Care and Stabilization* policies.

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MEDICAL STAFF:

Healthcare services like those owned and operated by SVMC are a collaboration between Hospital Staff and Medical Staff members. As in any collaboration, each party has important roles and responsibilities that they must adhere to. SVMC is committed to providing an excellent work environment for our Medical Staff employees and contingent workforce

The *Identification and Management of Disruptive Behavior policy* establishes that SVMC has 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
- Disrupt the orderly administration of the independent 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

SVMC requires Medical Staff members to be familiar with this Code of Conduct, in addition to the Bylaws governed by the Medical Staff Rules and Regulations.

Interactions with Physicians:

Federal and state laws and regulations govern the relationship between hospitals and physicians who may refer patients to SVMC. The applicable federal laws include the Anti-Kickback Law and the Stark Law. It is important that SVMC Staff who interact with physicians (particularly those SVMC Staff who make payments to physicians for services rendered, provide space or services to physicians, recruit physicians to the community, and/or arrange for physicians to serve in leadership positions in the organization) are aware of the requirements of the laws, regulations, and policies that address relationships between SVMC and physicians. If relationships with physicians are properly structured, but not diligently administered, a failure to administer the arrangements as agreed results in a violation of the law. Any arrangement with a physician must be structured to ensure compliance with legal requirements. Most arrangements must be in writing and reviewed by the Compliance Department. Failure to meet all requirements of these laws and regulations can result in serious consequences for SVMC.

Patient Referrals:

The Stark Law is a strict liability law prohibiting physicians from making referrals of Medicare patients to an entity that furnishes "designated health services" if the physician has a financial relationship with the entity, unless an exception applies. Further, Medicare will not pay for claims improperly referred and the entity has a duty to refund, as well as be liable for Civil Monetary Penalties for knowingly presenting or causing another to present an improper claim, the potential of exclusion and False Claims Act liability. SVMC accepts patient referrals and admissions based solely on the patient's medical needs and our ability to render the needed services.

No SVMC staff member or other person acting on behalf of SVMC is permitted to pay or offer to pay anyone, solicit or receive anything of value, directly or indirectly, in exchange for the referral of patients. Similarly, when making patient referrals to another healthcare provider, we do not take into account the volume or value of referrals that the provider has made to Sierra View.

Business Courtesies/Tokens of Appreciation:

Any entertainment, gift or token of appreciation involving physicians or other persons who are in

a position to refer patients to SVMC must be undertaken in accordance with the Non-Monetary Compensation and Medical Staff Incidental Benefits policies. This policy was developed to be in compliance with federal laws, regulations, and rules regarding these practices. Staff must consult SVMC policies or our Compliance Department prior to extending any business courtesy or token of appreciation to a potential referral source. See SVMC policy: [*Non-Monetary Compensation and Medical Staff Incidental Benefits*](#)

FEDERAL AND STATE FALSE CLAIMS ACTS (FCA):

Federal and State False Claims Acts prohibit any person or entity from, among other things, knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval, or knowingly making or using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved.

The penalties for violating the Federal or State False Claims Act include:

- Civil monetary penalties of up to \$20,000 for each false claim submitted;
- Up to three times the amount of damages the government sustains because of the false claim; and,
- The costs of the legal action brought to recover for the false claim.

A private citizen may file suit under the Federal and State False Claims Acts on behalf of the government if the citizen has direct and independent knowledge of the submission of a false claim. The government will then decide whether to intervene and take over the case, dismiss or settle the case, or let the private individual pursue the case on his or her own. In either case, the person who initially filed the case may receive a portion of the amount recovered in either litigation or settlement of the claim.

WHISTLEBLOWER PROTECTIONS:

Both the Federal and State False Claims Acts prohibit employers from retaliating or discriminating against an employee who, acting in good faith, investigates, reports or assists in uncovering a false claim or statement.

An employee who suffers discrimination or retaliation based on protected activities has the right to sue under both the Federal and State False Claims Act. If the employee can prove that his or her employer retaliated against him or her for engaging in protected activity, the employee is entitled to be “made whole.” The remedies may include:

- Reinstatement of the employee to his or her position;
- Two times the amount of back pay;
- Interest on the back pay; and,
- Compensation for any special damages (including litigation costs and reasonable attorneys’ fees).

As noted above, it is the policy of Sierra View Medical Center that no employee shall be punished solely on the basis that he or she reported what he or she reasonably believed to be an act of

wrongdoing or a violation of the SVMC Compliance Program.

Please see the *False Claims And Whistleblower Protection* policy.

BUSINESS AND FINANCIAL INFORMATION:

Accuracy, Retention, and Disposal of Documents and Records:

SVMC is committed to keeping accurate and complete records in accordance with applicable federal and state laws and regulations and SVMC policies and procedures.

Each SVMC staff member is responsible for the integrity and accuracy of our organization's documents and records, not only to comply with regulatory and legal requirements, but also to ensure that records are available to support SVMC's business practices and actions. No one may alter or falsify information on any record or document. Records must never be destroyed in an effort to deny governmental authorities information that may be relevant to a government investigation.

Medical and business documents and records are retained in accordance with the law and SVMC record retention policy. Medical and business documents include paper documents such as letters and memos, computer-based information such as e-mail or computer files on disk or tape, and any other medium that contains information about the organization or its business activities. It is important to retain and destroy records only according with our policy. SVMC Staff must not tamper with records. No one may remove or destroy records prior to the specified date without first obtaining permission as outlined in the SVMC records management policy.

To ensure the integrity of its records, SVMC shall maintain a comprehensive document system with policies and procedures covering the following with respect to all documents including information maintained in computer files: (a) creation, (b) distribution, (c) retention, (d) storage and retrieval, and (e) destruction.

Please refer to the *Records Management* policy in the policy library for additional details.

Coding and Billing for Services:

SVMC communicates its billing policies to all of its patients prior to, or, at the time of service or admission. SVMC bills its patients for services rendered and provides itemized bills free of charge upon request. The patient financial services office responds to patient questions in a timely and courteous manner. Adjustments are made to correct any over or under billings.

SVMC has implemented policies, procedures and systems to facilitate accurate billing to government payers, commercial insurance payers, and patients. These policies, procedures, and systems conform to pertinent federal and state laws and regulations. SVMC prohibits any SVMC Staff member from knowingly presenting or causing to be presented claims for payment or approval that are false, fictitious, or fraudulent.

In support of accurate billing, medical records must provide reliable documentation of the services

SVMC provided. It is important that all individuals who contribute to the medical record provide accurate information and do not destroy any information considered part of the official medical record. Accurate and timely documentation also depends on the diligence and attention of Medical Staff members who treat patients in our facilities. Medical Staff Members are expected to provide SVMC with complete and accurate information in a timely manner.

Confidential Information:

You are prohibited from using any information about SVMC for your personal benefit. Business information should be disclosed only as required in the performance of your job duties or as authorized by SVMC management. Employees may be held personally liable for any benefit gained from improper use of this information or damages resulting from its disclosure. Employees who violate this policy may also face disciplinary action, up to and including termination.

All SVMC communication systems, including phone systems, voice mail, portable electronic devices, Internet and Intranet access and e-mail, are company property and are to be used for business purposes. Reasonable and limited personal use of these resources is permitted; however, these communications may be monitored. You should assume that your personal communications on company-owned or maintained systems are not private. Patient and confidential information should not be sent through any communication system unless it is sent through a secure system which complies with HIPAA. Anyone who abuses SVMC information systems or uses them excessively for non-business purposes will be subject to discipline.

You are all responsible for using company resources and assets wisely, including time, materials, equipment, supplies and information. These resources are to be maintained and used for business purposes only. The occasional use of items that are negligible in cost, such as telephones and insignificant copying, is permitted. The use of company assets for personal financial gain unrelated to the organization is not allowed. All employees must obtain prior written approval from their supervisor to use company assets for charitable reasons.

Please see: [Email](#) policy; [Information Security](#) policy; [Workstation Use and Security and Internet](#) policy.

Q&A Computer Security

QUESTION: I am out of town and need confidential information from my office computer. I call the office and ask my assistant to get the information for me. To do so, I must tell him my computer security password. Have I violated SVMC policy?

ANSWER: Yes. You may forward emails to your assistant or other designee to be read while you are away, but it is a violation of IT Security policies to disclose computer passwords. You are responsible for protecting your password, and for the use or misuse of the same.

Charity Care:

SVMC is a not for profit organization, which provides hospital services to the community of Porterville and the greater area of Southeastern Tulare County. SVMC is committed to meeting the health care needs of all patients in the community, including those who may be uninsured or underinsured. As part of fulfilling this commitment, SVMC provides medically necessary services, without cost or at a reduced cost, to patients who qualify in accordance with program requirements. Please see the [Financial Assistance – Full Charity Care and Partial Discount policy](#)

Conflict of Interest:

A conflict of interest is any situation in which financial or other personal considerations may compromise or appear to compromise your integrity in business judgment, delivery of patient care, or ability to perform your job or responsibilities. A conflict of interest may arise if you engage in any activities to advance your personal interests at the expense of SVMC.

An actual or potential conflict of interest occurs when any person in a position to influence a decision which could result in personal gain for that individual, a relative or a friend as a result of the SVMC's business dealings. A relative is any person who is related by blood or marriage, or whose relationship with the person is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in the person's household. You have a duty to disclose to their supervisor and the Compliance/Privacy Officer if you believe that you have a financial interest which could put you in a conflict of interest situation.

Political Activity: SVMC and its employees are prohibited from expending public funds to promote a candidate in an election campaign. This means no SVMC employee shall partake in any form of support for a political candidate while on company time. Such an infraction could jeopardize SVMC's status as a not-for profit entity. Nor are employees permitted to endorse any candidate or political entity as a representative of SVMC. Such an infraction could jeopardize SVMC's status as a not-for-profit entity. Please see *Compliance - Conflict of Interest policy in the policy library for more information.*

Q&A Political Contributions or Activities

QUESTION: *I work for the committee to re-elect a local political candidate. Can I distribute campaign brochures to other SVMC employees? Can I wear a candidate button?*

ANSWER: *No. You may not distribute campaign material on SVMC property, or otherwise campaign for the candidate while on duty. You are, however, free to distribute this material after hours in non-work areas and off campus*

Gifts and Business Courtesies:

SVMC mandates limitations and conditions concerning the exchange of gifts and business courtesies from outside sources to SVMC employees and associates. It is not permitted to accept any amount of cash or cash equivalent (check, money order, credit card, or gift card/gift certificate during the course of your duties as an agent, employee, volunteer or contractor of SVMC, from any person or entity. Acceptance of gifts (tangible items) or favors during the course of your duties from any person or entity, with a value in excess of \$50.00, is not permitted.

Patients may donate to the Sierra View Foundation or other charitable organization in the name of the SVMC employee or employees they wish to recognize

Promotional items from vendors may be accepted as long as they are nominal in value (\$10.00 or less). Promotional items include, but are not limited to pens, notepads, mugs, binders or similar items which are pre-printed or embossed with the logo of a vendor or product name. Any gifts that are embossed or preprinted with the logo of a vendor or product name that exceed the \$10.00 value are unacceptable even if they do not reach the \$50.00 limit.

It is the responsibility of the Department leadership to monitor the value of all gifts received, and to contact the Compliance Department should there be a question as whether a gift is appropriate or not. Please see policy: *Compliance, Gifts and Business Courtesies, Exchange of*

Q&A Accepting Gifts

QUESTION: I work on a unit in the hospital. Upon being discharged, a grateful patient offered me \$20 in cash to thank me for the care they received. May I keep the cash?

ANSWER: No. You may not accept any amount of money in the form of cash, check, or pre-paid credit card from anyone in relation to your position or job performance at SVMC.

Outside Employment and Business Interests:

SVMC recognizes that some employees may hold additional jobs outside their employment with SVMC. In accordance with California Government Code section 1126, employees of SVMC are permitted to engage in outside work or hold other jobs to certain restrictions based on reasonable business concerns. EXEMPT EMPLOYEES ONLY: Outside employment for exempt employees requires prior written approval from your respective vice-president.

You are not permitted to work on any personal business venture on the SVMC premises or while working on SVMC time. In addition, employees are not permitted to use SVMC equipment, telephones, computers, materials, resources or proprietary information for any outside work. You must abstain from any decision or discussion affecting SVMC when serving as a member of an outside organization or board or in public office, except when specific permission to participate has been granted by the SVMC's Compliance Officer.

Please see: *Outside Employment policy* in the policy library for more information.

Contracting with SVMC:

You may not contract with SVMC to be a supplier, to represent a supplier to SVMC, or to work for a supplier to SVMC while you are an employee of SVMC. In addition, you may not accept money or benefits, of any kind, for any advice or services you may provide to a supplier in connection with its business with SVMC. Please see *Compliance - Conflict of Interest policy* in the policy library for more information.

Government Investigations:

It is SVMC's policy to comply fully with all state and federal laws and regulations. SVMC will cooperate with any reasonable request for information from any governmental entity. In doing so, however, it is essential that our employees' legal rights and the legal rights of the company are protected. It is also important that government requests for information be responded to in an accurate, complete and timely manner. Notify your supervisor, Vice-President and/or Compliance/Privacy Officer immediately if you receive a subpoena, search warrant or other legal document from a government agency regarding SVMC's business, whether at home or in the workplace.

SVMC encourages employees to cooperate with governmental authorities conducting an investigation; no adverse action will be taken against you for any lawful cooperation. Be aware that the law guarantees each person the right to be represented by legal counsel during any investigation or inquiry by any governmental agency. In such a scenario, SVMC will likely also be represented, and you should be aware of the opportunity for such representation. You are not legally required to notify SVMC of your cooperation with governmental authorities in an investigation; however, we would appreciate such notification.

For more information on government search warrants or unannounced visits by auditors/investigators, please refer to the *Government Search Warrants and Unannounced Visits* policies located in the policy library.

Exclusion List:

SVMC will not employ or conduct business with an individual or entity listed on a government exclusion list. Medical treatment provided to government insured patients (Medicare, Medicaid, TRICARE, etc.) cannot legally be billed for reimbursement if a person or entity on an exclusion list had any part in the care of that patient, whether direct or indirect, including the provision of equipment or supplies involved in the patient's treatment. Nor can an excluded person or entity have any part in the billing process for the care of a government insured patient. In addition, any service ordered or directed by an excluded physician is excluded from coverage under the Federal healthcare programs. For a hospital violating this law (by knowingly or in some cases even unknowingly employing or doing business with a person or entity on an exclusion list), penalties can be severe. By signing the attestation, you agree that you will immediately self-report to management and the Compliance/Privacy Officer if you receive notification of being excluded from participation in federal and/or state health care programs, including Medicare and MediCal.

or any government reimbursement program.

Please see *Compliance - Sanctions Screening* policy in the policy library.

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SUBJECT:
COMPLIANCE AUDITING AND MONITORING
SECTION:
Page 1 of 8

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

PURPOSE:

To establish the manner by which Sierra View Medical Center (SVMC) will effectively and efficiently audit and monitor identified risk areas related to federal, state and local laws and regulations, as well as organizational policies, procedures, and standards of conduct.

POLICY:

The Compliance Officer (CO), and leadership, shall be responsible to ensure that ongoing auditing and monitoring is properly executed, documented, and evidenced in accordance with the OIG auditing standards.

DEFINITIONS:

Monitoring: Day to day observance to ensure processes and procedures are in compliance with laws, regulations and local policies, which should be performed by the process owners.

Auditing: An objective, independent and formalized measure of compliance with either a procedure or outcome. Focus should be on areas of inherent or residual risk.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

1. Department directors, managers and supervisors are charged with the responsibility of monitoring all their departmental processes and procedures for compliance.
2. The CO and/or Compliance Committee will recommend and facilitate auditing and monitoring of identified risk areas (with emphasis on auditing). Risk areas may be identified through the regular course of business, external alerts, or internal reporting channels. Special attention will be given to the annually released Office of Inspector General's (OIG) Work Plan, which identifies specific topics of most concern to government agencies. Items on the OIG Work Plan which appear most applicable to SVMC will be strongly considered for internal audits.
3. Probe audits should be conducted a minimum of once per quarter (variation may occur based on size/scope of audit). Probe audits are smaller in scale, designed to quickly gauge if a particular process is performing acceptably, as opposed to a robust audit which identifies a more exact error rate. Sample size can vary depending on the risk and impact of having out-of-specification findings, and anticipated outcome. In general, most probe audits in this facility would be well-supported by a sample size of 30 ~~to 100~~.
4. A probe audit producing significant findings will warrant a more robust audit, especially if a payback to the Centers for Medicare and Medicaid Services (CMS) is anticipated. The probe audit should be completely random, with the sample selection performed in such a manner as to prevent bias. Use of the OIG-sponsored "Rat-Stats" program is recommended, or at least its methodology, in determining sample sizes and selecting random samples.

SUBJECT: COMPLIANCE AUDITING AND MONITORING	SECTION: Page 2 of 8
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~~5. The attached planning document (attachment 1) will assist auditors in defining the parameters of the audit, and producing CMS approved payback estimations.~~

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~~6.5. Acceptable audit error rates will vary depending on the particular subject, but often a figure of 10% is utilized in the healthcare profession as a maximum allowable limit. In which case, audits producing less than a 10% error rate would require corrective action (reimbursement); performance improvement measures could be enacted, but no further action may be required. For audits producing greater than a 10% error rate, a payback plan would need to be comprehensive and require advice by legal counsel, especially if systematic negligence or criminal conduct is suspected. Significant error rates generally indicate a trend dating back to an earlier point in time. Findings will be communicated to the department leader, who will be responsible for developing and implementing a corrective action plan to address identified issues. A corrective action plan would be mandatory. In either case, findings of errors will be reported to the responsible director, who will be referred to the Audit Review and Resolution policy for how to implement corrective action.~~

~~7.6. Any audit producing significant findings (resulting in a corrective action plan) shall require a follow-up audit, to be scheduled on a date after corrective action has been performed. The purpose will be to measure the effectiveness of the corrective action. This follow-up audit need not be as robust as the initial audit. Following a significant problem, random audits (sample size = 30) will be conducted once per quarter for at least two consecutive quarters. If the error rate remains at <10% after the first two quarters, the audits can be discontinued.~~

~~8.7. Directors will be primarily responsible for conducting and/or overseeing their own monitoring activities. Audits, however, will generally be performed with direction and guidance from the CO and Compliance Committee, and may involve contracted professionals. The CO will ensure the audits are conducted in accordance with guidelines set forth by the OIG.~~

~~9.8. The CO will verify completion of audits and any corrective action measures arising from them. The CO will also be required to validate corrective measures that address any weaknesses identified by the process.~~

~~10.9. The CO is responsible for regular, periodic reporting, but no less than annually, to the CEO and/or Board of Directors on the general status and outcome of compliance auditing and monitoring.~~

ATTACHMENTS

~~Sample Planning Document~~

REFERENCES:

- U.S. Department of Health & Human Services. (July 2018). *Audit Protocol*. Retrieved from <https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/protocol/index.html>.

CROSS REFERENCES:



Compliance Department Policy & Procedure Manual

SUBJECT: COMPLIANCE AUDITING AND MONITORING	SECTION: Page 3 of 8
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- [Compliance Reviews and Assessments](#)
- [COMPLIANCE PROGRAM/PLAN](#)

Field Code Changed

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SAMPLE PLANNING DOCUMENT

Approvals	Signatures	Date
Auditor in Charge	_____	_____
Senior Auditor	_____	_____
Audit Manager	_____	_____
Statistical Specialist	_____	_____

1. Review Objective: _____

2. Population: _____

3. Sampling Frame: _____

4. Sample Unit: _____

5. Survey and Background Information: _____

6. Sample Design: _____

7. Sample Size: _____

8. Source of Random Numbers: _____

9. Method of Selecting Sample Items: _____

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10. Review Time Per Sampling Unit: _____

11. Characteristics to be Measured: _____

12. Treatment of Missing Sample Items: _____

13. Estimation Methodology: _____

14. Other Evidence: _____

15. Description of How Results will be Reported: _____

SUBJECT:

COMPLIANCE AUDITING AND MONITORING

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SAMPLE PLANNING DOCUMENT DEFINITIONS
1. Review/Audit Objective

Discuss the basis for determining that sampling is needed to meet the audit objective. Describe what is to be achieved and the procedures, or combination of procedures, to be applied to achieve the audit objective.

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2. Population

The population or universe is the group from which information is desired. In other words, the population is the whole set of items on which to base a conclusion. The working papers should include a description of the population, the source document or the transaction to be tested, and a definition of the period covered by the test. For example, if the plan is to review all the outpatient claims submitted for payment by Dr. "A" in CY 2001, then the outpatient claims submitted for payment during CY 2001 by Dr. "A" become the population or universe. When multiple locations are involved, consider all or several locations as one population for drawing a sample if controls of each location are components of one overall control system.

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3. Sampling Frame

The sampling frame is the totality of the sampling units from which the sample will be selected. How the sampling frame differs from the population and the effect it will have on the conclusions drawn from the results should be documented in the working papers.

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4. Sample Unit

A sampling unit is any of the designated elements that compose the population of interest—for example, a psychiatric services claim, an inpatient claim, an outpatient claim, or a cost report line item.

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5. Survey and Background Information

This section is used for describing information gathered during the survey that is relevant to the statistical sampling plan.

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6. Sample Design

This is the type of sampling design to be used. Commonly used sample designs include simple random sampling, stratified sampling, and multistage sampling. This section of the Sample Planning Document also includes a description of the strata in a stratified sample design and the stages of a multistage sampling plan.

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7. Sample Size

Judgment is used in selecting the sample size. Specifically, judgment is used to determine three factors: the confidence level, the tolerable error rate (maximum rate of deviations from the prescribed control that is acceptable without altering the preliminary assessment of control effectiveness), and the expected population deviation rate (expected error rate). Once these factors are considered, sample selection software can be used to find the sample size. The OIG uses RATSTATS, which is a package of statistical software tools for performing random samples and evaluating the results.

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The sample size is discussed in the Sample Planning Document. The OIG Office of Audit Services' *Audit Policies and Procedures Manual*, Chapter 20-20-02, Sampling and Estimation Techniques in Auditing,

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dated August 1, 2001, includes a discussion of sample sizes that should be included in this section of the Sample Planning Document. The sample sizes discussed in the manual are included below.

8. Source of Random Numbers

The source for the random numbers used to select sample items is included in the sample planning document. The OIG uses the OAS Statistical Sampling Software (RAT-STATS).

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9. Method of Selecting Sample Items

The method of selecting the sample items using the random numbers is also included in this section of the Sample Planning Document.

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10. Review Time per Sampling Unit

Staff resources should be considered when developing the sampling plan. The time needed to select the sample, locate the sample units—claims, financial statements, and so on—and the time needed to review and analyze the sample units are important factors in designing a sampling plan.

11. Characteristics to be Measured

The purpose of using statistical sampling is to determine the extent to which an error or combination of errors is present in the population under study. This information should be included in item 11 of the Sample Planning Document. For example, the purpose of the sample is to estimate the value of overpayments due to duplicate payments. The characteristics to be measured are the conditions that should be present for the sampled item to be considered a duplicate. The amount associated with each duplicate payment is the measurement of the overpayment.

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12. Treatment of Missing Sample Items

Oftentimes, sample items cannot be found. The audit objectives and the characteristics being analyzed have a bearing on how the missing sample items should be handled. The Sample Planning Document should contain a procedure for handling missing sample items.

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13. Estimation Methodology

The sampling plan should include a description of the estimates to be reported, the rationale for using the estimates, and how they will be calculated. The sample design and the objective of the audit affect the methodology for estimations and the estimate calculations. Attributes sampling is used to estimate the rate or proportion of a characteristic or group of characteristics in a population. Variables sampling is used to estimate quantitative characteristics, usually dollars, in a population. For recovering overpayments, OIG uses the lower limit of the 90% two-sided confidence interval. For savings estimates or cost avoidance, OIG uses the appropriate estimator and discloses the mean point estimate in the audit report.

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14. Other Evidence

Although sample results normally stand on their own in terms of validity, OIG will combine sample results with other evidence in arriving at audit conclusions, and it includes this discussion in the Sample Planning Document.

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COMPLIANCE AUDITING AND MONITORING

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15. Description of How Results will be Reported

This section of the Sample Planning Document should be used to explain how much of the sampling techniques will be presented as well as how and where in the audit report the results will be presented. This section should explain any caveats and other circumstances bearing negatively or positively on the sample results.

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SUBJECT: COMPLIANCE OFFICE CONFIDENTIALITY AGREEMENT	SECTION: <i>Compliance</i> Page 1 of 2
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PURPOSE:

To define the confidentiality requirements of all individuals who work in the Compliance Office and members of the Compliance Committee.

POLICY:

Employees in the Compliance Office and members of the Compliance Committee (CC) have access to confidential information. This includes patient, employee, and business information of a sensitive nature that is not known to the public and/or the employee population. Anyone assigned to the Compliance Office or CC must not disclose such information to unauthorized individuals. Furthermore, they must agree in writing to take appropriate steps to protect sensitive information from unauthorized access and inappropriate disclosure

Confidential information is defined to mean “all information learned in the course of employment with Sierra View Medical Center (SVMC) and which is unknown to the general public and/or the employee population.” This includes, but is not limited to, financial information, technical information, information relating to the contents of contracts, or any other proprietary or valuable information of SVMC and its related entities. This also includes sensitive information concerning patients, employees, and vendors.

AFFECTED AREAS/PERSONNEL: *COMPLIANCE OFFICER, COMPLIANCE EMPLOYEES AND COMPLIANCE COMMITTEE*

PROCEDURE:

1. During their employment with SVMC, employees working in the Compliance Office, and CC members having access to confidential Compliance Office information, must agree in writing not to disclose any confidential information regarding SVMC or its clients to any person, firm, corporation, association, or other entity for any reason or purpose whatsoever; nor shall they make use of such confidential information for personal advantage. This will be accomplished by requiring all Compliance Office employees and CC members to sign a “Compliance Office Confidentiality Agreement.”
2. Upon termination of employment with SVMC, employees working in the Compliance Office, and CC members having access to confidential Compliance Office information, must agree not to retain any original or copies of any file, document, record, or memorandum relating in any manner whatsoever to their confidential compliance related employment with SVMC. All such files, documents, records and memoranda in their possession will be immediately returned to SVMC upon termination of employment.

CROSS REFERENCE:

- Compliance Committee Policy

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CONFIDENTIALITY AGREEMENT

Any information or documentation I have been furnished by or obtained from or through the Compliance Committee or the Compliance Officer is confidential and sensitive. I will maintain the confidentiality of such information or documentation and will not discuss it with nor furnish it to anyone other than the Compliance Officer, the Attorney for the Hospital, the Compliance Committee (in a meeting of that Committee), the Chief Executive Officer or a member of the Board of Directors of Sierra View Medical Center (SVMC).

In undertaking or participating in any research, review or investigation at the request of or to assist the Compliance Committee or the Compliance Officer, I may develop, use or be involved with personal or confidential information concerning employees, physicians or patients. I will maintain the confidentiality of information, documentation and results derived from or obtained through any such research, review or investigation and will not discuss them with or furnish them to anyone other than the Compliance Officer, the Attorney for the Hospital, the Compliance Committee (in a meeting of that Committee) or the Chief Executive Officer of SVMC.

I further understand that my duty to maintain the information in confidence imposed hereunder shall survive my resignation or termination from this Committee or my termination of employment for whatever reason from this organization.

Signature/Date

Printed Name/Title

Compliance Officer/Date

SUBJECT: DISINFECTANTS: THEIR SELECTION AND USE	SECTION: <i>Surveillance, Prevention, Control of Infection (IC)</i> Page 1 of 2
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PURPOSE:

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

POLICY:

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

AFFECTED PERSONNEL/AREAS: *ALL AREAS*

PROCEDURE:

To make the right selection of a product:

- A. Study the manufacturer's recommendations carefully, particularly the restrictions.
- B. Consult with the microbiologist for assistance in interpreting company claims and laboratory studies.
- C. Be sure which products can be used in specific areas and on particular types of equipment.
- D. Be sure that personnel will have the necessary personal protective equipment (PPE), such as gloves, and can be properly instructed in the use of the product.
- E. Purchase products in sizes appropriate for storage, usage, and economy.

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

A. Phenolic

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

B. Quaternary Ammonium Compounds

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

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

C. Iodine Solutions

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

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

REFERENCES:

- Basak SS, Adak A. Physiocochemical methods for disinfection of contaminated surfaces – a way to control infectious diseases. J Environ Health Sci Eng. 2024;22 (1): 53-64. Published 2024 March 7. Accessed April 23, 2026 from: <https://pmc.ncbi.nlm.nih.gov/articles/PMC11180059/#Sec3>
- Rutala WA, Weber DJ and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008. CDC Update June 2024. Accessed March 6, 2026 from: <https://www.cdc.gov/infectioncontrol/guidelines/disinfection/>
- The Joint Commission. (2026) Infection Prevention and Control. IC.04.01.01, EP 3 - Disinfection and Sterilization. Accessed March 9, 2026 from: <https://powerdms.com/manuals/publication/100516/general/standard/24714168>

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SCOPE OF SERVICES:

The scope of Sierra View Medical Center (SMVC)'s Emergency Operations Plan is to provide for a program that ensures effective mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care. This hospital has developed an “all hazards” approach that supports a level of preparedness sufficient to address a wide range of emergencies regardless of cause. The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgical Department, Wound Healing Center, Urology Clinic, Sierra View Community Health Clinic, Clinical Lab, ~~Surgery Clinic~~ and Medical Office Building of Sierra View Medical Center. The Emergency Operations Plan (EOP) and associated Emergency Management Program extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, contract staff, medical staff and associates, including contracted services of Sierra View Medical Center.

OBJECTIVES:

- Six (6) critical areas of emergency response shall be managed in order to assess the hospital’s needs and prepare personnel to respond to incidents. The six critical areas are:
 - Communication
 - Resources and assets
 - Safety and security
 - Personnel responsibilities
 - Utilities management
 - Patient clinical and support activities
- The objective of the Emergency Operations Plan is to effectively prepare for, manage an emergency, and restore the facility to the same operational capabilities as pre-emergency levels, to include the following:
 - Identify procedures to prepare and respond to potential disasters or emergencies
 - Provide education to personnel on the elements of the Emergency Operations Plan
 - Establish and implement procedures in response to an assortment of disasters and emergencies
 - Identify alternate sources for supplies and services in the event of a disaster or emergency through establishing mutual-aid agreements with neighboring hospitals and/or healthcare

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systems; public health departments; hazardous materials response teams; local fire department; local police departments; area pharmacies; medical supply vendors

- Identify recovery strategies and actions to be activated in the event of a disaster or emergency

GOAL:

~~Meet with local schools to plan and perform an evacuation drill on a district campus. Work with the Central California Healthcare Coalition to update and approve the Memorandum of Understanding (MOU) between the hospitals in the Coalition.~~

RESPONSIBILITY:

- The Safety Officer, in conjunction with the Safety Committee, is responsible for developing, implementing and monitoring all aspects of the Emergency Operations Plan, including hazard vulnerability analysis, mitigation, preparedness, response and recovery.
 - The Safety Officer shall also track National Incident Management System (NIMS) implementation.
 - It is understood that the Safety Officer has a working knowledge of emergency management, hospital operations (daily operations and emergency operations) and the Hospital Incident Command Center operations.
- Hospital leaders, as well as medical personnel, shall actively participate in the organization's Emergency Operations Plan.
- The Emergency Operations Plan shall be developed in coordination with community agencies.
 - The Hospital shall communicate its needs and vulnerabilities to community emergency response agencies, and identify the capabilities of the community in meeting the needs of the hospital.

SPECIFIC PROCEDURES IN RESPONSE TO A VARIETY OF EMERGENCIES BASED ON A HAZARD VULNERABILITY ANALYSIS PERFORMED BY THIS HOSPITAL:

- The Hospital has developed specific procedures in response to potential disasters and emergencies that may occur. Additionally, the Hospital will perform routine Hazard Vulnerability Analysis (HVA) to identify areas of vulnerability and undertake provisions to lessen the severity and/or impact of a disaster or emergency that could affect the services provided by the Hospital.
- The HVA is evaluated on an annual basis and input from the local fire department and community agencies will be obtained to assure that the Hospital is aware of hazards in the community to which an emergency response may be required.

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- This hospital has developed a Utilities Disruption Matrix designed to provide available operational hours prior to departmental shut down or commencing of evacuation procedures. The Utilities Disruption Matrix is based on the hospital being self-sufficient for up to 96 hours without the assistance of external resources.
- For each emergency identified in the hospital's HVA, the following shall be defined:
 - Mitigation activities that are designed to reduce the risk of and potential damage due to an emergency
 - Preparedness activities that organize and mobilize essential resources
 - Response strategies and actions to be activated during the emergency
 - Recovery strategies/actions that will help to restore the systems that are critical to resuming normal operations of the Hospital
 - A documented inventory of assets and resources on-site that are needed during an emergency. At a minimum, this inventory should include:
 - ♦ Personal Protective Equipment (PPE)
 - ♦ Water
 - ♦ Fuel
 - ♦ Staffing
 - ♦ Linen
 - ♦ Cleaning Supplies
 - ♦ Food
 - ♦ Medical and surgical resources
 - ♦ Pharmaceutical resources
 - The inventory of assets and resources shall be evaluated on an annual basis or as needed
 - Methods shall be in place for the monitoring of the inventory of assets and resources during an emergency

See Hazard Vulnerability Analysis (HVA) Policy / Utilities Disruption Matrix

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DEFINE AND INTEGRATE THE FACILITY'S ROLE WITH THE COMMUNITYWIDE EMERGENCY OPERATIONS EFFORTS TO PROMOTE INTEROPERABILITY BETWEEN THE FACILITY AND THE COMMUNITY:

- The Emergency Operations Plan shall be tested. Exercises shall be developed based on the Hospital's HVA. Exercises should validate the effectiveness of the Emergency Operations Plan and identify opportunities to improve.
- The Emergency Operations Plan shall be tested a minimum two (2) times per year, either in response to an actual emergency or in a planned exercise.
- One (1) exercise per year shall include an influx of volunteer or simulated patients.
- At least one (1) exercise per year shall be evaluated to see how effectively the Hospital performs when the Hospital cannot be supported by the local community for up to 96 hours. (Tabletop sessions are acceptable to meet the community portion of this exercise.)
- If applicable, the Hospital will participate in at least one (1) community-wide drill annually that is relevant to the priority of emergencies identified in the hazard vulnerability analysis. (Tabletop sessions are acceptable to meet the community portion of this exercise.)
- The Manager of the Environment of Care is identified as the designee whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement.
- The Hospital cooperates with all local, county and state emergency management drills. The Safety Officer is a member of the countywide emergency management system and coordinates with other agencies any large scale drills. Tulare County Department of Public Health & Human Services Agency/Emergency Medical Services (EMS) and statewide disaster planning efforts coordinate with local police, fire and ambulance services in conjunction with the acute care facilities.

See Emergency Operations Plan - Hospital Incident Command System Responsibilities Job Checklists, Hospital Command Center Policy and Emergency Management Evaluation Policy.

COMMAND STRUCTURE:

The command structure utilized by this facility in coordination with the community-wide command structure is the Hospital Incident Command System (HICS).

INITIATING THE PLAN, INCLUDING DESCRIPTION OF PLAN ACTIVATION:

The plan will be initiated when it has been determined that a disaster or emergency has occurred or has the potential for occurring.

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Definition of Emergency:

- The Joint Commission's definition of an emergency is *"a natural or man-made event that significantly disrupts the environment of care; that significantly disrupts care and treatment; or that results in sudden, significantly changed or increased demands for the organization's services. Some emergencies are called 'disasters' or 'potential injury-creating events'."*

When the facility is notified of an emergency, the person receiving notification will immediately notify the Chief Executive Officer or his/her designee of the situation, whether it be an internal or external emergency. The Nursing House Supervisor will respond to the site of an internal emergency and report back to the Chief Executive Officer, or his/her designee, the status of the situation. The Chief Executive Officer or his/her designee will evaluate the emergency to determine whether the Emergency Operations Plan will be activated. If the plan is to be activated, the Chief Executive Officer or his/her designee will notify the Switchboard Operator to call "Triage Code 1" (Internal) or "Triage Code 2" (External).

The Chief Executive Officer or appointed designee will assume responsibility of the Hospital Incident Command Center and activate the appropriate positions noted on the Incident Management Team Chart as deemed necessary for the occurrence.

- Until the Incident Command System is in place, the Chief Executive Officer or his/her designee will determine if the Labor Pool will be opened depending on the size of the emergency. If the Labor Pool is not opened, the House Supervisor may assign additional help to the Emergency Area as needed. Additional personnel will be called in as needed via the staff callback system.
- The House Nursing Supervisor will notify additional outside agencies that may need to assist the hospital in the event of an internal emergency. (i.e. fire department, police department or other agencies).

The recovery phase will be initiated after the emergency is over and the Engineering Department has evaluated the facility. The recovery phase of the plan is to be initiated by the Chief Executive Officer or his/her designee.

COMMUNICATION:

Notification of External Authorities:

- The Hospital shall have a communications system in place, including two-way radio equipment and operators who are familiar with the equipment's operation.
- The hospital will provide for alternate communication methods in the event of a failure. Two-way radio equipment and cell phones shall be available in the event of an emergency. In the event that cell phones are not working, microwave communications satellite phones, ham radios or portable 800 MHz radios may be used.

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- The Security/Branch Director will approve media access to the facility, with only the appointed Public Information Officer interacting with the media.

A medical record system will be used to meet the minimum requirements of emergency management operations.

See Disaster Communications Policy – Emergency Operations Policy Procedure Manual

PERSONNEL RESPONSIBILITIES:

Notification of Personnel When Emergency Operations Plan is initiated:

- In an emergency which is so widespread to be considered an emergency and/or involving mass casualties, all hospital personnel, regardless of position, are expected to report to the hospital for duty as soon as it is feasible to travel. Each department director maintains a current callback list of all personnel. Once the Emergency Operations Plan has been activated, the department director in cooperation with Human Resources will assign a staff member to initiate the callback list.
- In the event that there are excess personnel, the Hospital Command Center will communicate with department directors regarding rescheduling of personnel for future needs. The medical staff will report to the Chief of Medical Staff or Medical Specialist Officer for assignments.

See Hospital Incident Command System Responsibilities Job Checklists.

Alternate Roles and Responsibilities of Personnel During Emergencies:

- Personnel may not be assigned to their regular duties. Personnel will be asked to perform various jobs, which will be considered vital to the effective operation of the hospital. Personnel will be assigned duties based on the needs of the hospital. If personnel are not needed in their usual units/departments, they will be sent to the Labor Pool for assignment.

See Hospital Incident Command System Responsibilities Job Checklists and Labor Pool Policy

Identification of Personnel in Emergencies:

- Personnel on duty during activation of the Emergency Operations Plan will be identified by picture identification nametag, which is to be worn at all times by all personnel while on duty.
- Only persons wearing proper identification or possessing valid credentials shall be allowed entrance into the hospital during an emergency.

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Personnel Activities and Support:

- The Hospital has made provisions for staff support that can be implemented in the event of a community-wide emergency. Such provisions may include, but not limited to:
 - Temporary housing/lodging needs
 - Transportation needs
 - Family support needs, as necessary (including short term child care)
 - Incident stress debriefing and counseling

Orientation and Training:

- Personnel will attend orientation upon hire and annually thereafter, reviewing their specific roles and responsibilities during an emergency/disaster.
- In-service education will be given to specific staff on the backup communication system and obtaining supplies/equipment in the event of an emergency/disaster.
- The Safety Officer or designee is responsible for in-servicing personnel to the hospital wide Emergency Operations Plan.
- The department directors are responsible for in servicing department personnel on the department specific responsibilities during an emergency/disaster.

EMERGENCY CREDENTIALING OF CAREGIVERS:

- To provide a mechanism for emergency credentialing and granting of privileges to volunteer/non-staff licensed independent practitioners in the event of a disaster.

The Chief Executive Officer or Chief of Staff or their designee(s) may grant emergency privileges upon presentation of a valid picture ID (issued by a state, federal, or regulatory agency) e.g., driver's license or passport, and at least one of the following:

- A current license to practice or primary source verification of the license.
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
- Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity.

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- Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

Verification of Information:

- Verification of the required information shall be done by the Medical Staff Office or designee as soon as feasible. A record of this information will be retained in the Medical Staff Office.

Conditions of Emergency Privileges:

- The emergency designee must practice under the direction and supervision of an existing member of the Sierra View Medical Center Medical Staff.

See Emergency / Disaster Credentialing & Privileging Of Non-Staff Practitioners and Allied Professionals – Medical Staff Policy & Procedure Manual.

Authorization for Volunteer Caregivers During Disasters – Emergency Operations Procedure Manual – Response & Assignment of Staff

RESOURCES AND ASSETS:

- The Hospital keeps a documented inventory of assets it has on site that would be needed in the event of an emergency or disaster. At a minimum, the inventory should include:
 - Linen
 - Cleaning supplies
 - Personal protective equipment
 - Water
 - Food
 - Fuel
 - Staffing
 - Medical resources and assets
 - Surgical resources and assets
 - Pharmaceutical resources and assets

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- Methods are established to monitor quantities of assets and resources during an emergency or disaster.
- Arrange for emergency/disaster supporting services to be performed by local businesses, utility companies, government agencies and individuals. Emergency/disaster supporting services may include:
 - Transportation
 - Communications
 - Traffic control
 - Food supplies
 - Utility maintenance
 - Medical supplies
- These arrangements must be coordinated with the assistance of the Safety Officer, Tulare County Department of Public Health, or the local Emergency Management Agency Director, whenever possible.
- The hospital shall estimate its emergency needs for each kind of support and, when feasible, arrange to have supporting supplies, equipment and manpower pre-designated for hospital use.
- Essential supplies, pharmaceuticals, medical supplies, equipment, food, water, linen, cleaning supplies and utilities shall be provided to meet shelter requirements for up to 96 hours when the hospital cannot be supported by the community. Procedures are in place for the procurement of additional supplies in an emergency.
- In the event that the hospital cannot be supported by the local community for at least 96 hours, the Chief Executive Officer/Incident Commander, Incident Command staff, in consultation with community leaders, will evaluate the following options and implement those options that best serve the hospital and community:
 - Conservation of resources
 - Curtailment of services
 - Supplementing of resources from outside of the local community
 - Staged evacuation

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- Total evacuation

See Emergency Management - Bed Space Availability Form, Emergency Water Supply Policy, Equipment and Supplies - Emergency Management Policy.

SAFETY AND SECURITY:

- Efficient traffic flow must be established:
 - Prepare floor plans which designate areas for specific patient care functions and ensure that personnel are familiar with these plans
 - Prepare and have available traffic control tools to show external and internal routing of casualties and other traffic
 - Assign and train volunteers to perform traffic control and security functions
- At the time the Emergency Operations Plan is activated, the Security Department personnel on duty will be responsible for locking all exits and entrances with the exception of the ambulance entrance. The security staff shall maintain control of entry and egress from the facility. Personnel of the hospital are required to wear badges identifying them as personnel. Only persons with proper identification shall be admitted to the hospital during an emergency.

See Disaster Response Security Policy – Emergency Operations Procedure Manual

- Radioactive or Chemical Isolation and Decontamination:
 - There is a designated decontamination room with a separate ventilation system or ventilation shutoff available for radioactive or chemical isolation and decontamination. Personnel are trained in the response to radiological, biological, chemical or hazardous material contamination.
 - Arrange with a local or State Emergency Management Agency Director (if applicable) for the training of hospital personnel who would perform the radiological monitoring of casualties and hospital areas and the acquisition of necessary radiological monitoring equipment. This equipment shall be stored in the hospital as a part of its essential emergency supply equipment.

See Contamination With Radioactive Materials Policy – Emergency Operations Procedure Manual

UTILITIES MANAGEMENT:

- The hospital will provide for alternative sources of essential utilities, including:
 - An emergency source of electrical power capable of operating all essential electrical equipment and a plan for failure of back-up generators

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- An alternate source of safe water
- An alternate source for medical gas and vacuum delivery
- An alternate means of waste disposal in the event of sewage system failure
- Sufficient fuel to last for at least 96 hours of expanded operation

See Disruption of Services Procedure Policy, Disruption of Hospital Services Notification Policy,. See additional policies in the Utilities Management subsection.

PATIENT CLINICAL AND SUPPORT ACTIVITIES:

- Management of Patients During Emergencies (i.e., Scheduling, Modification or Discontinuation of Services, Control of Patient Information and Patient Transportation):
 - Upon activation of the Emergency Operations Plan, normal admission requirements will be modified. Initially, admissions to the hospital will be limited to those whose survival depends upon services obtainable only through hospital bed care.
 - Outpatient care will be restricted to those whose lives may ultimately depend upon the present expenditure of medical supplies and health manpower time.

All elective admissions and procedures will be canceled, including elective surgery, non-emergent outpatient procedures and transferring patients who are stable to be discharged.

- Patients may be transferred to other facilities, so that emergency victims may be accommodated.
- Individuals may be redirected or relocated for a Medical Screening Exam in the event that the hospital's Emergency Operations Plan is activated. (Section 1135(b) of the Social Security Act §489.24(a)(2)).
- In the event that the hospital's Emergency Operations Plan is activated, persons may be transferred prior to being stabilized if, based upon the circumstances of the emergency, the hospital is unable to provide proper care, treatment or services. (Section 1135(b) of the Social Security Act and CFR §489.24(a)(2)).

See Admissions and Bed Capacity Policy – Emergency Operations Procedure Manual

EVACUATION OF THE FACILITY:

- When a situation arises requiring evacuation of patients from threatened or affected areas, safety of lives is Sierra View Medical Center's primary concern. Authority to order an evacuation is vested

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only in the Chief Executive Officer, his/her designee, or the Safety Officer. Patients shall be evacuated to an area of safety by whatever means are available. Formal agreements are in place with ambulance services and alternate care sites to transfer patients as necessary.

- All personnel have been trained in evacuation procedures. Evacuation routes are posted throughout the hospital.
- Relocation to alternate health facility or place of safety (i.e., churches, schools):
 - Prepare maps of routes to the relocation site
 - Confirm periodically the availability of the relocation site
 - Establish lists of supplies and equipment, by priority, to be relocated
 - Arrange adequate transportation for evacuation and relocation

See Evacuation Procedure Policy – Emergency Operations Procedure Manual

Establishing an Alternate Care Site When the Environment Cannot Support Adequate Patient Care:

- Formal agreements are in place so that patients may be transferred to a facility that can provide adequate patient care. The Liaison Officer will be responsible for inter-facility communication between the hospital and the designated alternative care site, and for retaining records of which patients were transferred to and/or from an alternative care site. The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If any hospital equipment is transferred with the patient, the patient care unit is responsible for documenting what equipment was transferred with the patient so that the equipment may be retrieved during the recovery phase post emergency. The following agreements are in place:
 - Ambulance contract agreements for transfer of patients between facilities
 - Transfer agreements will be made between neighboring facilities
 - Emergency acquisitions of medical supplies, pharmaceuticals, food, equipment, water, linen, emergency repair services, etc.

NOTE: Alternate care sites must be able to provide the necessary resources to care for patients, i.e., emergency power, site access and security, access to or the ability to obtain utility resources, such as medical gases, vacuum, etc., communications, personnel.

See Evacuation Procedures Policy – Emergency Operations Procedure Manual

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CONTINUING AND/OR RE-ESTABLISHING OPERATIONS FOLLOWING AN EMERGENCY:

- The hospital has mechanisms in place to restore the operational capabilities of the facility to pre-emergency levels. Once the emergency is over, the Engineering Department, including the Facilities Manager, Safety Officer, Risk Manager and administration representatives, will begin assessing the damage to the facility and the environmental concerns to determine whether the facility can safely provide medical care to the community and provide a safe environment for patients, personnel and visitors.
 - Pictures and/or videos will be taken of all damages to the facility's buildings, grounds, equipment, etc., including all off-campus structures.
 - Architects, building inspectors and structural engineers may be called in to determine if the buildings are safe for occupancy.
 - All potential environmental concerns will be evaluated for proper function, i.e., hazardous waste, fuel tanks, to ensure there is not leakage into the local sewer or water system or any other impact on other environmental concerns.
 - Ensure personnel support programs have been instituted, i.e., crisis counseling, flexible work hours, cash advances, day care, particularly if personnel and the hospital have been directly impacted by the emergency.
 - Clear debris and secure unsafe buildings as necessary.
 - Restore internal and external communication devices.
 - Inventory equipment and supplies for damage and determine if additional supplies need to be obtained from suppliers. Pictures/videos will be taken of all damaged supplies and equipment for insurance purposes. Damaged supplies and equipment will be retained until approval is received from insurance providers for disposal.

Notify the community through local media services regarding the services the hospital will be providing and where they will be provided in the event that services are moved off the hospital campus.

- Notify the hospital's insurance provider and contact a third-party expert to prepare the claim.
- Ensure records and data have been protected and restore information as necessary from backup tapes.
- Keep detailed records.

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NIMS PREPAREDNESS FUNDING:

- The Hospital shall establish a working relationship with State and Tulare County Department of Health and Human Services Agency / EMS and state hospital associations to identify activities to obtain and appropriately allocate preparedness funding.
- A proactive process shall be developed and implemented to seek other federal funding to support preparedness that takes advantage of developing interoperability training with local and regional multi-disciplinary partners.

PERFORMANCE STANDARDS:

- There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization wide safety. The organizational Safety Committee will develop and establish performance measures and related outcomes, in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:
 - The measure can identify the events it was intended to identify
 - The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable
 - The measure has defined data elements and allowable values
 - The measure can detect changes in performance over time
 - The measure allows for comparison over time within the organization or between the organization and other entities
 - The data intended for collection is available
 - Results can be reported in a way that is useful to the organization and other interested stakeholders
- The Safety Committee on an ongoing basis monitors performance regarding actual or potential risk related to one or more of the following:
 - Personnel knowledge and skills
 - Level of personnel participation

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- Monitoring and inspection activities
- Emergency and incident reporting
- Inspection, preventive maintenance and testing of safety equipment
- Other performance measures and outcomes will be established by the Safety Committee, based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Safety Committee.
- To identify opportunities for improvement/corrective action, the Safety Committee will follow the organization's improvement methodology. The basic steps to this model will consistently be followed, and include planning, designing, measuring, analyzing/assessing, improving and evaluating effectiveness. Should the Safety Committee feel a team approach (other than the Safety Committee) is necessary for performance and process improvement to occur, the Safety Committee will follow the organization's performance improvement guidelines for improvement team member selection.
- Determination of team necessity will be based on those priority issues listed (high-risk, volume and problem prone situations and sentinel event occurrence). The Safety Committee will review the necessity of team development, requesting team participation only in those instances where it is felt the Safety Committee's contributions toward improvement would be limited (due to specialty, limited scope and/or knowledge of the subject matter). Should team development be deemed necessary, primarily, team members will be selected on the basis of their knowledge of the subject identified for improvement, and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.
- Performance improvement monitoring and outcome activities will be presented to the Safety Committee by the Safety Officer at least on a quarterly basis, with a report of performance outcome forwarded to the Organizational Performance Improvement Patient Safety Committee, Medical Executive Committee and Board of Directors quarterly.

ANNUAL EVALUATION OF THE EMERGENCY OPERATIONS PLAN OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS:

- The annual evaluation of the Emergency Operations Plan will include a review of the scope according to the current Joint Commission standards and National Incident Management System (NIMS) requirements to evaluate the degree in which the program meets accreditation standards, NIMS requirements and the current risk assessment of the hospital.
 - A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met.

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- The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met.
- The Emergency Operations Plan shall be revised and updated based on the annual evaluation of the Emergency Operations Program, including the Hazard Vulnerability Analysis.
- The performance and effectiveness of the Emergency Operations Plan shall be reviewed by the Safety Committee, the Performance Improvement/Patient Safety Committee, and Administration and reported to the Board of Directors.

REFERENCES:

- The Joint Commission (2026~~5~~). Hospital accreditation standards. EM.12.01.01 & NPG.03.02.01 Joint Commission Resources. Oak Brook, IL.
- Section 1135(b) of the Social Security Act. (n.d.) https://www.ssa.gov/OP_Home/ssact/title11/1135.htm.
- Code of Federal Regulations §489.24(a)(2). (1991). <https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr;sid=060daea35afcfbf6b1c6a8bf685d6f87;rgn=div5;view=text;node=42:5.0.1.1.7;idno=42;cc=ecfr>.

CROSS REFERENCES:

- [ACTIVATION OF THE COMMAND CENTER](#)
- [ADMISSIONS AND BED CAPACITY](#)
- [AUTHORIZATION FOR VOLUNTEER CAREGIVERS DURING DISASTERS](#)
- [CONTAMINATION WITH RADIOACTIVE MATERIALS](#)
- [DISASTER COMMUNICATIONS](#)
- [DISASTER RESPONSE SECURITY](#)
- [DISRUPTION OF SERVICES](#)

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- [EVACUATION PROCEDURES](#)
- [MEDICAL GASES](#)
- [PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION PLAN](#)
- [UTILITY SYSTEM OPERATIONAL PLANS AND FAILURE PROCEDURES](#)

SUBJECT: EMPLOYEE CODE OF CONDUCT TRAINING	SECTION: Page 1 of 1
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PURPOSE:

To ensure that employees receive Code of Conduct training.

POLICY:

Sierra View Medical Center (SVMC) requires all employees to read SVMC's Code of Conduct and to receive Code of Conduct training at new hire and annual orientation.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

1. The Compliance Officer (CO) shall ensure that a process is established for providing each employee with access to read SVMC's Code of Conduct and sign an electronic attestation upon hire and annually. Code of conduct training will also be provided at new hire orientation.
2. An electronic link to the Code of Conduct is provided on the Compliance page of SVMC's intranet, as well as contact information for the CO, Compliance office and Compliance Hotline.
3. New employees will be provided with the name and telephone number of the CO and the Compliance Hotline at new hire orientation.

REFERENCES:

- Federal Register / Vol. 63, No. 35/Monday, February 23, 1998
- The Health Care Compliance Association. (2025). *Complete healthcare compliance manual (2025 ed.). Professional's Manual, Chapter 1-3, 201921*

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CROSS REFERENCE:

- [CODE OF CONDUCT](#)
- [COMPLIANCE EDUCATION AND TRAINING](#)

Field Code Changed

SUBJECT: FACSIMILE MACHINE, UTILIZATION OF	SECTION: Page 1 of 2
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PURPOSE:

To ensure proper utilization of the facsimile machine.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to utilize facsimile (fax) machines to enhance patient care, and to support our physician community, while maintaining the confidentiality of all patient information.

AFFECTED AREAS/PERSONNEL: *ALL PERSONNEL*

PROCEDURE:

Due to the Federal and State Regulations regarding patient privacy, extreme care should be taken when faxing protected health information (PHI) to any outside agency. The California Department of Public Health (CDPH) has interpreted California Health and Safety Code § 1280.15 to mean that misdirected faxes fall into negligent disclosures, therefore the facility must report all such incidences. These disclosures open the facility to penalties and the individual who negligently faxed to a wrong number can face penalties from the California Office of Health Information Integrity (CalOHII).

All staff must follow the steps outlined below when faxing documents inside or outside the facility:

1. Patient-related information may be faxed only if confidentiality may be maintained, and if the patient, or the patient's representative, has consented to the release of information.
2. Recommended all requests for faxed records be accompanied by a fax from the requesting organization/office that includes a return fax number within the body of the request or preprinted on the header with the company name.
3. If the requesting party provides a fax number via verbal communication the sender shall write the number down, and then read back the number to the requesting party to verify that the number is correct. This read back will be completed twice to ensure that the receiving party is actively listening to the sender to ensure that the number is correct. The sender shall make a tick mark by the number each time the number is read back to the requestor to signify that the number has been confirmed as correct.
4. Any fax being originating from SVMC shall include a fax cover sheet, with Confidentiality Disclaimer. This includes faxes being sent within the facility with one exception. Staff members are not required to use a cover sheet if they are faxing to the Pharmacy Department or the MRI unit, and they are using the pre-programmed listed on the fax machine. These are the **ONLY** instances where a fax cover sheet does not have to be used.
5. The sender must request that the receiving party notify the sender upon receipt of the fax.

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6. The sender shall program the receiving fax number into the fax machine. It is recommended that the sender check the number at least twice prior to faxing the documents to ensure that the number has been entered correctly.
7. The sender shall await the fax transmission log to ensure that fax was transmitted correctly, and that it was transmitted to the number as verified in step 2 of these procedures.
8. If an error is detected after the fax is transmitted the sending party shall try to determine where the fax was sent. If the sender can determine who the incorrect receiving party is, the sender shall contact that party and ask that they send all documentation back to the SVMC. Additionally, the Privacy Officer is to be notified immediately of the PHI breach. All documentation related to the matter is to be kept and turned over to the Privacy Officer.

All staff members should be aware of the following requirements for faxing of documents:

- Fax transmission of physician's orders is allowed only if the information constitutes an order that could be transmitted verbally.
- Documents that are highly confidential and shall NOT be sent via the fax include, but are not limited to, Peer Review Committee communications, AIDS or HIV results, drug or alcohol abuse, venereal disease and mental health information.

Copies of documents sent via the fax machine may be deemed to have the same force and effect as an original document.

REFERENCES:

- [The Joint Commission \(20262\). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.](#)
- ~~The Joint Commission. (2017). Hospital accreditation standards. Oakbrook Terrace, Illinois~~
- California Health and Safety Code § 1280.15

SUBJECT: HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN	SECTION: <i>Hazardous Materials & Waste Management</i> Page 1 of 12
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I. EXECUTIVE SUMMARY

Each environment of care poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Hazardous Materials and Waste Management Program is designed to identify and manage the risks related to the presence of several types of materials and waste present in the buildings and portions of buildings operated and owned by Sierra View Medical Center (SVMC). The specific risks of each environment are identified by applying appropriate criteria to materials and waste to determine which have hazards. A Hazardous Material and Waste Management Program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for Hazardous Materials and Waste describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the organization's facilities. The Management Plan and the Hazardous Materials and Waste Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgical Department, Medical Office Building, Urology Clinic, Sierra View Community Health Clinic, Clinical Lab and Wound Healing Department of Sierra View Medical Center. The Hazardous Materials and Waste Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, contract staff, medical staff and associates including contracted services of Sierra View Medical Center.

II. PRINCIPLES

- A. The activities of the Hazardous Materials and Waste Management program are designed based on applicable national, state, and local codes and regulations and the inventory of materials in use and waste generated at each location housing healthcare services of Sierra View Medical Center.
- B. The specific activities, environments, protective equipment and engineering controls required to the risk of adverse human or environmental impact related to the handling, use, storage or disposal of materials and waste are determined from Safety Data Sheets (SDS) or other documents provided by suppliers and manufacturers.
- C. The four basic management requirements for assuring the minimum potential of adverse human or environmental impact of hazardous materials or hazardous waste include:

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1. Appropriate design of space, including installation and maintenance of engineering control systems and other equipment to manage the hazards of the types of materials or waste to be stored in the area.
2. Regular inspection and maintenance of the spaces where hazardous materials or hazardous waste is stored, handled, held for disposal, etc. to assure that all engineering controls are working properly, that proper procedures and controls for the separation, storing, and handling of hazardous materials or hazardous waste are being implemented, and that other equipment is used effectively.
3. Education and training of staff responsible for handling and using any hazardous materials or hazardous waste that addresses the specific hazards of each type and the procedures and controls required to manage those hazards.
4. Development and testing of emergency response procedures designed to minimize the human and environmental impact of any exposure to, release of, or spill of hazardous materials or hazardous waste.

III. OBJECTIVES

- A. Develop and maintain a site and area-specific inventory of Hazardous Materials or Hazardous Waste, SDS, and other appropriate documentation for each location housing healthcare services of Sierra View Medical Center.
- B. Develop and manage procedures and controls to select, transport, store, and use the identified hazardous materials or hazardous waste.
- C. Inspect all areas where hazardous materials and hazardous waste are stored, handled, and disposed of at least annually.
- D. Monitor hazardous gases and vapors as required by law, regulation, or industry standards of practice.
- E. Educate and train staff about the specific risks of hazardous materials and hazardous waste they use or are exposed to in the performance of their assigned duties and the procedures and controls for managing them.
- F. Respond to spills, releases, and exposures to hazardous materials and hazardous waste in a timely and effective manner.
- G. Analyze and report all spills, releases, and exposures to hazardous materials and hazardous waste as required by law, regulations, and the incident reporting process of Sierra View Medical Center.

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- H. Manage the Hazardous Materials and Hazardous Waste Program to assure compliance with the Joint Commission's requirements and other regulatory agency requirements.

IV. PROGRAM MANAGEMENT STRUCTURE

- A. The Safety Officer works with the Safety Committee to conduct a risk assessment of hazardous materials and hazardous waste throughout the organization. The results of the risk assessment are used to develop appropriate procedures and controls as the foundation of an appropriate Hazardous Material and Hazardous Waste Management Program is implemented. The Safety Officer also collaborates with the Manager of Safety and Security to develop reports of the Hazardous Material and Hazardous Waste performance for presentation to the Safety Committee on a quarterly basis.
- B. The reports summarize organizational experience, performance management and improvement activities, and other Hazardous Materials or Hazardous Waste issues.
- C. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Hazardous Materials and Hazardous Waste Program from the Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer (CEO) and other senior leaders to assure budget and staffing resources are available to support the Hazardous Materials and Hazardous Waste program.
- D. The CEO or designee of Sierra View Medical Center receives regular reports of the activities of the Hazardous Materials and Hazardous Waste program. The CEO or designee collaborates with the Safety Officer and other appropriate staff to address Hazardous Materials or Waste Management issues and concerns. The CEO or designee also collaborates with the Safety Officer to develop a budget and operational objectives for the Hazardous Materials and Waste program.
- E. The ~~Manager~~Director of Environmental Services, staff and selected outside service company staff schedule and complete all activities required to assure safe, effective management of hazardous chemical waste and regulated medical waste.
- F. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

V. ELEMENTS OF THE HAZARDOUS MATERIALS AND WASTE PLAN

~~EC.01.01.01~~EP6PE.02.01.01 – Management Plan for Hazardous Materials & Waste

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The Hazardous Materials and Waste Management program is described in this management plan. The Hazardous Materials and Waste Management plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse Hazardous Material (HAZMAT) event.

EC.02.02.01-EP1 PE.02.01.01 EP1 – Identifying and Inventorying Hazardous Materials & Hazardous Waste

The manager(s) of the components of the Hazardous Materials and Waste Program develop criteria based on law, regulation, or industry standards to identify the types of HAZMAT addressed by this program.

The manager(s) of the components of the Hazardous Materials and Waste Program participate in the proactive risk assessment with the Safety Committee to coordinate the development of a departmentalized inventory of hazardous materials and waste. The inventory lists the quantities, types, and location of hazardous materials and waste found in each department. The list includes chemicals, chemotherapeutic materials, and radioactive materials, regulated medical waste including medical sharps, gases and vapors. The inventory is updated at least annually.

The inventory of Hazardous Materials or Hazardous Waste is used to develop procedures and controls for selecting, handling, storing, transporting, using, and disposing. It is the policy of Sierra View Medical Center to use the least hazardous materials that are effective for their intended purpose.

EC.02.02.01-EP3/4 PE.02.01.01 EP4– Emergency Response Procedures

The manager(s) of the Hazardous Materials and Hazardous Waste components develop and maintain written emergency procedures and controls designed to assure rapid, effective response to spills and releases or exposures.

The emergency procedures and controls are designed to evaluate spills to determine if outside assistance is necessary. Incidental spills are managed by staff with training appropriate to the type of spill. All spills are documented as incidents.

Spills exceeding the capability of the trained staff of Sierra View Medical Center to neutralize the hazard and to manage the clean-up and disposal of the waste generated require implementation of the Code Orange hazardous materials emergency response plan.

In all such cases, the Incident Commander, or designee, assigns qualified staff to assess the area affected to determine if evacuation, ventilation, isolation, or other actions are required to manage the hazards until a commercial or fire department HAZMAT team arrives on site. The Sierra View Medical Center Incident Commander, or designee, works with the outside Incident Commander to coordinate the procedures for neutralizing and cleaning up the spill in a manner that minimizes human and environmental impact.

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The Sierra View Medical Center Incident Commander or designee and the Safety Officer prepare and file appropriate incident reports regarding the Hazardous Materials spill with the Risk Management Department and other outside regulatory agencies as required.

If spill kits, personal protective equipment, or other equipment and supplies were expended during the management of a hazardous material spill, the Safety Officer is responsible for acquiring and stocking replacements to appropriate areas.

EC.02.02.01-EP5 PE.02.01.01 EP4 – Hazardous Chemicals

Hazardous chemicals and chemical waste are managed in accordance with the organization procedures and controls and applicable laws and regulations from the time of receipt to the point of final disposal. The inventory of hazardous chemicals is maintained by the Safety Officer. The inventory for each department is maintained in a departmental log. The Safety Data Sheets corresponding to the chemicals in the inventory are available through an online electronic service and a fax on demand option for the same service. In addition, a complete set of current Safety Data Sheets is maintained by Environmental Services. Some department managers may choose to maintain hard copies of Safety Data Sheets for training and for immediate access due to the high risk of a spill or exposure related to normal daily operations.

The manager of each department with an inventory of hazardous materials implements the appropriate procedures and controls for the safe selection, storage, handling, use and disposal of them.

The procedures and controls include use of Safety Data Sheets to evaluate products for hazards before purchase, orientation and ongoing education and training of staff, management of storage areas, and participation in the response and analysis of spills and releases of or exposures to Hazardous Materials or Hazardous Waste.

The Director of Laboratory Services maintains an inventory of all laboratory chemicals as part of the Chemical Hygiene Plan. The plan is available for reference at all times. The Director of Laboratory Services is responsible for maintaining the plan, including an up to date reference library of Safety Data Sheets.

EC.02.02.01-EP6 PE.02.01.01 EP4– Radioactive Materials

Radioactive materials are managed by the Radiation Safety Officer (RSO). The RSO is responsible for assuring that all areas where radioactive materials are used are maintained in compliance with applicable Nuclear Regulatory Commission regulations.

All areas where radioactive materials are stored and where wastes are decayed are secured from entry by unauthorized staff. All second and third shift deliveries of radioactive materials by representatives of outside radio-pharmacy companies are monitored by the on duty RSO. A log of each delivery is maintained.

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Spills of and unwanted exposures to radioactive materials are managed by the RSO. Appropriate decontamination, monitoring, and treatment of any contaminated or exposed persons are managed by a qualified member of the medical staff or by referral to a qualified physician.

Reports of spills and exposures are reported to the Environmental Safety Committee and to outside agencies in accordance with applicable regulations.

If any outside inspections result in findings of inappropriate management of radioactive materials, the RSO shall develop and implement a plan of correction as soon as possible.

EC.02.02.01-EP7 PE.02.01.01 EP4 – The hospital minimizes risks associated with selecting and using hazardous energy sources

All equipment that emits ionizing and non-ionizing radiation is inventoried as part of the Medical Equipment Management Program.

The energy emitted by each piece of equipment is analyzed to determine the hazards posed to patients, staff and licensed independent practitioners.

The Safety Officer, the Radiation Safety Officer, and other appropriate individuals are responsible for determining what procedures and controls are required to minimize the risks. All staff and licensed independent practitioners who work with or around hazardous energy sources are oriented and trained to develop an understanding of how to perform work related tasks or how to interact with the environment where the source of the hazardous energy is in use. Staff and licensed independent practitioners are also provided with appropriate personal protective equipment including energy monitoring devices when appropriate.

The Safety Officer, the Radiation Safety Officer, and other appropriate individuals are responsible for determining what quality control programs are required to manage each type of hazardous energy source and for conducting any required quality control measurement, maintenance, calibration, testing, or monitoring.

When equipment or staff performance does not meet established standards, the Safety Officer, the Radiation Safety Officer, and other appropriate individuals are responsible for taking action to address the identified deficiencies.

EC.02.02.01-EP8 PE.02.01.01 EP4 – The hospital manages risks associated with disposing of hazardous medications

As part of the Hazardous Materials and Waste program, the Director of Pharmacy and the Nursing Directors of Oncology and Medical Surgical departments are responsible for the safe management of dangerous hazardous medications including chemotherapeutic materials. The pharmacy orders, stores, prepares, distributes, and disposes of hazardous medications. All materials mixed on site are managed in accordance with applicable regulations for assuring product safety and purity. All hazardous medications are managed at the bedside to assure that the

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materials, doses, and patients are all correct before any are administered. All hazardous medication waste including the material, tubing, bags, syringes, needles, etc. are disposed of in containers designed for and labeled as hazardous medication waste. Spills of hazardous medications are cleaned up by a trained member of the nursing staff. Spills ≥ 5 cc will be cleaned up by the HAZMAT First Responder team following appropriate procedures.

All staff exposed to hazardous medications is offered the option of treatment through the employee health program.

EC.02.02.01 EP1 & IC.02.01.01 EP6-PE.02.01.01 EP4– Management of Infectious and Regulated Medical Waste Including Sharps

Regulated medical waste are managed by the Environmental Services (EVS) department, which distributes and collects appropriate containers for collection for regulated medical waste and medical sharps. The containers are leak proof and puncture resistant.

The Environmental Services staff is responsible for collecting the filled containers and transporting them to a holding room.

The containers are then transported to a processing facility where the materials are sterilized and rendered unrecognizable. Once the materials are rendered harmless they are disposed of in accordance with applicable community waste regulations.

Any staff member, patient, or visitor exposed to regulated medical waste or suffering a subcutaneous injury related to a medical sharp will be offered treatment and health screening in accordance with employee health and emergency medical treatment procedures.

All spills of blood or body fluids will be cleaned up by nursing or environmental services staff. The areas affected will be sanitized following appropriate procedures for the material involved.

EC.02.02.01 EP9—10-PE.02.01.01 EP4– Management of Hazardous Gases and Vapors

The Director of Environmental Services and the Laser Safety Officer is responsible for identifying needs for monitoring gases and vapors. Monitoring requirements and action levels are determined from regulations and industry standards. In addition to chemical gases and vapors, the vapors related to the use of electro-cauterizing devices and lasers during surgical procedures are considered to be hazardous.

The Director of Environmental Services is responsible for identifying all locations requiring monitoring, appropriate test methods, and the appropriate standards against which results of monitoring are compared.

Results of monitoring are documented and reported to the Safety Committee as part of the quarterly report of Hazardous Materials and Hazardous Waste activities.

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If a monitored level is higher than the regulatory or industry standard action level, staff activity in the area is suspended or staff is supplied with appropriate protective equipment until the conditions that caused the excessive level are corrected.

~~EC.02.02.01 EP11~~ PE.02.01.01 EP2— Management of Permits, Licenses and Manifests

The Director of Environmental Services will maintain all required permits and licenses which are updated as required. Copies of the permits and licenses are posted in areas as required by law or regulation.

The Director of Environmental Services will maintain copies of all manifests required by law or regulation. The manifests are reviewed monthly to assure copies are returned from haulers. If a required manifest copy is not returned from the hauler within 30 days, the appropriate manager contacts the hauler. If a required manifest copy is not returned within 90 days, the affected manager reports the deficiency to the appropriate agency for follow-up action.

~~EC.02.02.01 EP12~~ PE.02.01.01 EP3— Labeling of Hazardous Materials and Waste

All staff using hazardous materials or managing hazardous waste are required to follow Federal DOT regulations for labeling. The team conducting environmental tours evaluates compliance with labeling requirements. Deficiencies are reported to appropriate managers for immediate follow-up, including re-education of the staff involved.

~~EC.02.02.01 EP17-18~~ PE.02.01.01 EP5— The Hospital Monitors Radiation Exposure of Radiology Staff

The Radiation Safety Officer will review staff dosimetry monitoring on at least a quarterly basis to assess whether staff radiation exposure levels are “as low as reasonably achievable and below regulatory limits. The findings are reported to the Radiation Safety Committee for review.

~~EC.02.02.01 EP19~~ PE.02.01.01 EP5— Routine Storage and Disposal of Trash and Regulated Medical Waste

The Environmental Services Department will collect, transport, and dispose of regular trash and regulated waste in accordance with all state and local regulations.

~~EC.04.01.01.1 EP1—EP11~~—The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported.

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The completed reports are forwarded to the Vice President of Quality and Regulatory Affairs who works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety (PIPS) Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management sections of the Environment of Care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.

The Safety Officer and the Performance Improvement Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

~~EC.04.01.01-EP15~~—Every twelve months the hospital evaluates each Environment of Care Management Plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks.

The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are

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acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, benchmarking programs, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of the Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Patient Safety Committee, and others as appropriate. The Safety Officer is responsible for implementing the recommendations in the report as part of the performance improvement process.

~~EC.04.01.03 EP2~~—Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

~~EC.04.01.05 EP1~~—Improving the Environment

When the Board of Directors, Senior Leadership, or Quality and Patient Safety concurs with the Safety Committee recommendations for improvements to the Environment of Care Management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement. All final improvement reports are summarized as part of the annual review of the program and is presented to hospital, performance improvement, and patient safety leadership.

Goal:

Work with Environmental Services, Pharmacy and Hospital Staff to bring down the high pounds of non-hazardous pharmaceutical waste rate, the current rate is in the 86th percentile in the Osborne Engineering Benchmarking Database. Meet with Environmental

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Services Manager, Pharmacy Director and Clinical Leaders to ensure we are properly separating non-hazardous pharmaceutical waste from other waste before disposal. Work with Environmental Services and Stericycle to develop a more accurate Hazardous Waste report that reflects not only cost but pounds of waste for the facility.

HR.11.03.01 EP1 – 5 HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the Environment of Care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department with assistance from the Education Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care Manager, department heads, the Vice President of Quality and Regulatory Affairs the Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs.

The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work. In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

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Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee.

When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF*

REFERENCES:

- The Joint Commission. Comprehensive Accreditation Manual for Hospitals. (20265) ~~PE.02.01.01EC~~
~~01.01.01-EP6~~ Oakbrook Terrace, IL.

CROSS REFERENCES:

- [CODE ORANGE- INTERNAL HAZARDOUS MATERIALS SPILL](#)

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I. EXECUTIVE SUMMARY

Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Life Safety Management Program is designed to identify and manage the risks of the ~~E~~environments of ~~C~~care operated and owned by Sierra View Medical Center (SVMC). The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for Life Safety describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the Life Safety Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Center, Wound Healing Center, Urology Clinic, Clinical Lab, Sierra View Community Health Center (SVCHC), ~~Surgery Clinic~~ and Medical Office Building of Sierra View Medical Center. The Life Safety Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted services of Sierra View Medical Center.

II. PRINCIPLES

- A. All buildings of Sierra View Medical Center housing patient care services must be designed, operated, and maintained to comply with the 2012 edition of the National Fire Protection Association (NFPA) Life Safety Code.
- B. All fire alarm, detection, and extinguishing systems and equipment must be maintained to comply with applicable codes and standards.
- C. All staff must be educated and trained to respond effectively to fire, smoke, or other products of combustion to minimize the potential of loss of life or property in the event of a fire.
- D. Appropriate temporary administrative and engineering controls must be designed, implemented, and maintained whenever existing deficiencies or conditions created by construction activities significantly reduce the level of life safety in any area where patients are cared for or treated.

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III. OBJECTIVES

- A. Design and construct all spaces intended for housing patient care and treatment services to meet national, state, and local building and fire codes.
- B. Conduct required fire drills in all buildings of Sierra View Medical Center that house patient care services.
- C. Calibrate, inspect, maintain, and test fire alarm, detection, and suppression systems in accordance with codes and regulations.
- D. Inspect and maintain all buildings housing patient care services to assure compliance with the applicable requirements of the 2012 edition of the NFPA Life Safety Code.
- E. Train all staff, volunteers, and members of the medical staff to respond effectively to fires.

IV. PROGRAM MANAGEMENT STRUCTURE

- A. The Safety Officer assures that an appropriate maintenance program is implemented. The Safety Officer also collaborates with the Safety Officer, Facilities Manager and Manager of Environment of Care to develop reports of Life Safety Management performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other fire safety issues.
- B. The facilities management technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe, reliable performance of fire safety equipment in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
- C. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.
- D. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Life Safety Management program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer and appropriate clinical staff. The Board collaborates with the Chief Executive Officer and Senior Leadership to assure budget and staffing resources are available to support the Life Safety Management program.
- E. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Life Safety Management program. The Chief Executive Officer collaborates with the Safety Officer and other appropriate staff to address fire safety

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issues and concerns. The Chief Executive Officer also collaborates with the Safety Officer to develop a budget and operational objectives for the Life Safety Management Program.

V. ELEMENTS OF THE LIFE SAFETY MANAGEMENT PLAN

EC.01.01.01-EP7PE.03.01.01 – Life Safety Management Plan

The Life Safety Management Program is described in this management plan. The Life Safety Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse outcome in the event of a fire.

EC.02.01.01-EP1PE.01.01.01 EP1 – Processes for Protecting Building Occupants and Property

The Facilities Manager and Safety Officer are responsible for coordinating the development of design, operations, maintenance, and training processes to minimize the potential for fires and of adverse consequences related to the presence of fire, smoke, or other products of combustion.

Design

The Safety Officer, Facilities Manager and other project managers collaborate with qualified design professionals, code enforcement, and facility licensing agencies to assure that buildings and spaces are designed to comply with local, state, and national building and fire codes. American Institute of Architects (AIA) guidelines are also considered in the design process for compliance with the International Building Codes with California amendments. The Facilities Manager assures that all required permits and inspections are obtained or completed prior to occupancy. The Facilities Manager permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of Sierra View Medical Center.

Management

The Facilities Manager oversees the design, implementation, and documentation of processes designed to assure optimal performance and continual compliance with code requirements of fire alarm, detection, and suppression systems. Similar programs are in place for maintenance of building elements operating conditions that play a role in the fire safety level of the environment.

The Facilities Manager is responsible for assuring that all renovation and new construction within existing buildings is done in a manner that preserves compliance with codes and standards.

Fire Response Process

The Safety Officer is responsible for the design and management of a fire response plan that meets the unique needs of the occupants of each department or service of Sierra View Medical

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Center. The current fire response plan is based on the “RACE” principle (remove from immediate danger, activate alarms, confine fire, extinguish or evacuate area). Area-specific response and evacuation plans that include training and equipment required to manage unique risks identified in areas are in place. The plans are evaluated annually as part of the overall program review.

~~EC.02.01.03~~—The hospital prohibits smoking on all facility grounds

Sierra View Medical Center has developed a Tobacco Free Environment policy. The policy prohibits the usage of any tobacco product (i.e., cigarettes, cigars, pipe, chewing tobacco, e-cigarettes) in any hospital building or grounds by all, including staff, visitors and patients.

Sierra View Medical Center has identified alternatives to tobacco products that are offered to all. Sierra View Medical Center has developed tobacco replacement resources to assist staff and patients with smoking cessation as desired.

The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.

~~EC.02.03.01~~ ~~EP4~~—The hospital maintains free and unobstructed access to all exits

Leaders in all areas of the hospital are responsible for assuring that equipment, furniture, and supplies are not stored in corridors. The condition of corridors is evaluated during each environmental rounds activity. All violations are reported to the Director of the area where the deficiency was identified, the Safety Officer, and the Safety Committee.

Repeated violations are evaluated to determine the probable cause and to develop a solution. Directors, where there are multiple violations over a 12 month period of time, may face disciplinary action through the Human Resources process.

~~EC.02.03.01~~ ~~EP9~~ PE.03.01.01 ~~EP4~~ – The hospital has a written fire response plan

The Safety Officer is responsible for coordinating the implementation of the fire response plan. All staff is oriented to the RACE (Rescue/Remove, Alert/Activate, Confine, and Extinguish/Evacuate) response model and effective use of portable fire extinguishers. In addition, all staff are oriented to the department or service-specific plans that account for the unique challenges posed by the condition of occupants and the design of space in which they work.

The department and area-specific fire response plans include information about:

1. The roles of all employees, medical staff, volunteers, contract staff and students near the point of fire origin.
2. The roles of all employees, medical staff, volunteers, contract staff and students away from the point of fire origin.

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Note: Sierra View Medical Center believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.

3. Operation of the fire alarm system
4. Exit routes and use of equipment used to relocate or evacuate patients, visitors, and staff

~~EC.02.03.03 EP1~~—7 Fire Drills

A comprehensive fire response plan is designed to each specific building or portion of a building housing care, treatment, or service areas owned or operated by Sierra View Medical Center. Each fire plan is modified to address physical limitations of occupants and features of the occupied spaces. All staff is educated about the general fire response procedure and the specific manner in which it is applied in assigned work areas.

Regular fire drills are conducted to reinforce training and education. At least 50% of the drills are unannounced. The frequency of drills is based on regulations and accreditation requirements. All healthcare, ambulatory healthcare and overnight sleeping areas are drilled at least once per shift per quarter.

If conditions evaluated as part of the Interim Life Safety Measures (ILSM) indicate a need for additional drills to enhance staff awareness of degraded life safety protection in various areas, there is documentation that the additional drills are performed. All freestanding business occupancies are drilled at least once per shift per year.

All fire drills are evaluated to determine if individual areas respond appropriately. An aggregate evaluation of fire drills is done at least twice a year. The aggregate analysis looks for patterns or trends of deficiencies. When deficiencies are identified, there is documentation that the deficiencies are corrected.

~~EC.02.03.05 EP1~~—28 PE.03.01.01 EP3 & PE.04.01.01 EP1 - Inspection, Testing, and Maintenance of Fire Safety Systems

The Facilities Manager works with qualified contractors and staff to design a program of calibration, inspection, maintenance, and testing to assure the reliability of all fire safety systems and equipment. The program includes systems and equipment such as fire sprinklers, smoke detection, fire pumps, fire dampers, doors, and shutters, and smoke control elements of the environment. Each system or piece of equipment is maintained to comply with requirements of the National Fire Protection Association or other applicable codes and standards.

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When deficiencies are identified, they are corrected within 48 hours. If a deficiency cannot be corrected within 48 hours, the Facilities Manager evaluates the impact of the deficiency using the ILSM criteria to determine if an ILSM plan needs to be put in place until the deficiency can be corrected. All ILSM plans are monitored for effect, and documentation demonstrating compliance with the plan is maintained by the Safety Officer.

~~LS.01.01.01 EP1~~—Life Safety Management

The Safety Officer is responsible for maintaining the Statement of Conditions. The Safety Officer prepares a quarterly report of the rate of completion of any Survey Related Plan for Improvement for the Safety Committee. If any items will not be completed within the The Joint Commission allowed 60 day grace period, the Safety Officer is responsible for preparing a letter to the appropriate Joint Commission staff requesting a time limited waiver within 30 days from the end of the survey.

~~LS.01.02.01 EP1~~—~~15PE.03.02.01 EP1~~ - 15 – Management of Fire Safety Risks

A program of Interim Life Safety Management based on Interim Life Safety Measures (ILSM) is used to manage degradation of the level of life safety required by NFPA 101 – 2012 Life Safety Code. The ILSM program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific Interim Life Safety Management Plan (ILSMP) is designed. The Facilities Manager and Safety Officer are responsible for implementation of the ILSMP. The implementation may include training, installation of engineering controls, posting of temporary advisory signs, and other actions deemed necessary. Affected staff are oriented and drilled, as appropriate, to familiarize them with the Interim Life Safety Management Plan.

The Safety Officer and Facilities Manager are responsible for monitoring the effectiveness of the implementation of the ILSMP. When deficiencies are identified, the Safety Officer and/or the Facilities Manager take appropriate action to resolve the deficiencies.

All monitoring and actions to resolve deficiencies related to an ILSMP are documented. The documentation is presented to the Safety Committee as part of the quarterly Life Safety Management report to the Committee. All ILSM evaluations, plans, and monitoring documentation are maintained for at least three years.

~~EC.04.01.01 EP1~~—~~EP11~~—The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

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Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Vice President of Quality and Regulatory Affairs who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the Chief Executive Officer, Board of Directors and Senior Leadership as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center.

Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and the recommendations of them.

The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

~~EC.04.01.01-EP15~~—Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plan associated with the Life Safety Management Program functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the

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operational results of each Environment of Care Program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the second quarter of the calendar year. Each report presents a balanced summary of an Environment of Care Program for the preceding calendar year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, Senior Leadership, The Board of Directors, the Performance Improvement Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

~~EC.04.01.03 EP2~~—Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

~~EC.04.01.05 EP1~~—Improving the Environment

When the leadership of the hospital, performance improvement, or patient safety concurs with Safety Committee recommendations for improvements to the Environment of Care Management Programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital leadership, performance improvement, and patient safety leadership.

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GOAL:

Audit all areas inside the facility for proper placement of exit signage and emergency lighting. If an area is found to be lacking proper signage and/or emergency lighting work with Engineering to correct the issue. Update the facility Fire Drill Form to ensure that all regulatory requirements are being met during Fire Drills.

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2—HR.11.03.01 EP1 - 5 Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department assisted by the Education Department coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work.

In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

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Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (202~~65~~). Hospital accreditation standards. ~~EC.01.01.01~~ EP7PE.03.01.01 Joint Commission Resources. Oak Brook, IL.
- National Fire Protection Association (NFPA) Life Safety Code 2012 Edition. Retrieved from <https://www.nfpa.org/Codes-and-Standards/All-Codes-and-Standards/Codes-and-Standards>.

CROSS REFERENCES:

- [FIRE RESPONSE PLAN](#)

SUBJECT: MARKETING UNDER THE HIPAA PRIVACY STANDARDS/HITECH	SECTION: Page 1 of 2
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PURPOSE:

To facilitate compliance with requirements of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Part 164 and the sections that relate to uses and disclosures of protected health information (PHI) for marketing purposes, and the Health Information Technology for Economic and Clinical Health Act (HITECH) component of the American Recovery and Reinvestment Act (ARRA).

POLICY:

An authorization signed by the patient or the patient's personal representative (as defined by state law) is required and must be obtained for any uses or disclosures of PHI for purposes of marketing under HIPAA Privacy Standards.

Refer to HIPAA Privacy Standards, 45 CFR Parts 160.101 and 164.501

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

DEFINITIONS:

Marketing - To make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service

Non-Marketing - Communication about a product or service that encourages recipients to purchase or use the product or service and the communication:

1. Is to provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual, only if any financial remuneration received by the covered entity in exchange for making the communication is reasonably related to the covered entity's cost of making the communication.
2. For the following treatment and health care operations purposes, except where the covered entity receives financial remuneration in exchange for making the communication:
 - a. For treatment of an individual by a health care provider, including case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual.
 - b. To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits, of the covered entity making the communication, including communications about: the entities participating in a health care provider network or health plan network; replace of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or

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- c. For case management or care coordination, contracting of individual with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of treatment.

PROCEDURE:

1. Authorization must be obtained from a patient or the patient's legal representative for any use or disclosure of PHI for marketing, except for communication in the form of:
 - a. A face-to-face communication made by a member of the facility workforce to an individual; or
 - b. A promotional gift (e.g., infant formula) of nominal value provided by the facility.
2. If the marketing involves direct or indirect remuneration to the facility from a third party (sale of PHI), the authorization must state that such remuneration is involved. Refer to the Authorization for Uses and Disclosures policy.
3. Facilities may communicate to patients via newsletters, mailings or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community-based initiatives or activities in which the facility is participating.
4. All documentation for marketing must be kept for a minimum of six (6) years.
5. Facilities that engage patients for marketing and/or promotional purposes (e.g., to use a patient's testimonial in marketing material) must have two forms executed:
 - a. Authorization for use and Disclosure of PHI for Marketing and/or Promotional Purposes
 - b. Consent for Use and Disclosure of Image, Voice, and/or Written Testimonials

REFERENCES:

- The Joint Commission. (2026). Hospital accreditation standards, [IM.12.01.01](#)- Oakbrook Terrace, Illinois.
- American Reinvestment and Recovery Act of 2009, Title XII, Subtitle D.

CROSS REFERENCES:

- [PATIENT PRIVACY – PROGRAM REQUIREMENTS](#)
- [AUTHORIZATION FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION](#)

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I. EXECUTIVE SUMMARY

The Environment of Care and the range of patient care services provided to the patients served by Sierra View Medical Center (SVMC) present unique challenges. The specific medical equipment risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Medical Equipment Management plan, based on various risk criteria, including risks identified by outside sources such as The Joint Commission, is used to eliminate or reduce the probability of adverse patient outcomes.

The Medical Equipment Management Plan describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other individuals coming to the organization's facilities. The management plan and the Medical Equipment Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Clinical Lab, Wound Healing Center, Urology Clinic, Sierra View Community Health Center, ~~Surgery Clinic~~ and Medical Office Building of Sierra View Medical Center. The Medical Equipment Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services, and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted staff and services of Sierra View Medical Center.

II. PRINCIPLES

- A. Selection of appropriate equipment to support the services of Sierra View Medical Center is an essential part of assuring safe, effective care and treatment are rendered to persons receiving services.
- B. Orientation, education, and training of operators of medical equipment are an essential part of assuring safe, effective care and treatment are rendered to persons receiving services.
- C. Assessment of needs for continuing technical support of medical equipment and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that medical equipment is safe and reliable.
- D. Effective management of medical alarms is a critical part of the patient safety program.

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III. OBJECTIVES

- A. Use established criteria to identify unique equipment risks. The identified risks are used to develop appropriate procedures and controls for maintenance and orientation and education programs.
- B. Identify and respond appropriately to equipment hazards and recall notices in a timely manner.
- C. Record, report, and analyze medical equipment problems, failures and user errors.
- D. Any event involving medical equipment and resulting in patient injury or death is treated as a Sentinel Event as defined by The Joint Commission. A complete Root Cause Analysis (RCA) is performed for each Sentinel Event.
- E. Manage the Medical Equipment Management program to assure compliance with The Joint Commission's requirements.

IV. PROGRAM MANAGEMENT STRUCTURE

- A. The Safety Officer is responsible for maintaining the Medical Equipment Management Program. Each department director is responsible for orienting new staff members to the capabilities, limitations, special applications of equipment, basic operating and safety procedures, emergency procedures if failure occurs, maintenance responsibilities, if applicable, and the reporting procedures for equipment problems, failures and user errors.
- B. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Medical Equipment Management Program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer and Senior Leadership to assure budget and staffing resources are available to support the Medical Equipment Management Program.
- C. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Medical Equipment Management Program. The Chief Executive Officer collaborates with the Safety Officer and other appropriate staff to address medical equipment issues and concerns. The Chief Executive Officer collaborates with the Safety Officer to develop a budget and operational objectives for the Medical Equipment Management Program.
- D. The Safety Officer assures that an appropriate Medical Equipment Maintenance Program is implemented.

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- E. The Safety Officer will develop reports of Medical Equipment Management Performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other medical equipment issues.
- F. The biomedical equipment technicians and selected outside contracted service staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe, reliable performance of medical equipment in a timely manner. In addition, the technicians and service company staff perform necessary repairs.

V. ELEMENTS OF THE MEDICAL EQUIPMENT PROGRAM

~~EC.01.01.01.EP8~~—Medical Equipment Management Plan

The Medical Equipment Management Program is described in this Management Plan. The Medical Equipment Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse event while being monitored, diagnosed or treated with any type of medical equipment.

~~EC.02.04.01.EP2~~—Written Criteria and Inventory

The Safety Officer is responsible for the development of criteria used to identify risks associated with medical equipment.

The criteria are used to evaluate risks related to the function of medical equipment, physical risks related to the use of equipment, and any history of patient safety issues related to the use of the equipment in the healthcare market.

The Safety Officer is responsible for assuring that all medical equipment is screened at the time of commissioning. The Medical Equipment Management screening procedure is applied, as appropriate, to loaner equipment, demonstration equipment, and equipment owned by physicians or other qualified individuals that is used as part of the care or treatment of a patient in any service of Sierra View Medical Center.

~~EC.02.04.01.EP3~~—Identifying High Risk Inventory

The Safety Officer and the Biomedical Department identifies high risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail.

~~EC.02.04.01.EP4 5~~—Inspection, Testing, and Maintenance Intervals

The Safety Officer uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.

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A computerized maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.

The Safety Officer is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.

The hospital's activities and frequencies for inspecting, testing, and maintaining the following items are in accordance with manufacturers' recommendations:

- Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements
- Medical laser devices
- Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes)
- New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies

Note: Maintenance history includes any of the following documented evidence:

- Records provided by the hospital's contractors
- Information made public by nationally recognized sources
- Records of the hospital's experience over time

~~EC.02.04.01.EP9~~—Emergency Procedures

The Safety Officer and appropriate clinical caregivers collaborate to identify life-critical medical equipment. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient, dependent on the function of the equipment.

The Safety Officer and the caregivers are responsible for developing appropriate resources to manage the response to the failure or disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.

The resources must include, but are not limited to, information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.

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Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job-related orientation process. All medical equipment emergency procedures are reviewed annually.

~~EC.02.04.01-EP40~~ ~~PE.05.01.01~~ - Quality Control and Maintenance of Radiologic Equipment

The hospital identifies quality control and maintenance activities to maintain the quality of the diagnostic computed tomography (CT), positron emission tomography (PET, magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. The hospital identifies how often these activities should be conducted.

~~EC.02.04.03~~—Medical equipment is maintained, tested, and inspected

The Safety Officer ensures that all medical equipment is inspected, tested and maintained.

~~EC.02.04.03-EP1~~—Equipment Inventory and Initial Testing

The Safety Officer and the Manager of the Environment of Care establishes and maintains a current, accurate, and separate inventory of all equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by Sierra View Medical Center, leased and rented equipment, and personally owned equipment used for the diagnosis, treatment, and monitoring of patient care needs.

The Safety Officer assures effective implementation of the program of planned inspection and maintenance. All equipment in the program is tested for performance and safety prior to use on patients.

~~EC.02.04.03-EP2~~—Testing of High Risk Equipment

The Safety Officer assures that scheduled testing of all life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Safety Officer will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

~~EC.02.04.03-EP3~~—Testing of Non-High Risk Equipment

The Safety Officer assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter.

If the quarterly rate of completion falls below 100%, the Safety Officer will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

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~~EC.02.04.03-EP4~~—Testing of Sterilizers

The Director of Surgical Services, staff and contracted service providers are responsible for testing and maintenance of all types of sterilizers used in Sierra View Medical Center. Records of load testing and regular maintenance are maintained by the Director of Surgical Services. Any improper results are documented as patient safety incidents and reported to Risk Management for evaluation and action.

~~EC.02.04.03-EP5~~—Testing of Dialysis Water Systems

The Director of Acute Renal Services is responsible for maintenance of dialysis equipment used in Sierra View Medical Center. The program of maintenance includes regular cleaning and disinfection of all dialysis equipment and testing for compliance with biological and chemical standards for the dialysis water supply. All out of range results will be documented as patient safety incidents and reported to Risk Management for evaluation and action. Any event resulting in a patient injury or death will be treated as a Sentinel Event.

~~EC.02.04.03-EP16~~PE.05.01.01-EP1— Testing & Calibration of Nuclear Medicine Equipment

Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The dates of these activities are documented.

~~EC.02.04.03-EP18~~PE.05.01.01- Quality of Radiological Images

The Hospital maintains the quality of the diagnostic computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. (~~See also EC.02.04.01, EP-10~~)

~~EC.02.04.03-EP20~~—Dosage Measurements

The Director of Radiology ensures that for diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following: (1) Measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted. (2) Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented.

~~EC.02.04.03-EP21~~PE.05.01.01- Evaluation of Computed Tomography (CT) Equipment

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For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented and presented to the Radiation Safety Committee. The evaluation includes the use of phantoms to assess the following imaging metrics: 1) Imaging uniformity 2) Slice thickness accuracy 3) Slice position accuracy (when prescribed from a scout image) 4) Alignment light accuracy 5) Table travel accuracy 6) Radiation beam width 7) High contrast resolution 8) Low contrast resolution 9) Geometric or distance accuracy 10) CT number accuracy and uniformity 11) Artifact evaluation .

EC.02.04.03-EP23PE.05.01.01 - Evaluation of Magnetic Resonance Imaging (MRI) Equipment

At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented and presented to the Radiation Safety Committee. The evaluation includes the use of phantoms to assess the following imaging metrics: (1) Imaging uniformity for all radiofrequency (RF) coils used clinically (2) Signal to noise (SNR) for all coils used clinically (3) Slice thickness accuracy (4) Slice position accuracy (5) Alignment light accuracy (6) High contrast resolution (7) Low contrast resolution (or contrast to noise ratio) (8) Geometric or distance accuracy (9) Geometric or distance accuracy (10) Magnetic field homogeneity (11) Artifact evaluation.

EC.02.04.03-EP23PE.05.01.01 - Evaluation of Nuclear Medicine (NM) Equipment

At least annually, a diagnostic medical physicist or nuclear medicine physicist conducts a performance evaluation of all nuclear medicine imaging equipment. The evaluation results, along with recommendations for correcting any problems identified are documented and presented to the Radiation Safety Committee. The evaluations are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics: (1) Imaging uniformity/system uniformity (2) High contrast resolution/system spatial resolution (3) Sensitivity (4) Energy resolution (5) Count rate performance (6) Artifact evaluation.

EC.04.01.01-EP1-EP11 - The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Electronic incident reports are completed by a witnessing staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

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In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Committee Chairperson provides summary information related to incidents to the Chief Executive Officer, Board of Directors, and Senior Leadership as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management areas of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement/Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

~~EC.04.01.01 EP15~~—Every twelve months the hospital evaluates each environment of care management plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with the Environment of Care (EC) functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each EC program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the second quarter of the calendar year. Each report presents a balanced summary of an EC program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

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In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Performance Improvement Patient Safety Committee, and others as appropriate. The manager of each EC program is responsible for implementing the recommendations in the report as part of the performance improvement process.

~~EC.04.01.03 EP2~~ Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

~~EC.04.01.05 EP1~~ Improving the Environment

When the leadership of the hospital, Performance Improvement, or Patient Safety concurs with Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

GOAL:

~~Work~~Continue to work with Renovo to develop a tracking system that can assist the hospital in locating equipment that is transported with a patient who has been sent to another facility. This goal was held up last year due to a change in leadership within Renovo.

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~~HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2~~HR.11.03.01 EP1 - 5
– Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their start date of employment.

The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the EC managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, the Patient Safety Officer, and others as appropriate to develop content materials for general and job related orientation and continuing education programs.

The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each EC program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work.

In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee.

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When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACTED SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (2026~~5~~). Hospital accreditation standards. ~~EC.01.01.01-EP8~~ Joint Commission Resources. Oak Brook, IL

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6. A dispute of a bill by a patient who claims to be the victim of any type of identity theft.
7. A patient who uses an insurance number, but never produces an insurance card or other physical documentation of insurance.
8. A notice or inquiry from an insurance fraud investigator for a private insurance company or a law enforcement agency.

B. RESPONSE TO POTENTIAL IDENTITY THEFT

Emergency Care - NO DELAY. Providing identification is not a condition for obtaining emergency care. The process of confirming a patient's identity must never delay the provision of an appropriate medical screening examination or necessary stabilizing treatment for emergency medical conditions.

In the event of any of the above red flags (or any other indication that a patient may be the victim of identity theft), the employee who becomes aware of such shall take action appropriate under the circumstances, including those resolutions as set forth in Attachment A. If a concern as to potential identity theft cannot be resolved, the employee shall promptly notify his or her supervisor. If the supervisor cannot resolve the concern as to potential identity theft, he/she shall notify the Compliance Officer, who shall determine the appropriate investigation and further action. Identity theft can be perpetrated by individuals/entities external to SVMC, as well as internally by staff or individuals/entities whom SVMC shares patient information with. All actions should be directed towards preventing and mitigating identity theft, as well as notification of the patient if identity theft is believed to have occurred. See attachment A.

1. Investigation of a red flag: In determining whether a red flag may indicate identity theft, SVMC will consider aggravating factors that may heighten the risk of identity theft, such as a data security incident that results in unauthorized access to a patient's account records, or notice that a patient has become aware of someone fraudulently claiming to obtain medical services in the name of the patient. SVMC will investigate all potential circumstances of identity theft.
2. Complaint by a patient: The Compliance Officer ~~or Chief Privacy Officer~~ will investigate any complaint by a patient of identity theft. The patient should be asked if he or she has filed a police report for identity theft, and a copy obtained if a report has been filed. The patient must complete either:
 - a. The ID Theft Affidavit developed by the FTC, including supporting documentation;
 - b. An ID theft affidavit recognized under California state law; or
 - c. A written statement that includes the following documentation:
 1. A statement that the patient is a victim of identity theft;

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2. A photocopy of the patient's driver's license or government-issued photo identification card;
3. Any other identification document that supports the statement of identity theft;
4. Specific facts supporting the claim of identity theft, if available;
5. Any other explanation that the patient did not incur the debt;
6. Any available correspondence disputing the debt;
7. Documentation of the residence of the patient at the date of service, including copies of utility bills, tax statements, or other statements from businesses sent to the patient at his or her residence;
8. A telephone number for contacting the patient;
9. Any information that the patient may have concerning the person who registered in his or her name;
10. A statement that the patient did not authorize the use of his or her name or personal information for obtaining services; or
11. A statement certifying that the representations are true, correct, and contain no material omissions of fact to the best knowledge and belief of the person submitting the certification.

3. Records requested by patient:

Identity theft victims may obtain a copy of the business transaction records maintained by SVMC (or by others on the Hospital's behalf) relating to identity theft free of charge. "Business transaction records" may include billing and medical record information. SVMC will provide these records upon the victim's written request, and will provide these records to any law enforcement which the victim authorizes. Before providing these records, SVMC must receive proof of identity, which may be a government-issued ID card in addition to a police report, and one of the three documents described above (i.e., a theft affidavit or a written statement). SVMC shall make a copy of all such information. SVMC may refuse to provide business transaction records if it determines in good faith that (i) the true identity of the person asking for the information cannot be verified, (ii) the request for the information is based upon a misrepresentation, or (iii) state or federal law prohibits disclosure of such information.

4. Action to mitigate identity theft:

If it is reasonably determined that a patient has been a victim of identity theft; SVMC shall mitigate, to the extent practicable, any harmful effect that is known to SVMC. SVMC will take the following actions:

- a. SVMC will cease collection on open accounts that resulted from identity theft.
- b. SVMC will cooperate with any law enforcement, bank, and/or credit card issuer investigation relating to the identity theft.

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- Other appropriate responses may include the following:

- ### C. NOTIFICATION OF A PATIENT

Notice shall only be delayed if law enforcement informs SVMC that disclosure of the identity theft or breach would impede a criminal investigation or jeopardize national security. A request for delayed notification should be documented including the name of the law enforcement officer and agency making the request. The patient should be promptly notified by the Compliance Officer or Chief Privacy officer after the law enforcement agency informs SVMC that notice will no longer impede the investigation or jeopardize national or homeland security.

D. UPDATING THE PROGRAM

The ~~Director of Compliance~~ Officer in collaboration with the Administrative Director of Revenue Cycle, Director of HIM/~~Chief Privacy Officer~~, Director of Informatics and Technology, IT & Data Management/Information Security Officer and other key leaders will evaluate the Program on an annual basis and will update the Program as necessary to reflect changes in the risks to patients or to SVMC from identity theft, based on factors such as:

- The experiences of SVMC with identity theft;
- Changes in methods of identity theft;
- Changes in methods to detect, prevent, and mitigate identity theft;
- Changes in the types of accounts that SVMC offers or maintains; and
- Changes in the business arrangements of SVMC, including mergers, acquisitions, alliances, joint ventures, and service provider arrangements.
- The effectiveness of the policies and procedures of SVMC in addressing the risk of identity theft in connection with the opening of patient accounts and with respect to existing patient accounts;
- Any third party service provider arrangements relevant to patient accounts;
- Significant incidents involving identity theft and management's response; and
- Recommendations for material changes to the Program.

SUBJECT:

**PATIENT IDENTITY THEFT PREVENTION,
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RULES)**

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REFERENCES:

- 16.C.F.R.681.2. Updated 12/15/2025. https://www.ecfr.gov/current/title-16/chapter-I/subchapter-F/part-681#se16.1.681_11
- *Fighting Identity Theft with the Red Flags Rule: A How to Guide for Business* (May 2013). Federal Trade Commission. Retrieved from <https://www.ftc.gov/tips-advice/business-center/guidance/fighting-identity-theft-red-flags-rule-how-guide-business>.

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RESPONSES TO POTENTIAL RED FLAG INCIDENTS		
IDENTITY THEFT RED FLAG	PREVENTION/MITIGATION PROCEDURE	POTENTIAL RESOLUTION [ONLY SUGGESTIONS]
Documents provided for identification appear to have been altered or forged.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process.*
Personal identifying information provided by the patient or applicant is not consistent with other personal identifying information. For example, the Social Security Number (SSN) range and date of birth do not correlate.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process.*
The photograph or physical description on the identification is not consistent with the appearance of the person presenting the ID.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process.*
The SSN provided is the same as that submitted by other persons opening an account or other customers.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions or billing process.*
The address and/or telephone number provided is the same or similar to an unusually large number of other persons opening an account or other patients.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions or billing process.*
Patient has an insurance number but never produces an insurance card or other physical documentation of insurance.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions or billing process. * Contact insurance company as necessary. If investigation does not indicate fraud, all contact and identifying information is re-verified with patient.
Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient(e.g., inconsistent blood type).	Investigate complaint, interview individuals as appropriate, review previous files for potential inaccurate records. Items to consider include: blood type; age; race; and other physical descriptions may be	Depending on the inconsistency and review of previous file, either delay/do not open a new patient account.* If the results of the investigation do not indicate

SUBJECT:
**PATIENT IDENTITY THEFT PREVENTION,
 DETECTION AND MITIGATION (RED FLAG
 RULES)**

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IDENTITY THEFT RED FLAG	PREVENTION/MITIGATION PROCEDURE	POTENTIAL RESOLUTION [ONLY SUGGESTIONS]
	evidence of medical identity theft.	fraud, all contact and identifying information is re-verified with patient.
Complaint/inquiry from an individual based on: a bill for another person; a bill for a product or service that the patient denies receiving; a bill from a healthcare provider that the patient never saw; and/or a notice of insurance benefits or Explanation of Benefits for health services never received.	Investigate complaint, interview individuals as appropriate	Discontinue collection on the account until identity has been resolved. Notify law enforcement as appropriate. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.
Complaint/inquiry from a patient about information added to a credit report by a healthcare provider or insurer.	Investigate complaint, interview individuals as appropriate.	Discontinue collection on the account until identity has been resolved. Notify law enforcement as appropriate. If investigation does not indicate fraud, all contact and identifying information is re-verified with patient.
A dispute of a bill by a patient who claims to be the victim of any type of identity theft.	Investigate complaint, interview individuals as appropriate.	Discontinue collection on the account until identity has been resolved. Notify law enforcement as appropriate. If investigation does not indicate fraud, all contact and identifying information is re-verified with patient
Complaint or question from patient about the receipt of a collection notice from a bill collector.	Investigate complaint, interview individuals as appropriate.	Discontinue collection on the account until identity has been resolved. Notify law enforcement as appropriate. If investigation does not indicate fraud, all contact and identifying information is re-verified with patient.
Patient or insurance company report that coverage for legitimate SVMC service is denied because insurance benefits have been depleted or a lifetime cap has been reached.	Investigate complaint, interview individuals as appropriate.	Additional documentation must be provided to resolve discrepancy and continue admissions or billing process. Contact insurance company as necessary. Notify law enforcement as appropriate. If investigation does not indicate fraud, all contact and identifying information is re-verified with patient.

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IDENTITY THEFT RED FLAG	PREVENTION/MITIGATION PROCEDURE	POTENTIAL RESOLUTION [ONLY SUGGESTIONS]
Mail sent to the patient is returned repeatedly as undeliverable although transactions continue to be conducted in connection with the patient's account.	Use skip-tracing or other procedures to find the patient's current mailing address.	Patient should be contacted, sufficient information provided to verify that address is correct, and contact information is updated.
SVMC is notified by a customer, a victim of identity theft, a law enforcement authority, or any other person that it has opened a fraudulent account for a person engaged in identity theft.	Investigation to determine if billing was made fraudulently.	Additional documentation must be provided to resolve discrepancy and continue admissions or billing process. Contact insurance company as necessary. Notify law enforcement as appropriate. If investigation does not indicate fraud, all contact and identifying information is re-verified with patient.
SVMC receives a notice or inquiry from an insurance fraud investigator for a private insurance company or law enforcement agency.	Investigation to determine if a security breach occurred within SVMC, or if theft or other improper use by SVMC staff of patient identity and health information occurred.	Discontinue billing process until inquiry is resolved. Assess security and monitoring devices in place and change passwords and other procedures as appropriate. Notify law enforcement as appropriate.
Personal identifying information provided by the patient is associated with known fraudulent activity as indicated by internal or third-party sources used by the Hospital. For example: the address on an application is the same as the address provided on a fraudulent application; or the phone number on an application is the same as the number provided on a fraudulent application.	Investigate complaint, interview individuals as appropriate.	Discontinue collection on the account until identity has been resolved. Notify law enforcement as appropriate. If investigation does not indicate fraud, all contact and identifying information is re-verified with patient.
Personal identifying information provided by the patient is of a type commonly associated with fraudulent activity as indicated by internal or third-party sources used by SVMC. For example: the address on an application is fictitious, a mail drop or prison; or the phone number on an application is invalid, or is associated with a pager or answering service.	Investigate complaint, interview individuals as appropriate.	Terminate credit until identity has been accurately resolved; discontinue attempting to collect on the account until identity has been resolved. Notify law enforcement as appropriate. If investigation does not indicate fraud, all contact and identifying information is re-verified with patient.

SUBJECT: PATIENT IDENTITY THEFT PREVENTION, DETECTION AND MITIGATION (RED FLAG RULES)	SECTION: Page 9 of 9
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*** In no event should treatment be refused or discontinued, unless such is purely elective. Credit and identity theft investigations should occur, with potential appropriate reporting, separate from provision of treatment to a patient.**

SUBJECT: PUBLIC RECORDS REQUEST	SECTION: Page 1 of 8
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PURPOSE:

The purpose of this policy is to set the guidelines for compliance with the California Public Records Act, commencing at Section 6250 of the California Government Code, and other related applicable statutes and case law, by setting forth the procedures to be followed when making records available to the public. It is the policy of the District that non-exempt public records be open for inspection and made available within a reasonable period of time to the requesting party. Pursuant to Section 6253 of the California Public Records Act, a fee equal to the direct cost of duplication may be charged to any person requesting a copy of a public record.

DEFINITIONS:

1. **“District”** the Sierra View Local Health Care District
2. **“Public Record”** includes any writing which contains information relating to the conduct of the public’s business and/or which is prepared, owned, used, or retained by the District.
3. **“Writing”** means any handwriting, typewriting, printing, ~~Pp~~photostatting, photographing, transmitting by electronic mail or facsimile and every other means of recording upon any tangible thing, any form of communication or representation.

AFFECTED PERSONNEL/AREAS: *ALL STAFF*

RECORDS AVAILABLE TO THE PUBLIC:

Agendas or any other writings, except for records exempt from disclosure (including, but not limited to, the items listed below) under section 6254 of the California Public Records Act, distributed to all or a majority of the members of a legislative body for discussion or consideration at an open session public meeting are disclosable to the public upon request, and shall be made available to members of the public in accordance with the provisions of section 54957.5 of the Ralph M. Brown Act. Confidential document and records reviewed or distributed in a closed session of a public meeting are not required to be made available.

All questions as to whether or not a record is exempt from disclosure according to this policy should be referred to counsel for the District.

RECORDS EXEMPT AND/ OR REQUIRING REFERRAL TO COUNSEL FOR THE DISTRICT:

- A. Preliminary drafts, notes, or interagency or intra-agency memoranda that are not retained by the District in the ordinary course of business, if the public interest in withholding those records clearly outweighs the public interest disclosure. Cal. Gov. Code. Sec.6254 (a).
- B. Records pertaining to pending litigation to which the District is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, until such litigation or claims have been finally adjudicated or otherwise settled. Cal.Gov. Code Sec. 6254 (b).

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- C. Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy. Cal. Gov. Code Sec. 6254 (c). HIPAA of 1996, Privacy Act of 1974.
- D. Requests for the Joint Commission’s final accreditation reports (that are forwarded to the State Department of Health Services) should be referred to counsel for the District.
- E. Confidential communications between the District and its attorneys. Evidence Code Section 954.
- F. Records of documents covered by the attorney work product privilege, or any other judicially recognized privilege, including but not limited to, the deliberative process privilege covered by the Evidence Code.
- G. A memorandum submitted to a state body or the District’s Governing Board by its legal counsel pursuant to subdivision (q) of California Government Code Section 11126 or 54956.9 until the pending litigation has been fully adjudicated or otherwise settled. The memorandum shall be protected by the attorney work-product privilege until the pending litigation has been finally adjudicated or otherwise settled. Cal.Gov. Code Sec. 6254.25.
- H. Trade Secrets – information claimed to be a trade secret at the time of submittal to the District may be treated as a trade secret in accordance with California Government Code Sec. 6254(k) and California Evidence Code Section 1060. **See below Procedure – Paragraph V.B.**
- I. Requests for contracts and rates for inpatient and outpatient services should be referred to counsel for the District.
- J. Request for contracts and rates for “major risk” and “managed risk” medical insurance program information should be referred to counsel for the District.
- K. Real estate appraisals, engineering or feasibility estimates and evaluations should be referred to counsel for the District.
- L. Request for records in which the public interest in non-disclosure outweighs the interest in disclosure Gov. Code Section 6255
- M. Materials privileged under some other statute. Cal. Gov. Code Sec. 6254(K)

PROCEDURE:

A. Requesting Copies of Public Records

1. Request for Copies. A public records request may be made in writing, orally in person, or by phone. The requests must be addressed to the Board of Directors of Sierra View Local Health Care District (SVLHCD). Requests may be made in paper or electronic form and may be sent by mail, facsimile, email or personally delivered. All requests must be made with sufficient clarity so as to reasonably describe an identifiable record.

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(Cal. Gov. Code Sec. 6253). Requests not meeting these criteria may be returned. Reasonable restrictions may be imposed upon general requests for voluminous classes of documents. Copies will not be provided if the disclosure would infringe a copyright or would constitute an unreasonable burden on the operation of the District or the record is exempt from disclosure under the California Public Records Act.

2. Response Time for Determination. The District shall determine within 10 days after the receipt of a public records request whether to comply with the request and shall immediately notify the requestor of its determination and the reasons therefore. Cal. Gov. Code Sec. 6253. ~~Such notification will include a public records reference number, which should be used in any further correspondence relating to the request.~~ The District may extend the determination period for up to 14 additional calendar days by providing the requestor with written notice of the extension period, (a) if there is a need to search for and collect the requested records from various offices that are separate from the office processing the request, (b) the need to search for, collect and appropriately examine a voluminous amount of separate and distinct records with respect to the request, (c) if there is the need to consult with another agency involving the request determination or (d) if there is the need to compile data, write- programming language or a computer program, or to construct a report to extract the data. Cal.Gov. Code Sec. 6253 (c). When the District dispatches the final determination to the requestor, and if the District determines that the request is for non-exempt public records, the District will notify the requestor of the approximate date by which the requested public information will be made available to the requestor. If immediate disclosure of the requested records is not possible, the District must provide the records to the requestor within a reasonable period of time.

B. Exempt Records and Trade Secrets

Records that are exempt from the Public Records Act will normally not be released. Exceptions of this policy may be granted at the discretion of the Chief Executive Officer (CEO), only after giving consideration to waiver of privilege as to those documents as to entire public and after giving consideration as to setting precedent as to future requests. Records claimed by third parties to be trade secrets or to otherwise exempt from disclosure will not be immediately released unless the District determines they are clearly public records.

Only information claimed to be a trade secret at the time of submittal to the District may be treated as a trade secret. California law defines trade secret in Civil Code Sec. 3426.1 (d) as materials that derive economic value from not being generally known or known to those who could use it to obtain value; and is and has been reasonably protected from disclosure. Notice will be sent by certified mail to the third party claiming exempt or trade secret status. Such third party is responsible for providing its current mailing address to the District. The notice shall include a copy of the request, and a request for a detailed and complete justification of the basis for exempt or trade secret status, to be provided within 15 calendar days of the date of the letter. If no justification is timely received, the subject records shall be released as ~~a~~-specified herein. Any justification claiming trade secret status must include a sworn declaration that should address the following six factors (Restatement of Torts Sec. 757):

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1. the extent to which the information is known outside of the person's business;
2. the extent to which it is known by employees and others involved in the person's business;
3. the extent of measures taken by the person to guard the secrecy of the information;
4. the value of the information to the person's business and to the person's competitors;
5. the amount of effort or money expended by the person in developing the information;
6. the ease or difficulty with which the information could be properly acquired or duplicated by others.

In addition, any justification must be specific enough so as to identify which specific information in a document constitutes a trade secret or is exempt so that it may be blocked out in a [document](#) ~~document~~, with the remaining information to be released. As a result, all documents subject to the request should be reviewed by the third party claiming exempt or trade secret status before submitting its justification to enable it to specifically segregate information contained in those documents that may or may not be released. Failure to so segregate may result in the release of all information.

The District shall evaluate the justification and any other information at its disposal and shall determine if the justification supports the claim that the material is in fact exempt or is a trade secret under California Government Code Section 6254 and Section 6254.7, respectively. If the District determines that the claim is bona fide and that the material is exempt or a trade secret, the District Administrative Office shall notify the requestor that the data sought is exempt or a trade secret and therefore cannot be released. The requestor shall be advised of its right to bring appropriate legal action to compel disclosure. Any such action should name the third party claiming an exemption from disclosure as a real party in interest.

If the District determines that the claim of exemption or trade secret is not meritorious or is inadequately supported by the evidence, the District shall promptly notify, by certified mail, the third party who claimed exempt or trade secret status that the justification is inadequate, and that the information shall be released after 10 calendar days from the date of receipt of such notice. Such third party shall also be advised of its right to bring appropriate legal action to prevent disclosure, and of its right to further respond. However, such further response, if inadequate, will not toll the 10-day period for release. In the event the third party cannot be reached at its last listed address with the District, the information shall be released after 15 calendar days of the date of such notice. Any legal action brought by the third party should name the requestor as a real party in interest.

The above procedures regarding exempt records and trade secrets do not apply to requests made by other governmental agencies for purposes of carrying out their official responsibilities, if such agencies agree to treat the disclosed material as confidential pursuant to a written confidentiality agreement with the District. The confidentiality agreement shall designate those persons authorized by the requesting governmental- agency to obtain the information. Cal. Gov. Code Sec. 6254.5(e).

The above procedures are also inapplicable if there requestor and the third party enter in to an agreement waiving any objections to the District's release of the requested information. A signed copy of the agreement must be provided to the District.

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C. Subpoenas

The Public Records Act is not applicable in situations where subpoenas have been issued against the District for document production. Any such subpoenas shall be referred to District Counsel's Office unless otherwise directed by that office, or handled following the ~~h~~H Handling of Subpoenas, Summons, and Complaints Policy.

D. Request for Access to Inspect Specific Files

It is the policy of the District that all records open for public inspection shall be available with the least possible delay and at the expense of the requesting party, except if the law provides an exemption from mandatory disclosure. Public records are open to inspection at all times during the office hours of the District, and every citizen has a right to inspect any public record as defined herein. To permit sufficient time for the District to compile the records for review, an appointment to view the records should be made by the requestor.

Records that are exempt from the Public Records Act and records claimed to contain trade secrets will be handled in the manner described in Subsection V.C. If a delay occurs, the requestor will be notified of the reasons and offered the option of either viewing that portion of the records that is available or waiting until the complete record is available.

The Board Clerk, or a designated representative, will be available to assist the requestor during the inspection. The requestor will be provided with the records and a work space. The Board Clerk or the designated representative will ensure that no records are removed or altered. If the requestor asks for photocopies or the electronic record of certain records, the Board Clerk will arrange for the copies and/or the electronic records to be provided to the requestor within a reasonable time period. The following requirements regarding fees will be applicable.

E. Request for Public Records in an Electronic Format

Per Government Code Section 6253.9

(a) Unless otherwise prohibited by law, any agency that has information that constitutes an identifiable public record not exempt from disclosure pursuant to this chapter that is in an electronic format shall make that information available in an electronic format when requested by any person and, when applicable, shall comply with the following:

1. The agency shall make the information available in any electronic format in which it holds the information.
2. Each agency shall provide a copy of an electronic record in the format requested if the requested format is one that has been used by the agency to create copies for its own use or for provision to other agencies. The cost of duplication shall be limited to the direct cost of producing a copy of a record in an electronic format.

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- (b) Notwithstanding paragraph (2) of subdivision (a), the requestor shall bear the cost of producing a copy of the record, including the cost to construct a record, and the cost of programming and computer services necessary to produce a copy of the record when either of the following applies:
 - 1. In order to comply with the provisions of subdivision (a), the public agency would be required to produce a copy of an electronic record and the record is one that is produced only at otherwise regularly scheduled intervals.
 - 2. The request would require data compilation, extraction, or programming to produce the record.
- (c) Nothing in this section shall be construed to require the public agency to reconstruct a record in an electronic format if the agency no longer has the record available in an electronic format.
- (d) If the request is for information in other than electronic format, and the information also is in electronic format, the agency may inform the requestor that the information is available in electronic format.
- (e) Nothing in this section shall be construed to permit an agency to make information available only in an electronic format.
- (f) Nothing in this section shall be construed to require the public agency to release an electronic record in the electronic form in which it is held by the agency if its release would jeopardize or compromise the security or integrity of the original record or of any proprietary software in which it is maintained.
- (g) Nothing in this section shall be construed to permit public access to records held by any agency to which access is otherwise restricted by statute.

F. Fees for Copies or Electronic Format of Public Records

There is no fee for less than ten (10) pages of public records. For ten or more pages, the fee is .25 cents per page for all pages, including the first nine (9). Staff time will not be charged for providing copies or electronic format of existing identifiable documents.

The Public Records Act requires “payment of fees covering direct costs of duplication, or a statutory fee, if applicable.” Cal. Gov. Code Sec. 626253(b). If the charges are estimated to exceed \$50.00, the requestor will be notified before the Board of Directors office begins processing the request. If the costs will exceed \$200.00, the District will require advance payment before the copies are made. In all other cases, the District Administrative Office will submit an invoice for any remaining charges.

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RESPONSIBILITIES

District Administrative Office

The District Administrative Office will have primary responsibility for coordinating the District's compliance with the California Public Records Act. That responsibility includes:

1. Receiving, logging, and tracking all requests for public records
2. Sending copies of requests to all applicable divisions within one business day
3. Assisting the public in understanding what information is available, and what must be done to obtain access to, or copies of, public records
4. Ensuring the District Counsel's Office have reviewed the request if necessary and provided their comments as to whether the requested records may be released
5. Requesting and obtaining the required information ~~ferom~~ from the appropriate division(s)
6. If a record has been identified as a trade secret or appears to be confidential, follow the procedures outlined above dealing with trade secrets
7. Providing the necessary notices and public records is within the appropriate periods as outlined in these guidelines
8. Ensuring that all records are safeguarded
9. Making sure that all originals of records are returned to the appropriate division as soon as possible
10. Ensuring that requests from the media are coordinated with the Marketing Department

The approved records will be provided within ten calendar days of the receipt of the request, unless the volume of the material warrants additional time.

If additional time is necessary, the District Administrative ~~onve~~ Office will provide the requestor a good faith estimate of when the copies will be available.

District Counsel

The District's Counsel Office will be responsible for providing legal guidance in determining which records may be released under the Public Records Act. The District Administrative ~~onve~~ Office shall provide District Counsel with those documents that are alleged to be trade secrets or exempt from the Public Records Act.

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In addition, the District Administration Office will immediately provide District Counsel with all correspondence relating to the justification of exempt or trade secret status. The District Administration Office will then be responsible for maintaining a separate file for those records which may not be released, and for releasing the remaining records pursuant to these guidelines.

REFERENCES:

- California Legislative Information (as of ~~January 1, 2025~~~~March 2019~~) Cal. Gov. Code Sec. ~~7290-7931. 6250-6276.48~~. Retrieved from leginfo.legislature.ca.gov
https://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml?tocCode=GOV&division=10.&title=1.&part=&chapter=&article=
- Summary of the California Public Records Act 2004 (August 2004). Retrieved from ag.ca.gov

CROSS REFERENCES:

- [Subpoenas, Summons, and Complaints Policy, Handling of](#)

SUBJECT: PATIENT PRIVACY – RIGHT TO REQUEST PRIVACY RESTRICTIONS	SECTION:
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure patients' the right to request privacy restrictions on the use or disclosure of their protected health information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, the Health Information Technology for Economic and Clinical Health Act (HITECH) component of the American Recovery and Reinvestment Act (ARRA) of 2009, and any and all other Federal regulations and interpretive guidelines.

POLICY:

Patients will be provided the right to request restriction of certain uses and disclosures of their PHI that is contained within the designated record set. Exceptions include psychotherapy notes, information compiled for use in civil, criminal or administrative actions, and information that is subject to prohibition by the Clinical Laboratory Improvements Amendments (CLIA). **Requests for such restrictions must be made in writing to the SVMC Privacy Officer (PO). No other SVMC employee may process such a request unless specifically authorized by the PO.** A determination to restrict uses or disclosures must be made very carefully to ensure the request can be met. Unless otherwise indicated below, SVMC may deny a request under certain circumstances.

Required disclosure restriction: SVMC must comply with a patient's request to restrict or limit the disclosure of the individual's protected health information (PHI) if 1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), **and** 2) the PHI pertains solely to a health care item or service for which the patient paid the facility out of pocket in full.

Emergency Treatment exception: If SVMC agrees to a restriction, HIPAA privacy regulations provide an exception in emergency treatment situations for a hospital or provider to use and disclose necessary information to treat the patient.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

REQUESTS FOR RESTRICTIONS AND TIMELY ACTION:

1. SVMC must permit a patient to request restrictions on the use and disclosure of PHI as contained in the designated record set. Requests for restrictions must be presented in writing (see attached sample restriction request form).
2. The written request must be routed to the PO. The PO and his or her designee are the only individuals who may agree to any such restriction requests.
3. The right to request restrictions and the process for making the request must be outlined in the Notice of Privacy Practices.

SUBJECT: PATIENT PRIVACY – RIGHT TO REQUEST PRIVACY RESTRICTIONS	SECTION: Page 2 of 3
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4. Unless otherwise required by law, SVMC must agree to a patient's request for restrictions or limitations for disclosures to the patient's health plan for payment or health care operations purposes if the patient has paid out of pocket in full for the health care item or service and the PHI pertains solely to that item or service.
5. For requests that are not required restrictions, the facility is not required to act immediately and should investigate its ability to meet the request prior to agreeing to the restriction.
6. The patient's request and the letter notifying the patient of the PO's decision must be filed with the designated record set.

PROVIDING THE RESTRICTION

Unless the request cannot be denied by law, the PO must ensure that the request can be met and that the designated record set is flagged per SVMC procedure.

DENIAL OF REQUEST

1. Except as otherwise required by law, SVMC may not deny a patient's request for restrictions or limitations for disclosures to the patient's health plan for payment or health care operations purposes if the patient has paid out of pocket in full for the health care item or service and the PHI pertains solely to that item or service.
2. The facility may deny any other request that is not a required restriction.
3. The patient must be notified of the denial by the PO in writing (see attached sample denial letter).

REQUIRED DOCUMENTATION

1. SVMC must document the following and retain such documentation:
 - a. The designated record sets that are subject to restriction; and
 - b. The titles of the persons or offices responsible for receiving and processing requests for access by individuals.
2. All correspondence and associated documentation related to a patient's requests for restrictions, including denials, must be maintained and retained per the Records Management Policy, or for six (6) years, whichever is longer.
3. All correspondence and associated documentation related to patient requests, including denials, must be maintained and retained per the Records Management Policy, EC.014, or for 6 years, whichever is longer.

SUBJECT: PATIENT PRIVACY – RIGHT TO REQUEST PRIVACY RESTRICTIONS	SECTION: Page 3 of 3
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TERMINATING A RESTRICTION

SVMC may terminate its agreement to a restriction, if:

1. The individual agrees to or requests the termination in writing;
2. The individual orally agrees to the termination and the oral agreement is documented; or
3. SVMC informs the individual that it is terminating its agreement to a restriction, except that such termination is only effective with respect to protected health information created or received after it has so informed the individual. Note: Restrictions may not be terminated without the patient's permission for disclosures to the patient's health plan for payment or health care operations purposes if the patient has paid out of pocket in full for the health care item or service and the PHI pertains solely to that item or service.

REFERENCES:

- American Recovery and Reinvestment Act of 2009, Title XIII, Subtitle D
- Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164
- The Joint Commission (2026). Hospital accreditation standards. EC.014. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- [RECORDS MANAGEMENT](#) Policy
- [NOTICE OF PRIVACY PRACTICES](#)

SUBJECT: SAFETY MANAGEMENT PLAN	SECTION: <i>Safety Management</i> Page 1 of 11
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I. EXECUTIVE SUMMARY

Each environment of care poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Environment of Care Safety (EC) Program is designed to identify and manage the risks of the Evironments of Care operated and owned by Sierra View Medical Center (SVMC). The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. An environmental safety program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for Environmental Safety describes the risk, safety, and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other individuals coming to the organization's facilities. The management plan and the environmental management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Wound Healing Center, Urology Clinic, Clinical Lab, Community Health Center and Medical Office Building of Sierra View Medical Center. The Management Plan for Environmental Safety and associated policies extends to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates including contracted services of Sierra View Medical Center.

II. PRINCIPLES

- A. The identification of specific risks faced by patients, employees, and others is essential for designing safe work areas and work practices.
- B. The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate staff to effectively use work environments and safe work practices to minimize the potential for adverse impact on them, patients, and other individuals coming into the environment.
- C. Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for improving the safety of the environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and increase staff knowledge.

SUBJECT: SAFETY MANAGEMENT PLAN	SECTION: <i>Safety Management</i> Page 2 of 11
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III. OBJECTIVES

- A. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Sierra View Medical Center.
- B. Perform additional risk assessments when changes involving these issues occur.
- C. Analyze accidents, incidents, and occurrences to identify root cause elements of those incidents.
- D. Make changes in the procedures and controls to address identified root causes of incidents.
- E. Conduct environmental rounds in all areas of the hospital and affiliated medical practices. Staff making rounds will evaluate the physical environment, equipment, and work practices. Rounds are conducted in all support areas at least annually and all patient care areas at least semi-annually.
- F. Present quarterly reports of EC management activities to the Safety Committee. The reports from each EC area manager will identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified EC issues. The Safety Officer coordinates the documentation and presentation of this information.
- G. Assure that all departments have current organization wide and department specific procedures and controls designed to manage identified risks.
- H. Review the risks and related procedures and controls at least once every three years to assure that the EC programs are current.
- I. Assign qualified individuals to manage the EC programs and to respond to immediate threats to life and health.
- J. Perform an annual evaluation of the management plan and the scope, objectives performance and effectiveness of the environmental safety program.
- K. Design and present environmental safety education and training to all new and current employees, volunteers, members of the medical staff and others as appropriate.

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IV. PROGRAM MANAGEMENT STRUCTURE

- A. The Safety Officer, Vice President of Quality and Regulatory Affairs and Manager of Infection Control work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program. They collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk-related procedures and controls, develop staff education and training materials, and manage day-to-day activities of the environmental safety program. They also collaborate with the Performance Improvement/Patient Safety Committee to integrate environment of care safety concerns into the Patient Safety program.
- B. The Environmental Safety Leadership Team coordinates the development of reports to the Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other environmental safety issues.
- C. The Safety Committee monitors and evaluates the processes used to manage the environment of care. Members of the Safety Committee are appointed by the Committee Chair. The Safety Committee meets a minimum of four (4) times per year. During each meeting, one or more EC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory changes, and other issues are presented as appropriate. The Committee acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes related to changes in regulations.

The Committee assigns individual's or group's responsibility for developing solutions to identified issues. Finally, the Committee maintains a tracking log to assure identified issues are acted on and that analysis of activities after implementation of changes demonstrates that the changes are effective.

Membership of the Committee includes representation from Nursing Administration, Facilities Management, Risk Management, Quality and Patient Safety, Human Resources, Senior Administration, Education, Medical Staff, Physician representation, Infection Control, and others as deemed appropriate.

- D. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the environmental safety program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer. The Board of Directors collaborates with the Chief Executive Officer and Senior Leadership to assure budget and staffing resources are available to support the environmental safety program.
- E. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Environmental Safety Program. The Chief Executive Officer collaborates with the ESLT and other appropriate staff to address environmental safety

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issues and concerns. The Chief Executive Officer also collaborates with the Safety Officer to develop a budget and operational objectives for the Environment of Care Safety Program.

- F. The Emergency Management Program contains provisions for management staff on duty to take immediate, appropriate action in the event of a situation that poses an immediate threat to life, health, or property.
- G. The Human Resources Department, with the assistance from the Education Department and other leadership staff, are responsible for the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and task specific safety and infection control procedures. The orientation and ongoing education and training emphasize patient safety.
- H. Department Directors are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work-related activities in a manner consistent with their training. Department Directors also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility.
- I. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

V. ELEMENTS OF THE ENVIRONMENTAL SAFETY MANAGEMENT PROGRAM

~~EC.01.01.01 EP1~~—Appointment of Environmental Safety Leadership

The Chief Executive Officer appoints a team of qualified individuals to assume responsibility for the development, implementation and monitoring of the environmental safety management program. The Environmental Safety Leadership Team (ESLT) includes the Safety Officer, Vice President of Quality and Regulatory Affairs and the Manager of Infection Control.

The ESLT coordinates the development and implementation of the environmental safety program and assures it is integrated with patient safety, infection control, risk management, and other programs as appropriate.

The ESLT maintains a current knowledge of environmental safety laws, regulations, and standards of safety, and assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety management program reflects the current risks present in the environment of Sierra View Medical Center.

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The Emergency Management program includes specific response plans for Sierra View Medical Center that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate event incident commander is appointed at the time any emergency response is implemented.

The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations pose an immediate threat to patients, staff, physicians, or visitors or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

The Chief Executive Officer has appointed the Safety Officer, the Nursing House Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

~~EC.01.01.01 EP4~~—Environmental Safety Management Plan

The Environmental Safety Management Program is described in this management plan. The Environmental Safety Management Plan describes the procedures and controls in place to minimize the potential adverse impact of the environment on patients, staff, and other people coming to the facilities of Sierra View Medical Center.

~~EC.02.01.01 EP1~~—The hospital identifies safety risks associated with the Environment of Care

The ESLT of Sierra View Medical Center performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others. The risk assessments use information from sources such as environmental rounds, the results of root cause analysis (RCA), incident reports, and external reports such as The Joint Commission Sentinel Event Alerts and FDA product recall notices.

The ESLT coordinates the risk assessment process with the Facilities Manager and Department Directors and others as appropriate.

~~EC.02.01.01 EP3~~—The hospital takes action to minimize or eliminate identified safety risks in the physical environment

The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of

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equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of environmental safety in a planned and systematic manner.

~~EC.02.01.01 EP14 & EP16~~PE.05.01.01— The hospital manages safety risks in the MRI environment

The Radiation Safety Officer (RSO) follows the MRI Safety Policy to ensure the safety of all patients, visitors, and staff who enter the MRI Suite. Staff is trained to eliminate or reduce identified risks. MRI staff are familiar with proper screening procedures for all patients and staff (*i.e. ferrous objects, metallic implants and devices*) and trained to recognize when patients display signs of claustrophobia, anxiety, or emotional distress.

~~LD.04.01.07 EP1~~—Development and Management of Policies and Procedures

The Safety Officer follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department heads with the development of department or job-specific environmental safety procedures and controls.

The organization-wide policies and procedures and controls are available to all departments and services on the organizational intranet. Departmental procedures and controls are maintained by department directors. The department directors are accountable for ensuring that all staff are familiar with organizational, departmental, and appropriate job-related procedures and controls. Department Directors are also accountable for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is accountable for implementing the policies, procedures and controls related to her/his work processes.

The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years.

The Safety Officer coordinates the reviews of policies and procedures with department heads and other appropriate staff.

~~EC.02.01.01 EP5~~PE.01.01.01 EP3 – The hospital maintains all grounds and equipment

The Facilities Manager is responsible for managing the appearance and safety of the hospital grounds. In addition, the Facilities Manager is responsible for assuring that the equipment used to maintain the grounds is in proper operating condition and that grounds staff is trained to operate and maintain the equipment.

The grounds include but are not limited to lawns, shrubs and trees, sidewalks, roadways, parking lots, lighting, signage and fences. External equipment includes but is not limited to mobile

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docking facilities, the oxygen storage facility, electrical service entrances and transformers, sewage and storm lift stations and equipment yards. Sierra View Medical Center does not provide any patient care, treatment, or services outside of hospital buildings. There are no patient activity areas outside of hospital buildings that require supervision by hospital staff.

The Facilities Manager is responsible for scheduling the work required to maintain the appearance and safety of hospital grounds. The Engineering staff and Security Officers make regular rounds of the grounds to identify unsafe conditions. The Security Supervisor and Engineering staff reports all deficiencies to the Facilities Manager for appropriate action.

~~EC.02.01.01 EP11~~—The hospital responds to product notices and recalls

The Manager of the Environment of Care and the Director of Materials Management coordinates a product safety recall system. The system is designed to quickly assess safety recall notices; to respond to those that affect Sierra View Medical Center; and to assure all active safety recalls are completed in a timely manner.

A quarterly report of safety recall notices that required action to eliminate defective equipment or supplies from Sierra View Medical Center is presented to the Environmental Safety Committee by the Manager of the Environment of Care and the Director of Materials Management.

~~EC.02.01.03 EP1~~—The hospital prohibits smoking except in specific circumstances

Sierra View Medical Center has developed a Tobacco Free Environment policy. The policy prohibits the usage of any tobacco product (i.e.: cigarettes, cigars, pipe, chewing tobacco, e-cigarettes) in any hospital building or grounds by all, including staff, visitors and patients.

Sierra View Medical Center has identified alternatives to tobacco products that are offered to all. Sierra View Medical Center has developed tobacco replacement product resources to assist staff and patients with smoking cessation as desired.

The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.

~~EC.02.01.03 EP6~~—The hospital takes action to maintain compliance with its smoking policy

The procedures for managing the use of smoking materials are followed and enforced by all leadership and staff.

~~EC.04.01.01 EP1—EP11~~—The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with Risk Management

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to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the Chief Executive Officer, Board of Directors and Senior Leadership as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies, including identification of opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and the Facilities Manager, who represents each of the seven management of the environment of care functions, use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement/Patient Safety Committee prepare quarterly reports to the leadership of Sierra View Medical Center. The quarterly reports summarize key issues reported to the Committees, with their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure Hospital leaders that management responsibilities have been carried out.

~~EC.04.01.01-EP15~~—Every twelve months, the hospital evaluates each environment of care management plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with the Environment of Care functions.

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The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement.

Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes.

The annual evaluation is distributed to the Chief Executive Officer, Board of Directors, Senior Leadership, the Performance Improvement/Patient Safety Committee and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

~~EC.04.01.03-EP2~~—Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement.

Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

~~EC.04.01.05-EP1~~ Improving the Environment

When the Senior Leadership or the Vice President of Quality and Regulatory Affairs concurs with the Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the

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timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital administration, performance improvement, and patient safety leadership.

GOAL:

- Continue working- to lower the OSHA Lost Workday Injury/Illness Quarterly Rate to the 50th percentile in the Osborne Engineering Benchmarking Database. The current rate is the ~~93rd percentile~~. 79th percentile. *Although we saw a significant drop we did not meet our goal of the 50th percentile*

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2HR.11.03.01 EP1 - 5
Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate.

The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with participation from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment.

The Human Resources Department, with participation from the Education Department, maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job-related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job-related orientation and continuing education programs. The content and supporting materials used for

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general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each EC program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work. In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *BOARD OF DIRECTORS, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, CONTRACTED SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (202~~65~~). Hospital accreditation standards. ~~EC.01.01.01-EP4~~ Joint Commission Resources. Oak Brook, IL.
- The Joint Commission (202~~63~~). Laboratory & Point-of-Care standards. ~~EC.04.01.01, EP1~~ Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- [WORKPLACE VIOLENCE PREVENTION PLAN](#)

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I. EXECUTIVE SUMMARY

Each environment of care poses unique security risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Security Management Program is designed to identify and manage the security risks of the environments of care operated and owned by Sierra View Medical Center (SVMC). The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. A security management program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for a Secure Environment describes the security risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the security of patients, staff, and other individuals coming to the organization's facilities. The management plan and the Security Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Wound Healing Center, Urology Clinic, Clinical Lab., Sierra View Community Health Clinic and Medical Office Building of Sierra View Medical Center. The Security Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted services of Sierra View Medical Center.

II. PRINCIPLES

- A. Security is a system made up of human assets and technology.
- B. Visible and clandestine components of the system are used to reduce the potential for criminal activity, the threat of workplace violence, and to increase feelings of security among patients, staff, and others coming to Sierra View Medical Center.
- C. Initial and ongoing assessment of security threats is essential for timely identification of changes in the types of security threats facing Sierra View Medical Center.
- D. Collection and analysis of information about adverse security events provides information to help predict and prevent personal violence, crime, and other incidents.
- E. Staff awareness of security is an essential part of an effective program. Sierra View Medical Center orients and trains all staff to the security program and to techniques for managing security risks related to work areas or daily activities.

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III. OBJECTIVES

- A. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Sierra View Medical Center.
- B. Perform additional risk assessments when changes in the campus design or patterns of security events indicate a change in the security threat level.
- C. Analyze security incidents and occurrences to identify root cause elements of them.
- D. Conduct ongoing random security patrols in all areas of the hospital, affiliated medical practices, and outpatient facilities. Staff making rounds evaluates the physical environment, equipment, and work practices. Rounds are conducted in all support areas and all patient care areas at least once per day.
- E. Present reports of Environment of Care management activities to the Environmental Safety Committee quarterly. The reports identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified security issues. The Safety/Security Officer coordinates the documentation and presentation of this information.
- F. Assure that all departments have current organization-wide and department-specific procedures and controls designed to manage identified security risks.
- G. Review the risks and related procedures and controls at least once every three years to assure that the security program is current.
- H. Assign qualified individuals to manage the program and to respond to immediate security threats.
- I. Perform an annual evaluation of the management plan and of the scope, objectives performance and effectiveness of the security program.
- J. Design and present security education and training to all new and current employees, volunteers, members of the medical staff, contract staff and others as appropriate.
- K. Provide timely response to emergencies and requests for assistance.
- L. Communicate with law enforcement and other civil authorities as needed.

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- M. Manage access to the grounds, buildings, and sensitive areas of Sierra View Medical Center.

IV. PROGRAM MANAGEMENT STRUCTURE

- A. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Security Program from the Environmental Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety/Security Officer.
- B. The Board of Directors collaborates with the Chief Executive Officer and other Senior Leadership to assure budget and staffing resources are available to support the Security Program.
- C. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Security program. The Chief Executive Officer collaborates with the Safety Officer and other appropriate staff to address security issues and concerns. The Chief Executive Officer also collaborates with the Safety/Security Officer to develop a budget and operational objectives for the Security Program.
- D. The Safety/Security Officer works under the general direction of the Chief Executive Officer or designee. The Safety Officer, in collaboration with the Environment of Care/Safety and Security Manager, is responsible for managing the Security Program. The Safety/Security Officer reports program findings to the Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other security issues.
- E. Department Directors are responsible for orienting new staff members to the department and job and to task specific security procedures. The orientation and ongoing education and training emphasize patient safety. Department Directors are also responsible for participating in the reporting and investigation of incidents occurring in their departments.
- F. Individual staff members are responsible for learning and following job and task specific procedures for secure operations.

V. ELEMENTS OF THE SECURITY PLAN

~~EC.01.01.01 EP1~~—Appointment of Security Leadership

The Chief Executive Officer of Sierra View Medical Center appoints the Safety Officer, and selects a qualified individual capable of overseeing the development, implementation and monitoring of the security program.

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The Safety Officer coordinates the development and implementation of the security program and assures it is integrated with the patient safety, information management, and other programs as appropriate. The Safety Officer job is defined by a job description. The Chief Executive Officer or designee evaluates the competence of the Safety/Security Officer annually.

The Safety Officer maintains a current knowledge of laws, regulations, and standards of security. The Safety Officer also continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of Sierra View Medical Center.

The Emergency Management program includes specific response plans for Sierra View Medical Center that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate Incident Commander is appointed at the time that any emergency response is implemented.

The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations pose an immediate threat to patients, staff, physicians, or visitors, or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

The Chief Executive Officer has appointed the Safety Officer, the Nursing House Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

EC.01.01.01 EP5NPG.11.01.01 – Management Plan for a Secure Environment

The Security Management Program is described in this management plan. The Security Management Plan describes the policies, procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse security event.

EC.02.01.01 EP1 – Proactive Risk Assessment

The Safety Officer of Sierra View Medical Center performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others.

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The Safety Officer works with Department Directors and Managers, the Patient Safety Officer, Risk Coordinator, the Vice President of Quality and Regulatory Affairs and others as appropriate.

EC.02.01.01-EP3NPG.11.01.01 – The hospital takes action to minimize or eliminate identified security risks in the physical environment

The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner.

LD.04.01.07-EP1—Development and Management of Policies and Procedures

The Safety Officer follows the administrative policy for the development of organization-wide and department-specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department heads with the development of department or job specific environmental safety procedures and controls.

The organization wide policies, procedures and controls are available to all departments and services on the organizational intranet. Departmental policies, procedures and controls are maintained by Department Directors. The Department Directors are responsible for ensuring that all staff is familiar with organizational, departmental, and appropriate job-related policies, procedures and controls. Department Directors are also responsible for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is responsible for implementing the policies, procedures and controls related to her/his work processes.

The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years. The Safety Officer coordinates the reviews of procedures with department heads and other appropriate staff.

EC.02.01.01-EP7NPG.11.01.01 – Identification of Patients, Staff, and Others Entering the Facility

The identification of staff is an interdisciplinary function. Several Directors share responsibility for designing identification systems and establishing procedures and controls to maintain the effectiveness of the systems.

The current systems in place at Sierra View Medical Center include photographic ID badges for all staff, volunteers, students, contracted staff and members of the medical staff, password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing/badges to facilitate rapid visual recognition of critical groups of staff.

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The identification of patients is also an interdisciplinary function. The current system includes personal identification of patients in medical records and by use of various arm band systems. It also includes functional identification of patients who are fall risks, have allergies to medications or nutritional products, have DNR orders or Advance Directives, who are undergoing surgery, who are receiving blood or blood products, and who are security risks.

The identification of others entering Sierra View Medical Center is managed by the Security and Materials Management Departments. The Safety Officer, in collaboration with the Chief Executive Officer and other appropriate staff, manages the procedures for identification of contractors and visitors. The Director of Materials Management manages the procedures for identification of vendors. The Safety Officer takes appropriate action to remove unauthorized persons from areas and to prevent unwanted individuals from gaining access to Sierra View Medical Center.

Sierra View Medical Center requires all guests/visitors on Sierra View Medical Center premises to wear authorized colored identification wristbands indicating the date and the area or department they are visiting or rendering services from:

- White – Radiology/Lab General Areas
- Orange – Distinct Part Skilled Nursing Facility (DPSNF)
- Purple – Radiology/Cath Lab
- Yellow – Emergency Department
- Blue – Post Anesthesia Care Unit (PACU)/Surgery
- Red – Intensive Care Unit (ICU)/Telemetry
- Green – Medical Surgical Unit
- Pink – Women's Services

EC.02.01.01 EP8NPG.11.01.01 EP1 – Identification and Management of Security Sensitive Areas

The Safety Officer is responsible for identifying security sensitive areas, and controls access to and from the security sensitive areas.

The following areas have been designated as sensitive areas:

- Cashiers Window
- Emergency Department
- Human Resources
- Labor & Delivery

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- Women's Services
- Pharmacy
- Information Services
- Health Information Management (HIM)
- Medication Rooms
- OTHERS as deemed necessary

Staff in each sensitive area participates in intensive training addressing the unique risks of the area and the procedures and controls in place to manage them. The Safety Officer assesses the need for reinforcement of department level education on an annual basis.

EC.02.01.01 EP9NPG.11.01.01 EP2 – Management of Security Incidents Including an Infant or Pediatric Abduction

The Safety Officer has developed procedures for rapid response to breaches of security. The on-duty Security Officers and local police have the manpower and technological resources to respond to a wide variety of incidents. The Safety Officer or a designee is responsible for assessing breaches of security and determining what resources are required to respond effectively.

The responding officers use appropriate written procedures and techniques, including use of force, to bring security incidents under control and to restore order.

The Safety Officer and the Vice President of Patient Care Services are responsible for the design and management of systems to reduce the threat of abduction of infants or children and to respond to any threats of or actual abductions.

The Safety Officer and the Clinical Directors of Neonatal and Pediatric Services are required to conduct at least one abduction drill annually. In addition, activations of the abduction alert system and all attempted or actual abductions of infants or children are treated as security incidents and reported and analyzed appropriately.

EC.04.01.01 EP1 – EP11—The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

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Incident reports are completed by the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Environment of Care Safety Committee Chairperson provides summary information related to incidents to the Chief Executive Officer and other leaders, including the Board of Directors, as appropriate.

The Safety Officer works with the Security Supervisor and the Safety Committee to collect information about Security deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven environments of care use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.

The Safety Officer and the Performance Improvement/Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

~~EC.04.01.01-EP15~~—Every twelve months the hospital evaluates each environment of care management plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives,

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performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources.

The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of the Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of the Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Performance Improvement/Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

~~EC.04.01.03-EP2~~—Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule.

The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

~~EC.04.01.05-EP1~~—Improving the Environment

When the Board of Directors, Senior Leadership or Quality and Patient Safety concurs with the Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

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The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to the Board of Directors, Senior Leadership and Quality and Patient Safety leadership.

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GOAL:

~~Continue working~~Work to reduce the number of Incidents of Automobile Thefts/100,000 Square Feet of Parking Area to the 50th percentile in the Osborne Engineering Benchmarking Database. The current rate is the 83rd 87th percentile. *Meet with Security leadership to discuss a new strategy to bring down the number*

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~~HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2~~HR.11.03.01 EP1 - 5
– Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, contract staff, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as contract staff, volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses the changes to the policies, procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department and the Education Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job-related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related

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orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work. In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: BOARD OF DIRECTORS, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, CONTRACTED SERVICES AND STAFF

REFERENCES:

- The Joint Commission (2026~~5~~). Hospital accreditation standards. ~~EC-01.01.01-EP5~~[NPG.11.01.01](#)
Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- [WORKPLACE VIOLENCE PREVENTION PLAN](#)

SUBJECT:
~~HOSPITAL SERVICE EXCELLENCE TEAMS –~~
~~PARTICIPATION AND GUIDELINES~~

SECTION:
Housewide Policy
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PURPOSE:

To identify the purpose and criteria for employee participation on SVMC's hospital service excellence teams. ~~Service Excellence Teams (SET) include the Awards and Recognition Committee, The Culture Team, The EPPEC Team and The Wellness Committee.~~ are designed based on business needs and can be established at anytime by the SLT members.

POLICY:

Service Excellence Teams are designed to enhance the overall morale and offer staff a fun, engaging and healthy workplace. Each ~~service team SET~~ will focus on events, activities, and initiatives which support SVMC's mission, vision and values. Each SET will have a VP-level executive sponsor.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

To be eligible to participate on a SVMC ~~Service Team~~ SET staff members must meet the following criteria:

- ~~In addition to being employed~~ Newly hired staff must complete at SVMC for at least six months of employment.
- ~~employees serving on a service team who transfer into a new position must get permission from their new leader to remain on the service team. Employees~~ Staff must be able to demonstrate success in their position and be viewed as a role-model of SVMC's values to be considered to participate on a service team. If a staff member is placed on a written level a notice of corrective action, the Director/Manager leader will ask their staff member to step down from their respective SET team and the Director/Manager leader will notify the SET executive sponsor. The staff member, if no further notice of corrective actions are issued can be re-considered for a SET after six (6) months from the NOCA.
- ~~No disciplinary actions including attendance resulting in a Notice of Corrective Action within the last six months from date of request to join a service team. Service members who receive a NOCA during their tenure on the service team will be removed from the team and can be considered to rejoin the team after 6 months of the NOCA and approval from their leader.~~
- Staff can self-select to join a team if they meet the above criteria with leadership approval and/or be recommended to join a team from their leadership team member.
- Existing staff serving on a service team who transfer into a new position Can remain on the SET with the approval of their new department leadership.

SUBJECT:

**HOSPITAL SERVICE EXCELLENCE TEAMS –
PARTICIPATION AND GUIDELINES**

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- Service on a team is not established for any certain period of time. As long as the staff member remains in good standing and continues to want to serve, they are afforded this opportunity.
~~Employees who are already serving on a service team and transfer into a new position must get permission from their new leader to remain on the service team.~~
- Staff may only serve on one (1) service team at a time.

At any point during the employee's tenure on a team, if any of the above listed criteria have not been met, the employee's membership will be withdrawn from the service team. This will be done discreetly and ~~confidentially~~confidentially, with the assistance of the staff member's ~~Service Team Executive Sponsor~~SET executive sponsor.

Time spent by employees performing tasks for their respective teams will be considered to be "hours worked" and employees will be paid at their base rate of pay. ~~Service on a SET is not intended to result in receiving overtime pay. Employees may not spend time performing tasks for their teams in a manner that would result in receiving overtime pay due to working more than 40 hours in a work week.~~ To avoid working greater than 40 hours in a work week, employees may be permitted to flex their scheduled hours, with prior authorization from the employee's respective department ~~Director/Manager~~leadership, based on the needs of the department. ~~Any employee who violates this provision of the policy will be subject to disciplinary action and removal from the team.~~

REFERENCES:

- PERSONAL CONDUCT
- PERFORMANCE ACCOUNTABILITY AND COMMITMENT
- ATTENDANCE AND PUNCTUALITY

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I. EXECUTIVE SUMMARY

The Environment of Care and the range of patient care services provided to the patients served by Sierra View Medical Center present unique challenges. The specific utility system risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Utility Systems Management Plan based on various risk criteria, including risks identified by outside sources such as the Joint Commission, is used to eliminate or reduce the probability of adverse patient outcomes.

The Utility Systems Management Plan describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the organization's facilities. The Management Plan and the Utility Systems Management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center (SVMC), Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Clinical Lab, Wound Healing Center, Urology Clinic, Sierra View Community Health Center, ~~Surgery Clinic~~ and Medical Office Building of Sierra View Medical Center. The Utilities Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted services of Sierra View Medical Center.

II. PRINCIPLES

- A. Utility systems play a significant role in supporting complex medical equipment and in providing an appropriate environment for provision of patient care services.
- B. Orientation, education, and training of operators, users, and maintainers of utility systems is an essential part of assuring safe, effective care and treatment are rendered to persons receiving services.
- C. Assessment of needs for continuing technical support of utility systems and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that the systems are safe and reliable.

III. OBJECTIVES

Design, operate and maintain utility systems serving the buildings that house the healthcare services of Sierra View Medical Center to provide a safe, comfortable, appropriate environment that supports patient care and business operations.

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Perform recommended maintenance to maximize system service life and reliability.

Manage the Utility Systems Management program to assure compliance with the Joint Commission requirements.

IV. PROGRAM MANAGEMENT STRUCTURE

- A. The Facilities Manager assures that an appropriate utility system maintenance program is implemented. The Facilities Manager also collaborates with the Safety Officer to develop reports of Utility Systems Management performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other utility systems issues.
- B. The Hospital's Board of Directors receives regular reports of the activities of the Utility Systems Management program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Facilities Manager and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer and other Senior Leaders to assure budget and staffing resources are available to support the Utility Systems Management program.
- C. The Hospital's Chief Executive Officer receives regular reports of the activities of the Utility Systems Management program. The Chief Executive Officer collaborates with the Facilities Manager and other appropriate staff to address utility system issues and concerns. The Chief Executive Officer collaborates with the Facilities Manager to develop a budget and operational objectives for the program.
- D. The facility maintenance technicians, and selected outside service company staff, schedule and complete all calibration, inspection, and maintenance activities required to assure safe, reliable performance of utility systems in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
- E. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

V. PROCESSES OF THE UTILITY SYSTEMS PLAN

EC.01.01.01-EP9PE.04.01.03 – Plan for the Safe, Reliable, Effective Operation of Utility Systems

The Utility Systems Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other individuals coming to the facilities of Sierra View Medical Center may experience an adverse event while being monitored, diagnosed, or treated

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with any type of medical equipment or being housed in an environment supported by the utility systems of Sierra View Medical Center.

~~EC.02.05.01 EP1~~—Design and Installation of Utility Systems

The Facilities Manager works with qualified design professionals, project managers, and the intended end users of the space of Sierra View Medical Center to plan, design, construct, and commission utility systems that meet codes and standards and the operational needs of the patient care and business activities of Sierra View Medical Center. The construction and commissioning procedures are designed to assure compliance with codes and standards and to meet the specific needs of the occupants of every space. In addition, the design process is intended to assure performance capability meets current needs and sufficient additional capacity is available to manage unusual demands and to help assure that future demands on utility systems can be met.

~~EC.02.05.01 EP3~~—Developing an Inventory of Utility Systems and Equipment

All utility systems' components and equipment are included in a program of planned calibration, inspection, maintenance, and testing. The components and equipment are inventoried at the time of installation and acceptance testing. The inventory is maintained on an ongoing basis by the Plant Operations staff. The inventory includes utility system equipment maintained by the Engineering and Maintenance staff and equipment maintained by vendors.

~~EC.02.05.01 EP4~~—Determining System Risk

The Facilities Manager identifies high-risk, operating components of utility systems on the inventory for which there is a risk of serious harm or death to a patient or staff member should the component fail. High-risk, operating components of utility system include life-support equipment.

~~EC.02.05.01 EP5 & EP6~~—Inspection, Testing, and Maintenance Intervals

The Facilities Manager uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.

A computerized maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.

The Facilities Manager is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.

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~~EC.02.05.02 EP1~~—~~4PE.04.01.05~~ – Management of Water Systems

The Facilities Manager and the Manager of Infection Control are responsible for identifying needs for procedures and controls to minimize the potential for the spread of infections through or by the utility systems.

Each clinical care service and support service is evaluated to determine the potential for hospital-acquired illness. Each potential is further evaluated to determine what role physical barriers and utility systems can play in contributing to or minimizing the potential.

The Facilities Manager and the Manager of Infection Control are responsible for developing procedures and controls to manage any identified potential for growth and/or transmission of pathogenic organisms in the domestic hot water system, cooling tower water, and other potential sources of waterborne pathogens.

The procedures may include periodic testing or treatment to control the risk and to inhibit the growth and spread of waterborne pathogens.

~~EC.02.05.01 EP15 & EP16~~—Management of Ventilation Systems

The Facilities Manager and the Manager of Infection Control are responsible for designing procedures and controls for monitoring the performance of air handling equipment. The procedures and controls address maintenance of air flow rates, air pressure differentials in critical areas, and managing the effectiveness of air filtration systems.

Air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by Plant Maintenance.

The performance of all new and altered air management systems is verified by a qualified service provider. At a minimum, flow rates and pressure relationships are measured as part of the commissioning of all new building projects and major space renovations.

Periodic measurements of air volume flow rates and pressure relationships are tested in sensitive areas throughout the hospital. When the measured system performance cannot be adjusted to meet code requirements or occupant needs, the Facilities Manager and Manager of Infection Control develops, when appropriate, a temporary Infection Control Risk Management plan to minimize the potential impact of the deficient performance.

~~EC.02.05.01 EP17~~—Mapping of Utility Systems

The Facilities Manager is responsible for maintaining up-to-date documentation of the distribution of all utility systems. The documents include as-built and record drawings, one line drawings, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations.

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Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on disc or on the Intranet server of the hospital.

~~EC.02.05.01 EP9~~—Labeling of Controls for System Shutdown and Recovery

The Facilities Manager is responsible for assuring that current documents showing the layout of utility systems and the locations of controls that must be activated to implement a partial or complete shut-down of each utility system are available at all times.

The documents must include the original layout of the systems and all modifications, additions, and renovations that affect the process for implementing a partial or complete shutdown of a system. The documents must include information that can be used to identify specific controls. The controls must be identified by a label, numbered tag or other device that corresponds to the information on the documents.

~~EC.02.05.01 EP9~~—13—Emergency Procedures

The Facilities Manager and appropriate clinical caregivers collaborate to identify life-critical medical equipment supported by the utility systems. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient dependent on the function of the equipment.

The Facilities Manager and the caregivers are responsible for developing appropriate resources to manage the response to the disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.

The resources must include, but are not limited to, information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.

Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job-related orientation process. All utility systems emergency procedures are reviewed annually.

~~EC.02.05.03 EP1~~—7 and ~~EC.02.05.07 EP1~~—10 PE.04.01.03 EP3 – Inspection, Testing, and Maintenance of Emergency Power Systems

The Facilities Manager is responsible for identifying all emergency power sources and for developing procedures and controls for inspection, maintenance, and testing to assure maximum service life and reliability. Sierra View Medical Center uses battery-powered lights, engine-

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driven generators, and large UPS stored energy systems to provide power for emergency lighting, operation of critical systems, and operation of information systems equipment.

Each required battery-powered emergency lighting device is tested for 30 seconds each quarter and for 90 minutes annually.

The Emergency Power Supply Systems (EPSS) supply power for emergency exits, patient ventilation, fire and life safety equipment, public safety, communications, data and processes that, if disrupted, would have serious life safety or health consequences. Each required EPSS system is tested in accordance with the code requirements for the class of device.

The Facilities Manager is responsible for assuring that appropriate inspection, maintenance, and testing of the essential electrical system is done. Each motor/generator set serving the emergency power system is tested under connected load conditions 12 times a year. All automatic transfer switches are tested as part of each scheduled generator load test.

Testing parameters are recorded and evaluated by the Plant Operations staff. All deficiencies are rectified immediately or a temporary secondary source of essential electrical service is put in place to serve the needs to critical departments or services until the primary system can be restored to full service.

If a failure during a planned test occurs, a full retest will be performed after appropriate repairs are made and the essential electrical system is functional again.

Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process specified by National Fire Protection Association (NFPA) 99, NFPA 101 and NFPA 110.

Batteries, fuel stored on site, controls, and other auxiliary emergency power equipment is inspected, maintained, and tested as required. The Facilities Manager, Engineering staff and contracted service providers are responsible for assuring the reliability of each component part of the emergency power systems by performing all required calibration, inspection, maintenance, and testing in a timely manner.

EC.02.05.05-EP2—Utility Systems Inventory and Initial Testing

The Facilities Manager establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by Sierra View Medical Center and leased or rented equipment.

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The Facilities Manager is responsible for implementation of the program of planned inspection and maintenance. All utility systems equipment is tested for performance and safety prior to use.

~~EC.02.05.05 EP4~~—Testing of High Risk Equipment

The Facilities Manager assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities Manager will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

~~EC.02.05.05 EP5~~—Testing of Infection Control Support Equipment

The Facilities Manager assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities Manager will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

~~EC.02.05.05 EP6~~—Testing of Non-High Risk Equipment

The Facilities Manager assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

~~EC.02.05.09 EP7~~—Medical Gas System Testing

All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection is done in accordance with the requirements of the 2012 edition of NFPA 99.

~~UM.EC.02.05.09 EP10~~—Modifying / Repairing Medical Gas Systems

When a new medical gas system is installed or an existing system is breached for any reason, the Facilities Manager coordinates certification of the system by a qualified service provider. The certification testing is done in accordance with the requirements of the 2012 edition of NFPA 99. The Facilities Manager maintains a permanent record of all certification testing.

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~~EC.02.05.09 EP11~~—Labeling & Accessibility of Medical Gas Controls

The Facilities Manager is responsible for assuring that all medical gas system control valves and monitoring stations are identified appropriately.

In addition, the Facilities Manager is responsible for assuring that each monitoring station and valve is accessible. Accessibility is evaluated during scheduled environmental tours. Deficiencies are reported to the appropriate manager for resolution.

~~EC.04.01.01 EP1—11~~—The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Administrative Director of Quality and Care, who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the Chief Executive Officer, Senior Leaders, and the Board of Directors, as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven environments of care use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

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The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement/Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

~~EC.04.01.01-EP15~~—Every twelve months the hospital evaluates each Environment of Care Management Plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, benchmarking programs, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities.

The findings of the annual review are presented to the Safety Committee by the end of the second quarter of the calendar year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Environmental Safety/Security Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, Senior Leadership, the Board of Directors, Department Directors, the Performance Improvement Patient Safety Committee, and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

~~EC.04.01.03-EP2~~—Analysis and actions regarding identified environmental issues

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UTILITY SYSTEMS MANAGEMENT PLAN

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The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1—Improving the Environment

When the Board of Directors, Senior Leadership, and the Vice President of Quality and Regulatory Affairs concurs with the Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

Goal:

Work with Engineering to search for opportunities to lower the Electricity Operating Cost (\$/sq.ft./qtr.). The facility is currently in the 96th percentile of the category in the Osborne Engineering Benchmarking database ~~find opportunities to conserve electricity throughout the facility. This will include changing of light fixtures and better management of timers for lighting and other equipment.~~

**~~HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2~~ HR.11.03.01 EP1 - 5
 – Orientation and Ongoing Education and Training**

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, contract staff and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their start date of employment. The Human Resources Department

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maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job-related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, and others as appropriate to develop content materials for general and job-related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care Program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work.

In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (202~~6~~⁵). Hospital accreditation standards. ~~EC.01.01.01-EP9~~PE.04.01.03 Joint Commission Resources. Oak Brook, IL.

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	09/02/2026
BOARD OF DIRECTORS APPROVAL	
	09/22/2026
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

**SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
September 22, 2026 BOARD APPROVAL**

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

	Pages	Action
I. <u>Policies:</u>		APPROVE
• Admission of a Newborn During the Night Shift	1-4	
• Boarder Newborns	5-7	
• Coroner Notification for Fetal Death	8-10	
• Critical Congenital Heart Disease Screening	11-16	
• Diabetic Patient During Labor, Delivery and Post-Partum	17-20	
• Drug Recall Procedure	21-23	
• Fall Prevention (Adult and Pediatric)	24-30	
• Guidelines for Determining Presence and Classification of Infection	31-57	
• Guidelines for Single Use Devices (Disposables), Reuse and Reprocessing of Patient Care Equipment	58-59	
• Guidelines for Waste Handling – Waste Management Program	60-63	
• Hospital-Approved Handwashing, Cleaning and Disinfectant Products	64-67	
• IV Extravasation – Neonates	68-70	
• Large for Gestational Age Infant	71-73	
• Management of Infant in the Isolette	74-77	
• MCH – Admission Criteria	78-79	
• Medications Restricted to Areas or Personnel	80-88	
• Photography of the Infant	89	
• Precautions for Antibiotic-Resistant Microorganisms	90-95	
• Standardized Procedure: Registered Nurses (RN) Ordering Lab Work for Radiology and Interventional Radiology (IR) Procedures	96-97	
• Small for Gestational Age Infant (SGA)	98-99	
• Sterile Products: Sterile Product Quality Assurance	100-114	
• Thrombolytic Therapy in Acute Ischemic Stroke	115-125	
• Tuberculosis Control Plan	126-153	
• Twins – Multiple Gestation	154-155	
• Verbal & Telephone Orders – Persons Permitted to Accept, Readback, and Authentication of	156-160	
• Vitamin K Injection for Vitamin K Deficiency Disease	161-163	
II. <u>Medical Staff Bylaws Revision</u>		
• Article XV Allied Health Professionals (Technical revision as current bylaws not consistent with Nurse Practice Act and Physician Assistant Board)	164-169	

SUBJECT: ADMISSION OF A NEWBORN DURING THE NIGHT SHIFT	SECTION: Page 1 of 4
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POLICY:

1. Function(s): To establish a standardized procedure to initiate Normal Newborn Orders for the admission and initial care of the normal, term newborn delivered by uncomplicated birth between 10:00 pm and 7:00 am.
2. Circumstances under which the Registered Nurse (RN) may initiate Normal Newborn Orders:
 - a. Setting: Maternal Child Health (MCH) Department
 - b. Supervision: Immediate supervision by the Pediatric Hospitalist on duty.
 - c. Condition: All newborns delivered at Sierra View Medical Center (SVMC) during the night shift; uncomplicated deliveries of mothers without perinatal or intrapartum risk factors.
 - d. Exclusions: Term infants born with complicated intrapartum or birth circumstances, infants less than 37 weeks gestation, infants exhibiting abnormal newborn behaviors and/or having APGAR scores of less than 8 at one and five minutes and less than nine at ten minutes.

PROCEDURE:

1. Definition: Registered Nurses responsible for the care of the neonate at the time of birth will utilize the following parameters to determine the need to notify the pediatrician for admission orders during the hours of 10:00 pm and 7:00am.
2. Data Base: Infants at the time of birth
 - a. Subjective: Any time the RN is concerned about the status of the newborn.
 - b. Objective:
 - Infant's mother is free of perinatal risk factors with uncomplicated labor and delivery
 - Infant's APGAR scores are 8-10 at one minutes, 8-10 at five minutes and 9-10 at ten minutes.
 - Infant exhibits no signs of respiratory, cardiovascular or anatomical abnormalities.
 - Infant vital signs are stable and within normal limits

SUBJECT: ADMISSION OF A NEWBORN DURING THE NIGHT SHIFT	SECTION: Page 2 of 4
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3. **Contraindications:**

- a. Unstable infants born with complications in mother's perinatal or intrapartum history, fetal distress, shoulder dystocia, vacuum or forceps-assisted delivery, and/or other birth trauma.
- b. Infants less than 37 weeks gestation
- c. Unstable blood glucose levels per Normal Newborn Orders
- d. Any time the infant exhibits:
 - Worsening condition
 - Temperature less than 97.5 or greater than 100.0 ° F (every ½ hour X 2)
 - Persistent pulse rate less than 95 or greater than 180
 - Persistent respiratory rate less than 30 or greater than 60
 - Oxygen saturation (via pulse oximetry) monitoring persistently less than 92% and/or requiring oxygen administration to maintain O2 saturation 92-96%

4. **Diagnosis: Normal Term Neonate**

5. **Plan: Evaluate the newborn at the time of delivery, assign APGAR score and complete admission assessment.**

a. **Treatment:**

- By 10:00 pm, notify Pediatric Hospitalist on duty or Pediatrician of expected delivery and provide information regarding the mother's perinatal history and intrapartum course and status.
- If infant meets Normal Newborn parameters, initiate Normal Newborn Orders (via order management) and notify admitting of infant's birth
- Notify Pediatric Hospitalist after 7:00am or at the time of physician rounds.
- Notify physician directly as needed if the infant's condition changes.

b. **Consultation Required: None**

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6. Documentation:
 - a. Electronic Medical Record (EMR): Record newborn's initial assessment with APGAR, admission assessment, medication administration, and routine care per unit protocol. All orders to be entered by the MCH RN utilizing the newborn admission order set with the order source of standardized procedure.
 - b. Document in EMR when and how the physician was notified of the infant's birth.
 - c. Document any follow-up concerns and physician notification as needed.

STAFF AUTHORIZED TO PERFORM THE STANDARDIZED PROTOCOL: RNs

REQUIREMENTS FOR ADMISSION OF NEWBORN DURING NIGHT SHIFT

1. Education: Licensed Personnel (RN)
 - a. Current California Registered Nurse License
 - b. Basic Life Support (BLS) and Neonatal Resuscitation (NRP) Provider Certification
 - c. Completion of the minimum RN competencies for the Labor & Delivery, Postpartum, Nursery/NICU
2. Training: As required by specific licensing board
3. Experience: N/A
4. Initial Evaluation: Upon orientation to Maternal Child Health Unit
5. Continuing Evaluation:
 - a. Maintains BLS and NRP provider certification
 - b. Completion of Maternal Child Health annual unit-specific clinical competencies.

DEVELOPMENT & APPROVAL of the STANDARDIZED PROCEDURE:

- A. **Method:** Interdisciplinary Committee & OB/GYN Department
- B. **Review Schedule:** Yearly

SUBJECT: ADMISSION OF A NEWBORN DURING THE NIGHT SHIFT	SECTION: Page 4 of 4
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REFERENCES:

California Board of Registered Nursing. (n.d.). *Nursing Practice Act*. Retrieved September 8, 2025, from <https://rn.ca.gov/practice/npa.shtml>

SUBJECT: BOARDER NEWBORNS	SECTION: Page 1 of 3
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PURPOSE:

To establish nursing guidelines in the care of boarder newborns

POLICY:

A boarder newborn is an infant who remains hospitalized after the birth parent or primary caregiver has been discharged and who continues to require medical observation, treatment, discharge planning, social services intervention, protective custody arrangements, feeding support, or other inpatient services. The infant does not require NICU-level care unless otherwise ordered by the provider.

1. Boarder status may apply when the birth mother is discharged, and
 - The infant requires continued inpatient medical treatment or observation.
 - The infant is medically stable but discharge is delayed due to social, legal, custody, or placement issues.
 - Child Protective Services/Child Welfare Services disposition is pending.
 - The birth mother has been discharged before the infant meets discharge criteria.
2. The baby should be changed to boarder status in the accommodations section of Meditech.

AFFECTED AREAS/ PERSONNEL: *MCH DEPARTMENT/NURSING STAFF*

PROCEDURE:

1. Obtain an order from the pediatrician for infant's status to be changed to "Boarder".
2. Unit Clerks will notify Admitting Department and Case Management that the infant's accommodation has been changed to "Boarder" along with current diagnoses.
3. Instruct parent(s), guardian(s), or caregiver(s) of desire for their participation in care while the infant remains in the hospital and arrange for times they can come to visit and care for the infant, or encourage parents to always remain with infant. If mother is breastfeeding and it is appropriate, instruct her in breast pumping, milk storage and transport to the hospital for the infant.
4. Provide an area where mother/parents can visit, care for, and feed infant.
5. Maintain ongoing communication with parents, guardians, and interdisciplinary team members regarding the infant's condition, treatment plan, discharge readiness, and anticipated discharge needs.

SUBJECT: BOARDER NEWBORNS	SECTION: Page 2 of 3
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6. Boarder newborns shall remain under continuous supervision within the newborn nursery or designated patient care area and shall be monitored in accordance with unit staffing plans, hospital security procedures, and standards of care.

Parent (s), guardian(s), or caregiver(s) ID bracelet must be matched with the infant's ID bracelet each time the parents visit.

DOCUMENTATION:

Document in the Electronic Medical Record (EMR) should include but is not limited to:

- Intake and output
- Vital signs as ordered
- *Parent (s), guardian(s), or caregiver(s)* visits
- Care provided by mother/parents when in unit
- *Parent (s), guardian(s), or caregiver(s)* response to teaching
- *Parent (s), guardian(s), or caregiver(s)* understanding of all care given to infant

The hospital recognizes the importance of maintaining the parent-infant relationship. Whenever feasible and safe, parents or designated caregivers shall be encouraged to participate in the infant's care, feeding, education, bonding, and discharge preparation during the boarder stay.

REFERENCES:

Association of Women's Health, Obstetric and Neonatal Nurses. (2024). *Standards for professional nursing practice in the care of women, newborns, and people across the life span* (9th ed.). Journal of Obstetric, Gynecologic & Neonatal Nursing. [https://www.jognn.org/article/S0884-2175\(23\)00246-0/fulltext](https://www.jognn.org/article/S0884-2175(23)00246-0/fulltext) [jognn.org]

Smith, V. C., Love, K., & Goyer, E. (2022). *NICU discharge preparation and transition planning: Guidelines and recommendations*. Journal of Perinatology, 42(Suppl 1), 7-21. <https://pmc.ncbi.nlm.nih.gov/articles/PMC9010297/> [pmc.ncbi.nlm.nih.gov]

Centers for Medicare & Medicaid Services. (2026). *42 CFR §482.43 Condition of participation: Discharge planning*. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.43> [ecfr.gov]

SUBJECT: BOARDER NEWBORNS	SECTION: Page 3 of 3
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Centers for Medicare & Medicaid Services. (2026). *Newborns' and Mothers' Health Protection Act (NMHPA)*. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpfa_factsheet [cms.gov]

Association of Women's Health, Obstetric and Neonatal Nurses. (2025). *Published resources and evidence-based clinical guidance*. <https://www.awhonn.org/resources-and-information/published-resources/>

SUBJECT: CORONER NOTIFICATION FOR FETAL DEATH	SECTION: 3 Page 1 of 2
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PURPOSE:

To establish nursing guidelines in cases of fetal demise by providing guidance for determining when notification of the County Coroner/Medical Examiner is required or appropriate.

POLICY:

- Maternal Child Health (MCH) staff and Registered Nurses (RNs) shall provide compassionate, family-centered nursing care following fetal demise and shall follow current California law, applicable county Coroner/Medical Examiner jurisdictional criteria, hospital policy, and Pathology procedures.
- When a fetal demise may fall within Coroner/Medical Examiner jurisdiction, the fetus, placenta, umbilical cord, membranes, and other potentially relevant specimens shall be preserved and handled according to Coroner/Medical Examiner instructions and applicable hospital chain-of-custody procedures.

AFFECTED PERSONNEL/AREAS: *MATERNAL CHILD HEALTH (MCH) STAFF; REGISTERED NURSES (RNs)*

PROCEDURE:

1. The RN shall notify the attending provider and follow the applicable County Coroner/Medical Examiner notification process when a fetal demise meets current county jurisdictional criteria or when the circumstances of the death create uncertainty regarding Coroner/Medical Examiner jurisdiction.
 - a. Fetal demises when a live birth has occurred or when the fetal demise is over 20 weeks and/or 17 ounces and/or 11 inches.
 - b. Fetal deaths when the underlying cause is unknown, including sudden, unexpected, or unusual deaths.
 - c. Deaths involving known or suspected criminal activity or a suspected criminal act, including suspected abuse or neglect.
 - d. Deaths following an accident, injury, or trauma, including old or new injuries that could have contributed to the death.
 - e. Deaths associated with drug addiction, accidental poisoning, or other circumstances identified by the County Coroner.
 - f. Other circumstances specifically identified by the County Coroner/Medical Examiner as falling within its jurisdiction.
2. The fetus and associated specimens should be handled according to Coroner/Medical Examiner instructions and institutional chain-of-custody procedures.

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 Page 2 of 2

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3. Products of conception that do not meet the above criteria may be handled as a surgical specimen. They are handled as follows:
 - a. Place in a container supplied by the pathology department and cover with formalin.
 - b. The physician completes a pathology requisition.
 - c. The specimen and requisition are delivered to the pathology area in the utility room. A patient face sheet, copy of the insurance information and an identification sticker must be with the specimen.
 - d. All specimens shall be labeled and transported in accordance with biohazard precautions and hospital policy.
 - e. Placenta, umbilical cord, and membranes should be retained whenever feasible pending determination of the appropriate pathology/coroner evaluation.
4. See policy "[FETAL DEMISE – CARE OF FETUS](#)" for fetal care guidelines.
5. The physician must:
 - a. Complete the fetal death certificate/report when required by California law for fetal deaths occurring at or beyond 20 weeks' gestation
 - b. Document clinical findings, suspected cause of death, and plan of care in the electronic medical record (EMR).
 - c. Discuss options for autopsy, placental pathology, and genetic testing with the family when appropriate.
 - Obtain required consents and follow hospital policy regarding autopsy authorization and financial approval processes.
 - If autopsy ordered by the physician, call Risk Management for approval of fees to be paid by hospital. If requested by family, they are responsible for costs and refer them to discuss with mortuary.

NURSING DOCUMENTATION IN EMR:

- Document all findings related to mother/fetus outcomes.
- Document date and time of Corner Notification.
- Disposition of fetus/surgical specimen in the mother's chart including name of mortuary.
- The mortuary will complete the death certificate if not completed by the physician.
- All specimens retained, released, or transferred and the receiving party.

SUBJECT:
CORONER NOTIFICATION FOR FETAL DEATH

SECTION:

Page 3 of ³2

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REFERENCES:

- American College of Obstetricians and Gynecologists. (2020). *Management of stillbirth* (Obstetric Care Consensus No. 10). *Obstetrics & Gynecology*, 135(3), e110-e132.
<https://doi.org/10.1097/AOG.0000000000003700>
- American College of Obstetricians and Gynecologists. (2024). *Supporting patients through stillbirth care: Toolkit for health care professionals*. <https://www.acog.org/education-and-events/publications/supporting-patients-through-stillbirth-care-toolkit-for-health-care-professionals>
- California Health and Safety Code § 102950. (2026). *Duty of registering fetal death*. California Legislative Information.
https://leginfo.ca.gov/faces/codes_displaySection.xhtml?sectionNum=102950&lawCode=HSC
- Centers for Disease Control and Prevention. (2024, May 16). *California coroner/medical examiner laws*. Public Health Law Program. <https://www.cdc.gov/phlp/php/coroner/california.html>
- County of Tulare Sheriff's Office. (n.d.). *Coroner information*.
<https://tularecounty.ca.gov/sheriff/media/coroner-information/>
- National Center for Health Statistics. (2024). *Guidelines for reporting live births, infant deaths, fetal deaths, and induced terminations of pregnancy*. Centers for Disease Control and Prevention.
<https://www.cdc.gov/nchs/data/nvss/reporting-guidelines-decision-tree.pdf>

SUBJECT: CRITICAL CONGENITAL HEART DISEASE SCREENING	SECTION: Page 1 of 6
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PURPOSE:

To facilitate the early detection of critical congenital heart disease (CCHD) by identifying those newborns with structural heart defects that are usually associated with hypoxia in the newborn period with the utilization of routine pulse oximetry screening of all eligible newborns.

POLICY:

All eligible newborn infants will be screened for CCHD prior to discharge with the use of pulse oximetry to identify pre and post-ductal low blood oxygen saturation. Eligible newborns include all live newborns delivered at or admitted to the unit except for newborns where the CCHD pulse oximetry screen has been determined not medically applicable. The CCHD pulse oximetry screen is **not** medically applicable for the following newborns:

- CCHD has been ruled out or diagnosed with an echocardiogram
- Newborn was diagnosed with CCHD prenatally

Screening will be performed on all other newborns unless the newborn is transferred to another facility at <24 hours of age.

The primary targeted conditions for screening identification include: hypoplastic left heart syndrome, pulmonary atresia, tetralogy of fallot, total anomalous pulmonary venous return, transposition of the great arteries, tricuspid atresia and truncus arteriosus. A passing (negative) screen does not exclude the possibility of CCHD.

A physician's order is not required for pulse oximetry screening of the newborn for CCHD.

Qualified / Applicable Personnel: *MCH DEPARTMENT/ RNs*

Screening may be performed by a registered nurse (RN) or respiratory care practitioner (RCP) as appropriate and results documented in the medical record. If RCP performing the screening, results must be reported to the RN assigned to infant.

DEFINITIONS:

CCHD: Critical Congenital Heart Disease, most severe form of congenital heart disease.

RH: Right Hand

PROCEDURE:

SUBJECT: CRITICAL CONGENITAL HEART DISEASE SCREENING	SECTION: Page 2 of 6
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CCHD SCREENING OF NEWBORNS

Equipment:

- Pulse oximeter-FDA approved for infants.
- Reusable or disposable pulse oximeter probe

Process:

- Routine pulse oximetry screening will be initiated after the eligible newborn is at least 24 hours of age and prior to discharge. If the newborn is on oxygen or respiratory support the screen will be performed at least 24 hours after the infant has been weaned from oxygen as long as the newborn is still eligible for screening (see Eligibility for Screening Algorithm attachment). *Key Point: Ideally all eligible newborns are to be screened when they are 24-48 hours of age. Key Point: If the newborn is being discharged home on oxygen, obtain an echocardiogram (if no prior echocardiogram was obtained during this hospitalization).*
- Infant should be on room air, warm, alert, calm and screen completed in a quiet environment. Avoid screening infant during a period of deep sleep. *Key Point: Consider bundling CCHD screening with other routine screening such as the hearing screen.*
- Inform parents about screening procedure and purpose. Provide parent education material for review.
- The initial screen may be completed by an RCP with results reported to the RN. *Key Point: Any follow-up screens will be performed by the RN staff only.*
- Select testing sites on the right hand and one foot that are clean and dry.
- Select correct disposable pulse oximetry probe according to patient weight (kg). *Key Point: Following screen, any disposable probes used will be recycled per hospital standards.*
- Obtain a pulse oximetry reading at each site, RH and foot, either at the same time or one after another (within a 5-minute time period). *Key Point: Evaluate pulse oximetry reading for at least 30 seconds to ensure that the device is appropriately tracking the baby's pulse rate.*
- Document the pulse oximetry readings in the medical record and report findings as indicated.
- Utilize Pulse Oximetry Screening Algorithm attachment to interpret results OR Any screening where the oxygen saturation is 95% or higher in the RH or Foot and there is 3%

SUBJECT: CRITICAL CONGENITAL HEART DISEASE SCREENING	SECTION: Page 3 of 6
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difference or less between the RH and Foot, this is considered a negative or passed screen and screening is complete.

- Any screening where the oxygen saturation is less than 90% in either the RH or Foot this is considered a positive or failed screen and requires immediate assessment and physician follow-up to rule out CCHD. Infant should remain on pulse oximetry and monitoring continued until instructed otherwise by the physician.
- Any screening where the saturation is between 90-94% in both the RH and Foot or there is 4% or more difference between the RH and Foot on three different measures, each separated by minimum of one hour is considered a positive or failed screen and requires follow-up to rule out CCHD.
- If the initial screen indicates an oxygen saturation of 90-94% in both the RH and Foot or there is 4% or more difference between the RH and Foot initiate follow-up as follows:
 - a. Nurse will assess the newborn and notify the physician caring for the newborn of the results of the initial screen.
 - b. Nurse will plan and perform a repeat pulse oximetry screen in 1 hour; all follow-up screens will be completed by RN staff.
 - c. If readings persist on the second screen this indicates a final positive or failed screen.
 - d. Notify physician of failed screen. COPY
 - e. If during the second screen the newborn has a pulse oximetry screen where the saturation is 95% or higher in either the RH or Foot with a 3% difference or less between the RH and Foot this is considered a final negative or passed screen and screening is complete. The nurse will notify the physician of the final screen results.
 - f. If during the second screen the newborn has a pulse oximetry screen where the saturation is less than 90% in either the RH or Foot this is considered a final positive or failed screen; notify physician.

SUBJECT: CRITICAL CONGENITAL HEART DISEASE SCREENING	SECTION: Page 4 of 6
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Management Plan

- **Passed Screen (Negative)**
 - Document pulse oximetry readings, results, and the completion of screening in the medical record as well as parent/family education provided.
- **Failed Screen (Positive)**
 - Any newborn with a positive screen for CCHD requires a comprehensive evaluation by a physician for causes of hypoxemia including infectious and pulmonary pathology.
 - If no pathologic or pulmonary etiology for hypoxemia found, immediate echocardiogram interpreted by a pediatric cardiologist is indicated.
 - Document pulse oximetry readings, results, and the completion of screening in the medical record as well as parent/family education provided. (Pulse Oximetry Screening Algorithm attachment)

Patient/Family Education

1. Instruct family on rationale for screening and the need for this screening prior to discharge.
2. Provide patient/family hand-out “CCHD Screening Program: Frequently Asked Questions” in appropriate language (English or Spanish)
3. Inform parents of results of CCHD screening and implications of results.
4. If failed screen, review follow-up plan for infant as outlined by the physician. Reportable Conditions Report immediately to the physician any failed screen results.

SUBJECT:

**CRITICAL CONGENITAL HEART DISEASE
SCREENING**

SECTION:

Page 5 of 6**Printed copies are for reference only. Please refer to the electronic copy for the latest version.****REFERENCES:**

- American Academy of Pediatrics. (2025). Newborn screening for critical congenital heart disease: A new algorithm and other updated recommendations: Clinical report. *Pediatrics*, 155(1), e2024069667. [American Academy of Pediatrics](#). [1, 2, 3, 4]
- Centers for Disease Control and Prevention. (2025). *Clinical screening and diagnosis for critical congenital heart defects*. U.S. Department of Health and Human Services. [CDC CCHD Screening Guide](#). [1, 2, 3, 4]
- HealthyChildren.org. (2024). *Pulse oximetry screening to detect newborn critical congenital heart disease*. American Academy of Pediatrics. HealthyChildren Parent Guide. [1]
- Kenner, C., & Lott, J. (2022). *Neonatal nursing care handbook: An evidence-based approach to conditions and procedures* (3rd ed.). Springer Publishing Company.
- Verklan, M. T., Walden, M., & El-Metwally, D. (2021). *Core curriculum for neonatal intensive care nursing* (6th ed.). Elsevier.

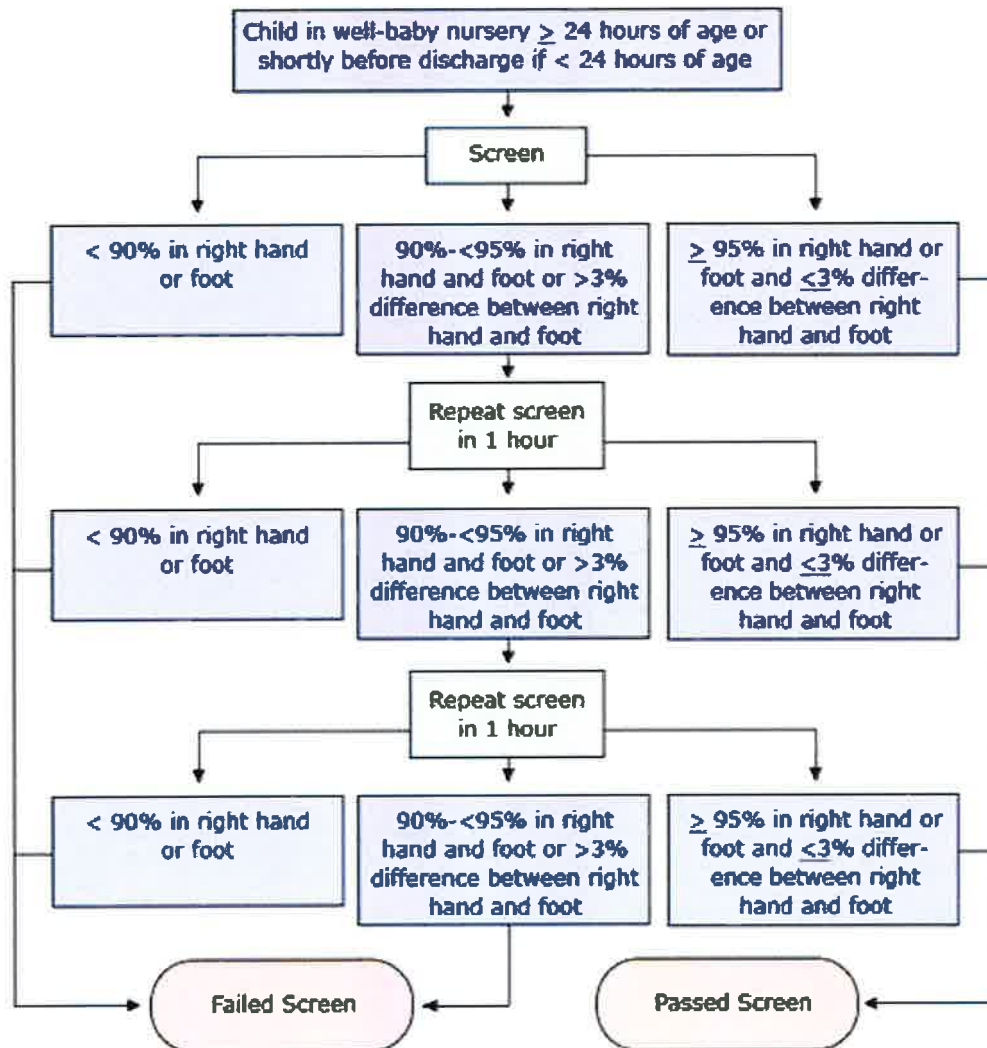
SUBJECT:
**CRITICAL CONGENITAL HEART DISEASE
SCREENING**

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Attachment A: Algorithm



SUBJECT: DIABETIC PATIENT DURING LABOR, DELIVERY AND POST-PARTUM	SECTION: Page 1 of 4
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PURPOSE:

To outline nursing priorities and care specific to the intrapartum patient with insulin-dependent diabetes.

POLICY:

Women with pregestational diabetes (type 1 or type 2) are at increased risk for maternal complications, including hypertensive disorders, infections, operative delivery, and postpartum hemorrhage. The fetus is at risk for congenital anomalies (especially cardiac and neural tube defects), macrosomia, neonatal hypoglycemia, preterm birth, and stillbirth. Intrapartum management focuses on maintaining maternal euglycemia (70–110 mg/dL) to reduce fetal and maternal complications, typically using frequent glucose monitoring and intravenous insulin as needed.

AFFECTED PERSONNEL: *MATERNAL CHILD HEALTH (MCH) STAFF, REGISTERED NURSES (RNs) AND LICENSED VOCATIONAL NURSES (LVNs)*

EQUIPMENT:

- Electronic fetal monitor
- Alaris IV Smart Pump
- Insulin syringes as indicated
- Blood Glucose Monitor and testing supplies

PROCEDURE:

1. Obtain Bedside Glucose Testing (BSGT):
 - a. On admission to the unit
 - b. Every 2 hours until active labor; then check BSGT every hour.
 - c. Every hour once placed on an IV insulin drip.
2. Observe and document intake and output hourly.
3. Assess skin at insulin injection sites for bruising or hypertrophy.
4. Examine feet for lesions, ulcers, lower extremity pulses.
5. Assess for signs or symptoms of Urinary Tract Infection (UTI) and/or Upper Respiratory Infection (URI).

SUBJECT: DIABETIC PATIENT DURING LABOR, DELIVERY AND POST-PARTUM	SECTION: Page 2 of 4
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6. Monitor signs/symptoms of hypoglycemia (cold, clammy skin, shaking, sweating, mental confusion or anxiety, light-headedness, pallor, numbness of tongue or lips).
7. Monitor for signs or symptoms of ketoacidosis: blood sugar greater than 220 mg/dl, presence of ketonuria, elevated beta-hydroxybutyrate, altered level of consciousness, Kussmaul's breathing (labored, deep breathing), acetone breath.
8. Mandatory continuous fetal monitoring.
9. Anticipate and prepare for assisted birth and possibility of shoulder dystocia at delivery.
10. Anticipate and prepare for a potentially high-risk newborn at delivery and possibility of need for full resuscitation. Notify pediatrician of diabetic mom admission for delivery.
11. If an insulin infusion is required: Use pre-mixed insulin, if unavailable consult with Pharmacy to compound (If Pharmacy is closed, the Nursing House Supervisor should be contacted for admixing.):
 - a. Infusion is always administered with the Alaris IV smart pump
 - b. Prime the infusion line thoroughly prior to administration.
 - c. Ensure that the patient has a patent IV with fluids infusing as ordered.
 - d. Insulin is a High Alert medication that requires the electronic co-signature of a second RN before administration of the drip.
 - e. Piggyback insulin into primary IV line at lowest possible port.
 - f. Target glucose range: 70 – 110 mg/dl (capillary blood).
 - g. Call covering provider if glucose values are either < 70 or > 180 on two consecutive readings
 - h. Titrate insulin according to ordered protocol.

*Discontinue insulin infusion at delivery.

*Vital signs should be assessed every 5-10 minutes during episodes of hypoglycemia including BSGT checks until the threshold of 70mg/dL is reached.

For planned inductions:

1. Give the usual subcutaneous insulin dose the evening before induction. Consider holding the AM dose if requested by the provider.

SUBJECT: DIABETIC PATIENT DURING LABOR, DELIVERY AND POST-PARTUM	SECTION: Page 3 of 4
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At delivery:

1. Discontinue insulin and glucose infusions immediately after birth as ordered.
2. Continue to check BSGT as ordered per provider.

Postpartum care:

1. Insulin requirements are usually lower than pre-pregnancy needs. The antepartum goals of glycemic control are usually relaxed.
2. Encourage breast feeding.
3. After delivery, the patient should be supplemented by short-acting insulin as determined by BSGT based off provider's order. .
4. Observe for signs or symptoms of infection, such as, mastitis, endometriosis, and wound infection and notify provider if they occur.
5. Monitor for signs or symptoms of postpartum hemorrhage, especially with those that have given birth to a macrosomic infant or have had prolonged or induced labors.

Laboratory Studies:

1. CMP or BMP and Urinalysis as ordered.
2. Additional labs as ordered.

EDUCATION:

1. Diabetes care should be reviewed with the patient and family, including blood glucose monitoring, urine testing for ketones, diet, and insulin administration.
2. Review medications, including side effects and dosing schedule.
3. Review signs and symptoms of hypoglycemia and hyperglycemia that the patient should immediately report.
4. Discuss labor plan of care, including need for continuous fetal monitoring and need for extra support personnel at delivery.
5. Provide patient specific discharge education instructions for diabetes self-care at home.

SUBJECT: DIABETIC PATIENT DURING LABOR, DELIVERY AND POST-PARTUM	SECTION: Page 4 of 4
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DOCUMENTATION:

1. All maternal and fetal assessments in the Electronic Medical Record (EMR).
2. All nursing and medical interventions and patient's response.
3. Insulin administration (requires 2nd RN for verification).
4. Time, indication, and results of glucose monitoring.
5. Provider notification, including indication and response.
6. Patient education

REFERENCES:

- American College of Obstetricians and Gynecologists. (2022). Gestational diabetes mellitus: Practice bulletin no. 223. *Obstetrics & Gynecology*, 140(3), e200–e211. <https://doi.org/10.1097/AOG.0000000000004665>
- American Diabetes Association. (2026). 12. Management of diabetes in pregnancy: Standards of care in diabetes—2026. *Diabetes Care*, 49(Suppl. 1), S216–S231. <https://doi.org/10.2337/dc26-S012>
- Schaefer-Graf, U. M., & Kautzky-Willer, A. (2021). Diabetes and pregnancy: Maternal and fetal outcomes. *Best Practice & Research: Clinical Obstetrics & Gynaecology*, 76, 1–14. <https://doi.org/10.1016/j.bpobgyn.2021.02.005>

SUBJECT: DRUG RECALL PROCEDURE	SECTION: <i>Medication Management (MM)</i> Page 1 of 3
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PURPOSE:

To provide a mechanism whereby potential drug hazards will be removed to protect the safety of patients at Sierra View Medical Center (SVMC).

POLICY:

Occasionally, drugs or pharmaceutical preparations may be recalled by the manufacturer, suppliers, or upon order of a regulatory body. Upon notification of such recall, a Pharmacist or designee shall immediately determine if the drug item is used by Sierra View Medical Center, and if so, shall remove all supplies of such drug from the pharmacy, nursing units, patient medication areas, and other areas where medications are located.

PROCEDURE:

A. Sterile Product Recall Procedure

1. A recall is received from the drug wholesaler, RASMAS-reporting software, Food and Drug Administration (FDA), Board of Pharmacy, Baxter or other reporting agencies.
2. The reported recall will include a manufacturer lot number.
3. A wholesaler report will produce information as to whether or not Sierra View Medical Center has received the affected lot as well as the date that the product was initially received by Sierra View Medical Center.
4. An electronic medical record (EMR) report will be generated that will note which patients had physician orders for the affected drug. The starting point for the search will be the time frame from when SVMC initially received the affected drug.
5. The IV compounding log is filed alphabetically by generic name and contains the manufacturer's lot number used in the preparation of the sterile product.
6. The IV compounding log will be manually searched for patients who received the drug with the affected lot number during the time frame identified by the EMR and McKesson reports.
7. Risk Management will be notified immediately of any patients who received the affected drug.
8. In the event of a pharmacy recall for a sterile product, the prescriber of the recalled drug and the Board of Pharmacy will be contacted within 12 hours of the recall notice.
9. In the event a compounded sterile product produces an ADR, a report to the BOP and FDA MedWatch will be made within 12 hours and immediately, respectively.

SUBJECT: DRUG RECALL PROCEDURE	SECTION: <i>Medication Management (MM)</i> Page 2 of 3
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- B. The specific steps taken in the event a manufacturer drug recall is issued:
1. A recall notice is received by any of the various reporting agencies, FDA, Board of Pharmacy (BOP), drug wholesaler (distributor).
 2. The Pharmacist in Charge/designee searches in Pyxis and in the Pharmacy and drug wholesaler purchasing history for all of the following areas.
 - a. Outpatient Areas (Ambulatory Surgery Department, Cancer Treatment Center, Wound Care, Urology, Academic Health Center, Surgery Clinic, Community Health Center, etc.)
 - b. Inpatient
 3. The pharmacy buyer and Pharmacist in Charge are responsible to assure removal of all the affected drugs by checking lot numbers or other criteria. This duty may be delegated to a Pharmacist or a designee.
 4. In the event where a medication is recalled due to safety reasons that are deemed a threat to life or limb, the prescribers will be immediately notified by the pharmacy.
 5. A Pyxis report and drug wholesaler buying history report is performed and attached to the recall notice.
 6. The drug is stored and sequestered into a designated area to await return to the appropriate source for destruction or return to manufacturer.
 7. The recall notice along with a recall check sheet is then filed for a period of three years.
 8. Quarterly or as needed or deemed necessary, the pharmacy will provide a summary of all recall activity to Medication Safety or Pharmacy and Therapeutics Committees for reporting purposes.
- C. On medication storage in the setting of temperature excursions
1. No medication or CSP will be dispensed or re-dispensed if it was not stored within the recommended range as established by the FDA or SVMC Pharmacy's master formula unless the manufacturer provides literature about how long the medication or CSP can deviate outside of the recommendation storage conditions.
 2. A CSP that is ineligible for dispensing or re-dispensing will be discarded.

DOCUMENTATION: Recall check sheet.

EDUCATION:

SUBJECT: DRUG RECALL PROCEDURE	SECTION: <i>Medication Management (MM)</i> Page 3 of 3
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- Patient, Family, Significant Other: N/A
- SVMC Staff: All pharmacy staff will receive education regarding the general medication recall policy.

REFERENCES:

- The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Pharmacy Law: California Edition. (2020) San Clemente, California: LawTech Publishing Group.

SUBJECT:
FALL PREVENTION (ADULT AND PEDIATRIC)

SECTION:
*Provision of Care, Treatment and
Services (PC)*

Page 1 of 8⁷

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PURPOSE:

To identify patients who may be at risk of falling and for the act of implementing the Fall Prevention Program to ensure a safer and protective environment for all patients.

DEFINITIONS:

1. **Fall** - a sudden, uncontrolled, unintended, assisted or unassisted event resulting in a person coming to rest on the ground/floor
2. **Unwitnessed Fall** - a report of a person who has landed or been found on the floor that is unwitnessed
3. **Fall Risk Screening Tool** - a documentation tool used to determine the level of fall prevention interventions initiated that are specific to each patient based on risk
4. **Risk Stratification** – for the purposes of this procedure, assigning a level of risk for a fall, based on an assessment of fall risk factors

POLICY:

The nurse will screen patients using the Fall Risk Screening Tool to determine patient risk and stratification for the risk of falling. This tool will be completed upon admission, and then once per shift. Additional considerations for assessing risks include but are not limited to, after any fall, post procedure as needed, upon transfer to another level of care as needed, or more frequently based on nursing judgment. When a patient is identified as “at risk”, patient-specific interventions will be implemented based on risk stratification. Patients who are comatose or completely immobile do not require fall risk interventions.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS*

EQUIPMENT:

- Yellow arm bands
- Yellow socks
- Yellow gowns
- Bed alarms
- Chair alarm
- Toilet alarm

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PROCEDURE:

- A. Pediatric patients three (3) years of age and younger, those who are not at developmental milestones/stages appropriate for age, and those with chronic medical conditions are considered at “high risk” for falls. As such, the Fall Risk Screening Tool does not need to be completed each shift for these patients.
- B. For inpatient areas the RN will initiate high fall risk interventions for pediatric patients three (3) years of age and younger, as appropriate. These include:
1. Orient patient and family to environment.
 2. Beds in low position, brakes locked.
 3. Children under the age of four (4) will be placed in cribs.
 - a. High-sided or bubble-top cribs will be used when the patient/parents state or child demonstrates that he/she might climb out.
 4. Consider use of nightlight on night shift.
 5. Call light and personal items within reach, as developmentally appropriate.
 6. Personal sensory aides and assistive devices accessible to the patient (i.e., eye glasses, hearing aids, safety straps, etc.).
 7. Ambulating patients must wear non-skid socks.
 8. Pediatric patients at risk for fall transported off the inpatient unit will be constantly supervised:
 - a. Inpatients under the age of four (4) should be transported in a crib, bassinet, in a car seat or may be carried in parents’ arms, but parent should be seated in a wheelchair.
 - b. Children transported off the unit will be constantly supervised.
 9. The RN will provide education on fall prevention interventions and purpose for the patient’s family/care giver and reinforce this as needed.
- C. In outpatient areas, the RN can consider using a crib, based on assessment of child and the family’s wishes.
1. Orient patient and family to environment.

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2. Beds in low position, brakes locked.
 3. Call light and personal items within reach, as developmentally appropriate.
 4. Personal sensory aides and assistive devices accessible to the patient (i.e., eye glasses, hearing aids, safety straps, etc.).
 5. Ambulating patients must wear non-skid socks.
 6. Pediatric patients at risk for fall transported off the inpatient unit will be constantly supervised.
 7. The RN will provide education on fall prevention interventions and purpose for the patient's family/care giver and reinforce this as needed.
- D. The nurse completes the Fall Risk Screening Tool to determine the patient's fall risk factors. Fall risk factors for patients over the age of three (3) include:
1. Ambulatory aid such as cane, prosthetic, walker, etc. (assistive devices, holds on to furniture when ambulating).
 2. History of a fall within the past 3 months.
 3. Secondary diagnosis
 4. Unsteady gait when transferring or ambulating
 5. IV infusion
 6. Cognition deficiencies (i.e., changes in mental status, unable to follow directions).
 7. Nursing judgment
- E. Interventions to **Prevent Patient Falls** in Adult and Pediatric Patients
1. The Fall Prevention Program has three (3) levels of intervention.
 2. **Level 1 interventions** are considered the Fall Prevention *Safety* portion of the program, and are initiated by the nursing team on admission for ALL inpatients and for outpatients, as appropriate. Level 1 interventions are:
 - a. Orient to Call light system
 - b. Call light within reach

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- c. Personal items and telephone within reach
 - d. Glasses and hearing aids on patient; ask family to bring from home
 - e. Patient and family education on Fall Prevention
 - f. Bed in lowest position with wheels locked
 - g. Reassess patient fall risk every shift and with status changes
 - h. Non-slip footwear when patient is out of bed
 - i. Instruct patient to call for assistance before getting out of bed or chair/toilet
 - j. Physically safe environment without spills, clutter, cords, or trip hazards. Consider use of nightlight on nightshift
 - k. Room and bathroom lighting operational
 - l. Bathroom call light cord within reach
 - m. Three (3) bed rails up; crib rails up in high position (peds)
3. **Level 2 interventions** are implemented for any patient whose fall risk screen results in identification of one (1) risk factor. Level 2 interventions include all level 1 interventions and:
- a. Reinforce fall prevention safety measures with patient and family
 - b. Use bed and chair alarms
 - c. For admitted patients, implement Visual Cues from Fall Management Kit as follows:
 - i. Place yellow wrist band on patient
 - ii. Post the two (2) star Fall Risk sign outside of the patient's room
 - iii. Provide yellow socks
 - d. Implement Targeted Toileting Program as follows:
 - i. Before shift change

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- ii. Before sleep
 - iii. After meals
 - iv. As indicated
 - e. These next interventions in Level 2 are based on patient-specific risk factors:
 - i. Monitor gait and stability and use gait belt as needed
 - Ensure that patient has their own assistive devices at the bedside. Check walkers and canes for non-skid covers.
 - Obtain Physical Therapy initial evaluation with physician order if deemed appropriate.
 - ii. Monitor for mental status changes and reorient to person, place and time, and minimize distractions as indicated
 - iii. Provide interpreter or use interpreter phone as indicated to ensure that patient and family understand measures needed to prevent falls
 - f. **For Outpatients (ED, Perioperative), implement visual cues as follows:**
 - i. Place yellow wrist band on patient
 - ii. None skid socks
4. **Level 3 interventions** are implemented for any patient whose fall risk screen results in more than one risk factor. The Emergency Department and Post Anesthesia RNs will communicate Level 3 fall risk scores to accepting departments prior to transfer so appropriate room assignment can be made for the patient. Level 3 interventions include all level 1 and level 2 interventions and:
- a. Arrange for a bed in one of the designated rooms nearest to the Nurses' Station when bed available
 - b. Reinforce fall prevention safety measures with patient and family

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- c. Use shower chair and stay within arm's length of the patient while in shower or during toileting
- d. Remain within arm's length of the high-risk fall patient when they are out of bed and alarms are not in use. Consider use of gait belt when appropriate
- e. Additional Visual Cues for inpatients
 - i. Post the *three (3) star* Fall Risk sign outside of the patient's room
 - ii. Provide yellow gown

F. Interventions for a Patient Fall:

- 1. Call for a Code STAR:
 - a. Dial 55 and ask Operator to announce a Code STAR overhead, giving your location (e.g., room number or unit/floor hallway)
 - b. Security staff will help maintain medical emergency vertical egress for responding staff.
 - c. The following staff report to the location of the Code STAR when available:
 - i. Nursing Supervisor or Unit Manager
 - ii. Charge Nurse
 - iii. Physical Therapist
 - iv. Chief Nursing Officer
 - v. Risk Management
- 2. Stay with the patient; do not attempt to mobilize the patient until help arrives.
- 3. If additional assistance is needed from Engineering staff, phone extension 55 and request Engineering help to your location.
- 4. Assess for injuries (i.e., abrasion, contusion, laceration, fracture - change in range of motion, head injury – change in level of consciousness) and provide appropriate first aide.
- 5. Obtain and record vital signs.

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6. Notify physician, using SBAR (Situation-Background-Assessment-Recommendation) format.
 7. Continue to monitor patient as condition warrants.
 8. Document facts/circumstances in patient medical record.
 9. Complete post fall intervention.
 10. Assess physiologic and environmental factors that contributed to the fall.
 11. Designate patient as a level 3 Fall Risk for the duration of their admission, initiate or escalate Fall Risk Interventions as appropriate, and modify the patient's plan of care based on risk factors leading to the fall.
 12. Notify all team members of patient fall and interventions implemented.
 13. Consider assistive devices to prevent repeat falls.
 14. Avoid use of restraints if at all possible. Restraints require physician order. Follow the *Restraints Policy and Procedure* using alternatives first and documenting them, and then using the least restrictive restraints when necessary.
 15. Notify the patient's next of kin of the fall and subsequent plan of care to prevent further falls.
- G. Documentation of a revised Fall Risk Assessment, Fall/Safety Care Plan, and Post Fall Assessment.
1. The nurse enters the Fall Risk Assessment into the medical record each shift and with any status changes.
 2. The Care Plan is updated daily and as needed based on patient status, including updates to the Fall/Safety Care Plan.
 3. Fall Risk assessment and intervention is part of the individualized plan of care for each inpatient, and for outpatients as indicated.

REFERENCES:

- Tool 3H: Morse Fall Scale for Identifying Fall Risk Factors. (July 2023). Agency for Healthcare Research and Quality. Rockville, MD. Retrieved from <https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/morse-fall-scale.html>.
- The Joint Commission. (2026). *National Patient Safety Goals and National Performance Goals*. <https://www.jointcommission.org/en-us/standards/national-patient-safety-goals>

SUBJECT: GUIDELINES FOR DETERMINING PRESENCE AND CLASSIFICATION OF INFECTION	SECTION:
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

Establish infection control standards to identify, classify and determine whether targeted infections are hospital or community-acquired.

Specific targeted hospital-acquired infections will be identified and classified.

POLICY:

Targeted infections will be determined to be hospital or community acquired by applying the following guidelines. (TJC Standards IC.04.01.01, EP3 and IC.06.01.01, EP1, EP3.

PROCEDURE:***General Instruction:***

- A. Information used to determine the presence and classification of an infection involves various combinations of clinical findings and results of laboratory and other diagnostic tests. Clinical evidence is derived from direct observation of the patient or review of information in the patient's chart or other ward or unit records. Laboratory evidence consists of results of cultures, antigen- or antibody-detection tests, and microscopic visualization methods. Supportive data are derived from other diagnostic studies, such as results of x-ray studies, ultrasound examination, computed tomography (CT) scan, magnetic resonance imaging, biopsies, and needle aspiration. For infections in which clinical manifestations are different in neonates and infants than in older persons, specific criteria are included.
- B. A physician's or surgeon's diagnosis of infection derived from direct observation during surgery, endoscopic examination, or other diagnostic study, or based on clinical judgment, is an acceptable criteria for an infection, unless there is compelling evidence to the contrary (e.g., written on wrong chart, or a presumptive diagnosis not substantiated by subsequent studies). For infections at some sites, however, a physician's clinical diagnosis in the absence of supportive data must be accompanied by initiation of appropriate antimicrobial therapy to satisfy the criteria.
- C. For an infection to be defined as nosocomial, there must be no evidence that the infection was present or incubating at the time of hospital admission. An infection that occurs in the following special situations is considered nosocomial: An infection that is acquired in the hospital and becomes evident after hospital discharge.
- D. Infection that occurs as the result of the following special situations is not considered nosocomial: (1) infection that is associated with a complication or extension of infection(s) already present on admission, unless a change in pathogen or symptoms strongly suggests the acquisition of a new infection; and (2) infection in an infant that is known or provided to have been acquired transplacentally (e.g., herpes simplex, toxoplasmosis, rubella, cytomegalovirus, and syphilis) and becomes evident shortly after birth.

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- E. Except for a few situations that are referred to in the definitions, no specific time during or after hospitalization is given to determine whether an infection is nosocomial or community-acquired. Therefore, each infection must be assessed for evidence that links it to hospitalization.

Surgical Site Infection (SSI):

A. Superficial Incisional SSI

1. Superficial incisional SSI must meet the following criteria: the infection occurs within 30 days after the operative procedure AND involves only skin or subcutaneous tissue of the incision and at least one of the following:
 - a. Purulent drainage from the superficial incision, with or without laboratory confirmation;
 - b. Organism isolated from an aseptically obtained culture of fluid or tissue from the superficial incision;
 - c. At least one of the following signs or symptoms of infection – pain or tenderness, localized swelling, redness or heat, and the superficial incision is deliberately opened by surgeon unless the incision is culture-negative;
 - d. Diagnosis of superficial incisional SSI by the surgeon or attending physician.

Note: The following are not reported as superficial incisional SSI: Stitch abscess (minimal inflammation and discharge confined to the points of suture penetration); infection of an episiotomy or newborn circumcision site (see Reproductive tract and skin soft tissue infection); infected burn wound; and incisional SSI that extends into fascia and muscle layers (see deep incisional SSI)

B. Deep incisional SSI:

1. Deep incisional SSI must meet the following criteria:
 - a. The infection occurs within 30 days after the operative procedure if no implant (i.e., a nonhuman-derived implantable foreign body [e.g., prosthetic heart valve, nonhuman vascular graft, mechanical heart or hip prosthesis] that is permanently placed in a patient during surgery) is left in place or within ninety days and the infection appears to be related to the operative procedure and this infection involves deep soft tissue (e.g., fascial or muscle layers) of the incision and it must meet at least one of the following:

SUBJECT: GUIDELINES FOR DETERMINING PRESENCE AND CLASSIFICATION OF INFECTION	SECTION:
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- Purulent drainage from the deep incision but not from the organ/space component of the surgical site;
- A deep incision that spontaneously dehisces or is deliberately opened by surgeon when patient has at least one of the following signs or symptoms—fever ($>38^{\circ}\text{C}$), localized pain or tenderness, unless wound is culture-negative;
- An abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic examination or radiologic examination; or
- Diagnosis of a deep incisional SSI by a surgeon or attending physician.

Notes:

- Report infection that involves both superficial and deep incision sites as deep incisional SSI.
- Report an organ/space SSI that drains through the incision as a deep incisional SSI.

C. Organ/Space SSI:

Note: An organ/space SSI involves any part of the anatomy (e.g., organs or spaces), other than the incision opened or manipulated during the operative procedure. Specific sites are assigned to organ/space SSI to further identify the location of the infection. The list indicates the specific sites that must be used to differentiate organ/space SSI. An example is appendectomy with subsequent subdiaphragmatic abscess, which would be reported as an organ/space SSI at the intra-abdominal specific site.

1. Organ/space SSI must meet the following criteria:
 - a. Infection occurs within the NHSN defined surveillance period (30 or 90 days after the operative procedure, depending on the procedure category). The infection is related to the operative procedure and the infection involves any part of the anatomy (e.g., organs or spaces) other than the incision, opened or manipulated during the operative procedure.
 - b. And meet at least one of the following:
 - Purulent drainage from a drain that is placed through a stab wound into the organ/space (if the area around a stab wound becomes infected, it is not an SSI—it is considered a skin or soft tissue infection, depending on its depth);

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- Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space;
- An abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination; or
- Diagnosis of an organ/space SSI by a surgeon or attending physician.

D. Specific Sites of Organ/Space SSI:

Arterial or venous infection	Myocarditis or pericarditis
Breast abscess or mastitis	Oral cavity (mouth, tongue or gums)
Disc space	Osteomyelitis
Ear, mastoid	Other infections of the lower respiratory tract
Endometritis	Other infections of the urinary tract
Endocarditis	Other male or female reproductive tract
Eye, other than conjunctivitis	Sinusitis
Gastrointestinal tract	Spinal abscess without meningitis
Intra-abdominal, not specified elsewhere	Upper respiratory tract, pharyngitis
Intracranial, brain abscess or dura	Vaginal cuff
Joint or bursa	
Mediastinitis	

Note: For infections involving the incision, use the term “incisional SSI.” The previous definitions are replaced by superficial incisional SSI and deep incisional SSI. Infections that involve the organ/space component of the surgical site (previously deep surgical wound infection at specific sites other than soft tissue) are now termed organ space SSI and combines with the specific sites listed above.

Primary Bloodstream Infection:

- A. Includes laboratory-confirmed bloodstream infection and clinical sepsis. The definition of clinical sepsis is intended primarily for infants and neonates.
- B. **Laboratory-Confirmed Bloodstream Infection** must meet the following criteria:
1. Recognized pathogen isolated from blood culture AND pathogen is not related to infection at another site¹.

¹ When an organism isolated from blood culture is compatible with a related nosocomial infection at another site, the bloodstream infection is classified as a secondary bloodstream infection. Exceptions to this are intravascular devices-associated bloodstream infections, all of which are classified as primary even if localized signs of infection are present at the access site.

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2. Fever ($>38^{\circ}\text{C}$), chills, or hypotension AND any of the following:
 - a. Common skin contaminant² isolated from two blood cultures drawn on separate occasions AND organism is not related to infection at another site.
 - b. Common skin contaminant isolated from blood culture from patient with intravascular access device AND physician institutes appropriate antimicrobial therapy
 - c. Positive antigen test on blood³ AND organism is not related to infection at another site.
 - d. Patient ≤ 12 months of age⁴ has one of the following: fever ($>38^{\circ}\text{C}$), apnea, or bradycardia AND all of the following:
 - Common skin contaminant isolated from two blood cultures drawn on separate occasions AND organism is not related to infection at another site.⁵

C. Clinical Sepsis must meet either of the following criteria:

1. One of the following clinical signs or symptoms with no other recognized cause: fever ($>38^{\circ}\text{C}$), hypotension (systolic pressure ≤ 90 mm Hg), or oliguria (>20 ml/hr) AND all of the following:
 - a. Blood culture not done or no organism or antigen detected in blood;
 - b. No apparent infection at another site;
 - c. Physician institutes appropriate antimicrobial therapy for sepsis.
2. Patient ≤ 12 months of age has one of the following clinical signs or symptoms with no other recognized cause: fever ($>38^{\circ}\text{C}$), hypothermia ($>37^{\circ}\text{C}$), apnea, or bradycardia AND all of the following:
 - a. Blood culture not done or no organism or antigen detected in blood

² Organisms that are normal skin flora (e.g., diptheroids, Bacillus sp., propionibacterium sp., coagulase-negative staphylococci, or micrococci).

³ Detection of bacterial, fungal or viral antigen (e.g., Candida sp., herpes simplex, varicella zoster, Haemophilus influenzae, streptococcus pneumoniae, Neisseria meningitidis, group B streptococci) by rapid diagnostic test (e.g., counter-immunoelectrophoresis, coagulation or latex agglutination).

⁴ These criteria apply specifically to infants < 12 months of age: they may infrequently apply to older infants and children.

⁵ When an organism isolated from blood culture is compatible with a related nosocomial infection at another site, the bloodstream infection is classified as a secondary bloodstream infection. Exceptions to this are intravascular device-associated bloodstream infections, all of which are classified as primary even if localized signs of infection are present at the access site.

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- b. No apparent infection at another site
- c. Physician institutes appropriate antimicrobial therapy for sepsis

Pneumonia:

- A. Pneumonia is defined separately from other infections of the lower respiratory tract. The criteria for pneumonia involve various combinations of clinical, radiographic and laboratory evidence of infection. In general, expectorated sputum cultures are not useful in diagnosing pneumonia, but may help identify the etiologic agent and provide useful antimicrobial susceptibility data. Findings from serial chest x-ray studies may be more helpful than those from a single x-ray film.
- B. **Pneumonia** must meet one of the following criteria:
 - 1. Rales or dullness to percussion on physical examination of chest AND any of the following:
 - a. New onset of purulent sputum or change in characteristics of sputum
 - b. Organism isolated from blood culture
 - c. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing or biopsy
 - 2. Chest radiographic examination shows new or progressive infiltrate, consolidation, cavitation or pleural effusion AND any of the following:
 - a. New onset of purulent sputum or change in character of sputum
 - b. Organism isolated from blood culture
 - c. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing or biopsy
 - d. Isolation of virus or detection of viral antigen in respiratory secretions
 - e. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
 - f. Histopathologic evidence of pneumonia
 - 3. Patient $\leq$ 12 months of age has two of the following: apnea, tachypnea, bradycardia, wheezing, rhonchi or cough AND any of the following:

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- a. Increased production of respiratory secretions
- b. New onset of purulent sputum or change in character of sputum
- c. Organism isolated from blood culture
- d. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing or biopsy
- e. Isolation of virus or detection of viral antigen in respiratory secretions
- f. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
- g. Histopathologic evidence of pneumonia
- h. Patient ≤ 12 months of age has chest radiologic examination that shows new or progressive infiltrate, cavitation, consolidation or pleural effusion AND any of the following:
 - i. Increased production of respiratory secretions
 - j. New onset of purulent sputum or change in character of sputum
 - k. Organism isolated from blood culture
 - l. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing or biopsy
 - m. Isolation of virus or detection of viral antigen in respiratory secretions
 - n. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
 - o. Histopathologic evidence of pneumonia

Urinary Tract Infection:

- A. Urinary tract infection includes symptomatic urinary tract infection, asymptomatic bacteriuria, and other infections of the urinary tract.
- B. **Symptomatic urinary tract infection** must meet with one of the following criteria:

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1. One of the following: fever ($>38^{\circ}\text{C}$), urgency, frequency, dysuria, or suprapubic tenderness AND a urine culture⁶ pf $\geq 10^5$ colonies/ml urine with no more than two species of organisms
2. Two of the following: fever ($>38^{\circ}\text{C}$), urgency, frequency, dysuria, or suprapubic tenderness AND any of the following:
 - a. Dipstick test positive for leukocyte esterase and/or nitrate
 - b. Pyuria (≥ 10 white blood cells ml³ or ≥ 3 WBC/high-power field of unspun urine)
 - c. Organisms seen on Gram stain of unspun urine
 - d. Two urine cultures with repeated isolation of the same uropathogen⁷
 - e. Urine culture with $\leq 10^5$ colonies/ml urine of single uropathogen inpatient being treated with appropriate antimicrobial therapy
 - f. Physician's diagnosis
 - g. Physician institutes appropriate antimicrobial therapy
3. Patient ≤ 12 months of age has one of the following: fever ($>38^{\circ}\text{C}$), hypothermia ($<37^{\circ}\text{C}$), apnea, bradycardia, dysuria, lethargy, or vomiting AND urine culture of $\geq 10^5$ colonies/ml urine with no more than two species of organisms AND/OR any of the following:
 - a. Dipstick test positive for leukocyte esterase and/or nitrate
 - b. Pyuria
 - c. Organisms seen on Gram stain or unspun urine
 - d. Two urine cultures with repeated isolation of same uropathogen with $\geq 10^2$ organisms/mls urine in non-voided specimens
 - e. Urine culture with $\leq 10^5$ colonies/ml urine of a single uropathogen in patient being treated with appropriate antimicrobial therapy
 - f. Physician's diagnosis

⁶ For urine specimens to be of value in determining whether a nosocomial infection exists, they must be obtained aseptically using an appropriate technique, such as clean catch collection, bladder catheterization or suprapubic aspiration.

⁷ Gram-negative bacteria or Staphylococcus saprophyticus

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- g. Physician institutes appropriate antimicrobial therapy
- C. **Asymptomatic bacteriuria** must meet either of the following criteria:
 - 1. Patient with or without an indwelling urinary catheter has no signs or symptoms of SUTI regardless of the age. Urine is cultured AND patient has no fever ($>38^{\circ}\text{C}$), urgency, frequency, dysuria, or suprapubic tenderness AND has urine culture of $\geq 10^5$ organisms/ml urine with no more than two species of organisms.
- D. **Other infections of the urinary tract** (kidney, ureter, bladder or tissues surrounding the retroperitoneal or perinephric spaces) must meet one of the following criteria:
 - 1. Organism isolated from culture of fluid (other than urine) or tissue from affected site
 - 2. An abscess or other evidence of infection seen on direct examination, during surgery, or by histopathologic examination
 - 3. Two of the three following: fever ($>38^{\circ}\text{C}$), localized pain, or tenderness at involved site AND any of the following:
 - a. Purulent drainage from affected site
 - b. Organism isolated from blood culture
 - c. Radiographic evidence of infection⁸
 - d. Physician's diagnosis
 - e. Physician institutes appropriate antimicrobial therapy
 - 4. Patient ≤ 12 months of age has one of the following: fever ($>38^{\circ}\text{C}$), hypothermia ($<37^{\circ}\text{C}$), apnea, bradycardia, lethargy or vomiting AND any of the following:
 - a. Purulent drainage from affected site
 - b. Organism isolated from blood culture
 - c. Radiographic evidence of infection
 - d. Physician's diagnosis

⁸ Radiographic evidence of infection includes abnormal results of ultrasound examination, CT scan, magnetic resonance imaging, or radiologist scan (e.g., gallium or technetium)

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- e. Physician institutes appropriate therapy

Bone and Joint Infection:

- A. Bone and joint infection includes osteomyelitis, joint or bursa infection and vertebral disk infection.
- B. **Osteomyelitis** must meet one of the following criteria:
1. Organism cultures from bone
 2. Evidence of osteomyelitis seen during surgery or by histopathologic examination
 3. Two of the following with no other recognized cause: fever ($>38^{\circ}\text{C}$), localized swelling, tenderness, heat or drainage at suspected site of infection AND any of the following:
 - a. Organism isolated from blood culture
 - b. Positive antigen test on blood
 - c. Radiographic evidence of infection
- C. **Joint or bursa infection** must meet one of the following criteria:
1. Organism isolated from culture of joint fluid or synovial biopsy
 2. Evidence of joint or bursa infection seen during surgery or by histopathologic examination
 3. Two of the following with no other recognized cause: joint pain, swelling, tenderness, heat, evidence of effusion or limitation of motion AND any of the following:
 - a. Organisms and white blood cells seen on Gram stain of joint fluid
 - b. Positive antigen test on blood, urine or joint fluid
 - c. Cellular profile and chemistries of joint fluid compatible with infection and not explained by underlying rheumatologic disorder
 - d. Radiographic evidence of infection
- D. **Vertebral disk space infection** must meet one of the following criteria:

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1. Organism isolated from culture of involved site tissue obtained during surgery or needle aspiration.
2. Evidence of infection at involved site seen during surgery or by histopathologic examination
3. Fever ($>38^{\circ}\text{C}$) with no other recognized cause or pain at involved site AND radiographic evidence of infection
4. Fever ($>38^{\circ}\text{C}$) with no other recognized cause AND pain at involved site AND positive antigen test on blood or urine

Cardiovascular System Infection:

- A. Cardiovascular system infection includes arterial or venous infection, endocarditis, myocarditis or pericarditis and mediastinitis. Mediastinitis is grouped with cardiovascular system infections because it most often occurs after cardiac surgery.
- B. **Arterial or venous infection** must meet one of the following criteria:
 1. Organism isolated from culture of arteries or veins removed during surgery AND blood culture not done or no organism isolated from blood culture
 2. Evidence of infection at involved vascular site seen during surgery or by histopathologic examination
 3. One of the following: fever ($>38^{\circ}\text{C}$), pain, erythema, or heat at involved vascular site AND both of the following:
 - a. More than 15 colonies cultured from intravascular cannula tip using semiquantitative culture method
 - b. Blood culture not done or no organism isolated from blood culture
 4. Purulent drainage at involved vascular site AND blood culture not done or no organism isolated from blood culture
 5. Patient ≤ 12 months of age has one of the following: fever ($>38^{\circ}\text{C}$), hypothermia ($<37^{\circ}\text{C}$), apnea, bradycardia, lethargy, pain, erythema, or heat at involved vascular site AND both of the following:
 - a. More than 15 colonies from intravascular cannula tip using semiquantitative culture method

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- b. Blood culture not done or no organism isolated from blood culture
- C. **Endocarditis** of natural or prosthetic heart valve must meet one of the following criteria:
 - 1. Organism isolated from culture of valve or vegetation
 - 2. Two of the following with no other recognized cause: fever ($>38^{\circ}\text{C}$), new or changing murmur, embolic phenomena, skin manifestations (i.e., petechiae, splinter hemorrhages, painful subcutaneous nodules), congestive heart failure, or cardiac conduction abnormality AND physician institutes appropriate antimicrobial therapy if diagnosis is made antemortem AND any of the following:
 - a. Organism isolated from two blood cultures
 - b. Organisms seen on Gram stain of valve when culture is negative or not done
 - c. Valvular vegetation seen during surgery or autopsy
 - d. Positive antigen test on blood or urine
 - e. Evidence of new vegetation seen on echocardiogram
- D. **Myocarditis or pericarditis** must meet one of the following criteria:
 - 1. Organism isolated from culture of pericardial tissue or fluid obtained by needle aspiration or during surgery
 - 2. Two of the following with no other recognized cause: fever ($>38^{\circ}\text{C}$), chest pain, paradoxical pulse, or increased heart size AND any of the following:
 - a. Abnormal electrocardiogram (ECG) consistent with myocarditis or pericarditis
 - b. Positive antigen test on blood
 - c. Evidence of myocarditis or pericarditis on histologic examination of heart tissue
 - d. Fourfold rise in type-specific antibody with or without isolation of virus from pharynx or feces
 - e. Pericardial effusion identified by echocardiogram, CT scan, magnetic resonance imaging, angiography, or other radiographic evidence of infection

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3. Patient ≤ 12 months of age has two of the following with no other recognized cause: fever ($>38^{\circ}\text{C}$), hypothermia ($<37^{\circ}\text{C}$), apnea, bradycardia, paradoxical pulse, or increased heart size AND any of the following:
 - a. Abnormal ECG consistent with myocarditis or pericarditis
 - b. Positive antigen test on blood
 - c. Histologic examination of heart tissue shows evidence of myocarditis or pericarditis
 - d. Fourfold rise in type-specific antibody with or without isolation of virus from pharynx or feces
 - e. Pericardial effusion identified by echocardiogram, CT scan, magnetic resonance imaging, angiography, or other radiographic evidence of infection

- E. **Mediastinitis** must meet one of the following criteria:
 1. Organism isolated from culture of mediastinal tissue or fluid obtained during surgery or needle aspiration
 2. Evidence of mediastinitis that is seen during surgery or by histopathologic examination
 3. One of the following: fever ($>38^{\circ}\text{C}$), chest pain, or sternal instability AND any of the following:
 - a. Purulent drainage from mediastinal area
 - b. Organism isolated from blood culture or culture of drainage from mediastinal area
 - c. Mediastinal widening on x-ray examination
 4. Patient ≤ 12 months of age has one of the following: fever ($>38^{\circ}\text{C}$), hypothermal ($<37^{\circ}\text{C}$), apnea, bradycardia, sternal instability AND any of the following:
 - a. Purulent drainage from mediastinal area
 - b. Organism isolated from blood culture or culture of drainage from mediastinal area
 - c. Mediastinal widening on x-ray examination

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Central Nervous System Infection:

- A. Central nervous system infection includes intracranial infection, meningitis or ventriculitis, and spinal abscess without meningitis.
- B. Intracranial infection (brain abscess, subdural or epidural infection and encephalitis) must meet one of the following criteria:
 1. Organism isolated from culture of brain tissue or dura
 2. Abscess or evidence of intracranial infection seen during surgery or by histopathologic examination
 3. Two of the following with no other recognized cause: headache, dizziness, fever ($>38^{\circ}\text{C}$), localizing neurologic signs, changing level of consciousness, or confusion, AND physician institutes appropriate antimicrobial therapy if diagnosis is made antemortem AND any of the following:
 - a. Organism seen on microscopic examination of the brain or abscess tissue obtained by needle aspiration or by biopsy during surgery or autopsy
 - b. Positive antigen test on blood or urine
 - c. Radiographic evidence of infection
 - d. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
 4. Patient ≤ 12 months of age has two of the following with no other recognized cause: fever ($>38^{\circ}\text{C}$), hypothermia ($<37^{\circ}\text{C}$), apnea, bradycardia, localizing neurologic signs, or changing level of consciousness AND physician institutes appropriate antimicrobial therapy if diagnosis is made antemortem AND any of the following:
 - a. Organisms seen on microscopic examination of brain or abscess tissue obtained by needle aspiration or by biopsy during surgery or autopsy
 - b. Positive antigen test on blood or urine specimen
 - c. Radiographic evidence of infection
 - d. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
- C. **Meningitis or ventriculitis** must meet one of the following criteria:

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1. Organisms isolated from culture or cerebrospinal fluid (CSF)
 2. One of the following with no other recognized cause: fever ($>38^{\circ}\text{C}$), headache, stiff neck, meningeal signs, cranial nerve signs or irritability, AND physician institutes appropriate antimicrobial therapy if diagnosis is made antemortem AND any of the following:
 - a. Increased white cells, elevated protein, and/or decrease glucose in CSF
 - b. Organisms seen on Gram stain of CSF
 - c. Organism isolated from blood culture
 - d. Positive antigen test on CSF, blood or urine
 - e. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
 3. Patient ≤ 12 months of age has one of the following with no other recognized cause: fever ($>38^{\circ}\text{C}$), hypothermia ($<37^{\circ}\text{C}$), apnea, bradycardia, stiff neck, meningeal signs, cranial nerve signs or irritability AND physician institutes appropriate antimicrobial therapy if diagnosis is made antemortem AND any of the following:
 - a. Increased white cells, elevated protein, and/or decreased glucose in CSF
 - b. Organisms seen on Gram stain of CSF
 - c. Organism isolated from blood culture
 - d. Positive antigen test on CSF, blood or urine
 - e. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
- D. Spinal abscess without meningitis** (an abscess of the spinal epidural or subdural space, without involvement of the CSF or adjacent bone structures) must meet one of the following criteria:
1. Organism isolated from culture or abscess in spinal epidural or subdural space
 2. Abscess in spinal epidural or subdural space seen during surgery or autopsy or by histopathologic examination

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3. One of the following with no other recognized cause: fever ($>38^{\circ}\text{C}$), back pain, focal tenderness, radiculitis, paraparesis, or paraplegia AND physician institutes appropriate antimicrobial therapy if diagnosis is made antemortem AND either of the following:
 - a. Organism isolated from blood culture
 - b. Radiographic evidence of spinal abscess

Eye, Ear, Nose, Throat and Mouth Infection:

- A. Eye infection includes conjunctivitis and other eye infections. Ear infections include otitis externa, otitis media, otitis interna, and mastoiditis. Nose, throat and mouth infections include oral cavity infections, upper respiratory infections and sinusitis.
- B. **Conjunctivitis** must meet either of the following criteria:
 1. Pathogen isolated from culture of purulent exudate obtained from conjunctiva or contiguous tissues, such as eyelid, cornea, meibomian glands, or lacrimal glands
 2. Pain or redness of conjunctiva or around eye AND any of the following:
 - a. WBCs and organisms seen on Gram stain of exudate
 - b. Purulent exudate
 - c. Positive antigen test on exudate or conjunctival scraping
 - d. Multinucleated giant cells seen on microscopic examination of conjunctival exudate or scrapings
 - e. Positive viral culture on conjunctival exudate
 - f. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
- C. **Eye infections other than conjunctivitis** must meet either of the following criteria:
 1. Organism isolated from culture of anterior or posterior chamber of vitreous fluid
 2. Two of the following with no other recognized cause: eye pain, visual disturbance, or hypopyon AND any of the following:

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- a. Physician's diagnosis
 - b. Positive antigen test on blood
 - c. Organism isolated from blood culture
- D. **Otitis externa** must meet either of the following criteria:
- 1. Pathogen isolated from culture or purulent drainage from ear canal
 - 2. One of the following: fever (38°C), pain, redness or drainage from ear canal AND organisms seen on Gram stain of purulent drainage
- E. **Otitis media** must meet either of the following criteria:
- 1. Organism isolated from culture of fluid from middle ear obtained by tympanocentesis or surgery
 - 2. Two of the following: fever (>38°C), pain in eardrum, inflammation, retraction or decreased mobility of eardrum, or fluid behind eardrum
- F. **Otitis internal** must meet either of the following criteria:
- 1. Organism isolated from culture of fluid from inner ear obtained at surgery.
 - 2. Physician's diagnosis
- G. **Mastoiditis** must meet either of the following criteria:
- 1. Organism isolated from culture of purulent drainage from mastoid
 - 2. Two of the following with no other recognized cause: fever (>38°C), pain, tenderness, erythema, headache or facial paralysis AND either of the following:
 - a. Organisms seen on Gram stain of purulent material from mastoid
 - b. Positive antigen test on blood
- H. **Oral cavity infection** (mouth, tongue or gums) must meet one of the following criteria:
- 1. Organism isolated from culture of purulent material from tissues or oral cavity
 - 2. Abscess or other evidence of oral cavity infection seen on direct examination, during surgery, or by histopathologic examination

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3. One of the following: abscess, ulceration or raised white patches on inflamed mucosa, or plaques on oral mucosa AND any of the following:
 - a. Organisms seen on Gram stain
 - b. Positive potassium hydroxide (KOH) stain
 - c. Multinucleated giant cells seen on microscopic examination of mucosal scrapings
 - d. Positive antigen test on oral secretions
 - e. Diagnostic single antibody titer (IgM) or a fourfold increase in paired serum samples (IgG) for pathogen
 - f. Physician's diagnosis and treatment with topical or oral antifungal therapy
- I. **Sinusitis** must meet either of the following criteria:
 1. Organism isolated from culture of purulent material obtained from sinus cavity
 2. One of the following: fever ($>38^{\circ}\text{C}$), pain or tenderness over the involved sinus, headache, purulent exudate, or nasal obstruction AND either of the following:
 - a. Positive transillumination
 - b. Radiographic evidence of infection
- J. Upper respiratory tract infection (pharyngitis, laryngitis, epiglottitis) must meet one of the following criteria:
 1. Two of the following: fever ($>38^{\circ}\text{C}$), erythema of pharynx, sore throat, cough, hoarseness or purulent exudate in throat, AND any of the following:
 - a. Organism isolated from culture of specific site
 - b. Organism isolated from blood culture
 - c. Positive antigen test on blood or respiratory secretions
 - d. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
 - e. Physician's diagnosis

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2. Abscess seen on direct examination, during surgery, or by histopathologic examination
3. Patient ≤ 12 months of age has two of the following: ($>38^{\circ}\text{C}$), hypothermia ($<37^{\circ}\text{C}$), apnea, bradycardia, nasal discharge, or purulent exudate in throat, AND any of the following:
 - a. Organism isolated from culture of specific site
 - b. Organism isolated from blood culture
 - c. Positive antigen test on blood or respiratory secretions
 - d. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
 - e. Physician's diagnosis

Gastrointestinal System Infection:

Gastrointestinal system infections include gastroenteritis, hepatitis, necrotizing enterocolitis, gastrointestinal tract infections, and intra-abdominal infections not specified elsewhere.

- A. **Gastroenteritis** must meet either of the following criteria:
1. Acute onset of diarrhea (liquid stools for more than 12 hours) with or without vomiting or fever ($>38^{\circ}\text{C}$) AND no likely noninfectious cause (e.g., diagnostic tests, therapeutic regimen, acute exacerbation of a chronic condition, psychological stress)
 2. Two of the following with no other recognized cause: nausea, vomiting, abdominal pain, or headache AND any of the following:
 - a. Enteric pathogen isolated from stool culture or rectal swab
 - b. Enteric pathogen detected by antigen or antibody assay on feces or blood
 - c. Evidence of enteric pathogen detected by cytopathic changes in tissue culture (toxin assay)
 - d. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen

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- B. Hepatitis** must meet the following criteria: Two of the following with no other recognized cause: fever ($>38^{\circ}\text{C}$), anorexia, nausea, vomiting, abdominal pain, jaundice, or history transfusion within the previous three months AND any of the following:
1. Positive antigen or antibody test for hepatitis A, hepatitis B or delta hepatitis
 2. Abnormal liver function tests (e.g., elevated alanine/aspartate aminotransferase [ALT/AST] and bilirubin)
 3. Cytomegalovirus (CMV) detected in urine or oropharyngeal secretion.
- C. Infant necrotizing enterocolitis** must meet the following criteria: Two of the following with no other recognized cause: vomiting, abdominal distention, or prefeeding residuals AND persistent microscopic or gross blood in stools AND any of the following abdominal radiographic abnormalities:
1. Pneumoperitoneum
 2. Pneumatosis intestinalis
 3. Unchanging “rigid” loops of small bowel
- D. Gastrointestinal (GI) tract infection** (esophagus, stomach, small bowel, large bowel, rectum), excluding gastroenteritis and appendicitis, must meet either of the following criteria:
1. Abscess or other evidence of infection seen during surgery or by histopathologic examination
 2. Two of the following with no other recognized cause and compatible with infection of the organ or tissue involved: fever ($>38^{\circ}\text{C}$), nausea, vomiting, abdominal pain, or tenderness AND any of the following:
 - a. Organism isolated from culture of drainage or tissue obtained during surgery or endoscopy of surgically placed drain
 - b. Organisms seen on gram stain, KOH stain, multinucleated giant cells seen on microscopic examination, drainage, tissue obtained during surgery, endoscopy or surgically placed drain.
 - c. Organism isolated from blood culture
 - d. Radiographic evidence of infection

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- e. Pathologic findings on endoscopic examination (e.g., *Candida* esophagitis or proctitis)
- E. **Intra-abdominal infection** (including gall bladder, bile ducts, liver [other than viral hepatitis], spleen, pancreas, peritoneum, subphrenic or subdiaphragmatic space, or other intra-abdominal tissue or area not specified elsewhere) must meet one of the following criteria:
 - 1. Organism isolated from culture of purulent material from intra-abdominal space obtained during surgery or needle aspiration
 - 2. Abscess or other evidence of intra-abdominal infection seen during surgery or by histopathologic examination
 - 3. Two of the following with no other recognized cause: fever ($>38^{\circ}\text{C}$), nausea, vomiting, abdominal pain, or jaundice AND any of the following:
 - a. Organism isolated from culture of drainage from surgically placed drain (e.g., closed suction drainage system, open drain, or T-tube drain)
 - b. Organisms seen on Gram stain of drainage or tissue obtained during surgery or needle aspiration
 - c. Organism isolated from blood culture and radiographic evidence of infection

Lower Respiratory Tract Infection (Excluding Pneumonia):

Lower respiratory tract infection (excluding pneumonia) includes infection such as bronchitis, tracheobronchitis, bronchiolitis, tracheitis, lung abscess, and empyema.

- A. **Bronchitis, tracheobronchitis, bronchiolitis, tracheitis, without evidence of pneumonia**, must meet either of the following criteria:
 - 1. Patient has no clinical or radiographic evidence of pneumonia AND has two of the following: fever ($>38^{\circ}\text{C}$), cough, new or increased sputum production, rhonchi, wheezing, AND either of the following:
 - a. Organism isolated from culture obtained by deep tracheal aspirate or bronchoscopy
 - b. Positive antigen test on respiratory secretions
 - 2. Patient ≤ 12 months of age has no clinical or radiographic evidence of pneumonia AND has two of the following with no other recognized cause: ($>38^{\circ}\text{C}$), cough, new or

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increased sputum production , rhonchi, wheezing, respiratory distress, apnea, or bradycardia AND any of the following:

- a. Organism isolated from culture of material obtained by deep tracheal aspirate or bronchoscopy
- b. Positive antigen test on respiratory secretions
- c. Diagnostic single antibody titer (IgM or fourfold increase in paired serum samples (IgG) for pathogen

B. Other infections of the lower respiratory tract must meet one of the following criteria:

1. Organisms seen on smear or isolated from culture of lung tissue or fluid, including pleural fluid
2. Lung abscess or empyema seen during surgery or by histopathologic examination
3. Abscess cavity seen on radiographic examination of lung

Reproductive Tract Infection:

A group of infections that occur in obstetrics and gynecology patients and in male urology patients is defined as reproductive tract infection. Such infections include endometriosis, episiotomy infection, vaginal cuff infection, and other infection of the male or female reproductive tract.

A. Endometriosis must meet either of the following criteria:

1. Organism isolated from culture of fluid or tissue from endometrium obtained during surgery, by needle aspiration or by brush biopsy
2. Purulent drainage from uterus AND two of the following: fever ($>38^{\circ}\text{C}$), abdominal pain, or uterine tenderness

B. Episiotomy site infection must meet either of the following criteria:

1. Purulent drainage from episiotomy
2. Episiotomy abscess

C. Vaginal cuff infection must meet one of the following criteria:

1. Purulent drainage from vaginal cuff

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2. Abscess at vaginal cuff
 3. Pathogen isolated from culture of fluid or tissue obtained from vaginal cuff
- D. **Other infections of the male or female reproductive tract** (epididymis, testes, prostate, vagina, ovaries, uterus, or other deep pelvic tissues, excluding endometriosis or vaginal cuff infection) must meet one of the following criteria:
1. Organism isolated from culture of tissue or fluid from affected site
 2. Abscess or other evidence of infection seen during surgery or by histopathologic examination
 3. Two of the following: fever ($>38^{\circ}\text{C}$), nausea, vomiting, pain, tenderness, or dysuria
AND either of the following:
 - a. Organism isolated from blood culture
 - b. Physician's diagnosis

Skin and Soft Tissue Infection:

Skin and soft tissue infection includes skin infection (other than incisional wound infection), soft tissue infection, decubitus ulcer infection, burn infection, breast abscess or mastitis, omphalitis, infant pustulosis, and newborn circumcision infection. Separate criteria are presented for each infection.

- A. **Skin infection** must meet either of the following criteria:
1. Purulent drainage, pustules, vesicles, or boils
 2. Two of the following affected sites: localized pain or tenderness, swelling, redness or heat AND any of the following:
 - a. Organism isolated from culture of aspirate or drainage from affected site; if organism is normal skin flora, must be pure culture of single organism
 - b. Organism isolated from blood culture
 - c. Positive antigen test on infected tissue or blood
 - d. Multinucleated giant cells seen on microscopic examination of affected tissue

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- e. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
- B. **Soft tissue infection** (necrotizing fasciitis, infectious gangrene, necrotizing cellulitis, infectious myositis, lymphadenitis, or lymphangitis) must meet one of the following criteria:
 - 1. Organism isolated from culture of tissue or drainage from affected site
 - 2. Purulent drainage from affected site
 - 3. Abscess or other evidence of infection seen during surgery or by histopathologic examination
 - 4. Two of the following at affected site: localized pain or tenderness, redness, swelling, or heat AND any of the following:
 - a. Organism isolated from blood culture
 - b. Positive antigen test on blood or urine
 - c. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
- C. **Decubitus ulcer infection**, including both superficial and deep infection, must meet the following criteria:

Two of the following: redness, tenderness, or swelling of wound edges AND either of the following:

 - 1. Organism isolated from culture of fluid obtained by needle aspiration or biopsy of tissue obtained from ulcer margin
 - 2. Organism isolated from blood culture
- D. **Burn infection** must meet one of the following criteria:
 - 1. Change in burn wound appearance or character, such as rapid eschar separation, or dark brown, black or violaceous discoloration of the eschar, or edema at wound margin, AND histologic examination of burn biopsy specimen that shows invasion of organisms into adjacent viable tissue or either of the following:
 - a. Organism isolated from blood culture in absence of other identifiable infection

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- b. Isolation of herpes simplex virus, histologic identification of inclusions by light or electron microscopy, or visualization of viral particles by electron microscopy in biopsy specimens or lesion scrapings
 2. Burn patient has two of the following: fever ($>38^{\circ}\text{C}$), hypothermia ($<36^{\circ}\text{C}$), hypotension (systolic pressure <90 mm Hg), oliguria (<20 ml/hr), hyperglycemia at previously tolerated level of dietary carbohydrate, or mental confusion AND any of the following:
 - a. Histologic examination of burn biopsy specimen that shows invasion or organisms into adjacent viable tissue
 - b. Organism isolated blood culture
 - c. Isolation of herpes simplex virus, histologic identification of inclusions by light or electron microscopy, or visualization of viral particles by electron microscopy in biopsy specimens or lesion scrapings
- E. **Breast abscess or mastitis** must meet one of the following criteria:
 1. Organism isolated from culture of affected breast tissue or fluid obtained by incision and drainage or needle aspiration
 2. Breast abscess or other evidence of infection seen during surgery or by histopathologic examination
 3. Fever ($>38^{\circ}\text{C}$), local inflammation of the breast, and physician's diagnosis
- F. **Omphalitis in newborn** (≥ 30 days of age) must meet either of the following criteria:
 1. Erythema and/or serous drainage from umbilicus and either of the following:
 - a. Organism isolated from culture of drainage or needle aspirate
 - b. Organism isolated from blood culture
 2. Erythema and purulent drainage at umbilicus
- G. **Pustulosis in infant** (≥ 12 months of age) must meet the following criteria:
 1. Infant has pustules AND physician's diagnosis or
 2. Physician institutes appropriate antimicrobial therapy
- H. **Circumcision infection in newborn** (>30 days of age) must meet one of the following criteria:

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1. Newborn has purulent drainage from circumcision site
2. Newborn has one of the following: erythema, swelling or tenderness at circumcision site AND pathogen isolated from culture of site
3. Newborn has one of the following: erythema, swelling, or tenderness at circumcision site, and skin contaminant isolated from culture of site AND physician's diagnosis or physician institutes appropriate antimicrobial therapy.

Systemic Infection:

Systemic infection is defined as infection that involves organs or systems, without an apparent single site of infection. Such infections are usually of viral origin and can usually be identified by clinical criteria alone (e.g., measles, mumps, rubella and varicella); they occur infrequently as nosocomial infections.

REFERENCES:

- California Department of Public Health (2017). Healthcare Associated Infections (HAI) Program. Update June 30, 2026. Accessed July 29, 2026.
<https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/HAIProgramHome.aspx>
- Centers for Disease Control and Prevention. *National Healthcare Safety Network (NHSN) Patient Safety Component Manual*. Updated January 2026. Accessed July 29, 2026.
https://www.cdc.gov/nhsn/pdfs/pscmanual/pscmanual_current.pdf
- Centers for Disease Control and Prevention. *CDC/NHSN Surveillance Definitions for Specific Types of Infections*. Updated January 2026. Accessed July 29, 2026.
https://www.cdc.gov/nhsn/pdfs/pscmanual/17pscnosinfdef_current.pdf
- Centers for Disease Control and Prevention. *Surgical Site Infection (SSI) Event*. NHSN Patient Safety Component Manual. Updated January 2026. Accessed July 29, 2026.
<https://www.cdc.gov/nhsn/pdfs/pscmanual/9pscscscurrent.pdf>
- Centers for Disease Control and Prevention. *Bloodstream Infection Event (Central Line-Associated Bloodstream Infection and Non-central Line Associated Bloodstream Infection)*.

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Updated January 2026. Accessed July 29, 2026.

https://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf

- Calderwood MS, Anderson DJ, Bratzler DW, et al. Strategies to prevent surgical site infections in acute-care hospitals: 2022 update. *Infect Control Hosp Epidemiol*. 2023;44(5):695-720. [doi:10.1017/ice.2023.67](https://doi.org/10.1017/ice.2023.67)
- Society for Healthcare Epidemiology of America (SHEA). *Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals: 2022 Updates*. Published 2023. Accessed July 29, 2026. <https://shea-online.org/compendium-of-strategies-to-prevent-healthcare-associated-infections-in-acute-care-hospitals/>
- Centers for Disease Control and Prevention. *Surgical Site Infection (SSI) Prevention Guideline*. Updated April 12, 2024. Accessed July 29, 2026. <https://www.cdc.gov/infection-control/hcp/surgical-site-infection/index.html>

SUBJECT: GUIDELINES FOR SINGLE USE DEVICES (DISPOSABLES), REUSE AND REPROCESSING OF PATIENT CARE EQUIPMENT	SECTION: Page 1 of 2
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure safe, clean, sterile equipment for use in patient care.

POLICY:

1. Single-use (disposable) supplies, equipment and devices are for one-time use in accordance with each manufacturer's instructions for use (IFU) and shall be discarded immediately after their intended single use.
2. Reuse of supplies, equipment or devices not intended for multi-use *shall not* be practiced by SVMC.

DEFINITIONS:

1. **OPIM** – Other potentially infectious material.
2. **Reprocessing:** The re-packaging and sterilization of single-use medical devices and supplies for use on other patients.
3. **SCD** – Sequential compression device.

PROCEDURE:**Single-use (disposable) supplies and equipment:**

1. Dispose of any sharp object immediately after use by placing it into a labeled sharps container.
2. Dispose of any non-sharp item in a regular trash receptacle (unless contaminated with blood or other potentially infectious materials (OPIM)).
3. Dispose of any non-sharp item contaminated with blood or OPIM in a red/biohazardous bag.

Reuse supplies/equipment not intended for multi-use:

1. This practice is expressly prohibited.

SUBJECT:

**GUIDELINES FOR SINGLE USE DEVICES
(DISPOSABLES), REUSE AND REPROCESSING
OF PATIENT CARE EQUIPMENT**

SECTION:

Page 2 of 2**Printed copies are for reference only. Please refer to the electronic copy for the latest version.****Reprocessing supplies/equipment:**

1. Identify the item(s) to be reprocessed by vendor or manufacturer.
2. Locate and review the manufacturer's recommendations for reprocessing (i.e., disposable pulse oximeter, sequential compression device (SCD) and pick-up, if applicable.)
3. Place item(s) in designated collection container for pickup by the approved reprocessing vendor.
4. Identify the current standards of care for possible reprocessing of item(s).
5. Review applicable regulatory requirements, standards of practice, and vendor qualifications related to medical device reprocessing.

REFERENCES:

- Disinfection and Sterilization: Guideline for Disinfection and Sterilization in Healthcare Facilities (2008. Updated June 2024) Centers for Disease Control & Prevention (CDC) Accessed August 4, 2026. Print Version:
https://www.cdc.gov/infection-control/media/pdfs/guideline-disinfection-h.pdf?CDC_AAref_Val=https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf
- CPG Sec. 300.500 *Reprocessing of Single Use* Devices. (1987. Rerelease 2005). Content current as of: April 22, 2022. From FDA Manual of Compliance Policy Guides. Accessed August 4, 2026. <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/compliance-manuals/manual-compliance-policy-guides> and <https://www.fda.gov/media/71769/download>
- California Code of Regulations, Title 22, Section 70831. Central Sterile Supply. Accessed on August 4, 2026. <https://www.law.cornell.edu/regulations/california/22-CCR-70831>

CROSS REFERENCES:

California Code of Regulations, Title 22, Section 70739. *Infection Control Program*. Retrieved on August 4, 2026. <https://www.law.cornell.edu/regulations/california/22-CCR-70739>

SUBJECT: GUIDELINES FOR WASTE HANDLING – WASTE MANAGEMENT PROGRAM	SECTION: Page 1 of 4
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide an effective waste management program in accordance with local, state, and federal requirements.

POLICY:

Sierra View Medical Center (SVMC) waste management program describes the procedure for identification, packaging, storage, collection and disposal of all waste generated. State and local regulations will be observed in the handling and disposal of SVMC waste.

PROCEDURE:

A. Definitions and Classifications of Wastes:

1. **Solid Waste** includes, but is not limited to, empty specimen containers, bandages, dressings containing non-liquid blood, paper towels, trash, and surgical gloves. Solid wastes shall be stored and eliminated in a manner to preclude the transmission of communicable disease.
2. **Medical Waste** is defined by the State of California Department of Health Services, 2017 which meets both of the following requirements:
 - a. The waste is composed of waste which is generated or produces as a result of any of the following actions:
 - Diagnosis, treatment, or immunization of human beings.
 - Research pertaining to the activities specified in the 2017 regulation.
 - The production or testing of biologicals.
 - The accumulation of properly contained home-generated sharps waste that is brought by a patient, a member of the patient's family, or by a person authorized by the enforcement agency.
 - b. The waste is either of the following:
 - Biohazardous waste.
 - Sharps waste.
3. **Biohazardous Waste** requires special disposal treatments such as autoclave, sewer disposal or incineration. Biohazardous waste includes all of the following:
 - a. Laboratory waste includes, but is not limited to, all of the following:
 - Human specimen cultures from medical and pathological laboratories,

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- Cultures and stocks of infectious agents from research and industrial laboratories,
 - Wastes from the production of bacteria, viruses, or the use of spores, discarded live and attenuated vaccines used in human health care or research, discarded animal vaccines, including Brucellosis and Contagious Ecthyma, and culture dishes and devices used to transfer, inoculate, and mix cultures.
- b. Human surgery specimens or tissues removed during surgery or at autopsy which are suspected by the attending physician and surgeon or dentist of being contaminated with infectious agents known to be contagious to humans.
- c. Waste which at the point of transport from the generator's site, at the point of disposal, or thereafter, contains recognizable fluid blood, fluid blood products, containers, or equipment containing blood that is fluid.
- d. Waste containing discarded materials contaminated with excretion, exudates or secretions from humans who are required to be isolated by infection prevention staff, the attending surgeon, or the local health officer to protect others from highly communicable diseases.
4. **Sharps Waste** means any devices having acute rigid corners, edges, or protuberances capable of cutting or piercing, including but not limited to, all of the following:
- a. Hypodermic needles, hypodermic needles with syringes, blades, and needles attached to tubing, syringes contaminated with biohazardous waste, acupuncture needles, and root canal files.
 - b. Broken glass items such as Pasteur pipettes and blood vials contaminated with biohazardous waste.
 - c. Any item capable of cutting or piercing the skin, that is contaminated with trauma scene waste.

B. Waste Disposal:

1. Personal Protective Equipment (PPE), including impervious gloves, shall be worn when handling biohazardous waste materials.
2. Containers filled with blood or body fluids:
 - a. Empty contents of containers designated "safe to empty" (low risk for splash potential) carefully into the sewer system. Then dispose of container in solid waste.
 - b. Containers filled with body fluids that have not been designated "safe to empty" are to be secured to prevent leakage and placed in a red bag labeled "biohazard waste." Place red bag in biohazard container to be picked up by Environmental Services for transport to secured area until waste handler takes for final disposal.

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**GUIDELINES FOR WASTE HANDLING – WASTE
MANAGEMENT PROGRAM**

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3. Segregate waste at the point of origin:
 - a. Solid waste (general trash) shall be placed in an appropriately-colored plastic lined trash receptacle. These wastes shall not be a nuisance or a breeding place for insects or rodents nor be a food source for either. Solid waste containers shall be stored and located in a manner that will protect against odors.
 - b. Biohazardous (infectious) waste, as defined above, shall be placed in a red-lined trash receptacle and then taken to the soiled utility room for disposal into a closeable, leak-proof, biohazard labeled container.
 - c. Sharps as defined above, shall be placed in a closeable, leak-proof, rigid, puncture-resistant container which, when sealed, cannot be reopened without great difficulty. Sharps containers shall be closed tightly and replaced when they are $\frac{3}{4}$ full. Sealed “full” containers are to be placed in the soiled utility room. Sharps containers shall be locked in areas where personnel are not present consistently. Safe handling of sharps:
 - Needles should not be recapped, bent, broken or otherwise manipulated by hand.
 - If a sharps safety device is available, activate the device immediately after needle use.
 - Dispose of sharps in a sharps container immediately after use.
 - Needles should always be secured by hospital personnel. (Never leave needles unattended).
 - Sharps used in the operating suite should be placed in a “safe zone” in the sterile field.
 - Report any sharps injuries to Employee Health Services immediately.
 - d. Glass items- regular trash.
 - e. Chemotherapy wastes are to be stored separately in rigid, leak-proof containers marked with “Chemotherapy” warning label.
 - f. Recognizable human anatomical remains shall be placed in a sealed container and transported to the locked facility in the back of the hospital.
 - g. Pharmaceutical Waste: Refer to pharmaceutical services policy, “Pharmaceutical Waste”

C. Final Disposal:

1. Environmental Services shall conduct rounds at least daily to empty and reline all waste receptacles. Movable bins, when used for transporting solid wastes from the premises, shall meet the following requirements:

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- a. Have tight-fitting covers.
 - b. Be in good repair.
 - c. Be leak-proof.
 - d. Be rodent-proof unless stored in a room or screened enclosure. Waste is stored in locked facility behind the hospital grounds.
 - e. Solid waste containers, including movable bins, shall be thoroughly washed and cleaned each time they are emptied unless soil contact surfaces have been completely protected from contamination by disposable liners.
2. Environmental Services shall remove biohazard waste from utility rooms at least daily.
 3. A licensed hauler removes the solid/biohazardous waste in accordance with all local and state regulations.

REFERENCES:

- California Department of Public Health. Medical Waste Management Program. Updated October 21, 2025. Retrieved on August 12, 2026 from:
<https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx>
- California Health and Safety Code, Sections 117600-118360 (2017). Medical Waste Management Act. Retrieved on August 12, 2026 from:
<https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/MedicalWasteManagementAct.pdf>

SUBJECT:
HOSPITAL-APPROVED HANDWASHING,
CLEANING AND DISINFECTANT PRODUCTS

SECTION:

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

PURPOSE:

To establish Infection Prevention-based standards for the review and approval of potential changes to established cleaning and disinfecting products and routines.

POLICY:

All products, reagents and schedules shall be approved by the Infection Prevention Manager and the Infection Prevention Council.

PROCEDURE:

ANTISEPTIC HAND HYGIENE PRODUCTS

1. Hand washing is considered the single most important procedure for preventing healthcare-associated infections. Handwashing removes transient microbial contamination acquired through microscopic holes in gloves, from contact with infected or colonized patients and other environmental sources.
2. Alcohol-based hand sanitizers are effective products for reducing the number of germs on the hands of healthcare providers (Table 1). Alcohol-based hand sanitizers that contain at least 60% alcohol are the preferred product for performing hand hygiene in most, but not all, clinical situations.
3. All hand hygiene products used at SVMC shall be approved by the Infection Prevention Council.
4. Factors influencing the effectiveness of hand hygiene products include:
 - a. The antibacterial agent and its concentration/strength
 - b. The harshness on skin
 - c. Possible interactions with lotions and gloves
 - d. The ability to be easily dispensed
5. Submission process for proposed product change
 - a. All proposed items will be reviewed for their effectiveness, safety, appropriateness and feasibility of application.
 - b. Any proposed change of products, equipment, techniques, etc., used in cleaning and/or disinfecting shall be submitted to Materials Managements for consideration by the Value Analysis Committee, the Infection Prevention Manager, and the Pharmaceutical & Therapeutic Infection Prevention Committee.
 - c. The department requesting the change in products, etc., shall be informed of the outcome (approval or disapproval) from the above stated vetting process. At this point, a representative from the department requesting the change must be prepared to present the product information to the Infection Prevention Council.

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- d. The final evaluation and approval will be done by the Infection Prevention Council and then codified through the Policy Approval Process.

GENERAL CHEMICAL DISINFECTANT PRODUCTS

There are many factors to consider that influence the effectiveness of disinfectants. For this reason, it is necessary to fully understand disinfection principles and apply this knowledge during the selection process.

1. During the selection process, the level of disinfection based on the Spaulding classification scheme, must be taken into consideration. For instance, does the proposed disinfectant need to function as a high-level disinfectant for critical items, etc.?
2. In any disinfection process, the item must first be free of dirt, blood, grime, bodily secretions and other extraneous materials that would inhibit the action of the disinfectant. Therefore, the first step in any disinfection process is the meticulous cleaning of medical instruments.
3. The efficiency of any disinfectant is dependent on product concentration and contact time, both of which are clearly described in the manufacturer's instruction for use (IFUs).
4. Disinfectants require an optimal environmental pH for effectiveness, which is described in the IFUs, and must be followed. Failure to do so could reduce disinfecting properties of the disinfectant and/or cause harm to the surgical instrument.
5. Most disinfectants function within an optimal temperature range therefore it is essential to take temperature into consideration when selecting a new product.
6. Cleaning and disinfecting agents must be used in accordance with the IFUs to ensure effectiveness.

Table 1 from Guideline for Hand Hygiene in Health-Care Settings

Antimicrobial Spectrum and Characteristics of Hand-Hygiene Antiseptic Agents*

Group	Gram-positive bacteria	Gram-negative bacteria	Mycobacteria	Fungi	Viruses	Speed of action	Comments
Alcohols	+++	+++	+++	+++	+++	Fast	Optimum concentration 60%–95%; no persistent activity
Chlorhexidine (2% and 4% aqueous)	+++	++	+	+	+++	Intermediate	Persistent activity; rare allergic reactions
Iodine compounds	+++	+++	+++	++	+++	Intermediate	Causes skin burns; usually too irritating for hand hygiene
Iodophors	+++	+++	+	++	++	Intermediate	Less irritating than iodine; acceptance varies
Phenol derivatives	+++	+	+	+	+	Intermediate	Activity neutralized by nonionic surfactants
Triclosan	+++	++	+	—	+++	Intermediate	Acceptability on hands varies
Quaternary ammonium compounds	+	++	—	—	+	Slow	Used only in combination with alcohols; ecologic concerns

Note: +++ = excellent; ++ = good, but does not include the entire bacterial spectrum; + = fair; — = no activity or not sufficient.

* Hexachlorophene is not included because it is no longer an accepted ingredient of hand disinfectants.

NOTE: In the state of California, the use of Triclosan has been banned in some products.

SUBJECT:
**HOSPITAL-APPROVED HANDWASHING,
CLEANING AND DISINFECTANT PRODUCTS****SECTION:****Page 3 of 4****Printed copies are for reference only. Please refer to the electronic copy for the latest version.****SELECTION OF DISINFECTANT PRODUCTS**

Although there is no 'universal' disinfectant, it is economically infeasible to purchase several products for similar disinfecting tasks. Limiting the numbers of products within an institution provides for better and more consistent use of available disinfectants. The following criteria and/or standards should be considered when evaluating disinfectants:

1. Formulation – especially the active ingredients and the product concentration.
2. Disinfectant activity on specific pathogens – for instance, does the product kill microbes at the expected level of disinfection?
3. The contact time or time of action should be less than 15 minutes.
4. Corrosiveness – at what concentration will the disinfectant cause harm to metallic surfaces?
5. Possible side effects such as skin irritation, staining or discoloration of materials, levels of toxicity and possible allergic reactions.
6. Effects of pH on product effectiveness – is disinfectant activity changes in the presence of an acidic or basic environment?
7. Product incompatibility with conditions such as hard water, or the presence of specific detergents or other chemicals commonly used during cleaning and disinfecting.
8. Considerations should include:
 - a. Purchasing disinfectants and cleaning agents from reputable and well-established companies.
 - b. Disinfectants and cleaning agents shall have an EPA registry number, easily understood Manufacturer's Instructions for Use (IFU) and a product Safety Data Sheet (SDS) that will be kept on file and consulted as needed.

A LIST OF SOME TYPICAL DISINFECTANTS

1. Omega (quaternary ammonium compound)
2. Bleach (sodium hypochlorite)
3. Sani-Cloth Plus (germicidal disposable wipes)
4. Moni-Chlor Wipes (sodium hypochlorite cloths)

SUBJECT:
**HOSPITAL-APPROVED HANDWASHING,
CLEANING AND DISINFECTANT PRODUCTS**

SECTION:

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REFERENCES

California Department of Public Health. California Code Regs. Title 22, §70739-Infection Control Program. Retrieved August 14, 2026. From:
<https://www.law.cornell.edu/regulations/california/22-CCR-70739>

Centers for Disease Control and Prevention. Disinfection and Sterilization Guideline (page 7-45): *Factors Affecting the Efficacy of Disinfection and Sterilization*. Updated November 23, 2023. Retrieved August 14, 2026. From:
<https://www.cdc.gov/infectioncontrol/guidelines/disinfection/efficacy.html>

Centers for Disease Control and Prevention. *Guidelines for Hand Hygiene In Healthcare Settings*. (2002, last updated 2024, March 18). Retrieved August 13, 2026. From:
<https://www.cdc.gov/handhygiene/providers/guideline.html>

Centers for Disease Control and Prevention. *Guidelines for Disinfection and Sterilization in Healthcare Facilities* (2008). Updated November 28, 2023. Retrieved August 14, 2026. From:
<https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/rational-approach.html>

Triclosan Fact Sheet, Triclosan: Biomonitoring California. Published 2013, updated 2018, Accessed August 14, 2026. From: <https://biomonitoring.ca.gov/chemicals/triclosan>

SUBJECT: IV EXTRAVASATION - NEONATES	SECTION:
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Page 1 of 3

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

PURPOSE:

To provide evidence-based guidelines for the recognition, assessment, treatment, monitoring, and documentation of intravenous infiltration and extravasation injuries in neonates, including the appropriate use of hyaluronidase and saline washout techniques to minimize tissue damage and promote healing.

DEFINITIONS:

Extravasation: inadvertent leakage of a vesicant, irritant, hyperosmolar, or tissue-damaging solution into surrounding tissue.

Infiltration: inadvertent leakage of a non-vesicant solution into surrounding tissue.

POLICY:

Hyaluronidase can be used to facilitate the resolution of subcutaneous infiltration in neonates according to the following criteria and implemented with a physician's order per Nursery protocol:

1. Indications for Hyaluronidase are extravasation involving drugs that are irritating to veins because of hyperosmolarity or extreme pH (i.e. Gentamicin, Calcium, Sodium Bicarbonate, Potassium Chloride, concentrated IV fluids).
2. Administer hyaluronidase as soon as possible after recognition of significant extravasation. Optimal effectiveness occurs when administered within the first hour; however, treatment may still be considered beyond one hour based on provider assessment and clinical severity
3. In treating intravenous extravasation, Hyaluronidase acts to reduce the local concentration of a damaging agent and increase its rate of absorption, thereby decreasing tissue exposure.

AFFECTED AREAS/ PERSONNEL: *MCH DEPARTMENT RNs*

EQUIPMENT:

- Hyaluronidase
- TB sterile syringe
- Five 5/8" needle (25 or 27 gauge)
- Sterile 2 x 2

SUBJECT: IV EXTRAVASATION - NEONATES	SECTION:
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PROCEDURE:

1. Stop IV infusion immediately.
2. Disconnect administration tubing.
3. Leave catheter in place initially, and attempt to aspirate residual drug or fluid from the catheter.
4. Notify provider.
5. Remove catheter after aspiration and antidote planning are completed.
6. Document area of extravasation by photographing.
7. Obtain order for Hyaluronidase: (150 units/mL) 30 units/0.2 mL subcutaneous x 5 doses.
8. Prep extravasated site by cleansing the area with approved neonatal skin antisepsis agents per current NICU practice guidelines.
9. Administration of Hyaluronidase:
 - a. 5 subcutaneous injections of 30 units/0.2 mL each in and around the edge of the extravasation site.
 - b. Change needle after each injection.
10. Saline washout to remove extravasated irritants from the affected site.
11. Cover affected areas with a light dressing so as not to cause undue pressure or rubbing of the wound. Consider hydrogel dressing for 48 hours.
12. Elevate affected extremity above the level of the heart.
13. Check injection site after 5 minutes for possible sensitivity reaction.
14. Application of warm or cold compresses should be based on the extravasated agent and organizational guidelines. Use caution with any temperature-based therapy in neonates due to risk of thermal injury or cold stress
15. Do not use affected extremity for 48 hours if possible.
 - a. No activity
 - b. No labs or IV starts for 24 hours
16. Complete Incident Report.

SUBJECT: IV EXTRAVASATION - NEONATES	SECTION: Page 3 of 3
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17. Notify Risk Management.

DOCUMENTATION:

- Observe and document the appearance of the lesion (induration, edema, discoloration, blanching and blister formation) every 15 minutes for two hours.
- Document treatment provided in Nurses' Notes in Electronic Medical Record (EMR).
- Document infant's tolerance of the procedure in Nurses' Notes in EMR.
- Chart any adverse reaction in Nurses' Notes in EMR.
- Chart Hyaluronidase in Electronic Medication Administration Record (EMAR) medication record.
- Complete Incident Report with as much detail as possible.
- Parent family education.

REFERENCES:

Nickel, B., Gorski, L., Kleidon, T., Kyes, A., DeVries, M., Keogh, S., Meyer, B., Sarver, M. J., Crickman, R., Ong, J., Clare, S., & Hagle, M. E. (2024). *Infusion therapy standards of practice* (9th ed.). *Journal of Infusion Nursing*, 47(1S), S1-S285. <https://doi.org/10.1097/NAN.0000000000000532>

Raisi, Z., Behzadi Fard, S., Behzadi Fard, S., & Khabazzadeh, F. (2023). Management of extravasation injury in infants: A systematic review of clinical trials. *Medical-Surgical Nursing Journal*, 12(1), e139426. <https://doi.org/10.5812/msnj-139426>

Sagheb, S., Mohseni, S. O., & Lamsehchi, A. (2022). A new approach to skin extravasation injury management during the neonatal period. *BMC Pediatrics*, 22(1), 451. <https://doi.org/10.1186/s12887-022-03511-y>

Nguyen, L. N., Takashima, M., Cunninghame, J., August, D., & Ullman, A. J. (2024). Extravasation identification and management in neonates and pediatrics: A cross-sectional survey. *Hospital Pediatrics*, 14(12), 1026-1034

SUBJECT: LARGE FOR GESTATIONAL AGE INFANT	SECTION:
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish nursing guidelines for the assessment and management of large for gestational age (LGA) babies who should be observed for hypoglycemia or birth trauma.

POLICY:

1. Large for gestational (LGA) age babies will be identified and treated according to standards of care.
2. Blood glucose screening will be performed on infants identified as LGA ($\geq 90^{\text{th}}$ percentile for gestational age), infants of diabetic mothers, and other at-risk newborns in accordance with current neonatal hypoglycemia guidelines.
3. An infant large for gestational age is an infant with a birth weight equal to or above the 90th percentile at any given gestational age.
4. Infants at risk to be LGA include those born to mothers with:
 - Diabetes
 - Multiparity
 - Predisposition for LGA babies

AFFECTED AREAS/ PERSONNEL: *MATERNAL CHILD HEALTH (MCH) DEPARTMENT;
REGISTERED NURSES (RN)'S*

PROCEDURE:

1. Admit infant as per admission policy.

Evaluate infant for potential problems related to LGA, including:
 - Cephalhematoma
 - Brachial palsy, phrenic nerve palsy, facial palsy
 - Fractured clavicle
 - Neurological deficits
 - Abnormal skin/bruising

SUBJECT: LARGE FOR GESTATIONAL AGE INFANT	SECTION:
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- a. Hypoglycemia
 - Initiate feeding as soon as possible after birth. Encourage breastfeeding
 - Feed infant every 1.5 to 3 hours. If breastfeeding, encourage mother to breastfeed on baby's demand such as whenever the baby expresses signs of early hunger (i.e. increased alertness, increased physical activity, mouthing or rooting).
 - Monitor blood glucose at 1, 2, 4, 6 hours of age then as ordered.
 - b. Polycythemia
 - Assess for clinical signs of polycythemia and obtain laboratory testing as ordered by the provider
 -
 - c. Respiratory distress
 - d. Hyperbilirubinemia
3. Follow Standard Normal Newborn Care
 - If hypoglycemic symptoms continue, notify physician and prepare for possible transfer to higher level of care as initiated by physician on a case-by-case basis.

DOCUMENTATION:

- Immediate delivery summary

REFERENCES:

- Academy of Breastfeeding Medicine. (2021). ABM clinical protocol #1: Guidelines for glucose monitoring and treatment of hypoglycemia in term and late preterm neonates (Revised 2021).
- American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2022). Guidelines for perinatal care (9th ed.). American Academy of Pediatrics.
- California Board of Registered Nursing. (n.d.). Nursing practice act. State of California Department of Consumer Affairs. Retrieved September 8, 2025, from <https://rn.ca.gov/practice/npa.shtml>
- California Legislature. (n.d.). California Business and Professions Code, Section 2725(c). Retrieved September 8, 2025, from <https://law.justia.com/codes/california/code-bpc/division-2/chapter-6/article-2/section-2725/>

SUBJECT: LARGE FOR GESTATIONAL AGE INFANT	SECTION:
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

- Murray, S. S., McKinney, E. S., Holub, K. S., & Jones, R. R. (2023). Foundations of maternal-newborn and women's health nursing (8th ed.). Elsevier.
- Troiano, N. H., Harvey, C. J., & Chez, B. F. (2019). High-risk and critical care obstetrics (4th ed.). Wolters Kluwer.

SUBJECT: MANAGEMENT OF INFANT IN THE ISOLETTE	SECTION:
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PURPOSE:

To set nursing guidelines for maintaining neutral thermal environment (NTE – the environmental temperature in which the infant is able to maintain a normal core temperature with minimal oxygen and caloric expenditure). Infants < 34 weeks gestation typically do not have the ability to maintain temperature regulation in an open crib.

POLICY:

- Infants with persistent axillary temperatures below 36.5°C (97.7°F), or infants at increased risk for thermal instability due to gestational age, birth weight, or clinical condition, should be placed in a thermoregulated environment (isolette) per nursing assessment and provider orders.
- A physician's order is required to wean an infant from the isolette. A nursing order is sufficient to initiate placing the infant in an isolette.

AFFECTED AREAS/ PERSONNEL: *MCH DEPARTMENT/RNs*

EQUIPMENT: Isolette

PROCEDURE:

1. Explain procedure to parents before starting.
2. Place infant in pre-warmed isolette using the Neutral Thermal Environment Chart (NTE)
3. Manually controlled isolette – the temperature in the isolette may be controlled by a thermostat. This keeps the environment at a set temperature and allows one to monitor the infant's temperature. The temperature is set to provide a neutral thermal environment:
 - a. Refer to Appendix A for NTE chart.
 - b. Infant should not be wrapped in blankets except when weaning to open crib.
 - c. Keep isolette away from cold walls, air currents, windows, and other cold objects.
 - d. The isolette's ambient temperature (air temperature) should be recorded simultaneously with the infant's axillary temperature so that changes in the infant's temperature can be interpreted appropriately.
 - e. An increase or decrease in body temperature will not be masked if the manually controlled ambient temperature has been stable and set in the appropriate neutral thermal environmental range.

SUBJECT: MANAGEMENT OF INFANT IN THE ISOLETTE	SECTION:
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- f. A change in the infant's body temperature caused by a change in the manually controlled ambient temperature (air temperature) could be detected by noting both the infant and ambient temperature changing in the same direction.
4. Servo controlled isolette – the servo control system uses the infant's skin temperature to control the temperature inside the isolette. The skin probe is placed on the baby's back or abdomen that measures his/her skin temperature. Changes in isolette temperature must be observed since the infant's skin temperature will not change:
 - a. Set the temperature control to maintain the infant's temperature within the normal range. Follow manufacturer-specific guidelines for skin probe placement, securement, and calibration.
 - b. Care should be taken to prevent the probe from coming off the skin. The unit will sense a lower temperature, increase the environmental temperature and possibly over-heat the infant.
 - c. Keep isolette away from cold walls, air currents, windows, and other cold spots.
 - d. Record the ambient temperature (air temperature), the skin temperature and the infant's temperature should be recorded and compared, to avoid masking of the infant's true condition.
 - e. These temperatures should be stable in order to state that the infant's temperature is stable. If an infant becomes febrile, the incubator temperature drops but there is no change in body temperature. Alternately, a decreasing body temperature would be corrected and held steady by an increase in the servo controlled ambient temperature (air temperature). These changes in the infant may be detected by noting changes in the environmental temperature.
5. Infant may be removed for feedings. Time outside the isolette should be individualized based on gestational age, thermal stability, respiratory status, and feeding tolerance.
6. Weaning from isolette:
 - a. Dress infant in hat, shirt, diaper and one blanket.
 - b. Check infant temperature prior to weaning process and then every 4 hours.
 - c. Decrease isolette temperature by 0.5 degree to 1 degree –every 4 hours. As room temperature is approached wrap infant in two blankets.
 - d. After weaning, repeat axillary temperature measurement every 3 – 4 hours for 24 hours and then every 8 hours until discharge.

SUBJECT: MANAGEMENT OF INFANT IN THE ISOLETTE	SECTION:
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- e. Stop weaning if infant's temperature falls below 36.5 degree C (97.7 F) and if the infant displays signs of cold stress.

DOCUMENTATION:

1. Document all vital signs and isolette temperatures.
2. Record infant's response to weaning process.
3. Record completion of weaning process in the Electronic Medical Record. (EMR)
4. Document parent/family education.

REFERENCE:

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

California Department of Health Care Services. (2024). *California Code of Regulations, Title 22: Social Security, Division 5—Licensing and Certification of Health Facilities*. California Department of Health Care Services.

Gardner, S. L., Carter, B. S., Enzman-Hines, M. I., & Hernandez, J. A. (2024). *Merenstein & Gardner's handbook of neonatal intensive care* (10th ed.). Elsevier.

National Association of Neonatal Nurses. (2022). *Neonatal nursing: Scope and standards of practice* (3rd ed.). National Association of Neonatal Nurses.

World Health Organization. (2022). *WHO recommendations for care of the preterm or low-birth-weight infant*. World Health Organization.

SUBJECT:
MANAGEMENT OF INFANT IN THE ISOLETTE
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Neutral Thermal Environment (NTE)
Temperature Guidelines

Age and Weight	Range of Temperature °C	Age and Weight	Range of Temperature °C
0-6hrs <1200g 1200-1500g 1501-2500g >2500g	34.0-35.4 33.9-34.4 32.8-33.8 32.0-33.8	72-96hrs <1200g 1200-1500g 1501-2500g >2500g	34.0-35.0 33.0-34.0 31.1-33.2 29.8-32.8
6-12hrs <1200g 1200-1500g 1501-2500g >2500g	34.0-35.4 33.5-34.4 32.2-33.8 31.4-33.8	4-12 days <1500g 1501-2500g >2500g 4-5 days 5-6 days 6-8days 8-10 days 10-12days	33.0-34.0 31.0-33.2 29.5-32.6 29.4-32.3 29.0-32.2 29.0-31.8 29.0-31.4
12-24hrs <1200g 1200-1500g 1501-2500g >2500g	34.0-35.4 33.3-34.3 31.8-33.8 31.0-33.7	12-14 days <1500g 1501-2500g >2500g	32.6-34.0 31.0-33.2 29.0-30.8
24-36hrs <1200g 1200-1500g 1501-2500g >2500g	34.0-35.0 33.1-34.2 31.6-33.6 30.7-33.5	2-3 weeks <1500g 1501-2500g	32.2-34.0 30.5-33.0
36-48hrs <1200g 1200-1500g 1501-2500g >2500g	34.0-35 33.0-34.1 31.4-33.5 30.5-33.3	3-4 weeks <1500g 1501-2500g	31.6-33.6 30.0-32.7
48hrs-72hrs <1200g 1200-1500g 1501-2500g >2500g	34.0-35.0 33.0-34.0 31.2-33.4 30.1-33.2	4-5 weeks <1500g 1501-2500g 5-6 weeks <1500g 1501-2500g	31.2-33.0 29.5-32.2 30.6-32.3 29.0-31.8

SUBJECT: MCH - ADMISSION CRITERIA	SECTION: Page 1 of 2
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POLICY:

- All patients of 20 weeks gestation or greater that present to the Labor & Delivery (L&D) Department, or that enter the hospital with L&D complaints will be assessed by the L&D unit. External fetal monitors should be applied to assess the fetal heart rate and uterine activity.
- Patients presenting for the observation of labor and/or prenatal testing will be admitted as ordered by the physician.

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

PROCEDURE:

1. Prenatal history should be available to the labor and delivery staff via the electronic medical record or faxed from the physician's office upon request to provide patient specific care.
2. The patient will be evaluated based on symptoms, complaint and reason for visit. Report to the physician will be given as soon as possible by the registered nurse.
3. An RN is to assess, admit if indicated by the physician and monitor the patient's progress as ordered per physician.
4. Admission criteria includes; but is not limited to:
 - a. Active labor:
 - 1) Uterine contractions with cervical change
 - 2) 5 cm cervix primigravida
 - 3) 6 cm multiparous
 - b. Rupture of Membranes
 - c. Antepartum care and observation as ordered per physician
5. Fetal monitoring is initiated upon admission and maintained per standardized care considering the risk factors present and fetal well-being, unless otherwise ordered by the physician.
6. When a patient is examined by a RN and determined not to be in active labor, the nurse should:
 - a. Follow Medical Screening Exam policy
 - b. Report the assessment to the physician
 - c. Request discharge status determination from the physician

SUBJECT: MCH - ADMISSION CRITERIA	SECTION: Page 2 of 2
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If patient stable for discharge. Discharge the patient as ordered, give and discuss discharge instructions with the patient. The patient and nurse will sign the discharge document jointly.

7. Document assessments, care provided and patients understanding of education and discharge instructions.

REFERENCES:

- American College of Obstetricians and Gynecologists. (2021). *Antepartum fetal surveillance (Practice Bulletin No. 229)*. Obstetrics & Gynecology, 137(6), e116-e127.
<https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2021/06/antepartum-fetal-surveillance> [[acog.org](https://www.acog.org)], [pubmed.ncbi.nlm.nih.gov]
- Association of Women's Health, Obstetric and Neonatal Nurses. (2024). *Fetal heart monitoring: Position statement*. Journal of Obstetric, Gynecologic & Neonatal Nursing, 53(3), e5-e9.
[https://www.jognn.org/article/S0884-2175\(24\)00040-6/fulltext](https://www.jognn.org/article/S0884-2175(24)00040-6/fulltext) [[jognn.org](https://www.jognn.org)]
- Association of Women's Health, Obstetric and Neonatal Nurses. (2024). *Standards for professional nursing practice in the care of women, newborns, and people across the life span (9th ed.)*. Journal of Obstetric, Gynecologic & Neonatal Nursing, 53(1), e4-e40.
[https://www.jognn.org/article/S0884-2175\(23\)00246-0/fulltext](https://www.jognn.org/article/S0884-2175(23)00246-0/fulltext) [[jognn.org](https://www.jognn.org)]

SUBJECT: MEDICATIONS RESTRICTED TO AREAS OR PERSONNEL	SECTION: <i>Pharmaceutical Services</i> 9 Page 1 of 6
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PURPOSE:

To provide guidelines for the safe administration of specific medications restricted to approved nursing units and patient care areas.

DEFINITIONS:

1. Approved areas: Areas as indicated in policy where medications may be administered.
2. Non-approved areas: Any unit where identified medications are not approved for administration.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that identified medications by nature of their pharmacology and indications require specific monitoring.

AFFECTED PERSONNEL/AREAS: *ALL NURSING AREAS AND PHARMACY*

PROCEDURE:

- A. Administration of medications in approved nursing units
 1. Restricted medications will be administered only in the approved units and with the requirements indicated in Addendum A of this policy and more specifically described in medication-specific policies, which may be referenced.
- B. Administration of medications in non-approved nursing units
 2. If the physician orders a medication listed in Addendum A for a patient located in a non-approved unit, and/or the requirements listed in Addendum A or medication specific policy, as referenced, cannot be met, the physician will:
 - a) Consider an alternative therapy.
 - b) Order the patient transferred to an appropriate unit.
 - c) Order the medication to be given using the criteria listed below:
 - i. The patient must have bedside monitoring to include continuous cardiac monitoring, pulse oximetry, and monitoring at least every 15 minutes or more frequently as indicated in Addendum A or in referenced medication specific policies. These vital signs will be documented as obtained.
 - ii. The medication must be administered under the direct supervision of the ordering physician.

SUBJECT:**MEDICATIONS RESTRICTED TO AREAS OR
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- iii. The ordering physician, nurse, or allied health professional administering the medication must have the appropriate credentials and meet the requirements listed in Addendum A or in medication-specific referenced policies.
- iv. Pharmacy must be notified by telephone that the criteria listed above have been met before they will send the needed medication(s).
- v. Staff involved in the care of the patient must complete appropriate competencies to manage the patient's care. It will be the responsibility of the unit manager to ensure their staff have the appropriate competencies and training before assigning them to a unit/or patient that requires use of these orders.

RASS Goal drips: Must complete Rass competencies

TOF Goal drips: Must have completed TOF competencies

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Addendum A

Titratable Continuous Infusions				
Drug Name	Approved Units	Additional Requirements Note: All titratable infusions must have a clinical goal to titrate by such as: Level of Pain, Sedation, Heart Rate, Blood Pressure, Mean Arterial Pressure (MAP), Blood Glucose, Train of Four (TOF) Level, etc.	Intubation Required	Intubation requirement exception for Comfort Care Note: If not required in column D, then defaulted to not required in comfort care. If Y in Column D and not explicitly marked Y in this column then default to N.
Cisatracurium	ED, Cath Lab, ICU, OR, OBOR, PACU	Train of Four (TOF); Cardiac Monitoring; Vital signs (HR, BP, RR) per standard of care of unit.	Y	N
Dexmedetomidine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes. Level of Sedation per protocol	N	
Diltiazem	ICU, ED, OR, OBOR, PACU, Cath Lab	Cardiac monitoring & vital signs (BP & HR) every 15 minutes for 30 minutes at start of infusion then every 4 hours.	N	
Dopamine	ICU, ED, OR, OBOR, PACU, Cath Lab	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Epinephrine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Esmolol	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Fentanyl	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & hemodynamics (BP & HR) continuously. Level of Sedation or Pain per protocol. End tidal CO2 monitoring.	Y	Y- See Fentanyl non-titratable
Heparin	All units	Coagulation monitoring per protocol.	N	
Insulin	ICU, ED, OR, OBOR, PACU, Cath Lab.	BG per protocol	N	
Ketamine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes. Level of Sedation or Pain per protocol	Y	N
Lidocaine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Midazolam	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care of unit. Level of Sedation per protocol.	Y	
Milrinone	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Morphine Drip-Sedation (RASS)	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care of unit. End tidal CO2 monitoring.	Y	See Morphine Drip-Comfort Care

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Morphine Drip-Comfort Care	All units	Level of Pain & Sedation per care team & protocol. Vital signs per standard of care of unit, unless specific orders exist otherwise for vital sign monitoring. Ex: Provider orders no vitals signs or vital signs per shift etc.	N	
Nicardipine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Nitroglycerin	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Nitroprusside	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes. Max 3 days, monitor for cyanide toxicity.	N	
Norepinephrine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Phenylephrine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Procainamide	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Propofol	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care of unit. Level of Sedation per protocol.	Y	N
Vecuronium	ICU, ED, OR, OBOR, PACU, Cath Lab.	Train of Four (TOF); Cardiac Monitoring; Vital signs (HR, BP, RR) per standard of care of unit.	Y	N
Patient Controlled Anesthesia (PCA's)				
Hydromorphone	All units	Level of Pain per protocol & vital signs per standard of care for unit or as directed by provider order. End tidal CO2 monitoring.	N	
Morphine	All units	Level of Pain per protocol & vital signs per standard of care for unit or as directed by provider order. End tidal CO2 monitoring.	N	
Non Titratable Continuous Infusions				
Acetylcysteine	ICU, ED, OR, OBOR, PACU, Cath Lab, MS & TELE	Reassess LFT's Every 4 to 6 hours unless otherwise directed by protocol	N	
Alteplase: Dose ≤ 2 mg/hr (Ex. Catheter directed thrombolytic therapy for DVT of lower extremity).	All units	Fibrinogen Q6Hr. Daily CBC.	N	

**SUBJECT:
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Alteplase: Dose exceeding 2mg/hr	ICU, ED, OR, OBOR, PACU, Cath Lab.	Stroke Tx: Vital signs and neurologic status should be checked every 15 minutes for two hours, then every 30 minutes for six hours, then every 60 minutes until 24 hours from the start of thrombolysis. All other: Continuous cardiac monitoring & hemodynamics (BP). Daily CBC	N	
Amiodarone	Cath Lab, ED, ICU, OR & OBOR, PACU, TELE	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation.	N	
Diltiazem	ICU, ED, OR, OBOR, PACU, Cath Lab & TELE	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation. TELE- May not exceed 10mg/hr.	N	
Dobutamine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Dopamine	ICU, ED, OR, OBOR, PACU, Cath Lab & TELE	TELE: Only for non-titratable doses for renal perfusion. Max on TELE unit is 3 mcg/kg/minute. Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation.	N	
Eptifibatide	ICU, OR, OBOR, ED, Cath Lab	CBC & CMP at baseline and at least Q24hr while on therapy. Platelet count recommended 2-4 hours after initiation and at 24 hours or prior to discharge whichever is first. Cardiac monitoring & vital signs per standard of care for unit.	N	
Fentanyl	ICU, ED, OR, OBOR, PACU, Cath Lab, TELE & MS.	For TELE & MS must be a fixed dose utilized for comfort care. Cardiac monitoring & vital signs per standard of care for unit. End tidal CO2 monitoring.	N	Y- Alert provider if respiratory rate <12 breaths/minute or persistent episodes of shallow breathing or apnea, oxygen saturation <90% or RASS score -2 or below. Staff must have completed RASS training.
Factor VII	ICU, ED, OR, OBOR, PACU, Cath Lab.	CBC & CMP at baseline and at least Q24hr while on therapy. Cardiac monitoring & vitals signs per standard of care for unit.	N	
Ferric Carboxymaltose	All units	Continuous pulse ox & heart rate monitoring required. Attending entry required (residents)	N	
Ferric Gluconate	All units	Continuous pulse ox & heart rate monitoring required. Attending entry required (residents)	N	
Iron Dextran	All units	Continuous pulse ox & heart rate monitoring required. Test dose required. Attending entry required (residents)	N	
Iron Sucrose	All units	Continuous pulse ox & heart rate monitoring required. Attending entry required (residents)	N	
Ketamine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care for unit. Level of Sedation or Pain per protocol.	Y	

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Lidocaine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation.	N	
Magnesium (40g premix)	OBOR, L&D, OR, PACU, ICU	Not for use for routine electrolyte replacement. Approved for use for Eclampsia/Preeclampsia & neuroprotection for imminent preterm birth.	N	
Naloxone	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP, pulse, respiratory rate, oxygen saturation) Q15M x 2 hrs and then per standard of care for unit. End tidal CO2 monitoring.	N	
Octreotide	All units	BG monitoring per protocol.	N	
Prothrombin Complex Concentrate (Kcentra)	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation.	N	
Vasopressin	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation.	N	
IV Push				
Adenosine	OR, OBOR, ED, PACU, ICU, Cath Lab.	Cardiac monitoring & hemodynamics (BP) continuously. Provider at bedside. Stress Test/Imaging may be performed in ICU and Cath Lab while pt on cardiac m monitor and provider administered. All units acceptable as determined by physician determination for urgent need but physician must be at bedside. Recommend pads in place and crash cart nearby.		
Alteplase- Bolus	Cath Lab, ED, or ICU			
Alteplase- Parapneumonic effusion	All units	Physician administered		
Alteplase- Catheter Occlusion	All units			
Amiodarone	All units as part of ACLS	IV push should only be used as part of ACLS. Otherwise use of controlled infusion pump required, refer to continuous non-titratable section above.		
Cisatracurium	ICU, ED, OR, OBOR, PACU, Cath Lab.	IV push should only be used as part of Rapid Sequence intubation outside of the approved areas for life saving treatment.		
Diltiazem	ICU, ED, OR, OBOR, PACU, Cath Lab & TELE	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at x1 at least 5-30 min after administration of		

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		bolus.		
Eptifibatide	ICU, OR, OBOR, ED, Cath Lab	See infusion section for additional parameters		
Esmolol	ICU, ED, OR, OBOR, PACU, Cath Lab	Cardiac monitoring & vital signs per standard of care of unit. OK in Tele/MS followed by transfer to appropriate unit for maintenance.		
Etomidate	All units	Administered by Anesthesia staff, physicians credentialed in Rapid Sequence Intubation and Deep Procedural Sedation and RNs who have completed RSI education. Cardiac monitoring & hemodynamics (BP & HR)		
Fentanyl	All units			
Glycopyrrolate	IV: Operating Suites End of Life Secretions (IM/SC/Oral/SL) All units	IV doses administered by Providers only		
Haloperidol	All units	All IV administration (at any dose) requires cardiac monitoring.		
Heparin	All units	Daily CBC		
Hydralazine	All units	BP x1 at least 10 mins after administration of bolus.		
Hydromorphone	All units			
Insulin Regular	All units	Baseline BG & BG Q1HR x2 post administration. Orders for IV bolus shall be restricted to x1 orders in MS & TELE.		
Iron Sucrose	All units	Continuous pulse ox & heart rate monitoring required. Attending entry required (residents)		
Ketamine	All units a part of RSI. Otherwise: ICU, ED, OR, OBOR, PACU, Cath Lab	Administered by Anesthesia staff, physicians credentialed in Rapid Sequence Intubation and Deep Procedural Sedation and RNs who have completed RSI and Procedural Sedation education. Cardiac monitoring & hemodynamics (BP & HR) continuous during Deep Sedation. May be administered outside of		
Labetalol	All units	Cardiac monitoring & vital signs per standard of care for unit. BP x1 after 5 mins since administration. RN to be ACLS certified		
Lidocaine	All units as part of ACLS	IV push should only be used as part of ACLS. Otherwise use of controlled infusion pump required, refer to continuous non-titratable section above.		
Metoprolol	ICU, ED, OR, OBOR, PACU, Cath Lab & TELE	Cardiac monitoring & vital signs per standard of care for unit. BP & HR x1 at least 5 minutes after bolus administration. RN to be ACLS certified.		
Midazolam	All units			

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Morphine	All units			
Octreotide	All units			
Phenobarbital	All units	Cardiac monitoring & continuous pulse ox with heart rate monitoring required		
Physostigmine	ICU, ED, OR, OBOR, PACU, Cath Lab	Cardiac monitoring & vital signs per standard of care for unit. If administering for reversal of toxic effects refer to poison control center for additional monitoring recommendations.		
Propofol	ICU, ED, OR, OBOR, PACU, Cath Lab	Administered by Anesthesia staff, physicians credentialed in Rapid Sequence Intubation and Deep Procedural Sedation and RNs who have completed RSI education. Cardiac monitoring & hemodynamics (BP & HR) continuous during Deep Sedation.		
Propanolol	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care for unit.		
Rocuronium	All units as part of Rapid Sequence Intubation, transfer to critical care unit for sustained intubation/deep sedation.			
Succinylcholine	All units as part of Rapid Sequence Intubation, transfer to critical care unit for sustained intubation/deep sedation.			
Tenectaplastase	ICU, ED, OR, OBOR, Cath Lab. All units for stroke alert	Ischemic Stroke Tx: Measure BP and perform neurological assessments every 15 minutes for the first 2 hours of initiation then every 30 minutes for the next 6 hours, then hourly until 24 hours after initiation of tenecteplase.		
Vecuronium	All units as part of Rapid Sequence Intubation, transfer to critical care unit for sustained intubation/deep sedation.			
Verapamil	ICU, ED, OR, OBOR, PACU, Cath Lab & TELE	Cardiac monitoring & vital signs per standard of care for unit. BP & HR x1 at least 5 minutes after bolus administration.		
General Anesthetic, Inhalation				
Desflurane	Operating Suites	Anesthesia staff only		87

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Isoflurane	Operating Suites	Anesthesia staff only		
Sevoflurane	Operating Suites	Anesthesia staff only		

SUBJECT: PHOTOGRAPHY OF THE INFANT	SECTION: Page 1 of 1
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide parents with a photograph commemorating their newborn.

POLICY:

- All infants born at Sierra View Medical Center (SVMC) will be photographed; any copies to be purchased must have a parent signature.
- SVMC will contract with a photography corporation that will photograph infants on a daily basis.
- The photography corporation will keep a negative for one (1) year.
- The photographer does rounds and offers the service to every mom who has delivered; on occasions when the photographer is not available, the registered nurse (RN) provides the moms who have delivered the business card of the photographer, so they can call and make arrangements if they'd like their babies photographed.
- The order form will be available in languages of primary populations served.
- Parents may photograph their infant.
- Videotaping of any type will not be permitted during delivery.

AFFECTED AREAS/ PERSONNEL: *MCH STAFF***PROCEDURE:**

1. Photography services for the newborn will be available prior to discharge, and may be taken with clothes on, per family preference.
2. All questions regarding the photographs must be forwarded to the photography corporation.
3. The contracted photography company will provide parents with necessary information to complete their picture order.

REFERENCES:

Mom365. (n.d.). *About Mom365*. Mom365. <https://mom365.com/about-mom365>

SUBJECT: PRECAUTIONS FOR ANTIBIOTIC-RESISTANT MICROORGANISMS	SECTION: <i>Surveillance, Prevention, Control of Infection (IC)</i>
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PURPOSE:

To provide isolation guidelines for the management of patients with active or a history of recent infection with Multi Drug-Resistant Organisms (MDROs). Some examples of MDROs include Methicillin-resistant *Staphylococcus aureus* (MRSA), Vancomycin-resistant *Enterococcus* (VRE), Carbapenem-resistant *Enterobacteriaceae* (CRE), *Streptococcus pneumoniae* and other MDROs (see Table 1).

The CDC recommends the implementation of a “multifaceted, evidence-based approach with four parallel strategies: infection prevention; accurate and prompt diagnosis and treatment; prudent use of antimicrobials; and prevention of transmission.” Thus, prevention of hospital-acquired infections (HAIs), especially from MDROs is achievable through consistent implementation of the appropriate isolation precautions which are presented within this SMVC policy.

POLICY:

Patients with an active MDRO infection shall be placed in isolation under the appropriate precautions as soon as possible. Patients with a history of an MDRO shall be placed in isolation under the appropriate precautions until determined to be free of the MDRO utilizing the guidelines provided. A patient who has a “colonized/non-infectious” MDRO such as MRSA in the nares does not need to be in Contact Precautions because the patient is not considered infectious.

AFFECTED AREAS/PERSONNEL:

- A. It is the responsibility of the physician and the nursing staff to place any patient positive for an MDRO culture in isolation under Contact Precautions until it is determined that the patient is no longer infectious.
- B. It is the responsibility of the Infection Prevention Department staff to monitor any patient positive for an MDRO infection through surveillance and to serve as a resource for the nursing and medical staff when determining patient room placement. The Infection Prevention Department will provide education regarding MDRO upon request or as needed when determined through surveillance. Electronic Medical Record (EMR) documentation of MDRO education by Registered Nurse or Physician is mandatory and must be placed in the appropriate area within the EMR.

PROCEDURE:

- A. Patients with a positive MDRO culture (other than “nasal” MRSA, etc.) shall be placed in isolation under Contact Precautions.
- B. Implement Contact Precautions as stated in Infection Prevention policy, including:
 - a. A private room
 - b. The use of gown and gloves whenever the staff enter the patient’s room

SUBJECT:
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- c. Strict adherence to hand hygiene – especially the use of hand washing with soap and water when working with a *C. difficile* patient
- d. The use of any additional personal protective equipment (PPE) described under each specific type of precaution, such as contact precautions, airborne precautions, droplet precautions, etc.
- e. The use of dedicated non-critical equipment or devices such as stethoscopes, etc. is recommended.

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Table 1

Type of MDRO	Laboratory Evidence	Isolation Precaution in addition to Standard Precautions	Removal of Isolation Precaution
Carbapenem-resistant Enterobacteriaceae (CRE)	Positive laboratory test of the bacterial family Enterobacteriaceae with susceptibility results that indicate resistance to Ertapenem, Doripenem, Imipenem and/or Meropenem (e.g. Escherichia coli, Klebsiella pneumoniae, Enterobacter species)	Contact	Discontinuation will be determined by Infection Prevention on a case by case basis
Clostridium Difficile (C. diff)	Positive laboratory result for Clostridium difficile	Contact	After 48 hours with no diarrhea
Extended Spectrum Beta- Lactamase Producers (ESBL)	Positive laboratory test with susceptibility results that indicated ESBL producers	Contact	Discontinuation will be determined by Infection Prevention on a case by case basis
Methicillin-resistant Staphylococcus aureus (MRSA)	Positive results for laboratory test, <i>excluding nasal swab</i> , for MRSA with susceptibility results that indicate resistance to oxacillin	Contact	Discontinuation will be determined by Infection Prevention on a case by case basis
Vancomycin-resistant Enterococci (VRE)	Positive result for laboratory test for Enterococcus faecalis, Enterococcus faecium or Enterococcus species unspecified with susceptibility results that indicate resistance to vancomycin	Contact	Discontinuation will be determined by Infection Prevention on a case by case basis

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C. Recommendation Readmission Diagnosis

- a. If a readmission diagnosis is related to the MDRO infection, follow contact precautions until treatment has been completed
- b. If a subsequent readmission diagnosis is unrelated to the MDRO infection, isolation is unnecessary (except for CRO) if all of the following conditions are met:
 - i. A culture from the previously infected MDRO site is negative
 - ii. The patient has no symptoms related to the previous admission

D. Cohort

- a. If the resistance pattern of the MDRO for two patients is the same and neither patient has any other potentially transmissible infection, then the patients may cohort
- b. If a private room is not available and cohorting with a patient with the same resistance pattern is not possible, then it is important to consider the site of infection and mode of transmission of the infecting pathogen and select roommates carefully. Consultation with Infection Prevention is advised before patient placement. Items for consideration during the decision process should include:
 - i. The source patient's hygienic habits,
 - ii. Contamination of the environment or
 - iii. Cognitive impairment.
 - iv. The roommate's condition, including non-intact skin, renal failure, immunocompromised condition or cognitive impairment.

E. Patient Transport

- a. Limit the movement and transport of the patient from the isolation room to essential purposes only.
- b. If transport or movement is necessary, ensure that the appropriate precautions are maintained to minimize the risk of transmission of microorganisms to other patients, the environment or equipment. Ensure that this information is included in the hand-off report given to staff **prior** to transporting the patient.
- c. The patient should be transported directly to the procedure room and immediately returned to the patient's room. The patient should not be in a holding room/area prior to or after the procedure.
- d. Exceptions include but are not limited to:

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- i. Patients that need to be kept in the Post Anesthesia Care Unit (PACU) for recovery
 - ii. A lack of available beds
 - iii. A backlog in the procedure schedule
 - e. For planning assistance, call the Infection Prevention Department at ext. 3781 or ext. 4722
- F. Duration of Contact Isolation Precautions**
- a. The patient is considered infectious and should be placed in isolation under the appropriate precautions for the duration of the MDRO-associated illness.
 - b. If the original MDRO culture site is no longer accessible (such as a closed wound, peritoneal or pleural fluid, catheter site, etc.) and the patient is asymptomatic for that site, then isolation is no longer necessary
- G. Discharge from Hospital**
- a. If the patient is being transferred to an extended care facility, then the removal of isolation precautions is per the receiving facility's admission criteria.
 - b. If the patient is discharged to home, then the removal of isolation precautions is at the discretion of the M.D. Patient education must be provided on MDROs and home care by the nurse who is discharging the patient. Education of MDRO/home care must be documented in the EMR.
 - c. If the patient is still in isolation and decides to leave the hospital against medical advice (AMA) *and* the patient poses a health risk to the community due to a communicable MDRO, a representative of the Infection Prevention Department or the House Supervisor (during afterhours or the weekend) shall notify the Tulare County Public Health Department, Communicable Diseases at (559) 685-5720.
- H. Cleaning of the Patient's Room**
- a. EVS staff must don appropriate protective equipment (gown, gloves, etc.) prior to entering the patient's room
 - b. The Occupied Room:
 - i. High-touch environmental surfaces should undergo thorough cleaning at least daily using a hospital-approved detergent disinfectant. Surfaces are left wet for a certain amount of time (contact time) depending on the disinfectant's instruction for use.
 - ii. Materials, such as the bucket of disinfectant, mop heads and rags, are changed after cleaning the room for the following (but not limited to) MDROs such as MRSA, VRE CRE or *C. difficile*.

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- c. Terminal Cleaning upon patient discharge. Clean the patient room with the appropriate disinfectant, making sure to follow the proper kill time.
 - i. The materials used during the cleaning/disinfecting process, such as the bucket of disinfectant, mop heads and rags, *etc.*, are changed after cleaning a room that housed a patient with an MDRO. Curtains are to be removed, placed in a plastic bag and laundered. Replace with clean curtains after the room has been terminally cleaned.
- c. Prior to exiting cleaned area, remove PPE, discard and perform hand hygiene.

REFERENCES:

Centers for Disease Control (CDC) and Prevention (2022). *COVID-19 & Antimicrobial Resistance*. Last reviewed: 16 July 2024. Accessed August 21, 2026. https://www.cdc.gov/antimicrobial-resistance/data-research/threats/covid-19.html?CDC_AAref_Val=https://www.cdc.gov/drugresistance/covid19.html

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee 2007. Updated September 2024. *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. Accessed August 21, 2026. <https://www.cdc.gov/infection-control/media/pdfs/Guideline-Isolation-H.pdf>

Centers for Disease Control and Prevention (CDC). MDRO Prevention and Control: Management of Multidrug-Resistant Organisms in Healthcare Settings (2006). Updated April 12, 2024. Accessed August 21, 2026. <https://www.cdc.gov/infection-control/hcp/mdro-management/prevention-control.html>

Cross Reference:

[Standard Precautions](#)

[Contact Precautions DP/SNF](#)

[Isolation and Standard Precautions](#)

SUBJECT: Registered Nurses (RN) Ordering Lab Work for Radiology and Interventional Radiology (IR) Procedures	SECTION: <i>Surgical Services</i> Page 1 of 2
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure safe and appropriate lab work is ordered for patients undergoing Radiology and Interventional Radiology (IR) procedures, including ultrasound, stereotactic biopsies, CT, MRI, and other IR-related interventions. This policy aims to facilitate proper patient management by ensuring pre-procedure lab values are assessed in accordance with age, procedure type, and medical history.

DEFINITIONS:

1. CBC (Complete Blood Count):
2. PT (Prothrombin Time):
3. INR (International Normalized Ratio):
4. PTT (Partial Thromboplastin Time):
5. HCG (Human Chorionic Gonadotropin):
6. BUN (Blood Urea Nitrogen):

POLICY:

A. Pre-procedure lab work may be ordered by Registered Nurses (RNs) for patients undergoing Radiology and interventional radiology procedures, as per the following guidelines:

1. Ultrasound/Stereotactic Biopsies:
 - o CBC
 - o PT/INR
 - o PTT
 - o HCG for patients age 55 or below (unless patient has undergone tubal ligation or hysterectomy).
2. CT Procedures:
 - o CBC
 - o PT/INR
 - o PTT
 - o HCG for patients age 55 or below (unless patient has undergone tubal ligation or hysterectomy).
 - o BUN/Creatinine for patients age 55 or above, or for patients with known renal disease.
3. IR Procedures:
 - o CBC
 - o PT/INR
 - o PTT
 - o HCG for patients age 55 or below (unless patient has undergone tubal ligation or hysterectomy).
 - o BUN/Creatinine for patients age 55 or above, or for patients with known renal disease.
4. MRI Sedation Patients Getting Contrast:
 - o HCG for patients age 55 or below (unless patient has undergone tubal ligation or hysterectomy).

- BUN/Creatinine for patients age 55 or above, or for patients with known renal disease.

AFFECTED PERSONNEL/AREAS: *RN's working in Radiology, IR and Cardiology, Radiology Technologists, Managers, Directors and Radiologists and Medical Directors*

EQUIPMENT:

- Laboratory Order Forms (Electronic or Paper)
- Patient Demographic Information Systems
- Electronic Health Record (EHR) Systems

PROCEDURE:

A. Preparation for Lab Work:

- a. Upon receiving a patient's order for a Radiology or IR procedure (e.g., biopsy, CT, MRI, or sedation-related procedure), the RN is responsible for reviewing the patient's age, medical history, and the type of procedure scheduled.
- b. Review patient history for any known renal issues, recent surgeries, or other relevant medical conditions.

B. Lab Work Order Based on Procedure Type:

- a. Ultrasound/Stereotactic Biopsies:
 - i. Order CBC, PT/INR, PTT, and HCG (if applicable, based on age and reproductive status).
- b. CT Procedures:
 - i. Order CBC, PT/INR, PTT, and HCG (if applicable).
 - ii. If the patient is age 55 or above, or has known renal disease, order BUN/Creatinine.
- c. IR Procedures:
 - i. Order CBC, PT/INR, PTT, and HCG (if applicable).
 - ii. If the patient is age 55 or above, or has known renal disease, order BUN/Creatinine.
- d. MRI Sedation Procedures with Contrast:
 - i. Order HCG (if applicable based on patient age).
 - ii. Order BUN/Creatinine for patients age 55 or above or those with known renal disease.

C. Verifying Lab Orders:

- a. Double-check that all orders have been appropriately placed in the EHR and that the required lab results will be available prior to the procedure.
- b. Ensure that all relevant personnel (radiology techs, procedural RNs and physicians) are notified of any potential contraindications or required preparations based on lab results.

D. Follow-Up:

- a. Review and document the results of the lab work.
- b. If any lab result is outside of the acceptable range, alert the physician or the appropriate medical staff for review and further instruction.

REFERENCES:

American Nurses Association. (2022). *Nursing practice standards for radiology*. Washington, DC: American Nurses Association.

Harrison, T. (2021). *Interventional radiology procedures: Pre- and post-care protocols*. Elsevier.

Smith, J., & Baker, S. (2020). *Clinical laboratory values and their implications in interventional radiology*. *Journal of Radiology Nursing*, 47(4), 23-29. <https://doi.org/10.1016/j.jradn.2020.06.005>

SUBJECT: SMALL FOR GESTATIONAL AGE INFANT (SGA)	SECTION:
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish nursing guidelines for the assessment and management of Small for Gestational Age (SGA).

POLICY:

- SGA babies will be identified and treated according to standards of care.
- An infant small for gestational age is an infant below the 10th percentile using the Intrauterine Growth Curve Form.
- Infants less than 2500 grams may require car seat challenge prior to discharge, see policy and procedure, "Car Seat Safety".

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

PROCEDURE:

1. Keep infant warm as cooling delays recovery from birth asphyxia and increases the risk of hypoglycemia.
2. The SGA infant is vulnerable to:
 - a. Hypoglycemia
 - Initiate early feeding if appropriate.
 - Monitor blood glucose at 1-2-4-6 hours of age and then as ordered.
 - b. Polycythemia
 - c. Perinatal asphyxia and must be closely observed for signs of respiratory distress such as:
 - Retractions
 - Flaring of nares
 - Grunting
 - Tachypnea
 - d. Hypothermia
 - Delay initial bath until infant is stable.
 - Place infant in warmer for warmth and easy observation.

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SMALL FOR GESTATIONAL AGE INFANT (SGA)**SECTION:****Page 2 of 2**

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3. Neonatal team should be ready when anticipating the birth of an infant who is small for gestational age.
4. Provide parent/family education regarding care of SGA infant.

DOCUMENTATION IN ELECTRONIC MEDICAL RECORD (EMR):

- Immediate Delivery Summary
- Vital signs/BSGT per policy or as ordered by the physician
- Newborn Assessment
- Newborn measurements
- APGAR Score
- Parent/family education provided

REFERENCES:

- American Academy of Pediatrics & American College of Obstetrics and Gynecologist . (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors.
- Mattson, S. & Smith, J. E. (2023). Core curriculum for maternal-newborn nursing (6th ed.). St. Louis, MO: Elsevier Saunders.

SUBJECT: STERILE PRODUCTS: STERILE PRODUCT QUALITY ASSURANCE	SECTION:
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PURPOSE:

To provide procedures to ensure that compounded sterile preparations (CSPs) prepared at Sierra View Medical Center (SVMC) are of high quality and sterility.

DEFINITIONS:

Biological Safety Cabinet (BSC), Class II – A ventilated cabinet with an open front and inward and downward unidirectional HEPA-filtered airflow and HEPA-filtered exhaust. A BSC used to prepare a CSP must be capable of providing an ISO Class 5 or better environment for preparation of the CSPs.

Beyond-use date (BUD) – The date, or hour and the date, after which a CSP must not be used, stored, or transported. The date is determined from the date and time the preparation is compounded.

Category 1 CSP – A CSP that is assigned a BUD of 12 hours or less at controlled room temperature or 24 hours or less refrigerated

Category 2 CSP – A CSP that may be assigned a BUD of greater than 12 hours at controlled room temperature or greater than 24 hours refrigerated

Compounded sterile preparation (CSP) – A preparation intended to be sterile that is created by combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug product or bulk drug substance.

Compounding aseptic isolator (CAI) – A type of RABS that uses HEPA filtration to provide an ISO Class 5 unidirectional air environment designed for compounding of sterile non-HDs.

Compounding aseptic containment isolator (CACI) – a type of RABS that uses HEPA filtration to provide an ISO Class 5 unidirectional air environment designed for the compounding of sterile HDs.

ISO Class 5 - An airborne-particulate standard that states there are no more than 3,520 particles of at least 0.5-microns in size per cubic meter.

Media-fill test: A simulation used to qualify processes and personnel engaged in sterile compounding to ensure that the processes and personnel are able to prepare CSPs without contamination.

Primary engineering control (PEC) - A device or zone that provides an ISO Class 5 or better environment through the use on non-turbulent air, unidirectional HEPA-filtered first air for compounding sterile preparations.

Restricted-access barrier system (RABS) – An enclosure that provides HEPA-filtered ISO Class 5 unidirectional air that allows for the ingress and/ or egress of materials through defined openings that have been designed and validated to preclude the transfer of contamination, and that generally are not to be opened during operations. Examples include CAIs and CACIs.

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Secondary Engineering Control (SEC) – The area where the PEC is placed (e.g., a cleanroom suite or an SCA).

Segregated Compounding Area (SCA) - Space designated for sterile-to-sterile compounding where a PEC is located within a demarcated area (of at least 3 foot perimeter). This area will be void of activities and materials extraneous to sterile compounding. This area shall not be in a location that has unsealed windows or doors that connect to outdoors, location with high traffic flow, or adjacent to food preparation areas or construction. The SCA must contain a PEC and is suitable for preparation of Category 1 CSPs only.

USP 797 - United States Pharmacopeia (USP) is a national quality agency that creates the sterile product quality standards. The “797” designation is the chapter that relates specifically to the sterile product environment.

POLICY STATEMENT:

It is the policy of SVMC that all compounded sterile preparations (CSPs) will adhere to USP 797 standards of practice. No CSP shall be compounded if it is known, or reasonably known, that the environment fails to meet criteria specified in the pharmacy’s written policies and procedures for the safe compounding of CSPs.

PROCEDURE:

- I. SVMC will administer aseptic manipulation competency evaluations to ensure a quality product.
 - A. The evaluation consists of the following:
 - a. Visual observation
 - b. Media-fill testing
 - c. Gloved fingertip and thumb (GFT) sampling on both hands
 - d. Surface sampling of the direct compounding area
 - B. Process validation is assured by using simulated production of the aseptic processes in use at SVMC, substituting growth media for medications to check sterility.
 - C. All staff responsible for CSPs must be trained in aseptic technique and demonstrate competency by direct observation and successful passing of a media-fill test.
 - D. Aseptic technique will be monitored and critiqued. Retraining will be considered if major technique violations are seen. Major violations may include:
 1. Violations of gowning, gloving and hand-washing policy
 2. Touching of critical sites
 3. Failure to wipe stoppers

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4. Failure to work within proper hood area
5. Blockage of “first air” to critical sites
6. Failure to clean hood properly and keep clean during compounding

E. Gloved fingertip sampling

Initial Competencies	Subsequent Competencies
Visual observation of hand hygiene and garbing (3 times)	Visual observation of hand hygiene and garbing (1 time)
GFS after visual observation of hand hygiene and garbing (3 times)	GFS after visual observation of hand hygiene and garbing (1 time)
Media-fill test	Media-fill test
GFS after the media-fill test	GFS after the media-fill test
Surface sample in the DCA after the media-fill test	Surface sample in the DCA after the media-fill test

Note: GFT sampling shall occur after production of CSPs but before sterilization with alcohol.

F. An actionable level is a CFU count (from both hands) greater than zero after garbing and greater than 3 CFUs after media-fill testing.

1. Employee will be retrained in hand-hygiene, garbing, glove and surface disinfection and conduct in compounding area. Sampling will be repeated and didactic testing repeated.
2. Actionable levels will result in removal from compounding duties and require retraining.
3. Repeated actionable levels will require complete retraining and removal from compounding until sampling meets minimum standards. Root cause for repeat positive sampling will be sought out by the pharmacist-in-charge.

II. The sterile-compounding areas will be cleaned as per USP 797 established standards. All cleaning materials must be non-shedding and dedicated to use in compounding areas and shall not be removed except for disposal.

A. Cleaning of the compounding areas must be documented on a cleaning log.

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B. Minimum cleaning frequency

Site	Cleaning	Disinfecting	Sporicidal
PEC(s) and equipment inside the PEC(s)	Daily and when surface contamination is known or suspected	Daily and when surface contamination is known or suspected	Monthly for entities compounding Category 1 or 2 CSPs
Removable work tray of the PEC	Daily on days when compounding occurs Monthly on all surfaces and the area underneath the work tray	Daily on days when compounding occurs Monthly on all surfaces and the area underneath the work tray	Monthly on all surfaces and the area underneath the work tray
Pass-through chambers	Daily on days when compounding occurs	Daily on days when compounding occurs	Monthly for entities compounding Category 1 or 2 CSPs
Work surface(s) outside the PEC	Daily on days when compounding occurs	Daily on days when compounding occurs	
Floor(s)	Daily on days when compounding occurs	Daily on days when compounding occurs	
Wall(s), plastic curtain(s), door(s), and door frame(s)	Monthly	Monthly	Monthly
Ceiling(s)			
Storage shelving and bin(s)			
Equipment outside the PEC(s)			

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- C. Disinfection of a PEC will be executed with sterile water, sterile 70% isopropyl alcohol (cleaning and disinfecting), and sporicidal agent approved by designated person, such as Peridox® or Decon-Spore (agent must be applied and be visibly wet for 3 minutes)
- D. Sterile 70% isopropyl alcohol must also be applied in the follow scenarios:
 - a. At the beginning of each shift and at the end of each shift
 - b. After a spill
 - c. At least every 30 minutes if the compounding process takes 30 minutes or less
 - d. Immediately after when compounding activities exceed 30 minutes, or
 - e. When surface contamination is known or suspected
- E. Daily mopping of the floor using a clean/low-shedding mop. Mop must be kept in the SCA or buffer area and only be used for cleaning the buffer area floor. Mopping will be done by trained personnel using approved cleaning agents and will mop in a direction from clean area to dirty area. To ensure proper contact time, the mopped floor must remain visibly wet for 10 minutes.
- F. Competency records of housekeeping staff will be kept in pharmacy for a minimum of three years after employment.
- G. Weekly cleaning
 - 1. Hoods must be disinfected using an approved disinfecting agent, sporicidal agent approved by designated person, such as Peridox® or Decon-Spore, will be used (agent must be applied and be visibly wet for 3 minutes). Use of this agent will occur after the use of sterile water and sterile 70% alcohol.
- H. Monthly cleaning
 - A. In addition to above cleaning, all surfaces in ISO classified areas or segregated compounding area will be wiped with sterile water and then sterile 70% alcohol including the inside of storage bins, carts, wheels, outside of hood, and wire racks, shelves, walls and ceilings, stools, and all other items in segregated compounding area
 - B. A sporicidal will be used on the entire room and outside AND inside the RABS or BSC. SVMC will use sporicidal agent approved by designated person, such as Peridox® or Decon-Spore (agent must be applied and be visibly wet for 3 minutes).
- I. Fixed glove assembly will be changed at least every 6 months or:
 - 1. When there is a visible tear;
 - 2. When a positive culture is obtained from sampling;

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3. When there is suspected contamination of product

IV. Certification or recertification

- A. Classified areas and PEC(s) will be recertified every six months by an outside agency.** During certification, the agency will evaluate the following:

1. Airflow testing
2. HEPA filter integrity testing
3. Total particle count testing
 - a. Failure to meet ISO standards will be immediately addressed PRIOR to the vendor leaving SVMC.
2. Corrective actions may include the following:
 - Replacing HEPA filters
 - Re-measuring the airborne particle count
 - Searching for mechanical causes
4. Dynamic airflow smoke pattern test

- B. In addition, classified areas will be recertified in the following circumstances:**

1. Classified area was redesigned
2. Classified area was constructed
3. Any PEC was replaced or relocated
4. Configuration of the room was altered that could affect airflow or air quality

- C. A corrective action plan will be implemented in response to any out-of-range results.**

1. LSE 100625
 - a. PEC - failure to meet ISO Class 5 specifications
 - a. Collaborate with vendor and troubleshoot section A. This may require assistance from the Engineering Department (e.g. replacing the HEPA filter or adjusting the air pressures).
 - b. Vendor to re-test the PEC.
 - c. If the PEC continues to fail, pharmacy personnel is unable to compound Category 1 CSPs. Pharmacy to conduct sterile compounding in a secondary certified PEC, if available.

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- d. In the absence of any other PEC, Pharmacy to contact contracted pharmacy to temporarily make compounded sterile preparations.
 - e. Exercise immediate-use compounding when appropriate until the PEC passes recertification.

- 2. SCE 101591
 - a. PEC - failure to meet ISO Class 5 specifications
 - a. Collaborate with vendor and troubleshoot section A. This may require assistance from the Engineering Department (e.g. replacing the HEPA filter or adjusting the air pressures).
 - b. Vendor to re-test the PEC.
 - c. If the PEC continues to fail, pharmacy personnel is unable to compound Category 1 or 2 CSPs. Pharmacy to conduct sterile compounding in a secondary certified PEC, if available.
 - d. Exercise immediate-use compounding when appropriate.
 - e. Hazardous sterile compounding is strictly prohibited unless an assessment of risk is completed.

 - b. SEC or buffer room - failure to meet ISO Class 7 specifications
 - a. Collaborate with vendor and troubleshoot section A. This may require assistance from the Engineering Department (e.g. replacing the HEPA filter or adjusting the air pressures).
 - b. Vendor to re-test the SEC.
 - c. If the SEC continues to fail, pharmacy personnel is unable to compound Category 2 CSPs. As long as the SEC satisfies the conditions of a SCA (non-hazardous) or C-SCA (hazardous), staff may exercise Category 1 sterile compounding per USP 797 and 800.
 - d. In the event that the conditions of neither the SCA nor C-SCA are met for non-hazardous or hazardous compounding respectively, exercise immediate-use compounding when appropriate.
 - e. Immediate-use compounding is strictly prohibited for hazardous drugs unless an assessment of risk is completed.

 - c. Anteroom – failure to meet ISO Class 7 specifications
 - a. If the anteroom is at least ISO Class 8, may continue normal operations in the non-hazardous buffer room. Meanwhile, the hazardous buffer room is limited to Category 1 sterile compounding as long as it satisfies the conditions of a C-SCA.
 - b. Collaborate with vendor and troubleshoot section A. This may require assistance from the Engineering Department (e.g. replacing the HEPA filter or adjusting the air pressures).
 - c. Vendor re-test the anteroom.

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- D. Decontamination and terminal cleaning of PEC and SEC will occur immediately AFTER recertification.

V. Viable Sampling

- A. The Department of Pharmacy or an outside agency will conduct viable surface and air sampling at least every one and six months, respectively.

1. In addition, sampling must be performed in the following circumstances:
 - a. In conjunction with the certification of new facilities and equipment
 - b. After any servicing of facilities or equipment
 - c. In response to identified problems (e.g. positive growth in sterility tests of CSPs)
 - d. In response to identified trends (e.g. repeated positive GFT sampling results, failed media fill testing, or repeated observations of air or surface contamination)
2. Surfaces include one surface in each PEC, surfaces of all classified areas, and pass-through chambers connecting to classified areas.

- B. An actionable level of colony-forming units (CFUs) upon viable surface sampling is:

1. **Action Levels for Surface Sampling**

ISO Class	Surface Sampling Action Levels (CFU/Plate)
5	>3
7	>5
8	>50

- C. An actionable level of CFUs upon viable air sampling shall be:

1. **Action Levels for Air Sampling**

ISO Class	Air Sampling Action Levels (CFU/m ³)
5	>1
7	>10
8	>100

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- D. Any actionable level in the PEC will result in the following action(s):
1. Immediate cessation of activity in the PEC.
 2. Immediate cleaning and disinfecting of PEC and SEC.
 3. Resampling of affected area after cleaning and disinfecting is completed.
 4. Evaluation of engineering controls.
 5. Communication with Infection Control and expert infectious disease consultation.
 6. Communication with Risk Department and investigation for any product potentially-contaminated.
 7. Review of cleaning and compounding operations and facility management.
 - a. If levels measured exceed above action levels, an investigation and corrective action must be taken to prevent future deviations.
 - b. Corrective action plans may include a change in procedure, facility, or equipment.
- E. Any actionable level outside the PEC will result in the following action(s):
1. Investigate the cause.
 2. Implement corrective action.
 3. Evaluate the trend if data is available.
 4. Resample the failed area to confirm corrective action was successful.
 5. Attempt to identify microorganisms recovered to the genus level.
- F. When evaluating the results, the designated person will examine the counts in relation to previous data to identify adverse results or trends.
- G. If needed, Pharmacy will adopt current SOPs when collecting viable surface samples to monitor environmental sterility.
- H. If needed, Pharmacy will adopt current SOPs when collecting viable air samples to monitor environmental sterility.
- VI. Quality Assurance/ Quality Control Testing
- A. Sterility testing of a Category 1 CSP will occur at least quarterly.
- a. In the event of a positive culture
 - i. Technician who compounded IV will be retrained in hand hygiene, garbing, gloving, and surface disinfection. Fingertip and sterility testing

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will be repeated under observation for technique. Technician will stop compounding until a negative test is obtained.

- ii. If repeat testing results in a positive response, the technician will be removed from compounding duties and completely retrained.
- iii. In addition to the above, if the product is a batched product where more than one dose of a preparation has been made:
 - The lot number of the product will be identified
 - Potential patients exposed to contaminated product will be identified using dispensing and administration records
 - The physicians involved in that patient's care and infection control officer will be notified of possible exposure as well as organism(s) involved in order to evaluate the patient.
- iv. Risk, Infection Control, and Chief Nursing Officer will be immediately informed.

B. Quantification testing shall be performed at a minimum of twice a year to ensure product integrity and to validate labeled strength.

- A. A random CSP will be sent out to a qualified laboratory to test for potency, endotoxin, and particulate matter. Pharmacy will follow the process outlined by the contracted laboratory.
- B. If the drug sample is identified as not within the standards for potency, endotoxin, or particulate matter:
 - a. The technician and pharmacist making/checking the product will be removed from sterile product processing and retrained.
 - b. A complete analysis of the compounding process will occur.
 - c. An additional product will be sent out for validation.
- C. All of the above steps will be performed and BUD dating will be confirmed by using standard reference materials and research.

VII. Compounding Room Temperature and Lighting

- A. The sterile compounding area shall have a well-lit working environment.

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- B. A room temperature of 68 degrees Fahrenheit and humidity below 60% is ideal for sterile compounding. The temperature and humidity will be recorded daily.
- In the event of a temperature excursion:
 - Engineering will be contacted for temperature or humidity correction.
 - Pharmacist-in-Charge will be notified.
 - If temperature > 40 degrees Celsius for at least 4 hours, any CSP exposed to these conditions will be discarded.

VIII. Pressure Differential

- A. A minimum of 0.02-inch water column is required for positive pressure to separate each ISO classified area, except in segregated compounding areas.
- B. Negative pressure will be negative 0.01 to negative 0.03 inches of water.
- C. A pressure gauge or velocity meter will be used to monitor airflow between the following paired areas:
- Ante-area and buffer areas
 - Ante area and outside the cleanroom suite
 - RABS and the SCA.
- D. The pressures will be documented and reviewed daily or by a continuous monitor.

IX. In the event of a product recall, SVMC will follow the established policy of [DRUG RECALL PROCEDURE](#)

X. All records will be retained for a minimum of three years.

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

EDUCATION:

SVMC Pharmacy Staff: All pharmacists and pharmacy technicians will receive education regarding the preparation of pharmacy-prepared IV admixtures.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Pharmacy Law: California Edition. (2024) San Clemente, California: Law Tech Publishing Group.
- USP 797.(n.d.). from <http://www.usp.org/compounding/general-chapter-797>.

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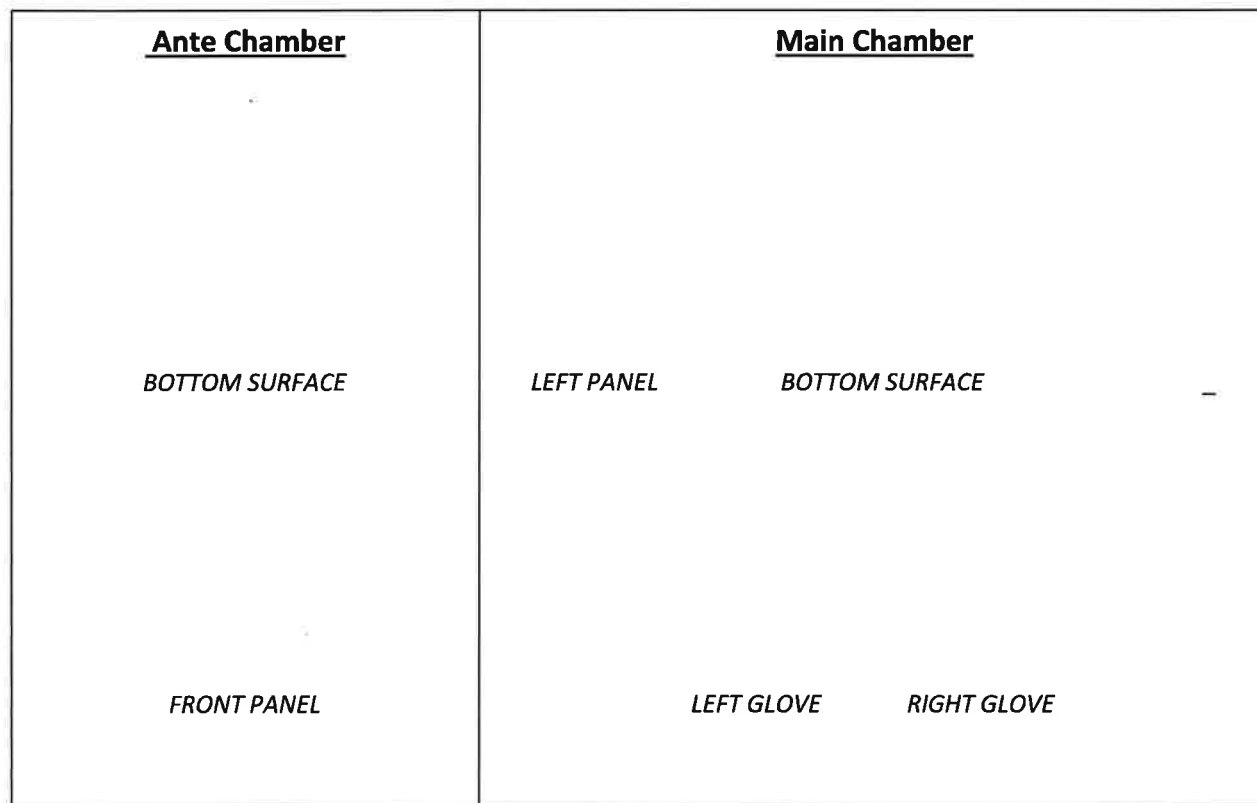
- CCR 1751.4 Facility and Equipment Standards for Sterile Compounding. Retrieved November 24, 2021, from <https://www.law.cornell.edu/regulations/california/16-CCR-Sec-1751-4>.

CROSS REFERENCES:

- [DRUG RECALL PROCEDURE](#)

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Map of NuAire COMPOUNDING ASEPTIC ISOLATOR – Main Pharmacy



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**SUITE “B” POSITIVE & NEGATIVE PRESSURE HOODS
ENVIRONMENTAL SAMPLING MAP**

Biological Safety Cabinet

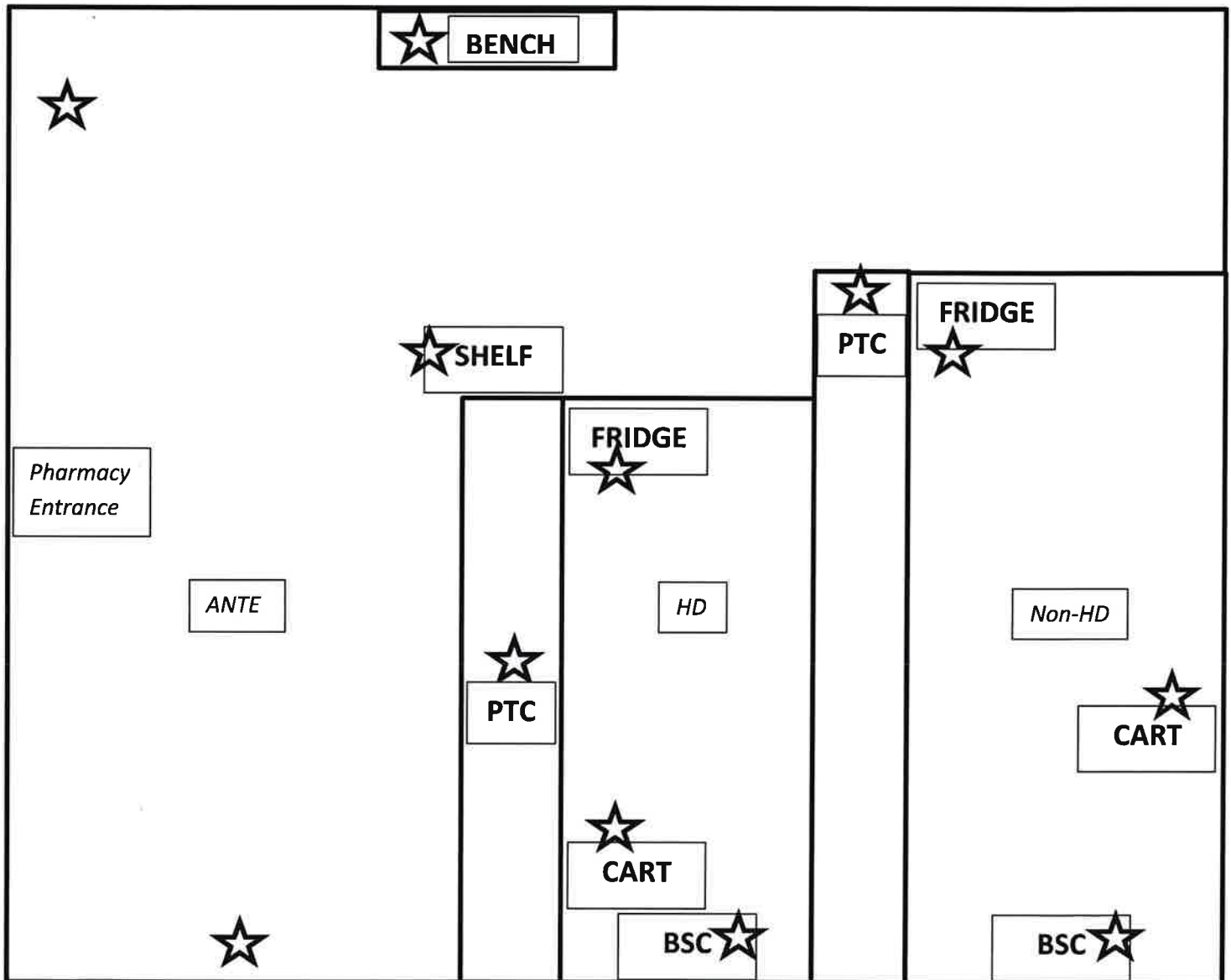
BOTTOM PANEL

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PURPOSE:

The purpose of this policy is to outline patient eligibility for thrombolytic therapy, drug administration, patient monitoring, and documentation for the care of the patient experiencing Acute Ischemic Stroke (AIS). These guidelines focus on early assessment and management of Emergency Department (ED) and inpatients with AIS.

Tenecteplase (TNK) is also a thrombolytic drug. It is endorsed by the American Heart Association as an alternative to Alteplase (TPA). Compared to Alteplase, it has a longer half-life and higher fibrin specificity. TNK has the benefit of a single bolus administration. TNK is recommended at a dose of 0.25 mg/kg (max 25 mg), administered within 4.5 hours of symptom Inclusion / exclusion criteria and contraindications are the same as Alteplase (TPA) for acute ischemic stroke.

Treatment should be initiated within 4.5 hours after the onset of stroke symptoms, and after exclusion of intracranial hemorrhage by a cranial computerized tomography (CT) scan or other diagnostic imaging method sensitive for the presence of hemorrhage.

Treatment Goals:

To act in accordance with the 8 D's of stroke survival:

- a. Detection (Early recognition)
- b. Dispatch (Early EMS activation)
- c. Delivery (Transport & management)
- d. Door (ED triage)
- e. Data (ED management, activation of stroke alert)
- f. Decision (Neurology & therapy selection)
- g. Drug (Reperfusion approaches)
- h. Disposition (admit or transfer)

For the inpatient: Early recognition, activation of the Rapid Response Team (RRT) & stroke alert, Decision, Drug, and Disposition.

- Management of the acute stroke patient as measured by time targets for stroke care, including consideration and administration of thrombolytic therapy.
- Reduce the complications of stroke through thrombolysis in eligible patients.
- Improve patient outcomes.

DEFINITIONS:

1. **Acute Ischemic Stroke (AIS):** A disruption of blood flow to the brain that can result in permanent damage. This disruption is usually caused by either cerebral thrombosis or cerebral embolism. AIS accounts for about 87% of all strokes.

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2. **Alteplase (rt-PA):** An FDA approved thrombolytic for AIS treatment.
3. **Last Known Well Time (LKWT):** The time in hours and minutes that the patient was last known to be at their “baseline” self.
4. **NIHSS – National Institute of Health Stroke Scale:** A stroke severity assessment scale.
5. **Stroke Alert:** An overhead page or electronic notification announcing the presence and location of a potential stroke patient. Activated anytime for any patient, via a defined process, that displays stroke signs and/or symptoms.
 - a. Patients with new or worsening neurological deficits (if prior NIHSS done, worsening of 3 or more points).
 - b. Anyone with a positive BE FAST, or FAST, exam
 - c. Any other sign or symptom concerning for stroke

The alert activates members of the stroke team who respond to the alert in a role-specific way.

6. **Tenecteplase** – a thrombolytic agent similar to Alteplase (TPA) with greater fibrin specificity and a longer half – life. FDA approved and ecommended in the American Heart / American Stroke Association clinical practice guidelines for AIS
7. **Thrombolytic:** An intravenously administered medication that binds to a thrombus in a blood vessel causing fibrinolysis, thereby restoring blood flow to the area distal of the clot. Alteplase and Tenecteplase are thrombolytics.

POLICY:

- A. A “stroke alert” may be called for any ED or Intensive Care Unit (ICU) patient presenting with signs or symptoms of an acute stroke. Inpatients, outside of the ICU, will precede the stroke alert with a Rapid Response Team (RRT) notification. The RRT will evaluate the patient and call the stroke alert.
- B. Also see policy “Stroke Alert and Acute Care Stroke Management” for additional treatment details.
- C. Prior to initiating thrombolytics for the treatment of AIS, the treating physician will evaluate all patients for inclusion and exclusion criteria. Inclusion and exclusion criteria are consistent with FDA approval guidelines.
 1. Inclusion Criteria
 - a. Age 18 years or older – equally recommended for ages ≤ 80 and > 80
 - b. Does not have diabetes and prior stroke

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- c. Working diagnosis of acute ischemic stroke with a measurable neurologic deficit. Mild, but disabling stroke symptoms (as defined by the patient) – thrombolysis is still recommended.

- i. Sudden numbness, weakness, or paralysis of the face, arm, or leg
- ii. Difficulty speaking or understanding simple statements
- iii. Decreased vision or transient blindness in one eye
- iv. An episode of double vision
- v. Unexplained dizziness, loss of balance, or sudden falls
- vi. Sudden, severe headache with no apparent cause

- d. LKWT established to be less than 180 minutes (3 hours) before treatment would begin.

- i. In some cases, this window may include those with symptom onset 180 to 270 minutes (3 to 4.5 hours) prior to presentation, with these additional EXCLUSION criteria:

- Age > 80 years
- Oral anticoagulant use regardless of INR
- Baseline NIHSS score > 25
- Imaging evidence of ischemic injury involving more than one third of the middle cerebral artery (MCA) territory
- History of both stroke and diabetes
- Intracranial hemorrhage has been **excluded** as the primary cause of stroke signs and symptoms prior to the initiation of Alteplase treatment.

****NOTE: Physician discretion may modify this list****

2. Exclusion Criteria / Contraindications: Alteplase therapy in patients with AIS is contraindicated in the following situations because of an increased risk of bleeding, which could result in significant disability or death:

- a. Evidence of intracranial hemorrhage on pretreatment evaluation
- b. History of intracranial hemorrhage
- c. Symptoms or imaging suggest subarachnoid hemorrhage on pretreatment evaluation
- d. Active internal bleeding
- e. Patient / family refusal

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- f. Presence of intra-cranial conditions that increase the risk of bleeding, such as intracranial neoplasm, arteriovenous malformation, or aneurysm
- g. Recent (within 3 months) intra-cranial, intra-spinal surgery, or serious head trauma
- h. History of ischemic stroke in previous 3 months
- i. Known aortic arch dissection
- j. Infective endocarditis (increased risk of intracranial hemorrhage)
- k. CT scan: No frank hypodensity, but early ischemic changes (mild to mod) are OK
- l. Blood glucose concentration of < 50 mg/dl or > 400 mg/dl
- m. Bleeding diathesis including, but not limited to:
 - i. Platelet count < 100,000/mm³, INR > 1.7, aPTT > 40 seconds, **or** PT > 15 seconds.
 - ii. History of warfarin use and an INR > 1.7 or PT > 15 sec
 - iii. Administration of heparin within 48 hours preceding stroke onset with an elevated aPTT greater than upper limit of normal at presentation
 - iv. Who have received a treatment dose of low-molecular-weight heparin within the previous 24 hours
 - v. Who are taking direct thrombin inhibitors or direct Factor Xa inhibitors, unless the laboratory tests are normal or the patient has not received a dose of these agents for > 48 hours.
- n. Current, severe, uncontrolled hypertension. Warning exists for systolic blood pressure (SBP) > 185 and diastolic blood pressure (DBP) > 110. Must be controlled and stabilized prior to thrombolysis.
 - 1. Post-thrombolysis, BP is **be maintained less than 180/105**.bold font here
- o. Arterial puncture at a non-compressible site in the previous 7 days.
- 3. Criteria with warnings (consider risk to benefit):
 - a. Pregnancy (Category C- consult with obstetrician-gynecologist and, possibly, a perinatologist)

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- b. Major surgery or serious trauma within previous 14 days
- c. Recent (within 21 days) gastrointestinal or genitourinary hemorrhage
- d. Recent (within 3 months) acute myocardial infarction (AMI) – Treatment with Alteplase is reasonable if the MI was a STEMI involving the right or inferior myocardium

Notes:

- Physician discretion may result in modification of this list based on clinical knowledge.
- In patients without recent use of oral anticoagulants or heparin, treatment with thrombolytics can be initiated before availability of coagulation test results but should be discontinued if INR is > 1.7 or PT is abnormally elevated.
- In patients without a history of thrombocytopenia, treatment with Alteplase can be initiated before availability of platelet count but should be discontinued if platelet count is < 100,000 mm³.

AFFECTED PERSONNEL/AREAS: *ALL INPATIENT NURSING UNITS, EMERGENCY DEPARTMENT, CT, PHARMACY, LABORATORY, MEDICAL STAFF*

EQUIPMENT:

- Stroke Reference Binder or Stroke Box
- Alteplase (rt-PA), from pharmacy or Pyxis
- Intravenous infusion pump with non-vented tubing

PROCEDURE:**A. Pre-Treatment:****Nurse responsibilities**

1. Identify patients with symptoms of neurological changes or acute stroke based on clinical presentation, positive (+) BE FAST exam, or early notification from pre-hospital personnel.
2. Establish and document the LKWT in a date and time format.
3. Immediately call an RRT, or stroke alert, based on nursing unit. The RRT will contact the responsible physician.

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4. RRT or ED registered nurse (based on location of the stroke alert) will accompany the patient to the CT scanner and to final disposition.
5. If in the ED, immediately notify the ED physician.

Note: For additional roles and responsibilities, see Stroke Alert and Acute Care Stroke Management: Emergency Department & Inpatient Units policy.

B. Treatment – thrombolytic administration:

Physician responsibilities

1. Definitive treatment decisions regarding thrombolytics and medical management of the patient may be made by the treating physician, in collaboration with the neurologist or tele-neurologist. When on-screen and consulting, the TeleNeurologist will determine eligibility for thrombolytic therapy.
2. Validate inclusion / exclusion criteria
3. Document verbal consent obtained from the patient's family
4. Document education provided to the patient and family regarding the risks and benefits of Alteplase.
5. Review the patient's vital signs and recent medical history
 - a. Initiate treatment for blood pressure as needed.
 - b. If SBP is 180-230 mmHg or DBP is 105-120 mmHg, suggested treatment is:
 - i. Labetalol 10 mg IV x 2 doses, followed by
 - ii. Nicardipine 5 mg/hour; titrate up to desired effect by 2.5 mg/hour every 5-15 minutes to a maximum of 15 mg/hour
 - iii. If BP is not controlled or DBP is > 140 mmHg, consider IV sodium nitroprusside (Nipride)
 - iv. Other agents, such as Hydralazine, can be considered
6. Final review of thrombolytic dose to be administered, in collaboration with nursing and pharmacy, as appropriate.

Tenecteplase: dosing is 0.25 mg/kg, MAX of 25 mg., given as an IV push over 5 seconds.

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7. Participate in the Thrombolytic time out process.

Nursing Responsibilities:

1. Establish / document accurate patient weight.
2. Perform and document the NIHSS prior to treatment, if not done by TeleNeurologist.
3. Alteplase & Tenecteplase are a high alert medication, requiring a 2nd registered nurse to verify:
 - a. Right patient, right medication, right dose, right time, and right route.
 - b. Ensure infusion is going into the intended channel by physically tracing the line from the solution, through the pump, and to the insertion site.
 - c. The infusion pump is programmed at the proper rate, including correct entry of patient's weight.
4. Prior to administration of the thrombolytic bolus, everyone in the room will participate in a "Thrombolytic Time Out"; an intentional pause to verify:
 - a. Right patient
 - b. Negative head CT
 - c. Home medications have been reviewed with the thrombolytic prescriber ()
 - d. Patient is not taking anticoagulation
 - e. Thrombolytic checklist completed
 - f. Blood pressure is controlled at or less than 185/110
6. Alternatively, administer a single IV bolus of Tenecteplase (TNK) over 5-10 sec. using a peripheral vein. Follow with a NS flush. Do not administer in a line containing a **dextrose solution as it is incompatible.**
7. Document medication administration.
8. Patient monitoring will be completed in the ED or ICU:
 - a. Hypertension management:

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9. **Must maintain blood pressure (BP) less than 180 / 105 mmHg to limit the risk of intracranial hemorrhage**
 - a. Baseline neuro checks and vital signs will be taken with subsequent neurological (neuro) checks and vital signs every 15 min for 2 hours
 - b. Neuro checks and vital signs every 30 minutes from hour 2 to hour 6.
 - c. Neuro checks and vital signs every 1 hour for the remaining 16 hours.

Note: Any patient that receives thrombolytics will be monitored at an ICU level of care for the first 24 hours.

Management of suspected intracranial hemorrhage:

1. Suspect the occurrence of intracranial hemorrhage following the start of the thrombolytic infusion if there is any acute neurological deterioration, new headache, acute hypertension, or nausea with vomiting.
2. If hemorrhage is suspected, do the following:
 - a. Immediately notify the responsible physician and the charge nurse.
 - b. Immediate non-contrast head CT, stroke protocol, or other imaging sensitive for hemorrhage.
 - c. If ordered, draw blood for CBC, PT, PTT, Fibrinogen, and Type and Cross.
3. If intracranial hemorrhage is present, as ordered by the physician:
 - a. Obtain fibrinogen results
 - b. Consider administering cryoprecipitate or platelets as needed
 - c. Consult neurologist and neurosurgeon as needed to arrange for treatment plan and possible surgical treatment options
 - d. Prepare for stat transfer to higher level of care
 - e. Also see the Thrombolytic Induced Intracranial Hemorrhage pathway.

C. Post-Treatment:

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Complete and document post- thrombolytic infusion NIHSS score by RN every 4 hrs for the first 24 hours, then every shift.

- Neuro checks and vital signs as listed above.
 - a. Monitor and control blood pressure – less than 180/105
- Continue to monitor for complications:
 - a. Bleeding – major and/or minor:
 - i. Avoid intramuscular injections and trauma to the patient
 - ii. Monitor any arterial and venous puncture sites frequently
 - iii. Gentle teeth brushing
 - iv. Avoid use of a manual razor for 24 hours
 - b. Orolingual angioedema or anaphylaxis
 - i. Has been observed up to several hours after thrombolytic administration, especially in patients receiving concomitant angiotensin-converting enzyme inhibitors (like Lisinopril)..
 - ii. Treatment:
 - i) Maintain airway – intubation may be necessary
 - ii) Discontinue alteplase infusion and hold ACE inhibitors
 - iii) Administer IV methylprednisolone 125 mg, as ordered
 - iv) Administer IV diphenhydramine 50 mg, as ordered
 - v) Administer famotidine 20 mg IV, as ordered
 - vi) If further increase in angioedema, administer epinephrine (0.1%) 0.3 ml subcutaneously or by nebulizer, 0.5 ml, as ordered.
 - vii) Infusion of Fresh Frozen Plasma (FFP) may be considered for ACEI – related, or refractory angioedema
 - c. Cholesterol embolization (rare)
 - d. Other allergic type reactions – rash, urticaria
- Obtain a follow up CT or MRI 24 hours post-treatment, before starting anti-coagulants or antiplatelet agents.

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- Perform nursing swallow screen prior to patient receiving any oral medications, liquid, or food (See policy: Stroke Alert and Acute Care Stroke Management: ED & Inpatient Units).
- If in the ED, provide SBAR (Situation, Background, Assessment, Recommendation) nursing report to accepting nurse, specifying details of thrombolytic administration and current status of neuro checks / vital signs. It is imperative that no vital sign or neuro check is missed.

REFERENCES:

- Demaerschalk, B.M., Kleindorfer, D.O., Adeoye, O.M., et al. (2015). Scientific rationale for in the inclusion and exclusion criteria for intravenous Alteplase in acute ischemic stroke: A statement for healthcare professionals from the American Heart Association / American Stroke Association. Stroke, 2016;(47), pages 1 – 61. <http://stroke.ahajournals.org>.
- Genentech (2017). *Emergency assessment of acute ischemic stroke*. USA: Genentech USA.
- Lyden, P. (2016). Using the National Institutes of Health Stroke Scale. Stroke, 2017;(48), downloaded from <http://stroke.ahajournals.org/>.
- Powers, W.J., Rabinstein, A.A., Ackerson, T. et al (2019). 2019 Update to the 2018 guidelines for the early management of patients with acute ischemic stroke: A guideline for healthcare professionals from the American Heart Association / American Stroke Association. Stroke, 2019(50), e344-e418. Downloaded from <http://stroke.ahajournals.org/>.
- UpToDate (2020). Tenecteplase: drug information. Retrieved from: https://www.uptodate.com/contents/tenecteplase-drug-information?topicRef=115775&source=see_link#F228469

CROSS REFERENCES:

- [Stroke Alert & Acute Care Stroke Management: Emergency Department & Inpatient Units](#) – SVMC Policies and Procedures
- [High-Alert Medications and Look Alike Sound Alike Medications](#) – SVMC Policies and Procedures

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ADMINISTRATION (Intravenous only) – After dose is calculated and medication is verified by 2nd RN, as detailed in attached policy.

1. Calculate the volume that will be unused (excess).

PRECAUTIONS

1. Use only for ACUTE ISCHEMIC STROKE.
2. Always use an infusion pump.
3. Use vented IV tubing.
4. Account for the amount of drug used to prime the IV tubing when withdrawing excess drug from the vial prior to administration.
5. Use caution for lab draws due to bleeding risk. Use IV lock when possible; avoid drawing through IV used for rt-PA administration.

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PURPOSE:

The Tuberculosis Control Plan (TCP) integrates Centers for Disease Control and Prevention (CDC) evidence-based research and guidelines across all entities and provides Sierra View Medical Center (SVMC) staff a comprehensive plan for the early detection, management, isolation and treatment of persons with active tuberculosis (TB). Adherence to the policies and procedures addressed in this TB Control Plan will assist in reducing the risk of exposure to patients, visitors and staff within the Sierra View Medical Center (SVMC) environment. This Tuberculosis Control Plan includes:

TB CONTROL PLAN – TABLE OF CONTENTS

Section I	Responsibility for TB Infection Prevention Program
Section II	TB Risk Assessment
Section III	Protocol for Early Detection
Section IV	Screening and Diagnosis • Diagnostic Measures (including Tuberculin Skin Test-TST) • Timely Infection Prevention Notification
Section V	Management and Isolation of Patients with Possible TB • Decision to Place Patient in Airborne Precautions • Airborne Precautions
Section VI	Other Circumstances (Patient Movement, OR, OB Patient)
Section VII	Engineering Controls
Section VIII	Discharge Planning
Section IX	Respiratory Protection of Employees/Fit Testing
Section X	Evaluation of Conversions/Transmission

POLICY:

Sierra View Medical Center (SVMC) is committed to providing a safe and healthful work environment for our staff, caregivers, and patients. In pursuit of this endeavor, the following TCP is provided to minimize or eliminate occupational exposure to TB in accordance with the corrected and updated 2005 CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities. It is the intent of SVMC to comply with California Code of Regulations Title 8, Section 5144, Subchapter 7 concerning respiratory protective equipment and OSHA Standard 29 CFR 1910.134 concerning respiratory protection for Mycobacterium tuberculosis (MTB).

DEFINITIONS/VOCABULARY

Acid-fast bacilli (AFB) - Bacteria that retain certain dyes after being washed in an acid solution. Most acid-fast organisms are mycobacteria. When AFB are seen on a stained smear of sputum or other clinical specimen, a diagnosis of TB should be suspected; however, the diagnosis of TB is not confirmed until a culture is grown and identified as *M. tuberculosis*.

Active TB - TB bacteria are dividing and multiplying within an affected individual's body, causing tissue and organ damage. A person with active TB is likely to be or soon become symptomatic.

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Aerosol - The droplet nuclei that are expelled by an infectious person (e.g., by coughing or sneezing); these droplet nuclei can remain suspended in the air and can transmit *M. tuberculosis* to other persons.

Anergy - The inability of an individual to react to skin-test antigens (even if the person is infected with the organisms tested) because of immunosuppression.

Bacille Calmette-Guérin (BCG) – The only vaccine currently used to prevent tuberculosis. It was developed by the French scientists Albert Calmette and Camille Guérin at the Institute Pasteur, Lille, between 1907 and 1921. It is a living, attenuated (weakened) variant of the bovine tubercle bacillus.

Bronchoscopy - Examination of the airways by means of a flexible or rigid tube. Modern instruments are fiber-optic and highly flexible and they enable specimens to be obtained from the lung by aspiration, washing, brushing and biopsy.

Cavity, pulmonary – It is defined as a gas filled space within the zone of pulmonary consolidation or within a mass or nodule. Cavities are present in many processes, such as TB, lung cancer, and other infections.

Cluster - Two or more PPD skin-test conversions occurring within a 3-month period among HCWs in a specific area or occupational group, and epidemiologic evidence suggests occupational (hospital acquired) transmission.

Culture - The process whereby bacteriological specimens are grown in an incubator. In the case of tuberculosis, this can take weeks.

Droplet nuclei - Microscopic particles (i.e., 1-5 mm in diameter) produced when a person coughs, sneezes, shouts, or sings. The droplets produced by an infectious TB patient can carry tubercle bacilli and can remain suspended in the air for prolonged periods of time and be carried on normal air currents in the room.

Ethambutol - One of the first-line anti-tuberculosis drugs, given during the first 2 months of therapy. Care is required in its use as it can cause visual disturbance (blurred and red/green color disturbance) and irreversible eye damage. Patients should be told that if they experience any visual disturbance they should stop taking the drug and seek medical advice.

Ethionamide - An antibiotic (second-line) used to treat cases of drug resistant tuberculosis.

Exposure -- The condition of being subjected to something (e.g. infectious agents) that could have a harmful effect. A person exposed to *M. tuberculosis* does not necessarily become infected.

First line drugs - Active, drug-sensitive TB disease is treated with a standard six-month course of four antimicrobial drugs: Isoniazid, Rifampicin, Pyrazinamide and Ethambutol. These are referred to as first line drugs for treating TB.

Fluoroquinolones - A class of antibiotics used to treat drug-resistant tuberculosis and some diseases caused by environmental mycobacteria. An example includes moxifloxacin.

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Haemoptysis (or Hemoptysis) - Expectoration (coughing up) of blood or of blood-stained spit from the bronchi, larynx, trachea, or lungs.

Health Disparity - a higher burden of illness, injury, disability, or mortality experienced by one group relative to another.

Healthcare Worker (HWC) - Those working for the agency that care directly for patients/clients.

Immunosuppressed - A condition in which the immune system is not functioning normally (e.g., severe cellular immunosuppression resulting from HIV infection or immunosuppressive therapy). Immunosuppressed persons are at greatly increased risk for developing active TB after they have been infected with *M. tuberculosis*. No data are available regarding whether these persons are also at increased risk for infection with *M. tuberculosis* after they have been exposed to the organism.

Incubation period - The interval between infection and the development of clinically evident disease.

Isoniazid – An antibiotic and one of the first line anti-tuberculosis drugs. It is particularly effective against actively replicating bacilli in the lung cavities. It is also used for preventive therapy in those with latent tuberculosis.

Latent tuberculosis - A term applied to the status of those infected with the tubercle bacillus but remaining healthy. It is assumed that the tubercle bacilli are in some dormant or resting ‘persister’ state.

Miliary tuberculosis - Is a form of disseminated tuberculosis, usually occurring in immunocompromised individuals. The lesions are millet-seed sized granulomas (Latin: milium – a millet seed) that are easily seen on chest radiographs. Miliary lesions differ from those of cryptogenic disseminated tuberculosis.

Multidrug-resistant TB (MDR TB) – TB disease caused by bacteria resistant to two of the most important medicines: INH and RIF.

Mycobacterium - The genus of bacteria which includes the tubercle and leprosy bacilli and the environmental mycobacteria. The name means ‘fungus bacteria’, in allusion to the mould-like pellicles they form on liquid culture media.

***M. tuberculosis* complex** -- A group of closely related mycobacterial species that can cause active TB (e.g. *M. tuberculosis*, *M. bovis*, and *M. africanum*); most TB in the United States is caused by *M. tuberculosis*.

Negative Pressure - An isolation room used for infectious patients from which the air is constantly being extracted to result in slight negative pressure in the room compared with the outside corridor. Any bacteria coughed by the patient will then be extracted through a filter system rather than blowing into the corridor.

Percutaneous - The route of administration through or via the skin.

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Prevalence - Prevalence is a measurement of all individuals affected by the disease at a particular time. This is distinct from incidence, which is a measurement of the number of new individuals who contract a disease during a particular period of time.

Positive PPD reaction - A reaction to the purified protein derivative (PPD) - tuberculin skin test that suggests the person tested is infected with *M. tuberculosis*. The person interpreting the skin-test reaction determines whether it is positive on the basis of the size of the induration and the medical history and risk factors of the person being tested.

Pulmonary tuberculosis - Tuberculosis of the lung. It is the most common form of tuberculosis. TB in the larynx and in open abscesses can be infectious.

Purified protein derivative (PPD) - tuberculin - A purified tuberculin preparation that was developed in the 1930s and that was derived from old tuberculin. The standard Mantoux test uses 0.1 ml of PPD standardized to 5 tuberculin units.

Rifampicin (Rifampin in the USA) - A member of a class of antibiotics termed the rifamycins, it is the most powerful of the first-line anti-tuberculosis drugs. It has the unique property of killing very slowly, replicating bacilli that persist in lesions.

Smear positive/smear negative - Smear positive means that bacteria can be seen when a sample of sputum is specially stained and examined under a microscope. It usually indicates an infectious patient. Smear negative means that the bacteria could not be seen in a specimen. It may mean that disease is absent or that bacteria are too few to be seen.

Sputum – Phlegm coughed up from deep inside the lungs. Sputum is examined for TB bacteria using a smear; part of the sputum can also be used to do a culture.

TB blood test – A test that uses a blood sample to find out if you are infected with TB bacteria. The test measures the response to TB proteins when they are mixed with a small amount of blood. Examples of these TB blood tests include QuantiFERON®-TB Gold In-tube (QFT-GIT).

Tuberculosis - A chronic infectious disease caused by the closely related species *Mycobacterium tuberculosis*, *M. bovis*, and *M. africanum*.

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AFFECTED AREAS/PERSONNEL: ALL HEALTHCARE WORKERS

SECTION I - RESPONSIBILITY FOR THE TB INFECTION PREVENTION PROGRAM

A. The fundamentals of a TB Control Plan should consist of administrative controls, environmental controls, and a respiratory protection program.

1. Administrative Controls: These are management measures that are intended to reduce the risk of exposure to persons with infectious TB and include:

- Assigning someone the responsibility for TB infection control in the health care setting;
- Conducting a TB risk assessment of the setting;
- Developing and implementing a written TB infection-control plan;
- Ensuring the availability of recommended laboratory processing, testing, and reporting of results;
- Implementing effective work practices for managing patients who may have TB disease;
- Ensuring proper cleaning, sterilization, or disinfection of equipment that might be contaminated (e.g., endoscopes);
- Educating, training, and counseling health care personnel, patients, and visitors about TB infection and TB disease;
- Screening, testing, and evaluating personnel who are at risk for exposure to TB disease. Early identification, isolation, and treatment of persons with TB, (e.g., provide and practice early patient screening in the Emergency Department, to identify potentially infectious patients, and prevent employee exposures).
- Using posters and signs to remind patients and staff of proper cough etiquette (covering mouth when coughing) respiratory hygiene; and
- Coordinating efforts between local or state health departments and high risk healthcare and congregate settings.

2. Environmental Controls: The use of environmental controls to reduce the concentration and prevent the spread of infectious droplet nuclei.

- Primary environmental controls consist of controlling the source of infection by using local exhaust ventilation (e.g., hoods, tents, or booths) diluting and removing contaminated air by using general ventilation.
- Secondary environmental controls consist of controlling airflow to prevent contamination of air in areas adjacent to the source airborne infection isolation (AIIR) rooms; and cleaning the air by correctly using high efficiency particulate air (HEPA) filtration.

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3. Respiratory-Protection Controls: Consists of the use of personal protective equipment in situations that pose a high risk of exposure to TB disease.

- Implementing a respiratory protection program;
- Training healthcare personnel on respiratory protection; and
- Educating patients on respiratory hygiene and the importance of cough etiquette procedures.

B. The Tuberculosis Control Plan was developed and approved by the Administrative staff and the Board of Directors, who have ultimate responsibility for the development of programs that create a safe work environment for the employees.

The Infection Prevention and Control Committee has the authority for implementation and ongoing evaluation of the TB Control Plan. Leadership is responsible for monitoring compliance with the plan. All employees are expected to follow the policies and procedures contained in the TB Plan.

SECTION II – RISK ASSESSMENT

Risk assessment includes:

- A. Analysis of the number of infectious TB patients admitted to the facility and each area in the facility
- B. Analysis of Healthcare Worker (HCW) Tuberculin Skin Test (TST) conversion and possible patient-to-patient TB transmission.
- C. Analysis of the management of infectious TB patients in the hospital, drug susceptibility patterns, and adequacy of treatment of TB patients.
- D. Analysis of relevant current epidemiological information for the geographic area (locally, statewide and nationally)

SECTION III - PROTOCOL FOR EARLY DETECTION

In order to protect healthcare workers, patients and visitors from exposure to tuberculosis, patients (across all SVMC entities) with known or suspected infectious tuberculosis will be promptly screened and identified. Control measures will be employed in accordance with this policy and local, state, and federal regulations. *See other SVMC entity-specific policies as appropriate.*

Characteristics of TB:

Symptoms of [TB disease](#) depend on where in the body the TB bacteria are growing. TB bacteria usually grow in the lungs (pulmonary TB). TB disease in the lungs may cause symptoms such as:

- A. Signs and symptoms of active TB:
 1. Productive, persistent cough of 3 weeks (or longer) duration (unclear etiology)
 2. Purulent bloody sputum/phlegm from deep inside the lungs (hemoptysis)
 3. Night sweats
 4. Pleuritic chest pain

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5. Unexplained weight loss
6. Loss of appetite (anorexia)
7. Easy fatigability
8. Fever of unknown origin

Symptoms of TB disease in other parts of the body depend on the area affected.

B. Certain groups experience disease and infection rates in excess of the general population. These groups include:

1. Persons with certain comorbid medical conditions: diabetes, cancer, and HIV infection alter the immune system's ability to fight TB
2. Babies and young children with weak immune systems
3. Geographic disparities:
 - a. Foreign-born persons from high prevalence countries (see listed reference)
 - b. Medically underserved low-income populations, including high risk minority, African American, Hispanics, Native Americans and Southeast Asians
 - c. Certain other populations that have been identified locally as having an increased prevalence of TB, such as homelessness, refugees and migrants, etc.
4. Close contacts with known infectious TB cases
5. Persons with alcohol use disorder and intravenous drug users
6. Residents of high-risk congregated settings:
 - a. Long-term care facilities (e.g., correctional facilities, skilled nursing)
 - b. Individuals experiencing homelessness

C. Medical Risk Factors:

1. Persons with HIV infection
2. Silicosis
3. Abnormal chest radiograph showing fibrotic lesions
4. Prolonged corticosteroid therapy
5. Organ transplants
6. Immuno-suppressive therapy
7. Hematologic and reticuloendothelial diseases
8. End-stage renal disease
9. Intestinal by-pass
10. Post-gastrectomy
11. Chronic malabsorption syndromes
12. Carcinomas of the oropharynx and upper GI tract

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13. Ten percent (10%) or more below ideal bodyweight

SECTION IV - SCREENING AND DIAGNOSIS

Diagnostic measures/assessment should be initiated on any person with suspected TB. The nursing staff shall notify the primary physician/hospitalist of any symptoms suggestive of TB upon initial patient assessment.

A. Diagnostic measures may include:

1. History and physical examination
2. Tuberculin Skin Test (TST)
3. Blood Assay for Mycobacterium tuberculosis (BAMT); Interferon Gama Release Assay (IGRA) or QuantiFERON-TB Gold test
4. Chest X-Ray
5. AFB sputum smear and culture
6. Others as prescribed

B. Tuberculin Skin test (TST): *See TST – ADMINISTRATION AND INTERPRETATION OF TB SKIN TEST POLICY*

1. PPD skin test results should be read by designated, trained personnel between 48-72 hours after injection. The skin test is to be read by the presence or absence of induration at the injection site. Redness or erythema are not to be measured. The transverse diameter of induration should be recorded in millimeters.
2. Test may be given to employees, healthcare providers, and patients. Patient results will be entered into the medical record.
3. Two-step TST Testing is used for new employees through Employee Health.

C. Notification of the Nursing Unit and Infection Prevention Department

1. In addition to notifying the nursing unit, the Infection Prevention Department shall be notified (ext. 3781 or 6121; Fax at 791-3819) by any person on the healthcare team in a timely manner of any suspect or confirmed TB diagnosis.
2. Notification can be accomplish by:
 - a. The **nursing units** should notify Infection Prevention **ASAP** when placing a patient in Airborne Precautions
 - b. **Physicians** can notify the nursing units/IP Department

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- c. The interpreting **radiologist** (or Imaging designee) shall be responsible for immediately notifying attending imaging staff, who will inform the nurse and Infection Prevention of any abnormal radiological findings suggestive of TB
- d. The **laboratory** will notify the nursing unit, physician and Infection Prevention of any **positive** results of in-patient AFB smears, cultures or TST as soon as possible.
- e. **Pharmacy** should notify the Infection Prevention Department when a patient has been placed on a new regimen of TB medications.

SECTION V - MANAGEMENT AND ISOLATION OF PATIENTS WITH POSSIBLE TUBERCULOSIS

A. Decision to place in Airborne Precautions (See Figure 1)

1. Signs and symptoms suggestive of TB may include:
 - a. Productive, persistent cough 3 weeks duration (unclear etiology)
 - b. Purulent or bloody sputum (hemoptysis)
 - c. Night sweats
 - d. Pleuritic chest pain
 - e. Unexplained weight loss
 - f. Loss of appetite (anorexia)
 - g. Easy fatigability
 - h. Fever of unknown origin
 - i. Abnormalities (i.e., cavitation) in the chest X-Ray including apical and posterior segments of the upper lobe, in the superior segments of the lower lobe or diffuse nodular infiltrates
2. Any patient with signs and symptoms suggestive of TB, **and** any of the following circumstances will be considered suspect for TB and placed into Airborne Precautions as soon as possible:
 - a. There is an order for sputum for AFB's
 - b. The physician writes "R/O suspect or confirmed TB"
3. The physician, infectious disease physicians, nurse, nursing supervisor or infection preventionist shall have the authority to implement Airborne Isolation Precautions when

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signs and symptoms are suggestive of TB (suspected or confirmed). The physician and Infection Prevention Team should be consulted as part of the decision making process.

B. Airborne Precautions (Airborne Infection Isolation Room (AIIR))

When a patient is placed in Airborne Precautions, the following should take place:

1. Assure the room is negative pressure or has a HEPA filter at bedside.
2. An Airborne Precautions sign (caddy as needed) shall be placed on the door to the patient's room.
3. The door will remain closed, except when entering or leaving the room
4. A National Institute for Occupational Safety and Health (NIOSH) approved **N-95 or Powered Air Purifying Respirator (PAPR)** should be donned by all staff (i.e., nursing, physicians, EVS, Lab, RT, Imaging, etc.) upon entering the room.

C. Airborne Infection Isolation Room (AIIR) Location

Designated Airborne Infection Isolation Rooms (AIIR) appropriate for the placement of patients with known or suspected TB are located in the following areas:

1. Main Hospital:

- a. Telemetry Department - Room 260
- b. Medical Surgical Department – Room 360

2. If a room is not a designated AIIR, it may be able to be adapted with an appropriately placed HEPA filter.

D. Inpatients with known or suspected TB:

1. Patient must be placed in Airborne Infection Isolation room (AIIR) or have a HEPA filter unit placed at bedside.
2. Patients on treatment for infectious TB who are re-admitted to SVMC shall be placed in the above designated room until infectiousness is ruled out.
3. Notify the Infection Prevention Department as soon as possible (Infection Prevention Department 3781).
4. Within 24 hours of diagnosis or strong suspicion of an active TB case, notification of the Tulare County TB Office must be done. The IP Team will initiate this process.
5. Adherence to Airborne Precautions/etiquette compliance by the staff and patient is mandatory.

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6. Any incident of noncompliance with Airborne Precautions protocol shall be reported to the area Clinical Director/Manager.
7. The physician shall be notified if the patient will not comply with Airborne Precaution protocols.
8. The physician and/or nurse will provide the following education to the patient in respiratory precautions:
 - a. Transmission of TB
 - b. Reasons for respiratory precautions and importance of compliance
 - c. Precautions, such as covering the mouth and nose with tissues when coughing or sneezing
 - d. Importance of staying inside the patient's room
 - e. Specific instructions for transportation to areas outside the patient's room

SECTION VI - OTHER CIRCUMSTANCES

A. Patient Movement to other locations:

1. A patient in Airborne Precautions shall not be routinely transported to other locations for a procedure/test unless it is deemed medically essential (and cannot be done in the patient's room).
2. If a patient in Airborne Precautions must be transported outside the patient's room for a medically essential procedure, the patient shall wear a surgical mask during the transfer and procedure. The mask should be changed if it is no longer effective (i.e., wet or soiled). If use of a mask is not possible during the procedure, the receiving department should use Airborne Precautions. Patient should be placed in a single room with a HEPA-filter. Staff should don an N-95 respirator or (PAPR) and follow other Standard Precautions (gown, face shield/goggles, gloves) if further exposure to body fluids is anticipated. Room should be exhausted for one hour (door closed) after the procedure with the HEPA-filter on.
3. If the patient requires mechanical ventilation, a HEPA-filter must be used on the expiratory side of the resuscitation bag or ventilator circuit. Portable ventilators are **not** equipped with closed circuit capability, therefore, a HEPA-filter **must** be placed prior to transporting active TB ventilated patients.
4. The minimum respirator is a fitting face-piece respirator and must be selected from those approved by CDC/National Institute for Occupational Safety and Health (NIOSH) under Title 42 CFR, Part 84. It must meet one of the following specifications:
 - Non-powered air-purifying respirators (N-95)
 - Powered air-purifying respirators (PAPRs) with high-efficiency filters; or
5. Outside the patient room, during transport within the hospital or clinics, the employee does not need respiratory protection because the patient is wearing a surgical mask.

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6. Staff should make **all** attempts to schedule the procedure at a time when it can be performed rapidly, when the patient is in a single room, and when waiting areas are less crowded (i.e., end of day).

B. Outpatients with known or suspected TB

1. Facility staff should be notified by physician's office staff in **advance** regarding a possible TB patient arrival.
2. Patient should be instructed to wear a surgical mask upon entering the facility and practice appropriate respiratory etiquette (i.e., use tissues while coughing, proper disposal, etc.).
3. Place patient in a room with a HEPA filter. If not readily available, patient is to wear a mask until placed in an appropriate room.
4. When appropriate, schedule suspect TB patients at times to avoid contact with immunocompromised patients

C. Aerosol-generating (high hazard, cough-inducing) procedures (i.e., bronchoscopy, airway surgeries, intubation/extubation, non-invasive positive pressure ventilation (e.g., CPAP, BIPAP, open Suctioning of tracheostomy or endotracheal tube)

1. Minimize such procedures when possible.
2. Use the HEPA units for aerosol-generating procedures.
3. HCWs should utilize Airborne Precautions during the procedure (i.e., N-95 respirator mask/PAPR, goggles/face shield, gloves and gown).
4. Following the procedure, confine the patient to the room or enclosure until coughing subsides or until patient is discharged. Have patient use tissues to contain any secretions.
5. Allow at least 1 hour following the procedure before placing another patient in the procedure room.
6. Document precautions taken on the patient record, including area of recovery.

D. During Emergency Department Care

1. The patient shall wear a surgical mask when being transported via emergency medical services (EMS) if TB is suspected or confirmed. Staff should be alerted to a possible TB patient.
2. The suspect patient should be provided supplies for respiratory etiquette (mask, tissues and hand sanitizer) and instructed on respiratory hygiene. This process should begin in the waiting room. The patient should be separated from other patients as soon as possible.
3. The patient should be placed in a private room with HEPA filtration. Airborne Precautions should be implemented.

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4. A mask should be worn at all times by the patient, until sufficient arrangements are made. The mask should be changed as necessary (i.e., when wet or soiled).
5. The patient should be processed as quickly as possible through the Emergency Department.

E. Operating Room (OR):

1. Elective operative procedures shall be deferred, if possible, until TB is no longer infectious.
2. OR procedures that must be done shall be completed with the door closed and traffic minimized.
3. If possible, procedures shall be performed at the end of the day.
4. A bacterial filter shall be placed on the endotracheal tube and/or expiratory side of the anesthesia breathing circuit.
5. OR personnel shall wear an N-95 respirator mask instead of a surgical mask during the procedure.
6. HEPA filtration should **not** be used during the operative procedure due to disruptions of normal air flow.
7. HEPA filtration will be required for air scrubbing the environment post-operation after the patient has been removed from the OR suite. Note: The HEPA unit must be disinfected prior to entry into the operating room.
8. Allow the HEPA-filter unit to run for at least 60 minutes after the patient has vacated the room.
9. Recovery shall be in an individual room meeting ventilation requirements.

F. PPD Positive Obstetric Patients

1. Obstetric patients and their newborns will be provided quality effective care that meets the requirements for effective management of TB.
2. Positive PPD skin test obstetric patients should have a documented chest radiograph in their medical records to verify disease status.
3. Asymptomatic PPD positive obstetrics patients **with** a documented x-ray within the last year do not require any additional precautions related to TB upon admission
4. Asymptomatic PPD positive obstetrics patients **without** a documented chest x-ray within the last year will require a chest x-ray as soon as possible after delivery. They (as well as the infants) will not require any additional precautions related to TB upon admission until the status of the x-ray is determined.
5. **Symptomatic positive PPD** patients will require Airborne Precautions:
 - a. Separation may be necessary:

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- 1) Mothers who are too ill to care for their infants or who need higher levels of care.
- 2) Neonates at higher risk for severe illness (e.g., preterm infants, infants with underlying medical conditions, infants needing higher levels of care).
- b. If the neonate remains in the mother's room, measures that can be taken to minimize the risk of transmission from a mother with symptomatic TB to her neonate include:
 - 1) Mothers should wear a mask and practice [hand hygiene](#) during all contact with their neonates. **Note:** Plastic infant face shields are not recommended and masks should **not** be placed on neonates or children younger than 2 years of age.
6. If an obstetric patient is undergoing active treatment for TB, place the patient under airborne precautions. The staff will contact the Infection Prevention Department. The Infection Prevention Department will communicate with the Tulare County TB Office. A determination will be made regarding the patient's current infectious status. The Birth Center will notify the Infection Prevention Department when the patient is discharged. The Infection Prevention Department will notify Tulare County of the discharge.

SECTION VII - ENGINEERING CONTROLS

A. Negative Pressure Rooms (AIIR)

1. Monitoring

- a. Negative airflow pressure rooms are kept at a constant "negative pressure". An alarm will notify HCW if negative pressure is disrupted. HCW may notify the Engineering Department for assistance.

B. Ventilation

1. Local exhaust ventilation

- a. Air from ventilation in the patient room is directly exhausted to the outside of the building, away from air intake vents.
- b. Precaution rooms and rooms used for treatment have a minimum of twelve (12) air exchanges per hour. Air is exhausted to the outside and not recirculated.

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C. HEPA Filtration

A HEPA air filtration unit is a portable device used to “clean” the air of a non-negative pressure patient room or area by creating high efficiency particulate air filtration (removal of respirable particles).

1. Installation of Unit

- a. Call Engineering when a HEPA unit is needed in a patient room.
- b. Engineering staff will install the unit in required area as per nursing staff and use appropriate particulate respirator and other protective equipment, as required due to patient condition.

2. Monitoring

Checked by staff. Staff will confirm HEPA unit is in place and is in working condition. Staff will call Engineering Department for assistance.

3. Unit Removal

Upon notification from nursing that the unit is no longer necessary:

- a. Engineering will be called to remove the HEPA unit.
- b. HEPA unit will remain “ON” in the patient’s room (to scrub the air) for at least one (1) hour, prior to being removed by Engineering (necessary only if patient had infectious TB).
- c. Unit will be cleaned by Environmental Services staff (must adhere to airborne precautions)
- d. Pre-filter will be changed every 1-3 months on average. If the MAP unit is utilized in the treatment of a patient with confirmed infectious disease, the Pre-filter should be replaced immediately after use by Bio-med every 3 months.
- e. HEPA filter should be replaced every 12 months on average when the MAP is used in continuous service. If the MAP unit is utilized in the treatment of a patient with confirmed infectious disease the Pre-filter should be replaced immediately after use by Bio-med every 3 months.
- f. Unit will be stored by Engineering.

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4. Maintenance Procedure

- a. HEPA filters are to be properly installed, tested, and maintained per manufacturer's instructions. HCW will maintain documentation in the patient's record indicating the time that the unit was used.
- b. Filters are to be installed to prevent leakage between filter segments and between the filter bed and its frame.
- c. A pressure sensing device in the filter system will determine the need for filter replacement. Changes will take place per manufacturer's recommendations by Engineering.
- d. Installation should allow for maintenance without contaminating the delivery system or area served.
- e. Engineering personnel are adequately trained on the installation and maintenance procedures. Respiratory protection is worn during maintenance and testing.

SECTION VIII - DISCHARGE PLANNING

A. Discontinuance of Airborne Precautions:

1. The following persons are authorized to discontinue isolation:
 - a. Attending physician
 - b. Infection Preventionist
2. Isolation may be discontinued if the patient is:
 - a. 3 consecutive sputum smears (at least 8 hours apart and one taken in the morning before brushing teeth, eating or drinking) for AFB are negative
 - b. 2 negative NAAT
 - c. With permission of Tulare County Health Department
 - d. When patients are found not to have infectious TB

B. TB Inpatient Notification/Discharge Planning:

Every health care provider who provides treatment for a patient with active tuberculosis must promptly report to the local health officer each diagnosis or suspected diagnosis of active TB. Also reportable are instances when the patient discontinues treatment for active TB.

A healthcare facility cannot discharge a person who is known or reasonably suspected to have active TB until after the discharge plan for the patient is approved by a Tulare County Public Health Official.

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To comply with the above regulations, the Infection Prevention Department will be the overall coordinator for the reporting process. Problems or concerns should be directed to the Infection Prevention Department. However, a team approach should be used to facilitate the initial reporting mechanism and discharge planning process between the facility and the Tulare County Health and Human Services Agency (TCHHSA) TB Office. Nursing, the patient's physician, Case Management and the Infection Prevention RN will collaborate to expedite the communication of information necessary to report TB cases and to obtain approval for the patient's discharge plan.

1. Within **24 hours** of diagnosis or strong suspicion of an active TB case (i.e. patient with symptoms suggestive of TB, positive chest radiograph with positive PPD or AFB smear), notification of the Tulare County TB Office must be done. Nursing staff or the patient's physician shall notify the IP Nurse to initiate this process.
2. When the Infection Preventionist receives notice of the patient actual or suspected diagnosis, the completed TB Suspect Case Report will be faxed or input in CalREDIE by the IP.
3. The Infection Preventionist and staff will communicate with Tulare County TB Office as necessary, to facilitate patient treatment/progress. Documentation of any communication shall be recorded in the patient's medical record.
4. As soon as a projected discharge date is known and at **least one day prior to discharge**, the Tuberculosis Discharge Treatment Plan will be completed and faxed to the Tulare County TB Officer or his/her designee. By phone: Monday through Friday (559)623-0690. By fax: (559)749-9780.
5. Notification of approval of the discharge plan will be sent from the Tulare County TB Office within approximately 24 to 48 hours after the plan was submitted as above. **The patient may not be discharged, transferred or released prior to receiving approval from the Tulare County Public Health Officer.** If the patient refuses to wait for the facility to receive the approved discharge plan form from the Health Department, the patient must sign out AMA and the TCHHSA TB Office must be informed immediately by hospital staff.
6. For medically necessary transfers to other acute care hospitals or correctional institutions, notification of the Tulare County TB Health Officer should be done ASAP. Document in the patient's medical record that the transfer was reported and to whom it was reported. The TB discharge plan will need to be completed.

SECTION IX - RESPIRATORY PROTECTION OF EMPLOYEES/FIT-TESTING

7. All employees are required to be fit-tested by Employee Health Services (EHS) for a NIOSH-approved N-95 respirator mask.

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8. The mask must seal the mask around the nose and mouth.
9. The mask must be “seal checked” for an effective seal each time before entry into an Airborne Precautions room. To do so, blow forcefully into the mask as it expands. The wearer should not feel air escaping around the edges of the mask.
10. As with any disposable mask, N-95 respirator shall be removed and disposed of immediately after a single use or when visibly soiled
11. If the employee fails the N-95 fit test, they must wear a Powered Air Purifying Respirator (PAPR).

SECTION X - EVALUATION OF CONVERSIONS/TRANSMISSION

A. Exposure to TB in a HCW (See APPENDIX D: Employee Health Policy *Tuberculosis screening Program* and Employee Screening Form)

1. A contact investigation among other HCWs, patients, and visitors after a confirmed exposure to active TB will be initiated by Infection Prevention and Employee Health.
2. The Infectious Disease Department Chair will also be consulted.
3. Employee Health and Infection Prevention will follow current CDC recommended guidelines for exposure of employees (i.e., baseline TST and follow up at 8 - 10 weeks).
4. An employee exposure line list will be developed. Any employee converting to positive will be managed by Employee Health. Appropriate measures will be implemented based on each individual case.
5. Previous positive TST employees will be evaluated for symptoms and will be recommended for a chest x-ray.
6. The Tulare County Office will be notified for community contact investigation and consultation as required.
7. Investigation will be performed to determine the cause of transmission.
8. An evaluation of the TB exposure/TB Control Plan and processes will be conducted, with possible opportunities for improvement to be developed and recommendations implemented.
9. Summary of findings and recommendations will be presented to the Infection Prevention Committee.

B. Patient-to-Patient/Visitor TB Transmission

1. Surveillance will be conducted by Infection Prevention to determine any additional cases of TB transmission related to other patients and visitors.

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2. Potential patient/visitor (as possible) exposures will be identified and the primary physician will be notified for recommended follow-up.
3. Tulare County TB Office will be notified as necessary.

C. Exposure Follow-up for Unrecognized TB at Time of Hospitalization

1. Investigation will be conducted to determine areas and persons potentially exposed.
2. All persons exposed shall be handled as above in A and B.

APPENDIX A

Fit Testing Procedure

1. Assignment of Responsibility- Employee Health Services.
2. Identify those HCWs to be fit-tested.
3. Select respirator- NIOSH-approved (minimum N- 95).
4. Instruct each HCW to abstain from eating, drinking, and chewing gum for a minimum of 15 minutes prior to being fit-tested.
5. HCW to fill out questionnaire/medical evaluation entitled, "Mandatory Information for those Employees Selected to use a Respirator" to determine the employee ability to use a respirator (see attachment). Evaluate the employee potential health problems that might limit the employee's ability to wear a respirator during performance of normal job duties. (Using a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used and the medical status of the employee.)
6. Fit-tester to review and determine HCW's ability to be fit-tested and wear N-95 in the clinical setting. If questionnaire results indicate health concerns and inability to wear respirator safely, do not continue with fit-testing. (Refer if needed, as designated by EHS.)
7. Describe to the employee the limitation of the respirator and the consequences for not wearing it correctly.
 - A. Limitations:
 - i) Respirator face-seal: leakage is not necessarily 100%.
 - ii) Lack of fit-checking each time used may increase risk of leakage.
 - iii) Qualitative tests rely on the subjective response of the HCW being fit-tested.
 - iv) Considerations of hygiene, damage, and breathing resistance all are factors in its use.

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B. Consequences:

- i) Risk of exposure to *M. tuberculosis*.

8. Train the healthcare worker on:

- A. How the N-95 respirator is to be applied to the face and how to adjust it.
- B. How to inspect the integrity (physical damage or soil) of the N-95 respirator.
- C. How to fit-check with each use.
- D. How to maintain the N-95 respirator (protect from elements.)
- E. How to store the N-95 respirator (clean, convenient, sanitary area, if it is to be reused due to shortage.)

When to dispose of the N-95 respirator (damaged or noticeable breathing resistance.)

- F. How to dispose of the N-95 respirator (regular trash.)
- G. How to obtain additional respirators.
- H. To return for fit-testing if the employee has facial changes (through weight loss/gain, medical conditions, facial surgery, etc.) or if there are any questions. Training can recur annually or as needed.
- I. Fit-testing and N-95 respirators are at no cost to the employee.

9. Inform the HCW of the ingredients of the fit-test solution and that they will be exposed to a fine mist.

10. Qualitatively (saccharin) fit-test an appropriate size respirator to the HCW following the instructions of the manufacturer's fit-test kit.

11. Allow the healthcare worker to practice how it should be worn.

12. If the HCW cannot be fitted with the available respirators, assign HCW to use (PAPR).

13. Maintain documentation of fit-testing in personnel file.

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APPENDIX B: FIT TESTING RECORD FOR RESPIRATOR USERS

 SIERRA VIEW MEDICAL CENTER	Fit Testing Record for Respirator Users
Employee: _____ Job Title: _____	
Department: _____ Extension: _____ Date of Birth: _____	
Description of condition requiring RPE use: _____	
Since your last fit test, has a physician diagnosed you with any major conditions that would interfere with your ability to use a respirator? Yes / No	
Employee signature: _____	
Fit Testing Record	
PE Manufacturer: 3M 1860 R / S Model Number: 1860 (N95) ☐ NIOSH Approval #: TC-84A-0006 Face-piece Type and Size: Regular / Small	
PE Manufacturer: Alpha Pro Tech Model Number: 695 (N95) ☐ NIOSH Approval #: TC-84A-0457 Face-piece Type and Size: Regular	
PE Manufacturer: _____ Model Number: _____ (N95) ☐ NIOSH Approval #: _____ Face-piece Type and Size: Regular / _____	
Medical Restriction Noted by Physician? Yes / No Odor Detection Adequate? Yes / No	
Date Fit Tested: _____ Qualitative Analysis: _____ X	
Pass / Fail Comments: _____	
_____ Signature of Fit Tester	

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APPENDIX C: TUBERCULOSIS SCREENING PROGRAM AND EMPLOYEE TB SCREENING FORM

1. General Information

- A. Participation in the MTB screening program is mandatory initially for all, and for HCWs annually thereafter.
- B. PPD skin tests are available to employees at no cost.
- C. Determination shall be made concerning any medical condition or treatment that leads to severely impaired cell-mediated immunity, thereby affecting the reading of a PPD skin test.
- D. An employee shall be counseled regarding the meaning of a PPD skin test result.
- E. PPD skin test results should be read by designated, trained personnel between 48-72 hours after injection. The skin test is to be read by the presence or absence of induration at the injection site. Redness or erythema are not to be measured. The transverse diameter of induration should be recorded in millimeters.
- F. PPD Positive Interpretation (definition):
 - i) A reaction of ≥ 5 mm is classified as positive in:
 - Persons with HIV infection or risk factors for HIV infection with unknown HIV status.
 - Persons who have had recent contact with persons with active TB
 - Persons who have abnormal chest radiographs consistent with old healed TB
 - ii) A reaction of ≥ 10 is classified as positive in all persons who do not meet any of the criteria above but who have other risk factors for TB including:
 - High-Risk Groups
 - a) Intravenous drug users known to be HIV seronegative
 - b) Persons with other medical conditions that have been reported to increase the risk of progressing from latent TB infection to active TB, including silicosis, gastrectomy, jejunio-ileal bypass surgery, being 10% or more below ideal body weight, chronic renal failure, diabetes mellitus, high dose corticosteroid and other immunosuppressive therapy, some hematologic disorder (e.g. leukemia and lymphomas), and other malignancies.

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- High-Prevalence Groups

- a) Foreign-born persons from high prevalence countries in Asia, Africa and Latin America
- b) Persons from medically underserved low income populations
- c) Persons from high-risk populations in their communities, as determined by local public health authorities

iii) Induration of ≥ 15 mm increase within a 2-year period is classified as positive for persons who do not meet any of the above criteria.

iv) Recent converters are defined on the basis of both induration and age:

- ≥ 10 mm increase within a 2-year period is classified as positive for persons < 35 years of age
- ≥ 15 mm increase within a 2-year period is classified as positive for persons ≥ 35 years of age
- ≥ 5 mm increase under certain circumstance (see "i" above).

2. New Healthcare Workers and PPD Skin Testing:

A. Healthcare workers with no documented evidence of PPD skin testing or those with history of BCG vaccine or those new healthcare workers who have documentation of a PPD (-) status, yet the documentation is greater than 12 months:

i) New healthcare workers with undocumented history of PPD testing or (PPD-more than 12 months ago) or treatment with BCG shall be tested upon hire using the two-step tuberculin skin testing method. If the first tuberculin test is negative, a second 5-TU shall be administered 1-3 weeks later. A positive second result probably indicates boosting from a past infection or prior BCG vaccination. Persons having a boosted reaction should be classified as a reactor, not a converter. If the second result is negative, the person is probably uninfected and a positive reaction to subsequent tests indicates a true tuberculin skin-test conversion.

ii) Use intermediate strength PPD 5 TU/0.1cc intradermal in the forearm.

B. PPD Positive New Healthcare Workers

i) Known PPD (+) new healthcare workers with professionally documented previous positive reaction or TB infection/treatment, or both, are exempt from further PPD screening and shall be evaluated by symptom review and risk evaluation using the employee screening form. Obtain chest x-ray if indicated.

ii) New healthcare workers with a history of possible significant previous reaction which is undocumented should be: 1) strongly encouraged to obtain

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documentation of previous (+) as many people are unclear on their medical history/testing, 2) probed to describe the “positive” test (i.e. where was it given, what did it look like, who told you it was positive, what was the follow-up?), 3) considered for skin testing if answers to questions in 2) clearly indicate that the HCW does not know their PPD history, 4) if unable to obtain documentation of skin test, then obtain chest x-ray at the hospital’s provider of employee health services, 5) if the chest x-ray is clear, consider the employee cleared for patient care activities. If the chest x-ray is abnormal, employee health services provider will evaluate for further follow-up/clearance for work. All new healthcare workers who react or convert to PPD (+) will need to be evaluated by chest x-ray and should be medically evaluated for further treatment and clearance for work.

3. Annual Healthcare Worker Evaluation for Clinical Employees:

All employees must have a PPD skin test annually (unless already documented positive). If the HCW converts their skin test to a (+), assess for symptoms of TB and refer to hospital’s provider of employee health services for chest x-ray, further medical evaluation, treatment if indicated, and clearance for work:

4. TB Exposure Incident:

A. Definition- An exposure incident is defined as any unprotected exposure to a patient/client with a (+) AFB smear, which results in identification as MTB, or if clinical diagnosis of MTB is confirmed by the health department.

B. Follow-up- Administer PPD skin testing to non-reactors at time of exposure and at 8-10 weeks after the exposure.

- i) If the skin test is negative, the healthcare worker shall revert to annual skin testing schedule.
- ii) If the skin test is positive, refer to PPD converter section above and work with the health department for proper follow-up.

C. Investigate the exposure incident for transmission risks, need for further education, procedural changes, and further employee contacts/exposures.

APPENDIX D: CLIENT/FAMILY EDUCATION MATERIAL

1. Healthcare workers from SVMC are practicing **Airborne Precautions** until deemed unnecessary. SVMC is dedicated to protecting the health and safety of its employees. The healthcare workers entering the patient’s room will wear a N-95/PAPR at all times. The reason for these **Airborne Precautions** is that the patient has been diagnosed with or has symptoms/diagnostic test results indicating suspicion of active tuberculosis:

- ☐ The patient has been diagnosed by a physician as having clinical signs/symptoms of active tuberculosis.

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- ☐ The health department has determined that the patient has or is suspicious for having active tuberculosis.
 - ☐ One of the laboratory tests done by the hospital indicates that they may have active tuberculosis (+ AFB sputum test).
2. You may contact the Tulare County Department of Health Services if you have additional questions. They will be involved with following up on contacts and exposed individuals. You may also contact your primary care physician.
 3. Active pulmonary/laryngeal TB is carried in airborne particles, or droplet nuclei, that can be generated when persons who have pulmonary or laryngeal TB sneeze, cough, speak, or sing. The particles are tiny, and normal air currents can keep them airborne for prolonged periods of time. Infection occurs when a susceptible person inhales droplet nuclei containing the TB bacteria.
 4. It is important that you take your anti-TB medicines exactly as prescribed.
 5. Visitors in the home- the Health Department will determine when it is safe for you to have visitors in the home.
 6. Do not leave your home until deemed safe by the health department. If you must go to a doctor's appointment or the Health Department, wear a regular mask until you are no longer considered infectious.
 7. While at home, always use tissues to cover your mouth and nose when coughing or sneezing. Take any other precautions that the Health Department has instructed you in.

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APPENDIX E: TUBERCULOSIS DISCHARGE TREATMENT PLAN

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 Tulare County Health & Human Services Agency Health Services Department Public Health / Tuberculosis Program	TUBERCULOSIS DISCHARGE TREATMENT PLAN
Discharge of a Suspected or Confirmed Tuberculosis Patient As of January 1, 1994, California State Health and Safety Codes mandate that patients suspected of or confirmed as having TB may not be discharged or transferred without prior Health Department approval. To facilitate timely and appropriate discharge, the provider should notify the Health Department 1-2 days prior to anticipated discharge to review the discharge criteria. (See Below) Tuberculosis Control Program (TBC) Response Plan For Weekday Discharge- Non Holiday: Monday – Thursday 8:am – 5:00pm. Upon a receipt of a completed discharge request form, TB staff will provide a response within 24 hours. To expedite your request, please include all laboratory and/or radiology reports. TBC staff will review the request and notify the submitter of approval, or will inform the submitter if additional information or action is required prior to discharge approval. If a home evaluation is needed to determine if the environment is suitable for discharge, the TBC staff will make a home visit within (1) working day notification. Holiday and Weekend Discharge If you anticipate a discharge on a weekend or holiday please contact the TB Control Program immediately. For discharge planned Friday through Sunday, a completed form must be received no later than 5pm on Wednesday. For holiday discharge, a completed form must be received no later than 5pm on the second preceding business day. Discharge Criteria Approval of patient discharge is dependent upon compliance of the discharge treatment plan meeting the guidelines included below. Final approval for discharge is granted by the Health Officer after receipt and review of the discharge plan. Forms must be filled out in entirety to avoid delay in approval. 1. Home with no at risk individual(s) in the home: ❖ Patient is on appropriate drug regimen ❖ Patient is clinically stable ❖ Patient deemed an acceptable candidate for home isolation 2. Home with high risk individual(s) in the home who have not been exposed: ❖ Patient is on appropriate drug regimen >1 week ❖ Patient is clinically stable ❖ Patient deemed an acceptable candidate for home isolation ❖ Contact(s) considered for or placed on prophylaxis 3. High Risk Setting: ❖ Patient is on appropriate drug regimen >2 weeks ❖ Patient clinically improving ❖ Three consecutive negative AFB smears In all instances, an accurately completed Discharge Treatment Plan must be submitted at least 24 hours prior to consideration for approval for discharge. If these criteria cannot be satisfied, discharge cannot be approved and the patient MUST be held until the next business day for appropriate arrangements to be made.	

SUBJECT: TUBERCULOSIS CONTROL PLAN	SECTION:
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REFERENCES:

California Tuberculosis Risk Assessment | Curry International Tuberculosis Center. Updated August 2024. Accessed 18 August 2026 at: <https://www.currytbcenter.ucsf.edu/products/california-tuberculosis-risk-assessment>.

Clinical Testing Guidance for Tuberculosis: Health Care Personnel. 15 December 2023. Accessed 18 August 2026 at: <https://www.cdc.gov/tb-healthcare-settings/hcp/screening-testing/index.html>

California Code of Regulations Title 8, Section 5144, Subchapter 7. Accessed 18 August 2026 at: <https://www.dir.ca.gov/title8/5144.html>

Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005. Center for Disease Control and Prevention. Accessed 19 August 2026 at: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e

OSHA Standard 29 CFR 1910.134. Accessed 19 August 2026 at: <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134>

Tuberculosis. Mayo Clinic Staff. 24 April 2025, Accessed 19 August 2026 at: <https://www.mayoclinic.org/diseases-conditions/tuberculosis/symptoms-causes/syc-20351250>

Tuberculosis Infection Control (Health Care Providers). Center for Disease Control and Prevention. Updated December 15, 2023. Accessed 19 August 2026 at: <https://www.cdc.gov/tb-healthcare-settings/hcp/infection-control/index.html>

CROSS REFERENCES:

TST- Administration and Interpretation of TB Skin Test

SUBJECT: TWINS – MULTIPLE GESTATION	SECTION: Page 1 of 2
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PURPOSE:

To establish guidelines in the nursing management of the patient with multiple gestation.

POLICY:

- Every patient with multiple gestation will be prepared at admission for the possibility of a cesarean section including lab tests, medications, and psychological preparation.
- Each fetus will be individually monitored following established protocols.
- Upon MD request, the patient may be taken to the operating room and prepared for vaginal delivery in the operating room (OR) with staff on hand in case an emergency cesarean section is needed at any time during the delivery.
- A neonatal team consisting of registered nurse and respiratory therapist with Neonatal Resuscitation Program (NRP) for each infant will be present at birth to provide neonatal resuscitation if necessary.

AFFECTED PERSONNEL/AREAS: *MCH DEPARTMENT, RNs*

EQUIPMENT:

- Fetal monitor with twin monitoring capability
- IV supplies

PROCEDURE:

1. Follow standard admission procedures.
2. Patient is to remain NPO except for ice chips.
3. Start an IV using an 18-gauge catheter.
4. Order pre-op labs, CBC, type and cross 2 units PRBCs.
5. Obtain consents for surgery per housewide policy.
6. Initiate patient admission assessment and history.
7. Notify the anesthesiology provider, respiratory therapist, the pediatrician, and as appropriate, the house supervisor or surgery services.
8. Follow established procedure for laboring patients.

SUBJECT: TWINS – MULTIPLE GESTATION	SECTION:
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9. Provide patient/family education regarding procedures and labor progress.

DOCUMENTATION:

- Document fetal monitoring of each fetus following established protocols.
- Document labor progress following established protocols.
- Document all physician notifications/consults.
- Document patient/family education.
- Document the delivery of each newborn under “Delivery Summary Multiple” with details that are specific to each twin (Twin A and Twin B).

REFERENCES:

- Mattson, S. & Smith, J. E. (2016). Core curriculum for maternal-newborn nursing (6th ed.). St. Louis, MO: Elsevier Saunders.
- Simpson, K. R., & Creehan, P. A. (2014). AWHONNs perinatal nursing (4th ed.). Philadelphia: Lippincott Williams & Wilkins Health.
- AWHONN. (2023). Core curriculum for maternal-newborn nursing. Elsevier

SUBJECT:
**VERBAL & TELEPHONE ORDERS –PERSONS
PERMITTED TO ACCEPT, READBACK, and
AUTHENTICATION OF**

SECTION:
Record of Care, Treatment and Services
Page 1 of 5

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

PURPOSE:

To define the organization's implementation of CMS 482.23 regarding the receipt of telephone or verbal orders from licensed independent practitioners (LIP) to include the following:

- Limitations and/or prohibitions on use of verbal orders
- Mechanisms to ensure the authenticity of the practitioner issuing a verbal or telephone order
- Elements required for inclusion in the verbal order process
- Situations in which a verbal or telephone orders may be used
- Organizational personnel authorized to receive and write a verbal or telephone order
- Requirements of organizational staff to read back verbal orders and confirm their read back using approved format

POLICY:

It is the position of the organization's leadership and the Medical Staff that verbal and telephone orders are allowed. However, in an effort to reduce errors, the use of these types of orders are discouraged except in situations when delay in treatment could compromise patient safety as listed below.

AFFECTED PERSONNEL/AREAS: *ALL REGISTERED/LICENSED STAFF; ALL PATIENT CARE AREAS*

PROCEDURE:

Limitations and/or prohibitions on the use of verbal orders

Prescribers are encouraged to enter all orders for medications, treatments and procedures whenever possible. Verbal and telephone orders are discouraged and should be used only if it is absolutely necessary. Verbal orders from prescribers that are present in the hospital are used only in emergencies or during procedures where it is impractical for the prescriber to enter the order, such as in surgery or the emergency department.

Mechanism to ensure the authenticity of practitioner

If the person receiving the order is unfamiliar with the voice of the practitioner issuing the order, the person authorized by the organization to receive orders should:

- Go to hospital intranet and verify practitioner on staff.
- Ask the practitioner if you may put them on speaker for others to offer authenticity verification.

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- If unable to verify through above methods, provide a fax number for physician to send a written, timed, dated, and signed order.

Elements required for inclusion in the verbal order process

Electronic

1. Enter/Select appropriate provider giving the verbal/telephone order.
2. Enter the Order Source of Telephone Order Read Back or Verbal Order Read Back from the list, as appropriate.
3. Begin typing the name of the order/medication in the search field and select the appropriate option provided. Edit order details, as necessary.

Paper

All orders are entered directly into the electronic order management system. However, if the system is unavailable, such as during a system downtime event, staff are to utilize paper orders and, when writing the telephone or verbal order, must ensure the following is documented:

1. The date and time the order is prescribed verbally or via telephone
2. The name of the individual prescribing the drug, treatment, dietary order, or laboratory test, followed by the first initial, last name and licensure of the individual taking the verbal or telephone order.
3. Medication orders shall include the following information:
 - a. Date and time the order is prescribed verbally or via telephone
 - b. The name of the individual prescribing the drug
 - c. The name of the drug
 - d. Drug dosage (strength or concentration)
 - e. Quantity and/or duration
 - f. Route drug is to be administered
 - g. Frequency of administration
 - h. Specific indications for use, as appropriate (e.g. all PRN orders)

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- i. Name and level of licensure of the individual receiving and documenting the order

Situations in which verbal and telephone orders may be used

- The prescribing practitioner has determined that the patient is in need of medication within a specific time period and he/she is unable to physically enter the order in the patient's medical record due to his/her physical location.
- To delay the medication, treatment, dietary order, or laboratory test would not be in the best interest of the patient's plan of care and treatment and therefore expedient ordering is necessary.
- The prescribing practitioner has determined that the patient is in need of medication, treatment, dietary or laboratory order in an urgent or emergent situation where verbal or telephone communication presents the swiftest method of accomplishing the order.

Persons authorized to accept and write a verbal or telephone order

- Registered Nurse
- Licensed Vocational Nurse
- Registered Pharmacist as per protocols established by the Medical Staff, as well as for clarification of medication orders received by licensed practitioner
- *Registered Dietitian if approval obtained from Interdisciplinary Practice Committee*
- Registered Respiratory Therapist (within the sphere of competence)
- Physical Therapist (within the sphere of competence)
- Clinical Laboratory Scientist, phlebotomist, lab clerical (within the sphere of competence)
- Registered Radiological/Imaging Technician, Nuclear Medicine Technician (within the sphere of competence)

Requirements for telephone order/verbal order read back

To prevent errors related to verbal/telephone orders, all individuals licensed and approved by this hospital to receive and record these types of orders must strictly observe the following practices when performing this function:

- Obtain all appropriate criteria information for verbal/telephone orders as listed above.

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Repeat back to the provider the information given to confirm accuracy. During the read back, the person receiving the order should not use any abbreviations. If the order is received for “BID” frequency, the receiver will read the order back “to be administered or drawn twice daily or two times per day”.

- Enter the order directly into the electronic order management system, following the process outlined above.

During a system downtime, use paper orders and write down the complete order on the physician’s order sheet of the specific patient’s medical record and read back to the physician for confirmation. The written order must indicate “TORB” for telephone order read back and “VORB” for verbal order read back with the name of the licensed independent practitioner (LIP) giving the order and the signature and title of the person who received the order. At no time is the receiver to record the order using unapproved abbreviations, range orders or metric symbols.

- The telephone or verbal order must be countersigned by the LIP as defined in the Medical Staff Health Information Management Rules and Regulations.
- If the order requires correction, the person questioning the original order must contact the LIP for clarification, then discontinue the original order within the order management system, indicate the reason for cancellation and enter the new clarified order. If using paper orders, the person who received the clarification order must utilize the next space below the original order and write “Order Clarification” followed by the new order reflecting the correction.

REFERENCES:

- California Department of Public Health, Title XXII §70263 (g)
- **California Code of Regulations, Title 22, § 70263(g).** <https://govt.westlaw.com/calregs>
(State regulatory requirement governing verbal and telephone orders.)
- **Centers for Medicare & Medicaid Services. (2026).** *State operations manual, Appendix A: Survey protocol, regulations and interpretive guidelines for hospitals.* U.S. Department of Health and Human Services. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_a_hospitals.pdf [[cms.gov](https://www.cms.gov)]
- **Institute for Safe Medication Practices. (2026).** *ISMP targeted medication safety best practices for hospitals (2026-2027).* https://online.ecri.org/hubfs/ISMP/Resources/ISMP_TargetedMedicationSafetyBestPractices_Hospitals.pdf [online.ecri.org]
- **Institute for Safe Medication Practices Canada. (2020).** *Strategies for safer telephone and other verbal orders in defined circumstances.* <https://ismpcanada.ca/bulletin/strategies-for-safer-telephone-and-other-verbal-orders-in-defined-circumstances/> [ismpcanada.ca]

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

- **The Joint Commission. (2026).** *National Patient Safety Goals and National Performance Goals.* <https://www.jointcommission.org/en-us/standards/national-patient-safety-goals>
[\[jointcommission.org\]](https://www.jointcommission.org/en-us/standards/national-patient-safety-goals)
- **Agency for Healthcare Research and Quality. (2024).** *Verbal orders and medication overrides: A dangerous combination.* PSNet. <https://psnet.ahrq.gov/web-mm/verbal-orders-and-medication-overrides-dangerous-combination>
-

CROSS REFERENCES:

- [*Abbreviations in the Medical Record*](#)– House-Wide Policy & Procedure Manual
- [*Requisitions, Collecting, Analysis & Reporting – Laboratory Standard Operating Procedure Manual*](#)

SUBJECT: VITAMIN K INJECTION FOR VITAMIN K DEFICIENCY DISEASE	SECTION: Page 1 of 3
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide Vitamin K injection to the infant for the prophylaxis of Vitamin K deficiency disease. Vitamin K deficiency disease is a bleeding disorder that usually develops shortly after birth. Newborns are susceptible because of the low levels of Vitamin K in the infant. Vitamin K does not easily cross the placenta to the newborn. Newborns can develop this condition if they are not administered Vitamin K shortly after birth.

POLICY:

All newborns in the Maternal Child Health Department will be given a Vitamin K injection for the prophylaxis of Vitamin K deficiency unless refused by guardian.

AFFECTED AREAS/PERSONNEL: *MCH REGISTERED NURSES*

The incidence of Vitamin K deficiency disease is divided into three categories:

1. Early onset presents within the first 24 hours of life with skin bruising, massive cephalohematoma, GI tract bleeding or intracranial hemorrhage.
2. The next category is classic hemorrhagic disease of the newborn that presents between 1 and 7 days of life.
3. The third category is late onset which occurs between 1 week and 6 months of life with peak between 2-8 weeks of life.

Infants who have the following disorders are also at risk for developing this disease:

- Biliary Atresia
- Celiac Disease
- Cystic Fibrosis
- Diarrhea
- Hepatitis
- Intestinal malabsorption disorders
- Maternal medication affecting Vitamin K metabolism (anticonvulsants, warfarin, certain antibiotics, and anti-tuberculosis medications)

EQUIPMENT:

- Alcohol prep

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- Vitamin K medication
- Adhesive bandage

PROCEDURE:

1. All newborns will be administered Vitamin K shortly after birth.
2. The nurse will explain to the newborn's parents the purpose of vitamin K injections and why it is important for their infant to receive vitamin K.
3. Prophylactic Vitamin K (Phytonadione) will be administered as follows:
1 mg intramuscular (IM) x 1.
4. Nurse will follow the "five rights of medication administration."
5. Refusal of Vitamin K injection:
 - a. Patient's mother must sign "Refusal of Vitamin K" Form.
 - b. Patient's mother must be informed of the purpose of Vitamin K.
 - c. Pediatrician must be notified of parents refusing the vitamin K injection for their newborn.

DOCUMENTATION:

1. The nurse will document on the Electronic Medication Administration Record (EMAR) the administration of Vitamin K including:
 - a. Date and Time
 - b. Site
 - c. Co-witness with another Registered Nurse (RN)
2. If the newborn's parents refuse the injection, the refusal form must be completed and kept in the newborn's chart.
3. Documentation in the newborn's nurse's notes must show that education was given and that the parents refuse the injection to be given to the newborn.

REFERENCES:

SUBJECT:

**VITAMIN K INJECTION FOR VITAMIN K
DEFICIENCY DISEASE**

SECTION:

Page 3 of 3**Printed copies are for reference only. Please refer to the electronic copy for the latest version.**

Hand, I., Noble, L., & Abrams, S. A.; American Academy of Pediatrics. (2022). *Vitamin K and the Newborn Infant*. Pediatrics, 149(3), e2021056036. <https://doi.org/10.1542/peds.2021-056036> [publications.aap.org]

Centers for Disease Control and Prevention. (2025). *Protect Your Baby from Bleeds: Vitamin K Deficiency Bleeding*. <https://www.cdc.gov/vitamin-k-deficiency/fact-sheet/index.html> [cdc.gov]

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). (2026). *Vitamin K Prophylaxis in Newborns*. <https://www.awhonn.org/vitamin-k-prophylaxis-in-newborns/> [awhonn.org]

The Medical Staff and the Hospital bylaws shall be consistent. Neither the Medical Staff nor the Board of Directors may unilaterally amend the bylaws. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the medical staff bylaws.

14.5 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these bylaws. These bylaws apply with equal force to both genders wherever either term is used.

ARTICLE XV ALLIED HEALTH PROFESSIONALS

15.1 DEFINITIONS

"ALLIED HEALTH PROFESSIONAL (AHP)" means a health care professional, other than a physician, dentist, podiatrist or clinical psychologist, who holds a license or other legal credential, as required by California law, to provide certain professional services.

Allied Health Professionals are ~~neither employees of the hospital nor, pursuant to the terms of these bylaws, not~~ eligible for medical staff membership pursuant to the terms of these bylaws, but have been granted a service authorization to provide certain clinical services.

"SERVICE AUTHORIZATION" means the permission granted to an Allied Health Professional to provide specified patient care services within his or her qualifications and scope of practice.

15.2 QUALIFICATIONS

An Allied Health Professional who is ~~not neither an employee of the hospital nor~~ eligible for medical staff membership is eligible for a service authorization in this hospital if he or she:

- (a.) Holds a license, certificate or other legal credential in a category of AHPs which the board of directors has identified as eligible to apply for service authorizations (*see Section 15.4-1*); and
- (b.) Documents his or her experience, background, training, current competence, judgment, and ability with sufficient adequacy to demonstrate that any patient treated by the practitioner will receive care of the generally recognized professional level of quality established by the medical staff; and
- (c.) Is determined, on the basis of documented references: to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting so as not to affect adversely patient care, and to be willing to commit to and regularly assist the medical staff in fulfilling its obligations related to patient care, within the areas of the practitioner's professional competence and credentials; and
- (d.) Agrees to comply with all Medical staff Bylaws, Medical staff and protocols to the extent applicable to the AHP; and
- (e.) Maintains professional liability insurance with a suitable insurer, with minimum limits as determined jointly by the medical executive committee and board of directors.

15.3 CATEGORIES OF ALLIED HEALTH PROFESSIONALS ELIGIBLE TO APPLY FOR SERVICE AUTHORIZATION

The categories of AHPs, based on occupation or profession, which shall be eligible to apply for service authorization in the hospital and the corresponding service authorization prerogatives, terms, and conditions for each such AHP category shall be designated by the Board of Directors, upon the recommendation of the Medical Executive Committee, and when approved by the Board of Directors, shall be set forth in the Medical Staff rules and regulations. Such actions by the Medical Executive Committee and the Board of Directors shall be based upon the recommendations of the relevant departments for the designation of categories of AHPs eligible to apply for service authorization and the delineation of corresponding service authorization prerogatives, terms and conditions for each AHP category. The Board of Directors shall review the designation of categories of AHPs eligible to apply for service authorizations at least annually and at other times, within its discretion or upon the recommendation of the Medical executive committee.

Current Categories of AHP are: Certified Nurse Midwife; Physician Assistant; Certified Nurse Anesthetist; Nurse Practitioners; Ph.D (psychologist non-licensed clinical) ; OD (optometrist)

15.4 PROCEDURE FOR GRANTING SERVICE AUTHORIZATION

15.4-1 (a.) An AHP whose scope of practice allows independent practice must apply and qualify for a service authorization and must designate a physician member of the active medical staff who, concurrently with the AHPs application, applies for and is granted privileges to be responsible, to the extent necessary, for the general medical condition of patients for whom the AHP proposes to render services in the hospital.

(b.) An AHP whose scope of practice allows independent practice must apply and qualify for a service authorization and must designate a physician member of the active medical staff who has applied for, and been granted specific privileges in accordance with the medical staff bylaws, rules and regulations, to ~~supervise~~ collaborate and direct the exercise of service authorizations by the same category of AHP as that of the applicant. An AHP under this section may apply to work under the ~~supervision~~ collaboration of one active medical staff member or, within the medical executive committee's discretion, a group of medical staff members so long as each of the medical staff members has separately applied for and been granted privileges to ~~supervise~~ collaborate with the AHP or the category of AHPs to which the applicant belongs. Whenever an AHP will ~~be supervised~~ have collaboration by more than one Active Staff member, such ~~supervision~~ collaboration must be in strict accordance with rules and regulations developed by the appropriate department and approved by the medical executive committee.

(c.) All AHP applications for initial granting and renewal of service authorizations shall be submitted to the Interdisciplinary Practice Committee. All such applications shall be processed in a parallel manner to that provided in Articles IV and V for Medical staff members, except that the Interdisciplinary Practice Committee shall perform the function which would otherwise be performed by the Credentials Committee, unless otherwise specified in the medical staff rules and regulations.

15.4-2 Except as is provided under Article VII, 7.2, an AHP who (1) has received a final adverse decision regarding his or her application for a service authorization, or (2) withdrew

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his or her application for a service authorization following an adverse recommendation by the Medical executive committee, or (3) after having been granted a service authorization has received a final adverse decision resulting in termination of the authorization, or (4) has relinquished his or her service authorization following the issuance of a Medical staff or Board of directors recommendation adverse to his or her service authorization, shall not be eligible to re-apply for the service authorization affected by such decision or recommendation for a period of at least 24 months from the date that the adverse decision became final, the application was withdrawn, or the AHP relinquished his or her service authorization.

15.4-3 An AHP who does not have licensure or certification in an AHP category identified as eligible for service authorizations pursuant to Section 15.4-1, may not apply for a service authorization but may submit a written request to the President/CEO, asking the Board of directors to consider designating the appropriate category of AHPs as eligible to apply for service authorizations. Upon receipt of such a request, the Board of directors shall forward a copy of the request to the Medical executive committee for its recommendation, and shall also request the recommendation of any affected department or division. The Board of Directors shall consider such request and the Medical executive committee's recommendation, as well as the recommendation of any affected department or division, either before or at the time of its annual review of the categories of AHP, in accordance with Section 15-3.

15.4-4 Each AHP who is granted a service authorization shall be assigned to the medical staff department appropriate to his or her occupational or professional training and, unless otherwise specified in the medical staff rules and regulations, shall be subject to terms and conditions that parallel those specified in Article II - Membership, as they may logically apply to AHPs and may be appropriately tailored to the particular category of AHPs. Each AHP who practices independently must maintain communication with the relevant physician under Section IV. 4.1 in order to enable the physician to assume responsibility, to the extent it is indicated, for the general medical condition of the patient. Each AHP who does not practice independently shall be subject to the supervision of one or more members of the active Medical staff who have been granted privileges to provide such supervision or direction by the Board of directors upon recommendation of the Medical executive committee.

15.5 PREROGATIVES

The prerogatives which may be extended to a member of a particular category of AHP shall be defined in the medical staff rules and regulations. Such prerogatives may include:

- (a.) Provision of specified patient care services subject to a medical staff member responsibility, to the extent indicated, for the patient's general medical condition and under the general oversight of the medical staff, and, where the AHP does not practice independently, also under the supervision and direction of a member of the active medical staff who has been granted specific privileges to supervise that category of AHP. AHP services must be consistent with the service authorization granted to the AHP and within the scope of the AHPs licensure or certification.
- (b.) Service on medical staff and hospital committees except as otherwise expressly provided in the medical staff bylaws, rules and regulations. An AHP may not serve as chair of medical staff committees.
- (c.) Attendance at meetings of the department to which he or she is assigned. An AHP may not vote at department meetings.

15.6 RESPONSIBILITIES

Each Allied Health Professional shall:

- (a) Meet those responsibilities required by the medical staff rules and regulations and if not so specified, meet those responsibilities specified in Section 2.6 as are generally applicable to the more limited practice of the AHP. ~~If AHP require physician supervision~~collaboration; The scope of a given AHP is limited by his/her ~~supervising~~collaborative physician. Whatever medical specialty a physician practices limits the AHP's scope of practice.
- (b.) Retain appropriate responsibility within his or her area of professional competence for the care of each patient in the hospital for whom he or she is providing services.
- (c.) Participate, when requested, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in evaluating AHP applicants, in ~~supervising~~onboarding initial AHP appointees of his or her same occupation or profession or of an occupation or profession which is governed by a more limited scope of practice statute, and in discharging such other functions as may be required by the medical staff from time to time.
- (d.) Countersignature requirements –
 - i AHP – Countersignatures, dated and timed for ~~all medical records~~admission orders of all patients cared for by the AHP within 14 days.
 - ii ~~The medical record for which an eligible AHP issued a Schedule II drug order must be reviewed, countersigned, and dated by the supervising physician within seven (7) days.~~
- (e.) Certified Registered Nurse Anesthetists (CRNA), ~~Certified Nurse Midwives (CNMs) and Nurse Practitioners (NPs)~~ do not require physician supervision or ~~countersignatures~~ of documents and orders with the exception of admission orders. While these advanced practice providers do not require physician supervision they have access to collaboration with physicians in their scope of practice.
- (f.) Each Physician Assistant shall maintain a current written Professional Practice Agreement with a supervising physician. The Professional Practice Agreement shall define clinical practice, responsibilities, scope of services, methods of communication and collaboration, processes for consultation and referral, and any other elements required by applicable law. The supervising physician shall remain responsible for ensuring that consultation is available as needed.
- (g.) Each Allied Health Professional shall be reviewed periodically for quality, periodic peer and professional practice evaluation through the Medical Staff's performance improvement processes.

15.7 TERMINATION, SUSPENSION OR RESTRICTION OF SERVICE AUTHORIZATIONS

15.7-1 GENERAL PROCEDURES

- (a) At any time, the Chief of Staff or Chairman of the Department or Division to which the AHP has been assigned may recommend to the medical executive

committee that an AHP's service authorization be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Inter-disciplinary Practice Committee), if the Medical executive committee (MEC) agrees that corrective action is appropriate, the MEC shall recommend specific corrective action to the hospital's Board of directors. A notification letter regarding the recommendation shall be sent by certified mail to the subject AHP. The notification letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation. Nothing in this Section shall prevent the chief of staff, chair of the department or designee to which the AHP has been assigned, or medical executive committee from imposing a summary suspension or restriction. In such case, except for actions involving clinical psychologists, the procedure in this Section shall be followed. In cases involving clinical psychologists (licensed), the procedure in Section 6.3 shall be followed.

(b) Nothing contained in the Medical staff Bylaws shall be interpreted to entitle an Allied Health Professional, except a clinical psychologist, to the procedural rights set forth in Articles VI and VII. However, an AHP shall have the right to challenge any recommendation which would constitute grounds for a hearing under Article 7.2 of the Bylaws (to the extent that such grounds are analogous to the Allied Health Professional) by filing a written grievance (i.e. a letter objecting to the recommended action and requesting an interview) with the Medical executive committee within fifteen (15) days of receipt of the Notification Letter. Upon receipt of a grievance, the Medical executive committee or its designee shall appoint an ad hoc committee composed of practitioners not previously involved in the recommendation or otherwise biased to afford the AHP an opportunity for an interview concerning the grievance. Although such interview shall not constitute a "hearing" as established by Article VII of the Bylaws, and need not be conducted according to the procedural rules applicable to such hearings, the purpose of the interview is to allow both the AHP and the party recommending the action the opportunity to discuss the situation and produce evidence in support of their respective positions. Minutes of the interview shall be retained.

(c) Within 30 days following the interview, the ad hoc committee, based on the interview and all other aspects of the investigation, shall make a final recommendation to the board of directors, which shall be communicated in writing, sent by certified mail, to the subject AHP, with a copy to the medical executive committee. The final recommendation shall discuss the circumstances giving rise to the recommendation and any pertinent information from the interview. Prior to acting on the matter, the board of directors shall offer the affected practitioner and the medical executive committee the right to appeal to the Board or a subcommittee thereof, under such terms as the board of directors may determine. The final decision by the board of directors shall become effective upon the date of its adoption. The AHP shall be provided promptly with notice of the final action, sent by certified mail, with a copy to the medical executive committee.

15.7-2 AUTOMATIC SUSPENSION, TERMINATION OR RESTRICTION

A. Notwithstanding Section 15.7-1 above, an AHP's service authorization shall automatically terminate in the event that:

1. The AHPs certification, license or other legal credential expires or is revoked.
2. With respect to an AHP who must practice under physician supervision:
 - (a) The Medical staff membership or privileges to supervise the AHP of the supervising physician is terminated, whether such termination is voluntary or involuntary; or
 - (b) The supervising physician no longer agrees to act in such capacity for any reason or the relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason therefore;

Where the AHPs service authorization is automatically terminated for reasons specified in (b) above, the AHP may apply for reinstatement as soon as the AHP has found another physician active Medical staff member who agrees to supervise the AHP and receives privileges to do so. In this case, the medical executive committee may, in its discretion, expedite the reapplication process.

B. Notwithstanding Section 15.7-1, above, in the event that the AHP's certification or license is restricted, suspended, or made the subject of an order of probation, the AHPs service authorization shall automatically be subject to the same restrictions, suspensions, or conditions of probation.

C. Where the AHPs privileges are automatically terminated, suspended, or restricted pursuant to this subsection, the notice and interview procedures under subsection 15.7-1. shall not apply, and the Allied Health Professional shall have no right to an interview except, within the discretion of the medical executive committee, regarding any factual dispute over whether or not the circumstances giving rise to the automatic termination, suspension, or restriction actually exist.

15.7-3 APPLICABILITY OF SECTION

The rights afforded by this section shall not apply to any decision regarding whether a category of AHP shall be eligible for a service authorization and the terms or conditions of such decision pursuant to Section 15.3 of this article.

15.8 REAPPLICATION

Initial and renewal service authorization approvals shall be for a period of up to two years. Each Allied Health Professional must reapply for a renewed service authorization in accordance with Section 15.4.

ADOPTED by the medical staff:

MEETING MINUTES

MINUTES FROM PREVIOUS MEETING SUBMITTED FOR APPROVAL

MEETING MINUTES

BOARD OF DIRECTORS MONTHLY MEETING SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly August 25, 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 5:07 p.m.

Board Attendance:

- Liberty Lomeli, Chair - Present
- Bindusagar Reddy, Vice Chair - Present
- Areli Martinez, Secretary – Absent
- Hans Kashyap, Director – Present
- Martha A. Flores, Director – Present

Others Present: Donna Hefner, President/Chief Executive Officer, Roger Larsen, Interim Chief Financial Officer, Brandy Irwin, Chief Nursing Officer, Kim Pryor-DeShazo, Director of Marketing and Community Services, Jennifer Regalado, Compliance Manager, Gary Wilbur, Administrative Director of General Services, Terry Villareal, Clerk to the Board, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

Chair LOMELI inquired if there was a motion to approve the agenda. Vice Chair REDDY moved to approve the agenda, the motion was seconded by Director FLORES. The motion was carried with the following vote:

FLORES	Yes
KASHYAP	Yes
REDDY	Yes
LOMELI	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:08 p.m. to discuss the following items:

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

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

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

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

The Board paused its discussion of Closed Session Item C due to time constraints and reconvened in Closed Session following the conclusion of Open Session.

- III. Open Session: Chair LOMELI adjourned Closed Session at 5:35 p.m., reconvening in Open Session at 5:36 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
REDDY	Yes
LOMELI	Yes

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 FLORES. The motion was carried with the following vote by the Board:

FLORES	Yes
KASHYAP	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 and Informational Reports were presented for approval (Consent Agenda attached to the file copy of these Minutes). Following review and discussion, it was moved by Director FLORES, seconded by Vice Chair REDDY, and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
REDDY	Yes
LOMELI	Yes

VI. Approval of Minutes:

- A. Motion made by Director FLORES and seconded by Vice Chair REDDY to approve the July 28, 2026, Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
REDDY	Yes
LOMELI	Yes

VII. Business Items

A. July 2026 Financial Report

Roger Larsen, Interim CFO presented the July monthly financial report. Following review and discussion, it was moved by Vice Chair REDDY, seconded by Director FLORES and carried to approve the July Monthly Financial Report as presented. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
REDDY	Yes
LOMELI	Yes

B. Investment Report – Quarter Ending June 30, 2026

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

FLORES	Yes
KASHYAP	Yes
REDDY	Yes
LOMELI	Yes

C. Capital Report – Quarter Ending June 30, 2026

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

FLORES	Yes
KASHYAP	Yes
REDDY	Yes
LOMELI	Yes

D. Conflict of Interest Code

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

FLORES	Yes
KASHYAP	Yes
REDDY	Yes
LOMELI	Yes

E. Resolution 08-25-26/01 Resolution to Purchase Real Property at 380 W. Putnam Avenue, Porterville, CA 93257

This item is deferred to the end of the meeting.

VIII. SVLHCD Board Chair Report

Board Chair Liberty Lomeli provided an overview of the current state of medicine and the challenges facing rural hospitals, highlighting workforce shortages, reimbursement pressures, advances in technology, and continued healthcare consolidation. He discussed the potential impacts of these trends on Sierra View Medical Center and emphasized opportunities involving community trust, telehealth, evolving rural payment models, and regional partnerships.

IX. CEO Report

The CEO provided an overview of August performance highlights, organizational accomplishments, community engagement, and upcoming initiatives.

- Reported 34,000 website sessions, 375,000 social media views, and a social media following of approximately 12,000. The hospital maintained a 3.9-star Google rating and received 243 additional reviews in August, bringing the total to 5,619.
- Provided an update on California Rural Health Transformation grant applications. Nearly \$5 million in known funding requests have been submitted, including applications supporting the OB Nest Program, Warrior Centric Care, and modernization of the Elekta MOSAIQ electronic health record system. A workforce recruitment and retention application was also in progress.

- Announced the summer edition of *Health Insights*, which featured patient stories, physician development, stroke care recognition, patient experience initiatives, hospital news, and Board of Directors election information.
- Highlighted employee engagement activities that provided staff with opportunities to connect and learn about hospital programs and resources.
- Shared public health alerts regarding confirmed measles cases in Kern County and a human case of West Nile virus in Tulare County.
- Promoted the Sierra View Foundation's *Midnight in Manhattan* fundraiser, scheduled for September 18 at Eagle Mountain Casino.
- Recognized Karen Taylor as the June Employee of the Month and Ana Weber as the July Employee of the Month.
- Recognized Crystal Lucas as the June Leader of the Month and Whitney Watts as the July Leader of the Month.
- Reported participation in four community outreach activities, including a backpack giveaway at the Terra Bella Community Health Center, the Eagle Mountain Casino Health Fair, a community blood drive, and breastfeeding education and support services.
- Reviewed upcoming events and initiatives, including the REACH Helicopter Showcase, Fiesta de Oro employee celebration, Run for Life, the Scrub Fair, *Midnight in Manhattan*, and the Unitek graduation.

X. Announcements:

Regular Board of Directors Meeting – August 28, 2026, at 5:00 p.m.

XI. Closed Session: Board adjourned Open Session at 6:17 p.m., reconvening in Closed Session at 6:25 p.m. to discuss the following items:

- 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.

During Closed Session Item C, Vice Chair Reddy briefly stepped out of the room on several occasions to take telephone calls for his on-call duty. During the initial Closed Session, he stepped out at 5:20 p.m. for approximately one minute or less. He stepped out again at 5:28 p.m. and returned at 5:32 p.m. After the Board reconvened in Closed Session to continue Item C, Vice Chair Reddy stepped out at 6:53 p.m. and 6:59 p.m., each for approximately one minute or less. He also stepped out at 7:06 p.m. and returned at 7:08 p.m., and stepped out at 7:11 p.m. and returned at 7:19 p.m.

- D. Conference with Sierra View Local Health Care District Real Property Negotiator regarding purchase of property for sale. Cal. Gov. Code § 54956.8.
Property: 380 W. Putnam Avenue, Porterville, CA 93257.
SVMC Negotiator: Ron Wheaton
Negotiating Party: George Wilson, represented by Rebecca Brann, Henry Schein Dental Practice Transitions. Estimated date of disclosure October 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), Significant Exposure to Litigation; Anticipated Litigation; and Pending Litigation: Conference with Legal Counsel. Estimated Disclosure: 3 years after completion of the matter.
 - G. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter – One (1) Item. Estimated Date of Disclosure January 1, 2027, for materials that are not part of an individual's private personnel file.
 - H. Pursuant To Gov. Code Section 54956.9(D)(2), Conference With Legal Counsel About Recent Work Product (B)(1) And (B)(3)(F): Significant Exposure To Litigation; Privileged Communication (1 Items).
- XII. Open Session: Chairman LOMELI adjourned Closed Session at 7:52 p.m., reconvening in Open Session at 7:53 p.m.
- C. Discussion Regarding Trade Secrets and Strategic Planning
Recommended Action: Information Only; No Action Taken
 - D. Discussion Regarding Real Property for Sale Located at 380 W. Putnam Avenue
Recommended Action: Information Only; No Action Taken
 - E. Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning
Recommended Action: Information Only; No Action Taken
 - F. Conference with Legal Counsel Regarding Pending Litigation
Recommended Action: Information Only; No Action Taken
 - G. Discussion Regarding Confidential Personnel Matter
Recommended Action: Information Only; No Action Taken
 - H. Conference with Legal Counsel
Recommended Action: Information Only; No Action Taken

The Board revisited Open Session Business Item E that was previously deferred.

- E. Resolution 08-25-26/01 Resolution to Purchase Real Property at 380 W. Putnam Avenue, Porterville, CA 93257
Following review and discussion, it was moved by Director FLORES seconded by Vice Chair REDDY and carried to approve resolution 08-25-26/01 for the purchase of the property at 380 W. Putnam Avenue. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Abstain

REDDY	Yes
LOMELI	Yes

XIII. Adjournment

The meeting was adjourned at 8:18 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

Business Items

SUBJECT:
SVLHCD INVESTMENT POLICY

SECTION:
LEADERSHIP

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SIERRA VIEW LOCAL HEALTH CARE DISTRICT

INVESTMENT POLICY

ADOPTED SEPTEMBER 22, 2026

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I. INTRODUCTION

Sierra View Local Health Care District (“District”) is a California Health Care District formed by resolution of the Tulare County Board of Supervisors. The District was created pursuant to the California Health and Safety Code §32000 to address health care needs in the southeast portion of Tulare County. It is governed by an elected five-member board of directors.

The purpose of this investment policy is to identify various policies and procedures that will foster a prudent and systematic investment program designed to seek the District’s objectives of safety, liquidity and return on investment through a diversified investment portfolio. This policy also serves to organize and formalize the District’s investment-related activities, while complying with all applicable statutes governing the investment of public funds. This policy is written to incorporate industry best practices and recommendations from sources such as the Government Finance Officers Association (GFOA), California Municipal Treasurers Association (CMTA), California Debt and Investment Advisory Commission (CDIAC) and the Association of Public Treasurers (APT).

This investment policy was endorsed and adopted by the District’s Board of Directors and is effective as of the 1st day of October, 2026, and replaces any previous versions.

II. SCOPE

This policy covers all funds and investment activities under the direct authority of the District, as set forth in the State Government Code, Sections 53600 *et seq.*, with the following exceptions:

- Proceeds of debt issuance shall be invested in accordance with the District’s general investment philosophy as set forth in this policy; however, such proceeds are to be invested pursuant to the permitted investment provisions of their specific bond indentures.
- CalPERS, OPEB trusts, and the investment of employees’ deferred compensation funds invested pursuant to Government Code Section 53609
- Any other funds specifically exempted by the Board of Directors.

POOLING OF FUNDS

Except for cash in certain restricted and special funds, the District will consolidate cash and reserve balances from all funds to maximize investment earnings and to increase efficiencies with regard to investment pricing, safekeeping and administration. Investment income will be allocated to the various funds based on their respective participation and in accordance with generally accepted accounting principles.

III. PRUDENCE

Pursuant to California Government Code, Section 53600.3, all persons authorized to make investment decisions on behalf of the District are trustees and therefore fiduciaries subject to the *Prudent Investor Standard*:

“...all governing bodies of local agencies or persons authorized to make investment decisions on behalf of those local agencies investing public funds pursuant to this chapter are trustees and therefore fiduciaries subject to the prudent investor standard. When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including, but not limited to, the general economic conditions and the anticipated needs of the District, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and

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maintain the liquidity needs of the District. Within the limitations of this section and considering individual investments as part of an overall strategy, investments may be acquired as authorized by law.”

The CFO and other authorized persons responsible for managing District funds acting in accordance with written procedures and this investment policy and exercising due diligence shall be relieved of personal responsibility for an individual security’s credit risk or market price changes provided that the CFO or other authorized persons acted in good faith. Deviations from expectations of a security’s credit or market risk should be reported to the Board of Directors in a timely fashion and appropriate action should be taken to control adverse developments.

IV. OBJECTIVES

The District’s overall investment program shall be designed and managed with a degree of professionalism worthy of the public trust. The overriding objectives of the program are to preserve principal, provide sufficient liquidity, and manage investment risks, while seeking a market-rate of return.

- **SAFETY.** Safety of principal is the foremost objective of the investment program. Investments will be undertaken in a manner that seeks to ensure the preservation of capital in the overall portfolio. To attain this objective, the District will diversify its investments by investing funds among a variety of securities with independent returns.
- **LIQUIDITY.** The investment portfolio will remain sufficiently liquid to meet all operating requirements that may be reasonably anticipated.
- **RETURN ON INVESTMENTS.** The investment portfolio will be designed with the objective of attaining a market rate of return throughout budgetary and economic cycles, taking into account the investment risk constraints for safety and liquidity needs.

V. DELEGATION OF AUTHORITY

Authority to manage the District’s investment program is derived from California Government Code, Sections 41006 for City Treasurers and 53600 *et seq.*

The Board of Directors is responsible for the management of the District’s funds, including the administration of this investment policy. Management responsibility for the cash management of the District’s funds is hereby delegated to the CFO.

The CFO will be responsible for all transactions undertaken and will establish a system of procedures and controls to regulate the activities of subordinate officials and employees. Such procedures will include explicit delegation of authority to persons responsible for investment transactions. No person may engage in an investment transaction except as provided under the terms of this policy and the procedures established by the CFO.

The District may engage the services of one or more external investment advisers, who are registered under the Investment Advisers Act of 1940, to assist in the management of the District’s investment portfolio in a manner consistent with the District’s objectives. External investment advisers may be granted discretion to purchase and sell investment securities in accordance with this investment policy.

The District’s overall investment program shall be designed and managed with a degree of professionalism that is worthy of the public trust. The District recognizes that in a diversified portfolio, occasional measured losses may be inevitable and must be considered within the context of

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the overall portfolio's return and the cash flow requirements of the District.

VI. ETHICS AND CONFLICTS OF INTEREST

All participants in the investment process shall act as custodians of the public trust. Investment officials shall recognize that the investment portfolio is subject to public review and evaluation. Thus, employees and officials involved in the investment process shall refrain from personal business activity that could create a conflict of interest or the appearance of a conflict with proper execution of the investment program, or which could impair their ability to make impartial investment decisions.

Employees and investment officials shall disclose to the CFO any material interests in financial institutions with which they conduct business, and they shall further disclose any large personal financial/investment positions that could be related to the performance of the investment portfolio. Employees and officers shall refrain from undertaking any personal investment transactions with the same individual with whom business is conducted on behalf of the District.

VII. INTERNAL CONTROLS

The CFO is responsible for establishing and maintaining an internal control structure designed to ensure that the assets of the entity are protected from loss, theft or misuse. The internal control structure shall be designed to provide reasonable assurance that these objectives are met. The concept of reasonable assurance recognizes that (1) the cost of a control should not exceed the benefits likely to be derived; and (2) the valuation of costs and benefits requires estimates and judgments by management.

Periodically, as deemed appropriate by the District and/or the Board of Directors, an independent analysis by an external auditor shall be conducted to review internal controls, account activity and compliance with policies and procedures.

VIII. AUTHORIZED FINANCIAL INSTITUTIONS, DEPOSITORIES, AND BROKER/DEALERS

The CFO shall maintain procedures for establishing a list of authorized broker/dealers and financial institutions which are approved for investment purposes that are selected through a process of due diligence as determined by the District. Due inquiry shall determine whether such authorized broker/dealers, and the individuals covering the District are reputable and trustworthy, knowledgeable and experienced in Public District investing and able to meet all of their financial obligations. These institutions may include "primary" dealers or regional dealers that qualify under Securities and Exchange Commission (SEC) Rule 15c3-1 (uniform net capital rule).

In accordance with Section 53601.5, institutions eligible to transact investment business with the District include:

- Institutions licensed by the state as a broker-dealer, as defined in Section 25004 of the Corporations Code, with proof of FINRA certification.
- Institutions that are members of a federally regulated securities exchange.
- Primary government dealers as designated by the Federal Reserve Bank and non-primary government dealers.
- Nationally or state-chartered banks.
- Savings association or federal association (as defined in Section 5102 of the Financial Code).
- The Federal Reserve Bank.
- Direct issuers of securities eligible for purchase.

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Selection of financial institutions and broker/dealers authorized to engage in transactions will be at the sole discretion of the District, except where the District utilizes an external investment adviser in which case the District may rely on the adviser for selection.

All financial institutions which desire to become qualified bidders for investment transactions (and which are not dealing only with the investment adviser) must supply the CFO with audited financials and a statement certifying that the institution has reviewed the California Government Code, Section 53600 *et seq.* and the District's investment policy. The CFO will conduct an annual review of the financial condition and registrations of such qualified bidders.

To the extent practicable, the CFO shall endeavor to complete investment transactions using a competitive bid process whenever possible. The District's CFO will determine which financial institutions are authorized to provide investment services to the District. It shall be the District's policy to purchase securities only from authorized institutions and firms.

Selection of broker/dealers used by an external investment adviser retained by the District will be at the sole discretion of the adviser. Where possible, transactions with broker/dealers shall be selected on a competitive basis and their bid or offering prices shall be recorded. If there is no other readily available competitive offering, best efforts will be made to document quotations for comparable or alternative securities. When purchasing original issue instrumentality securities, no competitive offerings will be required as all dealers in the selling group offer those securities at the same original issue price.

Public deposits will be made only in qualified public depositories as established by State law. Deposits will be insured by the Federal Deposit Insurance Corporation, or, to the extent the amount exceeds the insured maximum, will be collateralized in accordance with State law.

IX. AUTHORIZED INVESTMENTS

The District's investments are governed by California Government Code, Sections 53600 *et seq.* Within the investments permitted by the Code, the District seeks to further restrict eligible investments to the guidelines listed below. In the event a discrepancy is found between this policy and Code, the more restrictive parameters will take precedence. Percentage holding limits and minimum credit requirements listed in this section apply at the time the security is purchased.

Any investment currently held at the time the policy is adopted which does not meet the new policy guidelines can be held until maturity and shall be exempt from the current policy. At the time of the investment's maturity or liquidation, such funds shall be reinvested only as provided in the current policy.

An appropriate risk level shall be maintained by primarily purchasing securities that are of high quality, liquid, and marketable. The portfolio shall be diversified by security type and issuer to avoid incurring unreasonable and avoidable risks regarding specific security types or individual issuers.

1. MUNICIPAL SECURITIES include obligations of the District, the State of California and any local District within the State of California, provided that:

- The securities are rated in a rating category of "A" or its equivalent or better by at least one nationally recognized statistical rating organization ("NRSRO").
- No more than 5% of the total portfolio may be invested in any single issuer.
- No more than 30% of the total portfolio may be in Municipal Securities.
- The maximum maturity does not exceed five (5) years.

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2. **MUNICIPAL SECURITIES (REGISTERED TREASURY NOTES OR BONDS)** of any of the other 49 states in addition to California, including bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, District, or authority of any of the other 49 states, in addition to California.
 - The securities are rated in a rating category of “A” or its equivalent or better by at least one NRSRO.
 - No more than 5% of the total portfolio may be invested in any single issuer.
 - No more than 30% of the total portfolio may be in Municipal Securities.
 - The maximum maturity does not exceed five (5) years.
3. **U.S. TREASURIES** and other government obligations for which the full faith and credit of the United States are pledged for the payment of principal and interest. There are no limits on the dollar amount or percentage that the District may invest in U.S. Treasuries, provided that:
 - The maximum maturity does not exceed five (5) years.
4. **FEDERAL AGENCIES** or United States Government-Sponsored Enterprise obligations, participations, or other instruments, including those issued by or fully guaranteed as to principal and interest by federal agencies or United States government-sponsored enterprises. There are no limits on the dollar amount or percentage that the District may invest in Federal District or Government-Sponsored Enterprises (GSEs), provided that:
 - No more than 30% of the total portfolio may be invested in any single District/GSE issuer.
 - No more than 20% of the total portfolio may be invested in callable District securities.
 - The maximum maturity does not exceed five (5) years.
5. **BANKER’S ACCEPTANCES**, provided that:
 - They are issued by institutions which have short-term debt obligations rated “A-1” or its equivalent or better by at least one NRSRO; or long-term debt obligations which are rated in a rating category of “A” or its equivalent or better by at least one NRSRO.
 - No more than 40% of the total portfolio may be invested in Banker’s Acceptances.
 - No more than 5% of the total portfolio may be invested in any single issuer.
 - The maximum maturity does not exceed 180 days.
6. **COMMERCIAL PAPER**, provided that the securities are issued by an entity that meets all of the following conditions in either paragraph (a) or (b) and other requirements specified below:
 - a. **SECURITIES** issued by corporations:
 - (i) A corporation organized and operating in the United States with assets more than \$500 million.
 - (ii) The securities are rated “A-1” or its equivalent or better by at least one NRSRO.
 - (iii) If the issuer has other debt obligations, they must be rated in a rating category of “A” or its equivalent or better by at least one NRSRO.
 - b. **SECURITIES** issued by other entities:
 - (i) The issuer is organized within the United States as a special purpose corporation, trust, or limited liability company.

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- (ii) The securities must have program-wide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.
 - (iii) The securities are rated “A-1” or its equivalent or better by at least one NRSRO.
- No more than 25% of the total portfolio may be invested in Commercial Paper. Under a provision sunseting on January 1, 2031, no more than 40% of the total portfolio may be invested in Commercial Paper if the District’s investment assets under management are greater than \$100,000,000.
 - No more than 5% of the total portfolio may be invested in any single issuer.
 - The maximum maturity does not exceed 397 days.
- 7. NEGOTIABLE CERTIFICATES OF DEPOSIT (NCDs)**, issued by a nationally or state-chartered bank, a savings association or a federal association, a state or federal credit union, or by a federally licensed or state-licensed branch of a foreign bank, provided that:
 - The amount of the NCD insured up to the FDIC limit does not require any credit ratings.
 - Any amount above the FDIC insured limit must be issued by institutions which have short-term debt obligations rated “A-1” or its equivalent or better by at least one NRSRO; or long-term obligations rated in a rating category of “A” or its equivalent or better by at least one NRSRO.
 - No more than 30% of the total portfolio may be invested in NCDs.
 - No more than 5% of the total portfolio may be invested in any single issuer.
 - The maximum maturity does not exceed five (5) years.
- 8. FEDERALLY INSURED TIME DEPOSITS** (Non-Negotiable Certificates of Deposit) in state or federally chartered banks, savings and loans, or credit unions, provided that:
 - The amount per institution is limited to the maximum covered under federal insurance.
 - No more than 20% of the total portfolio will be invested in a combination of federally insured and collateralized time deposits.
 - The maximum maturity does not exceed five (5) years.
- 9. COLLATERALIZED TIME DEPOSITS** (Non-Negotiable Certificates of Deposit) in state or federally chartered banks, savings and loans, or credit unions in excess of insured amounts which are fully collateralized with securities in accordance with California law, provided that:
 - No more than 20% of the total portfolio will be invested in a combination of federally insured and collateralized time deposits.
 - The maximum maturity does not exceed five (5) years.
- 10. PLACEMENT SERVICE DEPOSITS**, provided that:
 - No more than 30% of the total portfolio may be invested in a combination of qualifying placement service deposits.
 - The full amount of each deposit along with accrued interest must at all times be insured by the Federal Deposit Insurance Corporation (FDIC) or the National Credit Union Administration (NCUA).
 - Under a provision sunseting on January 1, 2031, no more than 50% of the portfolio may be invested in deposits through a placement service, including Certificates of Deposit, if the District is a city, district or local District that does not pool money with other local agencies.
 - The maximum maturity does not exceed five (5) years.

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11. COLLATERALIZED BANK DEPOSITS. District's deposits with financial institutions will be collateralized with pledged securities per California Government Code, Section 53651. There are no limits on the dollar amount or percentage that the District may invest in collateralized bank deposits.

12. REPURCHASE AGREEMENTS collateralized with securities authorized under California Government Code, maintained at a level of at least 102% of the market value of the Repurchase Agreement. There are no limits on the dollar amount or percentage that the District may invest, provided that:

- Securities used as collateral for Repurchase Agreements will be delivered to an acceptable third party custodian.
- Repurchase Agreements are subject to a Master Repurchase Agreement between the District and the provider of the repurchase agreement. The Master Repurchase Agreement will be substantially in the form developed by the Securities Industry and Financial Markets Association (SIFMA).
- The maximum maturity does not exceed one (1) year.

13. LOCAL GOVERNMENT INVESTMENT POOLS (LGIP)

a. **STATE OF CALIFORNIA LOCAL DISTRICT INVESTMENT FUND (LAIF)**, created by California Government Code Section 16429.1, provided that:

- The District may invest up to the maximum amount permitted by LAIF.
- LAIF's investments in instruments prohibited by or not specified in the District's policy do not exclude the investment in LAIF itself from the District's list of allowable investments, provided LAIF's reports allow the CFO to adequately judge the risk inherent in LAIF's portfolio.

b. **SHARES OF BENEFICIAL INTEREST ISSUED BY A JOINT POWERS AUTHORITY (JPA)**, provided that:

- The JPA is organized pursuant to California Government Code Section 6509.7 and invests in the securities and obligations authorized in subdivisions (a) to (r), inclusive.
- Each share shall represent an equal proportional interest in the underlying pool of securities owned by the JPA.
- The JPA has retained an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of \$500 million, and has at least five years' experience investing in instruments authorized by Section 53601, subdivisions (a) to (q).

c. **OTHER LOCAL GOVERNMENT INVESTMENT POOLS (LGIP)**

- Other LGIPs permitted by the District (such as a County Pool as defined by California Government Code Section 27000.3).
- No more than 20% of the total portfolio may be invested in LGIPs other than LAIF and JPAs.

14. CORPORATE MEDIUM TERM NOTES (MTNs), provided that:

- The issuer is a corporation organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States.

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- The securities are rated in a rating category of “A” or its equivalent or better by at least one NRSRO.
- No more than 30% of the total portfolio may be invested in MTNs.
- No more than 5% of the total portfolio may be invested in any single issuer.
- The maximum maturity does not exceed five (5) years.

15. ASSET-BACKED, MORTGAGE-BACKED, MORTGAGE PASS-THROUGH SECURITIES, AND COLLATERALIZED MORTGAGE OBLIGATIONS FROM ISSUERS NOT DEFINED IN SECTIONS 3 AND 4 OF THE AUTHORIZED INVESTMENTS SECTION OF THIS POLICY, provided that:

- The securities are rated in a rating category of “AA” or its equivalent or better by a NRSRO.
- No more than 20% of the total portfolio may be invested in these securities.
- No more than 5% of the total portfolio may be invested in any single Asset-Backed or Commercial Mortgage security issuer.
- The maximum maturity does not exceed five (5) years.

16. MUTUAL FUNDS AND MONEY MARKET MUTUAL FUNDS that are registered with the Securities and Exchange Commission under the Investment Company Act of 1940, provided that:

a. **MUTUAL FUNDS** that invest in the securities and obligations as authorized under California Government Code, Section 53601 (a) to (k) and (m) to (q) inclusive and that meet either of the following criteria:

- (i) Attained the highest ranking or the highest letter and numerical rating provided by not less than two (2) NRSROs; or
- (ii) Have retained an investment adviser registered or exempt from registration with the Securities and Exchange Commission with not less than five years’ experience investing in the securities and obligations authorized by California Government Code, Section 53601 and with assets under management in excess of \$500 million.

- No more than 10% of the total portfolio may be invested in shares of any one mutual fund.

b. **MONEY MARKET MUTUAL FUNDS** registered with the Securities and Exchange Commission under the Investment Company Act of 1940 and issued by diversified management companies and meet either of the following criteria:

- (i) Have attained the highest ranking or the highest letter and numerical rating provided by not less than two (2) NRSROs; or
- (ii) Have retained an investment adviser registered or exempt from registration with the Securities and Exchange Commission with not less than five years’ experience managing money market mutual funds with assets under management in excess of \$500 million.

- No more than 20% of the total portfolio may be invested in the shares of any one Money Market Mutual Fund.

c. No more than 20% of the total portfolio may be invested in these securities.

17. SUPRANATIONALS, provided that:

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- Issues are US dollar denominated senior unsecured unsubordinated obligations issued or unconditionally guaranteed by the International Bank for Reconstruction and Development, International Finance Corporation, or Inter-American Development Bank.
- The securities are rated in a rating category of “AA” or its equivalent or better by a NRSRO.
- No more than 30% of the total portfolio may be invested in these securities.
- No more than 10% of the total portfolio may be invested in any single issuer.
- The maximum maturity does not exceed five (5) years.

X. PROHIBITED INVESTMENT VEHICLES AND PRACTICES

- State law notwithstanding, any investments not specifically described herein are prohibited, including, but not limited to futures and options.
- In accordance with Government Code, Section 53601.6, investment in inverse floaters, range notes, or mortgage derived interest-only strips is prohibited.
- Investment in any security that could result in a zero-interest accrual if held to maturity is prohibited. Under a provision sunseting on January 1, 2031, securities backed by the U.S. Government that could result in a zero- or negative-interest accrual if held to maturity are permitted.
- Trading securities for the sole purpose of speculating on the future direction of interest rates is prohibited.
- Purchasing or selling securities on margin is prohibited.
- The use of reverse repurchase agreements, securities lending or any other form of borrowing or leverage is prohibited.
- The purchase of foreign currency denominated securities is prohibited.
- The purchase of a security with a forward settlement date exceeding 45 days from the time of the investment is prohibited.

XI. INVESTMENT POOLS/MUTUAL FUNDS

The District shall conduct a thorough investigation of any pool or mutual fund prior to making an investment, and on a continual basis thereafter. Annually, the CFO shall seek responses to the following questions from any investment pool or mutual fund in which the District invests:

- A description of eligible investment securities, and a written statement of investment policy and objectives.
- A description of interest calculations and how it is distributed, and how gains and losses are treated.
- A description of how the securities are safeguarded (including the settlement processes), and how often the securities are priced and the program audited.
- A description of who may invest in the program, how often, what size deposit and withdrawal are allowed.
- A schedule for receiving statements and portfolio listings.
- Are reserves, retained earnings, etc. utilized by the pool/fund?
- A fee schedule, and when and how it is assessed.
- Is the pool/fund eligible for bond proceeds and/or will it accept such proceeds?

XII. COLLATERALIZATION

CERTIFICATES OF DEPOSIT (CDS). The District shall require any commercial bank or savings and loan association to deposit eligible securities with an District of a depository approved by the State Banking Department to secure any uninsured portion of a Non-Negotiable Certificate of Deposit. The value of eligible securities as defined pursuant to California Government Code, Section 53651, pledged against a Certificate of Deposit shall be equal to 150% of the

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face value of the CD if the securities are classified as mortgages and 110% of the face value of the CD for all other classes of security.

COLLATERALIZATION OF BANK DEPOSITS. This is the process by which a bank or financial institution pledges securities, or other deposits for the purpose of securing repayment of deposited funds. The District shall require any bank or financial institution to comply with the collateralization criteria defined in California Government Code, Section 53651.

REPURCHASE AGREEMENTS. The District requires that Repurchase Agreements be collateralized only by securities authorized in accordance with California Government Code:

- The securities which collateralize the repurchase agreement shall be priced at Market Value, including any Accrued Interest plus a margin. The Market Value of the securities that underlie a repurchase agreement shall be valued at 102% or greater of the funds borrowed against those securities.
- Securities used as collateral for Repurchase Agreements will be delivered to an acceptable third-party custodian.
- Financial institutions shall mark the value of the collateral to market at least monthly and increase or decrease the collateral to satisfy the ratio requirement described above.
- The District shall receive monthly statements of collateral.

XIII. DELIVERY, SAFEKEEPING AND CUSTODY

DELIVERY-VERSUS-PAYMENT (DVP). All investment transactions shall be conducted on a delivery-versus-payment basis.

SAFEKEEPING AND CUSTODY. To protect against potential losses due to failure of individual securities dealers, and to enhance access to securities, interest payments and maturity proceeds, all cash and securities in the District's portfolio shall be held in safekeeping in the District's name by a third party custodian, acting as agent for the District under the terms of a custody agreement executed by the bank and the District. All investment transactions will require a safekeeping receipt or acknowledgment generated from the trade. A monthly report will be received by the District from the custodian listing all securities held in safekeeping with current market data and other information.

The only exceptions to the foregoing shall be depository accounts and securities purchases made with: (i) local government investment pools; (ii) time certificates of deposit, and, (iii) mutual funds and money market mutual funds, since these securities are not deliverable.

XIV. MAXIMUM MATURITY

To the extent possible, investments shall be matched with anticipated cash flow requirements and known future liabilities.

The District will not invest in securities maturing more than five (5) years from the date of trade settlement, unless the Board of Directors has by resolution granted authority to make such an investment.

XV. RISK MANAGEMENT AND DIVERSIFICATION

MITIGATING CREDIT RISK IN THE PORTFOLIO

Credit risk is the risk that a security or a portfolio will lose some or all its value due to a real or perceived change in the ability of the issuer to repay its debt. The District will mitigate credit risk by adopting the following strategies:

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- The diversification requirements included in the “Authorized Investments” section of this policy are designed to mitigate credit risk in the portfolio.
- No more than 5% of the total portfolio may be deposited with or invested in securities issued by any single issuer unless otherwise specified in this policy.
- The District may elect to sell a security prior to its maturity and record a capital gain or loss in order to manage the quality, liquidity or yield of the portfolio in response to market conditions or the District’s risk preferences.
- If a security owned by the District is downgraded to a level below the requirements of this policy, making the security ineligible for additional purchases, the following steps will be taken:
 - Any actions taken related to the downgrade by the investment manager will be communicated to the CFO in a timely manner.
 - If a decision is made to retain the security, the credit situation will be monitored and reported to the Board of Directors.

MITIGATING MARKET RISK IN THE PORTFOLIO

Market risk is the risk that the portfolio value will fluctuate due to changes in the general level of interest rates. The District recognizes that, over time, longer-term portfolios have the potential to achieve higher returns. On the other hand, longer-term portfolios have higher volatility of return. The District will mitigate market risk by providing adequate liquidity for short-term cash needs, and by making longer-term investments only with funds that are not needed for current cash flow purposes.

The District further recognizes that certain types of securities, including variable rate securities, securities with principal paydowns prior to maturity, and securities with embedded options, will affect the market risk profile of the portfolio differently in different interest rate environments. The District, therefore, adopts the following strategies to control and mitigate its exposure to market risk:

- The District will maintain a minimum of six months of budgeted operating expenditures in short-term investments to provide sufficient liquidity for expected disbursements.
- The maximum stated final maturity of individual securities in the portfolio will be five (5) years, except as otherwise stated in this policy.
- The duration of the portfolio will generally be approximately equal to the duration (typically, plus or minus 20%) of a Market Benchmark, an index selected by the District based on the District’s investment objectives, constraints and risk tolerances.

XVI. REVIEW OF INVESTMENT PORTFOLIO

The CFO shall periodically, but no less than quarterly, review the portfolio to identify investments that do not comply with this investment policy and establish protocols for reporting major and critical incidences of noncompliance to the Board of Directors.

XVII. PERFORMANCE EVALUATION

The investment portfolio shall be designed to attain a market-average rate of return throughout budgetary and economic cycles, taking into account the District’s risk constraints, the cash flow characteristics of the portfolio, and state and local laws, ordinances or resolutions that restrict investments.

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The CFO shall monitor and evaluate the portfolio's performance relative to the chosen market benchmark(s), which will be included in the CFO's quarterly report. The CFO shall select an appropriate, readily available index to use as a market benchmark. Benchmarks may change over time based on changes in market conditions or cash flow requirements.

XVIII. REPORTING

MONTHLY REPORTS

Monthly transaction reports will be submitted by the CFO to the Board of Directors in accordance with California Government Code Section 53607.

QUARTERLY REPORTS

The CFO will submit a quarterly investment report to the Board of Directors which provides full disclosure of the District's investment activities within 45 days after the end of the quarter. These reports will disclose, at a minimum, the following information about the District's portfolio:

1. An asset listing showing par value, cost and independent third-party fair market value of each security as of the date of the report, the source of the valuation, type of investment, issuer, maturity date and interest rate.
2. Transactions for the period.
3. A description of the funds, investments and programs (including lending programs) managed by contracted parties (i.e. LAIF; LGIPS, outside money managers and securities lending agents)
4. A one-page summary report that shows:
 - a. Average maturity of the portfolio and modified duration of the portfolio;
 - b. Maturity distribution of the portfolio;
 - c. Percentage of the portfolio represented by each investment category;
 - d. Average portfolio credit quality; and,
 - e. Time-weighted total rate of return for the portfolio for the prior one month, three months, twelve months and since inception compared to the District's market benchmark returns for the same periods;
5. A statement of compliance with investment policy, including a schedule of any transactions or holdings which do not comply with this policy or with the California Government Code, including a justification for their presence in the portfolio and a timetable for resolution.
6. A statement that the District has adequate funds to meet its cash flow requirements for the next six months.

ANNUAL REPORTS

A comprehensive annual report will be presented to the Governing Board. This report will include comparisons of the District's return to the market benchmark return, suggest policies and improvements that might enhance the investment program, and will include an investment plan for the coming year.

XIX. REVIEW OF INVESTMENT POLICY

The investment policy will be reviewed and adopted at least annually within 120 days of the end of the fiscal year, to ensure its consistency with the overall objectives of preservation of principal, liquidity and return, and its relevance to current law and financial and economic trends.

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Any recommended modifications or amendments shall be presented by Staff to the Board of Directors for their consideration and adoption.

Prepared by:

CFO

Approved:

Alex Reed-Krase, Attorney at Law
District Attorney

Approved:

Liberty Lomeli, Board Chair
Board of Directors

Date:

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GLOSSARY OF INVESTMENT TERMS

AGENCIES. Shorthand market terminology for any obligation issued by a *government-sponsored entity (GSE)*, or a *federally related institution*. Most obligations of GSEs are not guaranteed by the full faith and credit of the US government. Examples are:

FFCB. The Federal Farm Credit Bank System provides credit and liquidity in the agricultural industry. FFCB issues discount notes and bonds.

FHLB. The Federal Home Loan Bank provides credit and liquidity in the housing market. FHLB issues discount notes and bonds.

FHLMC. Like FHLB, the Federal Home Loan Mortgage Corporation provides credit and liquidity in the housing market. FHLMC, also called “Freddie Mac” issues discount notes, bonds and mortgage pass-through securities.

FNMA. Like FHLB and Freddie Mac, the Federal National Mortgage Association was established to provide credit and liquidity in the housing market. FNMA, also known as “Fannie Mae,” issues discount notes, bonds and mortgage pass-through securities.

GNMA. The Government National Mortgage Association, known as “Ginnie Mae,” issues mortgage pass-through securities, which are guaranteed by the full faith and credit of the US Government.

PEFCO. The Private Export Funding Corporation assists exporters. Obligations of PEFCO are not guaranteed by the full faith and credit of the US government.

TVA. The Tennessee Valley Authority provides flood control and power and promotes development in portions of the Tennessee, Ohio, and Mississippi River valleys. TVA currently issues discount notes and bonds.

ASSET BACKED SECURITIES. Securities supported by pools of installment loans or leases or by pools of revolving lines of credit.

BANKER’S ACCEPTANCE. A money market instrument created to facilitate international trade transactions. It is highly liquid and safe because the risk of the trade transaction is transferred to the bank which “accepts” the obligation to pay the investor.

BENCHMARK. A comparison security or portfolio. A performance benchmark is a partial market index, which reflects the mix of securities allowed under a specific investment policy.

BID. The indicated price at which a buyer is willing to purchase a security or commodity.

BROKER. A broker brings buyers and sellers together for a transaction for which the broker receives a commission. A broker does not sell securities from their own position.

CALLABLE. A callable security gives the issuer the option to call it from the investor prior to its maturity. The main cause of a call is a decline in interest rates. If interest rates decline, the issuer will likely call its current securities and reissue them at a lower rate of interest.

CERTIFICATE OF DEPOSIT (CD). A time deposit with a specific maturity evidenced by a certificate.

COLLATERAL. Securities or cash pledged by a borrower to secure repayment of a loan or repurchase agreement. Also, securities pledged by a financial institution to secure deposits of public monies.

COLLATERALIZED BANK DEPOSIT. A bank deposit that is collateralized at least 100% (principal plus interest to maturity). The deposit is collateralized using assets set aside by the issuer such as Treasury securities or other qualified collateral to secure the deposit in excess of the limit covered by the Federal Deposit Insurance Corporation.

COLLATERALIZED MORTGAGE OBLIGATIONS (CMO). Classes of bonds that redistribute the cash flows of mortgage securities (and whole loans) to create securities that have different levels of prepayment risk, as compared to the underlying mortgage securities.

COLLATERALIZED TIME DEPOSIT. Time deposits that are collateralized at least 100% (principal plus interest to maturity). These instruments are collateralized using assets set aside by the issuer such as Treasury securities or other qualified collateral to secure the deposit in excess of the limit covered by the Federal Deposit Insurance Corporation.

COMMERCIAL PAPER. The short-term unsecured debt of corporations.

COUPON. The rate of return at which interest is paid on a bond.

CREDIT RISK. The risk that principal and/or interest on an investment will not be paid in a timely manner due to changes in the condition of the issuer.

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DEALER. A dealer acts as a principal in security transactions, selling securities from and buying securities for their own position.

DELIVERY VS. PAYMENT (DVP). A securities industry procedure whereby payment for a security must be made at the time the security is delivered to the purchaser's agent.

DISCOUNT. The difference between the par value of a bond and the cost of the bond, when the cost is below par. Some short-term securities, such as T-bills and banker's acceptances, are known as discount securities. They sell at a discount from par and return the par value to the investor at maturity without additional interest. Other securities, which have fixed coupons, trade at a discount when the coupon rate is lower than the current market rate for securities of that maturity and/or quality.

DIVERSIFICATION. Dividing investment funds among a variety of investments to avoid excessive exposure to any one source of risk.

DURATION. The weighted average time to maturity of a bond where the weights are the present values of the future cash flows. Duration measures the price sensitivity of a security to changes interest rates.

FEDERAL DEPOSIT INSURANCE CORPORATION (FDIC). The Federal Deposit Insurance Corporation (FDIC) is an independent federal District insuring deposits in U.S. banks and thrifts in the event of bank failures. The FDIC was created in 1933 to maintain public confidence and encourage stability in the financial system through the promotion of sound banking practices.

FEDERALLY INSURED TIME DEPOSIT. A time deposit is an interest-bearing bank deposit account that has a specified date of maturity, such as a certificate of deposit (CD). These deposits are limited to funds insured in accordance with FDIC insurance deposit limits.

FIDUCIARY. A person or organization that acts on behalf of another person(s) or organization that puts their clients' interest ahead of their own as they are bound both legally and ethically to act in the best interests of their clients.

JOINT POWERS AUTHORITY (JPA). An entity created by two or more public agencies that share a common goal in order to jointly exercise powers common to all members through a joint powers agreement or contract.

LEVERAGE. Borrowing funds in order to invest in securities that have the potential to pay earnings at a rate higher than the cost of borrowing.

LIQUIDITY. The speed and ease with which an asset can be converted to cash.

LOCAL DISTRICT INVESTMENT FUND (LAIF). A voluntary investment fund open to government entities and certain non-profit organizations in California that is managed by the State Treasurer's Office.

LOCAL GOVERNMENT INVESTMENT POOL. Investment pools that range from the State Treasurer's Office Local District Investment Fund (LAIF) to county pools, to Joint Powers Authorities (JPAs). These funds are not subject to the same SEC rules applicable to money market mutual funds.

MAKE WHOLE CALL. A type of call provision on a bond that allows the issuer to pay off the remaining debt early. Unlike a call option, with a make whole call provision, the issuer makes a lump sum payment that equals the net present value (NPV) of future coupon payments that will not be paid because of the call. With this type of call, an investor is compensated, or "made whole."

MARGIN. The difference between the market value of a security and the loan a broker makes using that security as collateral.

MARKET RISK. The risk that the value of securities will fluctuate with changes in overall market conditions or interest rates.

MARKET VALUE. The price at which a security can be traded.

MATURITY. The final date upon which the principal of a security becomes due and payable. An investment's term or remaining maturity is measured from the settlement date to final maturity.

MEDIUM TERM NOTES. Unsecured, investment-grade senior debt securities of major corporations which are sold in relatively small amounts on either a continuous or an intermittent basis. MTNs are highly flexible debt instruments that can be structured to respond to market opportunities or to investor preferences.

MODIFIED DURATION. The percent change in price for a 100-basis point change in yields. Modified duration is the best single measure of a portfolio's or security's exposure to market risk.

MONEY MARKET. The market in which short-term debt instruments (T-bills, discount notes, commercial paper, and banker's acceptances) are issued and traded.

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MONEY MARKET MUTUAL FUND. A mutual fund that invests exclusively in short-term securities. Examples of investments in money market funds are certificates of deposit and U.S. Treasury securities. Money market funds attempt to keep their net asset values at \$1 per share.

MORTGAGE PASS-THROUGH SECURITIES. A securitized participation in the interest and principal cash flows from a specified pool of mortgages. Principal and interest payments made on the mortgages are passed through to the holder of the security.

MUNICIPAL SECURITIES. Securities issued by state and local agencies to finance capital and operating expenses.

MUTUAL FUND. An entity which pools the funds of investors and invests those funds in a set of securities which is specifically defined in the fund's prospectus. Mutual funds can be invested in various types of domestic and/or international stocks, bonds, and money market instruments, as set forth in the individual fund's prospectus. For most large, institutional investors, the costs associated with investing in mutual funds are higher than the investor can obtain through an individually managed portfolio.

NATIONALLY RECOGNIZED STATISTICAL RATING ORGANIZATION (NRSRO). A credit rating District that the Securities and Exchange Commission in the United States uses for regulatory purposes. Credit rating agencies provide assessments of an investment's risk. The issuers of investments, especially debt securities, pay credit rating agencies to provide them with ratings. The three most prominent NRSROs are Fitch, S&P, and Moody's.

NEGOTIABLE CERTIFICATE OF DEPOSIT (CD). A short-term debt instrument that pays interest and is issued by a bank, savings or federal association, state or federal credit union, or state-licensed branch of a foreign bank. Negotiable CDs can be traded in a secondary market.

OFFER (ASK). An indicated price at which market participants are willing to sell a security. Also referred to as the "ask price".

PAYDOWN. A reduction in the principal amount owed on a bond, loan, or other debt.

PLACEMENT SERVICE DEPOSITS. A private service that allows local agencies to invest in FDIC-insured deposits with one or more banks, savings and loans, and credit unions located in the United States. IntraFi (formerly known as CDARS) is an example of an entity that provides this service.

PREMIUM. The difference between the par value of a bond and the cost of the bond, when the cost is above par.

PRIMARY DEALER. A financial institution (1) that is a trading counterparty with the Federal Reserve in its execution of market operations to carry out U.S. monetary policy, and (2) that participates for statistical reporting purposes in compiling data on activity in the U.S. Government securities market.

PRUDENT INVESTOR (PRUDENT PERSON) RULE. A standard of responsibility which applies to fiduciaries. In California, the rule is stated as "Investments shall be managed with the care, skill, prudence and diligence, under the circumstances then prevailing, that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of like character and with like aims to accomplish similar purposes."

REGIONAL DEALER. A financial intermediary that buys and sells securities for the benefit of its customers without maintaining substantial inventories of securities and that is not a primary dealer.

REPURCHASE AGREEMENT. Short-term purchases of securities with a simultaneous agreement to sell the securities back at a higher price. From the seller's point of view, the same transaction is a reverse repurchase agreement.

SAFEKEEPING. A service to bank customers whereby securities are held by the bank in the customer's name.

SECURITIES AND EXCHANGE COMMISSION (SEC). The U.S. Securities and Exchange Commission (SEC) is an independent federal government District responsible for protecting investors, maintaining fair and orderly functioning of securities markets and facilitating capital formation. It was created by Congress in 1934 as the first federal regulator of securities markets. The SEC promotes full public disclosure, protects investors against fraudulent and manipulative practices in the market, and monitors corporate takeover actions in the United States.

SECURITIES AND EXCHANGE COMMISSION (SEC) RULE 15c3-1. An SEC rule setting capital requirements for brokers and dealers. Under Rule 15c3-1, a broker or dealer must have sufficient liquidity in order to cover the most pressing obligations. This is defined as having a certain amount of liquidity as a

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percentage of the broker/dealer's total obligations. If the percentage falls below a certain point, the broker or dealer may not be allowed to take on new clients and may have restrictions placed on dealings with current client.

STRUCTURED NOTE. Notes issued by Government Sponsored Enterprises (FHLB, FNMA, etc.) and Corporations, which have imbedded options (e.g., call features, step-up coupons, floating rate coupons, derivative-based returns) into their debt structure. Their market performance is impacted by the fluctuation of interest rates, the volatility of the imbedded options and shifts in the shape of the yield curve.

SUPRANATIONAL. A Supranational is a multi-national organization whereby member states transcend national boundaries or interests to share in the decision making to promote economic development in the member countries.

THIRD PARTY CUSTODIAN. An independent, third-party custodial safekeeping provider that has a fiduciary responsibility for safekeeping their client's assets to minimize the risk of a fraudulent transaction.

TOTAL RATE OF RETURN. A measure of a portfolio's performance over time. It is the internal rate of return, which equates the beginning value of the portfolio with the ending value; it includes interest earnings, realized and unrealized gains, and losses in the portfolio.

U.S. TREASURY OBLIGATIONS. Securities issued by the U.S. Treasury and backed by the full faith and credit of the United States. Treasuries are considered to have no credit risk and are the benchmark for interest rates on all other securities in the US and overseas. The Treasury issues both discounted securities and fixed coupon notes and bonds.

TREASURY BILLS. All securities issued with initial maturities of one year or less are issued as discounted instruments and are called Treasury bills. The Treasury currently issues three- and six-month T-bills at regular weekly auctions. It also issues "cash management" bills as needed to smooth out cash flows.

TREASURY NOTES. All securities issued with initial maturities of two to ten years are called Treasury notes and pay interest semi-annually.

TREASURY BONDS. All securities issued with initial maturities greater than ten years are called Treasury bonds. Like Treasury notes, they pay interest semi-annually.

VOLATILITY. The rate at which security prices change with changes in general economic conditions or the general level of interest rates.

YIELD TO MATURITY. The annualized internal rate of return on an investment which equates the expected cash flows from the investment to its cost.

FINANCIALS

FINANCIAL REPORTS FROM THE PREVIOUS MONTH

FINANCIAL PACKAGE
Aug-26

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

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Sierra View Medical Center
Financial Statistics Summary Report
August 2026

		Aug-26				YTD				Increase/ (Decrease)		
Statistic		Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 26 YTD	Aug-25	% Change
<u>Utilization</u>												
SNF Patient Days												
	Total	31	35	(4)	-11.9%	62	35	27	76.3%	27	35	129.6%
	Medi-Cal	31	-	31	0.0%	62	-	62	0.0%	27	35	129.6%
Sub-Acute Patient Days												
	Total	1,044	1,052	(8)	-0.8%	2,098	2,109	(11)	-0.5%	2,132	(34)	-1.6%
	Medi-Cal	475	464	11	2.3%	940	955	(15)	-1.5%	965	(25)	-2.6%
Acute Patient Days		1,632	1,736	(104)	-6.0%	3,167	3,501	(334)	-9.5%	3,392	(225)	-6.6%
	Acute Discharges	448	472	(24)	-5.0%	857	951	(94)	-9.9%	952	(95)	-10.0%
	Medicare	170	174	(4)	-2.2%	345	358	(13)	-3.6%	358	(13)	-3.6%
	Medi-Cal	203	229	(26)	-11.3%	389	471	(82)	-17.4%	471	(82)	-17.4%
	Contract	67	65	2	3.1%	108	116	(8)	-6.8%	116	(8)	-6.9%
	Other	8	4	4	100.1%	15	7	8	114.4%	7	8	114.3%
Average Length of Stay		3.64	3.68	(0.04)	-1.0%	3.70	3.68	0.02	0.4%	3.56	0.13	3.7%
Newborn Patient Days												
	Medi-Cal	136	158	(22)	-14.0%	313	346	(33)	-9.6%	345	(32)	-9.3%
	Other	46	36	10	28.2%	75	79	(4)	-4.5%	82	(7)	-8.5%
	Total	182	194	(12)	-6.2%	388	425	(37)	-8.6%	427	(39)	-9.1%
Total Deliveries		106	104	2	1.5%	201	222	(21)	-9.4%	225	(24)	-10.7%
Medi-Cal %		72.64%	79.49%	-6.85%	-8.6%	80.10%	79.49%	0.61%	0.8%	78.51%	1.59%	2.0%
<u>Case Mix Index</u>												
Medicare		1.3933	1.4491	(0.0558)	-3.9%	1.4020	1.4491	(0.0471)	-3.3%	1.4520	(0.0500)	-3.4%
Medi-Cal		1.1489	1.0840	0.0649	6.0%	1.1470	1.0840	0.0630	5.8%	1.0934	0.0536	4.9%
Overall		1.2193	1.2216	(0.0023)	-0.2%	1.2310	1.2216	0.0094	0.8%	1.2176	0.0134	1.1%
<u>Ancillary Services</u>												
<u>Inpatient</u>												
Surgery Minutes		6,917	6,984	(67)	-1.0%	13,632	14,644	(1,012)	-6.9%	15,294	(1,662)	-10.9%
Surgery Cases		83	84	(1)	-0.9%	159	179	(20)	-11.1%	186	(27)	-14.5%
Imaging Procedures		1,427	1,497	(70)	-4.7%	2,797	3,137	(340)	-10.8%	3,296	(499)	-15.1%
<u>Outpatient</u>												
Surgery Minutes		12,376	14,198	(1,822)	-12.8%	27,012	29,749	(2,737)	-9.2%	31,053	(4,041)	-13.0%
Surgery Cases		174	183	(9)	-5.2%	377	384	(7)	-1.9%	400	(23)	-5.8%
Endoscopy Procedures		214	179	35	19.5%	420	375	45	11.9%	394	26	6.6%
Imaging Procedures		4,340	4,058	282	6.9%	8,874	8,503	371	4.4%	8,505	369	4.3%
MRI Procedures		278	297	(19)	-6.4%	610	623	(13)	-2.0%	654	(44)	-6.7%
CT Procedures		1,406	1,305	101	7.7%	2,903	2,734	169	6.2%	2,888	15	0.5%
Ultrasound Procedures		1,500	1,351	149	11.1%	3,089	2,830	259	9.2%	2,921	168	5.8%
Lab Tests		34,842	33,270	1,572	4.7%	71,731	69,709	2,022	2.9%	70,139	1,592	2.3%
Dialysis		10	5	5	94.2%	28	11	17	159.5%	12	16	133.3%

Sierra View Medical Center
Financial Statistics Summary Report
August 2026

Statistic	Aug-26				YTD				Fiscal 26 YTD	Increase/ (Decrease) Aug-25	% Change	
	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.				
Cancer Treatment Center												
Chemo Treatments	2,061	1,920	141	7.4%	4,234	4,022	212	5.3%	4,131	103	2.5%	
Radiation Treatments	1,877	1,670	207	12.4%	3,756	3,498	258	7.4%	2,765	991	35.8%	
Cardiac Cath Lab												
Cath Lab IP Procedures	13	18	(5)	-28.0%	23	38	(15)	-39.2%	35	(12)	-34.3%	
Cath Lab OP Procedures	37	36	1	2.2%	73	76	(3)	-3.8%	64	9	14.1%	
Total Cardiac Cath Lab	50	54	(4)	-7.8%	96	114	(18)	-15.6%	99	(3)	-3.0%	
Outpatient Visits												
Emergency	3,622	3,383	239	7.1%	7,114	7,089	25	0.4%	6,839	275	4.0%	
Total Outpatient	15,576	14,214	1,362	9.6%	31,579	29,782	1,797	6.0%	29,829	1,750	5.9%	
Staffing												
Paid FTE's	904.91	902.60	2.31	0.3%	904.08	902.60	1.48	0.2%	898.62	5.46	0.6%	
Productive FTE's	790.23	781.84	8.39	1.1%	790.23	781.84	8.39	1.1%	743.86	46.37	6.2%	
Paid FTE's/AOB	4.91	4.99	(0.08)	-1.5%	4.88	4.96	(0.08)	-1.5%	5.10	(0.22)	-4.2%	
Revenue/Costs (w/o Case Mix)												
Revenue/Adj.Patient Day	11,020	10,519	501	4.8%	11,214	10,857	357	3.3%	11,226	(12)	-0.1%	
Cost/Adj.Patient Day	2,912	2,868	44	1.5%	2,859	2,896	(37)	-1.3%	2,794	65	2.3%	
Revenue/Adj. Discharge	50,367	50,638	(271)	-0.5%	53,801	52,090	1,711	3.3%	52,538	1,262	2.4%	
Cost/Adj. Discharge	13,307	13,804	(497)	-3.6%	13,714	13,893	(179)	-1.3%	13,076	638	4.9%	
Adj. Discharge	1,250	1,165	84	7.2%	2,392	2,351	41	1.7%	2,334	58	2.5%	
Net Op. Gain/(Loss) %	-5.61%	-4.29%	-1.33%	30.9%	-1.41%	-2.63%	1.22%	-46.4%	1.21%	-2.62%	-216.0%	
Net Op. Gain/(Loss) \$	(883,693)	(661,140)	(222,553)	33.7%	(455,651)	(836,392)	380,741	-45.5%	375,086	(830,737)	-221.5%	
Gross Days in Accts Rec.	95.04	100.75	(5.70)	-5.7%	95.04	100.75	(5.70)	-5.7%	94.97	0.07	0.1%	
Net Days in Accts. Rec.	33.84	43.55	(9.72)	-22.3%	33.84	43.55	(9.72)	-22.3%	42.74	(8.90)	-20.8%	

Sierra View Local Health Care District

Balance Sheet

	Aug-26	Jul-26
Assets		
Current Assets:		
Cash & Cash Equivalents	5,519,227	10,539,159
Short-Term Investments	2,343,365	-
Assets Limited As To Use	1,632,878	1,168,353
Patient Accounts Receivable	196,613,252	195,083,692
Less Uncollectables	(14,251,164)	(13,974,094)
Contractual Allowances	(164,799,565)	(164,008,600)
Other Receivables	45,930,574	32,020,026
Inventories	4,622,960	4,673,990
Prepaid Expenses and Deposits	4,090,773	4,236,070
Less Receivable - Current	314,043	314,043
Total Current Assets	82,016,345	70,052,640
Assets Limited as to use, Less		
Current Requirements	33,234,063	33,152,142
Long-Term Investments	130,985,763	143,044,519
Property, Plant and Equipment, Net	69,182,548	69,257,659
Intangible Right of use Assets	125,959	136,289
SBITA Right of use Assets	1,812,767	1,949,981
Lease Receivable - LT	341,227	366,946
Other Investments	250,000	250,000
Prepaid Loss on Bonds	965,062	986,042
Total Assets	318,913,733	319,196,217
Liabilities and Funds Balances		
Current Liabilities		
Bond Interest Payable	173,608	86,804
Current Maturities of Bonds Payable	4,235,000	4,235,000
Current Maturities of Long Term Debt	0	0
Account Payable and Accrued Expenses	5,143,061	5,631,920
Accrued Payroll and Related Costs	8,456,962	7,667,031
Estimated Third-Party Payor Settlements	3,732,840	3,762,840
Lease Liability - Current	130,972	130,972
SBITA Liability - Current	1,606,351	1,655,578
Total Current Liabilities	23,478,793	23,170,144
Self-Insurance Reserves	1,943,450	1,933,422
Capital Lease Liab LT	0	0
Bonds Payable, Less Curr Reqt	24,640,000	24,640,000
Bonds Premium Liability - LT	1,454,686	1,493,511
Lease Liability - LT	11,442	22,629
SBITA Liability - LT	580,789	688,737
Other Non Current Liabilities	-	-
Deferred Inflow - Leases	603,064	627,561
Total Liabilities	52,712,224	52,576,004
Unrestricted Fund	266,128,611	266,128,611
Profit or (Loss)	72,897	491,602
Total Liabilities and Fund Balance	318,913,733	319,196,217

Sierra View Local Health Care District

Income Statement

For Period

Aug-26

	ACTUAL	BUDGET	VARIANCE	% VARIANCE	ACTUAL YTD	BUDGET YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	5,500,870	5,604,837	(103,967)	(2%)	10,872,207	11,461,464	(589,257)	(5%)
Inpatient - Ancillary	18,322,567	18,282,876	39,691	0%	36,580,047	38,100,311	(1,520,264)	(4%)
Total Inpatient Revenue	23,823,437	23,887,713	(64,276)	(0%)	47,452,254	49,561,775	(2,109,521)	(4%)
Outpatient - Ancillary	39,114,563	35,119,238	3,995,325	11%	81,228,223	72,907,947	8,320,276	11%
Total Patient Revenue	62,938,000	59,006,951	3,931,049	7%	128,680,477	122,469,722	6,210,755	5%
Medicare	(19,510,662)	(20,582,758)	1,072,096	(5%)	(40,438,833)	(42,722,932)	2,284,099	(5%)
Medi-Cal	(20,341,806)	(16,435,545)	(3,906,261)	24%	(40,882,786)	(34,256,293)	(6,626,493)	19%
Other/Charity	(7,065,163)	(6,834,867)	(230,296)	3%	(13,776,864)	(14,202,781)	425,917	(3%)
Discounts & Allowances	(451,111)	(57,877)	(393,234)	679%	(1,285,753)	(117,015)	(1,168,738)	999%
Bad Debts	(474,208)	(367,871)	(106,337)	29%	(1,484,834)	(735,741)	(749,093)	102%
Total Deductions	(47,842,950)	(44,278,918)	(3,564,032)	8%	(97,869,070)	(92,034,762)	(5,834,308)	6%
Net Service Revenue	15,095,051	14,728,033	367,018	2%	30,811,406	30,434,960	376,446	1%
Other Operating Revenue	649,892	696,797	(46,905)	(7%)	1,535,021	1,393,594	141,427	10%
Total Operating Revenue	15,744,943	15,424,830	320,113	2%	32,346,427	31,828,554	517,873	2%
Salaries	6,510,178	6,410,013	(100,165)	(2%)	13,038,046	13,098,021	59,975	0%
S&W PTO	657,661	700,645	42,984	6%	1,355,257	1,427,090	71,833	5%
Employee Benefits	1,573,066	1,555,958	(17,108)	(1%)	3,186,670	3,111,916	(74,754)	(2%)
Professional Fees	2,182,606	1,949,458	(233,148)	(12%)	4,285,197	3,901,413	(383,784)	(10%)
Purchased Services	979,609	1,007,015	27,407	3%	1,806,166	2,014,030	207,864	10%
Supplies & Expenses	2,776,740	2,418,345	(358,395)	(15%)	5,294,366	5,023,163	(271,203)	(5%)
Maintenance & Repairs	285,938	299,082	13,144	4%	597,439	598,164	725	0%
Utilities	362,707	293,888	(68,819)	(23%)	641,385	587,776	(53,609)	(9%)
Rent/Lease	39,702	38,646	(1,056)	(3%)	76,525	77,292	767	1%
Insurance	118,375	124,899	6,524	5%	269,713	249,798	(19,915)	(8%)
Depreciation/Amortization	794,082	850,945	56,863	7%	1,588,750	1,702,131	113,381	7%
Other Expense	347,973	437,076	89,103	20%	662,564	874,152	211,588	24%
Impaired Costs	-	-	-	0%	-	-	-	0%
Total Operating Expense	16,628,636	16,085,970	(542,666)	(3%)	32,802,079	32,664,946	(137,133)	(0%)
Net Gain/(Loss) From Operations	(883,693)	(661,140)	(222,553)	34%	(455,651)	(836,392)	380,741	(46%)
District Taxes	140,212	140,212	-	0%	280,424	280,424	-	0%
Investment Income	502,356	458,286	44,070	10%	1,119,747	916,572	203,175	22%
Other Non - Operating Income	27,873	40,585	(12,712)	(31%)	55,944	81,170	(25,226)	(31%)
Interest Expense	(65,847)	(72,113)	6,266	9%	(124,617)	(144,226)	19,609	14%
Non-Operating Expense	(21,607)	(34,963)	13,356	38%	(85,582)	(69,926)	(15,656)	(22%)
Total Non-Operating Income	582,987	532,007	50,980	10%	1,245,915	1,064,014	181,901	17%
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	(300,706)	(129,133)	(171,573)	133%	790,264	227,622	562,642	247%
Net Incr/(Decr) in the Fair Value Invstmt	(117,998)	166,666	(284,664)	(171%)	(717,367)	333,332	(1,050,699)	(315%)
Net Gain/(Loss)	(418,704)	37,533	(456,237)	(1,216%)	72,897	560,954	(488,057)	(87%)

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
August-26

	Current Month	YTD
Cash flows from operating activities:		
Operating Income/(Loss)	(883,693)	(455,651)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation/Amortization	794,082	1,588,750
Provision for bad debts	277,070	855,331
		-
Change in assets and liabilities:		-
Patient accounts receivable, net	(738,596)	(1,722,650)
Other receivables	(13,910,548)	(16,207,960)
Inventories	51,030	(17,055)
Prepaid expenses and deposits	145,297	(1,289,029)
Advance refunding of bonds payable, net	20,980	41,959
Accounts payable and accrued expenses	(488,859)	(201,856)
Deferred inflows - leases	(24,497)	(48,994)
Accrued payroll and related costs	789,930	(1,643,086)
Estimated third-party payor settlements	(30,000)	1,215,809
Self-insurance reserves	10,028	1,788
Total adjustments	(13,104,083)	(17,426,992)
Net cash provided by (used in) operating activities	(13,987,776)	(17,882,644)
Cash flows from noncapital financing activities:		
District tax revenues	140,212	280,424
Noncapital grants and contributions, net of other expenses	(11,602)	(58,298)
Net cash provided by (used in) noncapital financing activities	128,610	222,126
Cash flows from capital and related financing activities:		
Purchase of capital assets	(708,640)	(1,175,988)
Proceeds from sale of assets	-	-
Proceeds from debt borrowings	-	-
Proceeds from lease receivable, net	25,719	51,364
Principal payments on debt borrowings	-	(4,400,000)
Interest payments	-	(608,825)
Issuance of bonds payable and bond premium liability	-	-
Net change in notes payable and lease liability	(31,147)	(61,650)
Net changes in assets limited as to use	(546,446)	3,903,934
Net cash provided by (used in) capital and related financing activities	(1,260,514)	(2,291,164)
Cash flows from investing activities:		
Net (purchase) or sale of investments	11,940,757	11,133,152
Investment income	502,356	1,119,747
Net cash provided by (used in) investing activities	12,443,113	12,252,899
Net increase (decrease) in cash and cash equivalents:	(2,676,566)	(7,698,782)
Cash and cash equivalents at beginning of month/year	10,539,159	15,561,375
Cash and cash equivalents at end of month	7,862,592	7,862,592

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS

August 2026

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
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
Jul-26	12,659,822	2,053,834	14,713,656
Aug-26	12,145,388	223,263	12,368,651

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

August 2026 Summary of Other Activity:

220,500	M-Care interim payments
2,763	Miscellaneous
<u>223,263</u>	08/26 Total Other Activity