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

AGENDA
September 23, 2025

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): **Evaluation – Quality of Care/Review**

C. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation; Anticipated Litigation; and Pending Litigation: **Conference with Legal Counsel**; (3 Items). Estimated Disclosure: 3 years after completion of each 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 concerning use and benefit of real property** (1 Item). Estimated date of disclosure July 1, 2027.

E. **Conference with Sierra View Local Health Care District Real Property Negotiator to get additional direction from the board on sale of property pursuant to Cal. Gov. Code § 54956.8.**
Property: APN: 215-330-060 and 205-330-060-064, Strathmore, CA 93267.
Sierra View Local Health Care District Hospital Negotiator: Ron Wheaton.
Prospective Purchaser: Matt Thomas with Bloom Group / any other interested parties.
Estimated date of disclosure: September 1, 2026.

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): **Discussion Regarding Trade Secrets Pertaining to Facility Upgrades for Service Line Improvement**. Estimated date of disclosure September 1, 2026

G. 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 September 1, 2026.

H. Pursuant to Gov. Code Section 54957(b): **Discussion Regarding Confidential Personnel Matter Chief Executive Officer Contract Review** (1) Item. Estimated Date of Disclosure September 23, 2025 for materials that are not part of an individual's private personnel file.

I. 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 Item).

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

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING AGENDA
September 23, 2025

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

A. Chief of Staff Report
Recommended Action: Information only; no action taken

B. Quality Review: Report and Evaluation of Quality of Care
Recommended Action: Approve/Disapprove Report as Given

C. Discussion of Three (3) Items Regarding Significant Exposure to Litigation; Anticipated Litigation and Pending Litigation
Recommended Action: Information only; no action taken

D. Discussion Regarding Trade Secrets and Strategic Planning for Real Property Development
Recommended Action: Approve Motion to Formalize Direction to Leadership

E. Conference with Sierra View Local Health Care District Real Property Negotiator Concerning Possible Sale of the Real Property located at APN: 215-330-060 and 205-330-060-064, Strathmore, CA 93267
Recommended Action: Approve Motion to Formalize Direction to Leadership

F. Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning for Facility Upgrades for Service Line Improvement
Recommended Action: Approve Motion to Formalize Direction to Leadership

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

H. Discussion Regarding Personnel Matter, Chief Executive Officer Contract Review
Recommended Action: Motion to Approve/Disapprove new CEO contract

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

VI. Public Comments

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

VII. Consent Agenda
Recommended Action: Approve/Disapprove Consent Agenda as presented

Background information has been provided to the Board on all matters listed under the Consent Agenda, covering Medical Staff and Hospital policies, and these items are considered to be routine by the Board. All items under the Consent Agenda covering Medical Staff and Hospital policies are normally approved by one motion. If discussion is requested by any Board member(s) or any member of the public on any item addressed during public comment, then that item may be removed from the Consent Agenda and moved to the Business Agenda for separate action by the Board.

VIII. Approval of Minutes

A. August 26, 2025 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove August 26, 2025 Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

A. Annual Graduate Medical Education Report
Recommended Action: Approve/Disapprove Report at Given

B. SVMC Patient Portal Presentation
Recommended Action: Information Only; No Action Required

C. August 2025 Financials
Recommended Action: Approve/Disapprove August Financial Report as Presented

D. Update on District 2 Vacancy
Recommended Action: Information only; No Action Required; Board May Pass Motion if Necessary to Provide Additional Direction to Leadership Based on Report

X. SVLHCD Board Chair Report

XI. SVMC CEO Report

XII. Announcements:

Regular Board of Directors Meeting – October 28, 2025 at 5:00 p.m.

XIII. Adjournment

PUBLIC NOTICE

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

PUBLIC NOTICE ABOUT COPIES

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

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

HOSPITAL POLICIES AND REPORTS FOR REVIEW
APPROVED BY SENIOR LEADERSHIP TEAM

SUBJECT:	SECTION:
UROLOGY CLINIC- BUSINESS HOURS	***UROLOGY*** **Page 1 of 1**

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

PURPOSE:

To ensure a predictable and organized operation of the Urology Clinic.

POLICY:

The Urology Clinic will maintain posted hours of operation.

AFFECTED PERSONNEL/AREAS: *ALL UROLOGY CLINIC PERSONNEL AND MEDICAL STAFF*

PROCEDURE:

A. General hours of the Urology Clinic: Monday through Friday, between 8:00am and 4:30pm and will close for lunch from 12:00 noon to 1:00pm.

B. The Urology Clinic will be closed for holidays. As established by house-wide policy, the following are deemed as observed holidays:

New Year's Day, President's Day, Memorial Day, Independence Day (July 4), Veteran's Day, Labor Day, Thanksgiving, Christmas Day.

C. Signage

A notice will be posted on the entry door when the office is closed for a holiday or vacation.

The notice will include instructions to be followed in the case of a medical emergency.

D. Unplanned Closing/Change of Schedule

If an unplanned closing or change of schedule occurs (i.e., power failure, medical emergency at the hospital requiring the physician, other emergency), notice will be posted immediately to advise patients, guests, vendors, and delivery personnel.

Notice will include instructions to be followed in the case of a medical emergency.

CROSS REFERENCE:

- Human Resources: Employee Handbook

SUBJECT: **CAPITAL BUDGETING PROCESS**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define the guidelines for development and implementation of Sierra View Medical Center's (SVMC's) capital budget.

POLICY:

1. On an annual basis, Sierra View Medical Center shall develop a capital budget consistent with the strategic goals of the institution and the needs of the population it serves and in conjunction with the annual review of the Plan for the Provision of Patient Care. Special consideration will be given to those requests placing highest priority on high risk or problem prone processes that can affect patient safety**.**

    a. The capital budget shall be developed through the combined effort of the Hospital's Administration, Department Directors and the Medical Staff.

    b. The Board of Directors shall approve the capital budget as part of the annual budgeting process.

    c. Acquisitions related to the Capital Budget may be constrained if the Hospital is not in compliance with its current operating budget.

2. The Vice President of Finance shall be functionally responsible for coordinating the development, approval and implementation of the Hospital's annual capital budget as well as its long-term capital plan.

3. All software, equipment, furnishings and facility construction projects with a cost greater than $5,000 and with a useful life greater than one year will be considered a capital acquisition.

4. A Project Initiation Document (PID) will be completed for all items to be considered during the capital budget process. Written financial justification must accompany all requests, as well as applicable vendor quotes and/or ECRI price and technology analysis. Each request must be signed by the Vice President responsible for the department making the request. Requests without the Vice President's signature and quotes will not be accepted and will be returned to the submitting department.

    a. The financial justification must address the costs of additional personnel, installation, freight, sales tax and supplies resulting from the purchase.

5. In addition to capital requests for the year being planned, each Department Director will consider capital needs for an additional two fiscal years.

6. Physician requests for capital items must be routed through the Medical Staff Office. This department will be responsible for working with the appropriate Department Director to ensure the necessary forms are submitted.

7. Senior Management will determine the amount of funds available for capital acquisitions in the coming fiscal year.

8. A Capital Budget Committee (CBC) shall be formed with seven members as follows:

   a. Chair – Administrative Director, General Services

   b. Co-Chair – Supply Chain Manager

   c. Five members from Ancillary and Support Services, Patient Care Services and Financial Services. The members will be reviewed on an annual basis and are subject to annual change.

   d. In addition, technical advisors may be appointed from General Services, Project Management and Information Technology and will be used on an as-needed basis.

9. All PIDs will be reviewed by the CBC and prioritized based upon the identified needs and strategic plan of the Hospital.

   a. Equipment requests will need review and approval by General Services. Software/Hardware requests will need review and approval by Information Technology .

      It will be the Department Director's responsibility to obtain this approval, prior to submitting requests to the CBC.

10. A discretionary fund may be established as part of the process. This category of funds may be expended only at the discretion of the President/CEO.

11. An amount for contingencies shall be appropriated as part of the budget. This category of funds may not be expended without the prior approval of Senior Management.

    a. To be considered, written financial justification must accompany all requests. The financial justification must address any additional operational costs resulting from the purchase.

12. In the interest of maintaining the dollar limit of the budget, substitutions for items on the approved list may occur.

    a. Substitutions will be considered by Senior Management. This process will involve any department director(s) who may be impacted by a substitution.

    b. Proposed substitutions must be submitted using a PID and shall be approved by the appropriate Vice President prior to submission to Senior Management.

13. On a quarterly basis, the Board of Directors will be updated as to the status of the Capital Budget.

14. Items appearing on the approved capital budget and not ordered within the fiscal year must be re-submitted for approval during the next capital budget cycle. There will be no roll over from one fiscal year to the next.

AFFECTED PERSONNEL/AREAS: *ALL PERSONNEL*

REFERENCES:

- The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- General Accounting Manual, Annual Operating Budget

SUBJECT: **COLLABORATIVE GOVERNANCE**	SECTION: ***Leadership (LD)*** **Page 1 of 12**

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

POLICY:

Designated nursing care departments participate in collaborative governance (CG). It is the responsibility of management to incorporate collaborative governance, clarify expectations and to facilitate participation and achievement of collaborative governance goals. It is the responsibility of nursing staff members to provide input, participate, communicate and follow outlined procedures.

DEFINITIONS:

Collaborative governance*:* provides a framework, based on the belief that nurses closest to the patient are in the best position to make decisions related to patient care and nursing practice. This framework allows nurses, management and other skill levels or disciplines to work collaboratively to develop nursing practice and patient care delivery while empowering clinical nurses to participate and lead decision-making processes at all levels across the organization, based on evidence-based practice. It also provides for additional manager infrastructures and processes to address management issues.

Responsibility: ownership plus impact; two way process; must be allocated and must be accepted. *Individuals cannot accept responsibility without a level of authority.*

Authority: the right to act and make decisions in areas where responsibility has been given and accepted. There are four levels of authority described on page ~~8~~9.

Accountability: retrospection to evaluate effectiveness of judgments or decisions. Requires non-punitive corrective action where appropriate, and monitoring/ feedback.

MEASUREABLE OUTCOMES OF COLLABORATIVE GOVERNANCE**:**

Goals are to meet or exceed highest level of benchmark (national, regional, state, and ~~SVDH~~SVMC)

1. Quality of patient care – National Data Bank of Nursing Quality Indicators (NDNQI), CALNOC, and other Nursing Sensitive Indicators as defined by regulatory agencies

2. Patient experience – per designated data collection vendor and other department-specific satisfaction measurements

3. Nursing retention expressed as turnover and vacancy rates

4. Nurse satisfaction including professionalism, governance, communication, relationships and others

    a. NDNQI RN Practice Environment Survey

5. Nursing strategic goal achievement – goal 90%

6. Professional growth~~.~~

a. Goal is to increase the number of professionally certified nurses by ~~1~~2.5%/year

b. Goal is to increase the number of RN's actively enrolled in courses of study leading to BSN, MSN or APN by ~~1~~2.5% per year.

c. Participation in patient care and nursing practice decision making as evidenced by >5% documented participation.

- Clinical nursing representation on all appropriate committees and task forces
- Participation in unit and CG activities:
  - % of RN attendance > 75% of the meetings
  - RN membership on Unit-Based Nursing Councils >75%

PURPOSES OF COLLABORATIVE GOVERNANCE**:**

1. To provide an organizational structure through which professional excellence will be achieved, utilizing Dr. Tim Porter O'Grady's tenants of collaborative governance and Patricia Benner's "novice to expert" model as guides.

2. To provide an opportunity for participation in the patient care and nursing practice decision making.

3. To develop and maintain a climate of practice in which clinical excellence and optimal patient care outcomes are promoted through accountability and collaboration.

4. To provide a forum for exchange of ideas and information that enhance the quality of nursing care delivered at SVDH.

5. To assure practice and patient care decisions will be consistent with established policies and procedures, following standards of practice from professional organizations, The Joint Commission and other relevant state and federal laws and regulations.

6. To support our nursing philosophy of Compassion, Strength, and Commitment. These values support the Nursing Division's role in accountability for evidence based practice, quality outcomes and individual competence through clinical advancement from novice to expert.

7. To provide the responsibility, accountability and authority to practice nursing care via practice models appropriate to the patient population and setting.

8. To establish and maintain a professional collegial environment in which staff members practice guided by the Sierra View District's Standards of Performance.

METHODOLOGY:
A councilor methodology is used to achieve the goals of collaborative governance.

RESPONSIBILITIES OF COUNCILS, NURSING MANAGEMENT, MAGNET STEERING COMMITTEE, AND OTHERS:

COUNCIL STRUCTURE AND RELATIONSHIPS**:**

Nursing collaborative governance councils relate to both nursing management and hospital committees to assure appropriate communication, education and approval processes

1. Unit Based Council (UBC) responsibilities include:

    a. Assure communication processes bring ideas to Nursing Division Councils as appropriate and ideas/solutions back to staff

    b. Update and involve nursing management/advisor.

    c. Document communications when appropriate.

    d. Assure Nurses receive timely and informative communication about what's going on and what's being done with their input, including reporting in staff meetings, posting information, utilize communication trees, newsletters, among others.

    e. Assess obstacles, opportunities and ideas for improvement, involving staff in the planning stages. Implement appropriate changes related to patient care and nursing practice, with management support.

    f. Identify evidence-based solutions to: provide better, more efficient care to meet patients' needs; achieve department and nursing goals; and foster innovation under the guidance of the Evidence Based Practice Council.

    g. Select, monitor, and evaluate data relating to the quality of nursing care and take action when data shows downward trends or address problem prone processes, initiating a PI project under the guidance of the Nursing Quality Council.

    h. Establish processes and activities to improve relationships with staff – including other disciplines, physicians, and departments.

    i. Provide input regarding finances/budget – being aware of hospitals'/unit's financial status, contributing ideas to improve profitability, and having a say in resource allocation in collaboration with Department Leadership.

    j. Establish peer recognition processes by creating innovative ways to reward and recognize staff.

k. Serve as Magnet Champions, helping to sustain, enhance and acculturate forces of Magnetism within the Nursing Division.

l. Working with Magnet Steering Committee to support "Friends of Nursing" fund raising activities.

2. Education and Professional Development Council

a. Collaborate with other Councils to develop, implement and evaluate education/training needed to support decisions and educational initiatives.

b. Conduct learning needs assessment and develop/implement educational plans based on identified needs.

c. Establish an effective communications platform to disseminate educational information

d. Assess, develop, implement, and evaluate innovative professional development strategies.

e. Address and support recruitment/retention recommendations. Meet at least annually with the Human Resources Recruiter.

f. Support professional recognition activities.

g. Develop, implement, evaluate and support the Professional Development and Recognition Program.

h. Revise/Review professional growth and development aspects of job Descriptions for nurses.

i. Review professional nursing portfolios for completeness and forward recommendations for final approval to Directors and Clinical Managers.

j. Encourage and promote educational achievement and advancement.

k. Develop, implement and evaluate strategies to enhance certification, education and professional growth activities.

l. Oversight of Magnet Cheer Champions.

m. Nurse's Week: accountable to obtain a minimum of 6 nominees for Nurse of the Year in the category of COMMITMENT.

3. Evidence Based Practice Council (EBPC)

a. Serve as consultant to the Professional Practice Council for assistance with research-based issues or projects that involve nursing.

b. Develop, implement and evaluate education related to research and EBP (Evidence Based Practice) as it relates to nursing orientation, on-line, department specific, and case studies in collaboration with Education and Professional Development Council.

c. Actively participates to develop, review, recommend approval, implement and educate nursing practice/patient care standards, policies and procedures.

d. Define, promote and integrate standards of clinical nursing practice that are consistent with or exceed national, regional and community standards of practice.

e. Assure nursing practice standards are ethical, current, evidence-based, theoretically sound and aligned with SVDH's mission and strategic goals.

f. Coordinate clinical nursing practice initiatives with appropriate unit/organization-wide nursing councils and other disciplines, committees, task forces and medical staff as indicated.

g. Collaborate with other disciplines as needed to investigate practice related problems, issues or concerns and recommend appropriate action for practice changes.

h. Nurse's Week: accountable to obtain a minimum of six (6) nominees for Nurse of the Year in the category of STRENGTH.

4. Professional Practice Council

a. Collaborate with peers and other departments as appropriate to investigate problems and concerns and recommend appropriate action for both quality assurance and performance improvement activities.

b. Provide direction to nursing units in the measurement and assessment of patient care and clinical performance activities to include data analysis and tool development.

c. Advise nurses and other disciplines about Nurse Practice/Board rules and regulations related activities having an impact on nursing practice and patient care across the organization.

d. Facilitate discussion of concerns, issues and other related activities having an impact on nursing practice and patient care across the organization.

e. Participates in Nursing Peer Review activities as referred by other departments or medical staff.

f. Utilizing the Just Culture process, identify practice issues/trends to develop appropriate communication/education to all departments.

g. Advise nurses and other disciplines about Nurse Practice/Board rules and regulations related activities having an impact on nursing practice and patient care across the organization.

h. Nurse's Week: accountable to obtain a minimum of six (6) nominees for Nurse of the Year in the category of COMPASSION.

i. Educate and reinforce hospital policy and procedure to ensure compliance.

5. Nursing Quality Council (NQC)

a. Review and select national clinical performance data for benchmark/comparison of Nursing Sensitive Indicators by participation in Collaborative Nursing Outcomes Coalition (CalNoc) and National Data Bank of Nursing Quality Indicators (NDNQI).

b. Review, coordinate, and prioritize PI proposals according to strategic goals and QA monitors.

c. Facilitate approval of Nursing PI projects requiring administrative approval for resources.

d. Review activities for clinically acceptable indicators and use of the PI model. Evaluate collected data for appropriateness and timeliness of actions taken.

e. Maintain a listing of current/completed quality assurance/PI projects and relevant findings to be available to all clinical staff.

f. Identify ways to capture data from the electronic health record.

6. Nursing Management Council (NMC)

a. Provides a forum for innovation, creativity, and sustainability of a culture of nursing excellence

b. Provide oversight for all Council activities

c. Assess progress toward/completion of nursing strategic goals.

d. Assist in developing a sense of team among patient care employees.

e. Develop and implement action plans to achieve nursing goals, demonstrating innovation, sustainability, participation, acculturation and progressive outcomes.

f. Participate in the promotion and recognition of the Nursing profession

g. Review/approve magnet educational programs

h. Serve as the information hub for all hospital wide nursing initiatives & activities.

i. Approve nursing standards, policies and procedures from other Councils

ROLES AND RESPONSIBILITIES

1. Role of Nursing Management – Directors and Clinical Managers. These pivotal leaders work in partnership and facilitative roles with nursing leaders on Councils. Their role is to:

   a. Facilitate unit Councils and other forums that assure participation in patient care/nursing practice decision making.

   b. Encourage majority participation in surveys, including NDNQI Practice Environment RN Satisfaction.

   c. Assure education and professional development and Unit Education Calendar visibly posted, current and discussed at staff meetings.

   d. Via role modeling, 1:1 goal setting, setting expectations, encouragement and coaching, support a work environment of nursing excellence.

   e. Assure nurse representative is involved in PI projects, task forces, QA, EBP, and development of policies/procedures.

   f. Assure timely submission of requested reports for Councils, e.g. interim reports and re-designation.

   g. Encourage commitment to Nursing through certification, assuring mentoring of at least one RN per year.

   h. Promote involvement in professional organizations, community activities, and networking opportunities.

   i. Assure visibility and accessibility.

   j. Promote positive image of nursing

   k. Share Magnet successes with colleagues and staff nurses.

   l. Educate and involve all disciplines and levels of nurses in sustaining the Magnet environment.

m. Assure unit-specific care is evidence-based on national standards that are known by nurses and incorporated in patient population standards of care.

n. Assure that the Nursing Code of Ethics, Nurse Practice Act, Nursing Bill of Rights and other core standards are visible and understood.

2. Role of Magnet Steering Committee

a. Conduct ongoing analysis of maturation, sustainability, acculturation and participation related to the Forces of Magnetism (FOM) and Sources of Evidence.

b. Assure orientation and education to the Forces of Magnetism (FOM) and an environment of innovation and nursing excellence.

c. Keep current with ANCC/Magnet changes, research and EBP, providing timely education and recommendations.

d. Monitor/provide guidance and leadership for Nursing Division Council Chairs, nursing leadership and administrators to close gaps and identify innovative solutions in systems and processes.

e. Identify and utilize appropriate resources to serve on committees/Councils or accomplish tasks that promote efficiency and effectiveness.

f. Provide an environment of motivation and commitment to Magnet Designation through celebration, continuous communication and education of FOM/nursing excellence.

g. Prepare, revise, and maintain timely documentation materials including designated aspects of the annual report for Nursing Division and ANCC Interim report.

h. Coordinate continuous readiness and Magnet surveys, collate results and provide reports and recommendations.

i. Recommends to VP of Patient Care Services projects to be included in the disbursement of Friends of Nursing Funds.

j. Via presentation, publication, participation in mail lists, benchmark and share innovation and experience with other Magnet and Magnet journey hospitals.

3. Role of the VP of Patient Care Services

a. Support and role model collaborative governance.

b. Mentor and encourage all nursing levels in governance, professional development and nursing excellence.

c. Serves as an advisor to Organization-Wide multidisciplinary committees.

d. Assure nursing and magnet goals aligned with organizational goals and directions.

e. Maintain visibility and accessibility to all levels of nursing staff.

4. Council Chair

a. Meet with Department Facilitator prior to the meeting to allow Facilitator to coach and give ideas and direction.

b. Submit minutes from each meeting to the Department Facilitator.

LEVEL OF AUTHORITY

The right to act and make decisions in the areas where one is given and accepts responsibility. When people are asked to share in the work, they must know their level of authority with regard to that work. Levels of authority determine a person's right to act in the area he/she is given.
Sierra View District Hospital's Nursing Division recognizes there are (4) levels of authority as follows:

- ***Level I*** – Data Gathering – "Get information, bring it back to me, and I will decide what to do with it."
- ***Level II*** – Data gathering + recommendations – "Gather the data, look at the situation and make some recommendations, and I will pick from one of those recommendations what we will do next. I will still decide".
- ***Level III*** – Data gathering + recommendations [pause] + act: -- " Collect the data, look at the situation, make some recommendations, and pick one that you will do. But before you carry it out, I want you to stop (or pause) and check with me before you do it."
- ***Level IV*** – Act and inform/update – "Do what needs to be done and tell me what happened or update me later."

COMMUNICATION:

Avenues for communication of information to and from councils to staff must be in place. All minutes should be completed using standardized templates for content and format. Decisions/actions are to be discussed at staff meetings and minutes disseminated.

Council representatives may participate in other appropriate hospital, nursing or departmental committees and task forces. Some of the communication methods utilized include: minutes, suggestion box/bulletin boards, newsletters, communication trees, email, mail boxes, staff meetings and Council meetings, among others.

APPOINTMENT TO MEMBERSHIP/SELECTION:

Characteristics and Criteria for Council membership include:

- RN's and other skill levels representative of all shifts
- Serve as a positive role model as a Magnet champion.
- Demonstrated desire to sustain an environment of excellence in patient care and nursing practice
- Most recent/prior year performance evaluation ratings = meet/exceed expectations or outstanding. (i.e. score of "3, 4 or 5")
- Serve as an effective voice for all staff members
- Demonstrated clinical/job competency
- Positive attitude
- Effective communication skills
- Dedicated and willing to actively serve/participate (attend at least 75% meetings, timely follow up and pre-meeting preparation)
- Unit Council chair – must have a least one year experience as a RN

MEMBERSHIP:

UBC (Unit Based Council)

- Members will be chosen by Clinical Managers and/or Directors.
- Approach nominees 1:1 to offer position on Council, review policy, clarify expectations, and obtain commitment to serve
- Announce membership

Nursing Division Councils – members chosen from UBC, or other members of the Nursing Division identified by Nursing Management Council. Advisors are members of Magnet Steering Committee, and VP of Patient Care Services.

- Education and Professional Development Council (EPDC)
- Evidence Based Practice Council (EBPC)
- Professional Practice Council (PPC)

- Nursing Management Council (NMC)
- Nursing Quality Council (NQC)

FREQUENCY OF MEETINGS**:**

- Unit Councils will establish frequency, day, length of meeting based on complexity, and issues.
- Unit Councils may be configured to meet unit needs as long as the collaborative governance goals to achieve and sustain an environment of nursing excellence are met.
- Nursing Division Councils generally meet on a monthly basis.
- Councils may elect not to meet for one month a summer or in November/December, depending on agenda and needs.
- Council Meeting Days may be utilized as a mechanism to promote collaboration, support and sufficient time to work on Council agenda and initiatives.
- Time spent by employees performing tasks for their respective Councils will be considered to be "hours worked" and employees will be paid at their base rate of pay. Employees may not spend time performing tasks for their Councils 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, but only with prior authorization from the employee's respective department Director. Whether or not hours may be "flexed" will be based on the needs of the department. Any employee who violates this provision of the policy will be subject to disciplinary action.

COUNCIL PERFORMANCE/EXPECTATIONS:

Members should notify the Chair if unable to attend. If 35% of meetings are missed, the Department Director will discuss expectations with the member and automatically remove him/her if there are no extenuating circumstances. Members are expected to complete follow up and actions for which they have assumed responsibility.

AFFECTED PERSONNEL/AREAS: *NURSING DIVISION*

REFERENCES:

- Aiken, Linda H. (2002) Superior outcomes for Magnet hospitals: the evidence base. Magnet Hospitals Revisited: Attraction and Retention of Professional Nurses, Washington, DC: American Nurses Publishing, pp 61-81.
- Aiken, L.H., Havens, D.S., Sloane, D.M. March 2000. The Magnet nursing services recognition program: a comparison of two groups of magnet hospitals. *American Journal of Nursing,* 100(3): 26-36.

- Anthony, M.K., (Jan. 31, 2004). Collaborative governance Models: The Theory, Practice and Evidence. *Journal of issues in Nursing*, Vol. #9, no.1, manuscript 4.
- Brooks, B.A. (Jan. 31, 2004). Measuring the Impact of Collaborative governance. *Online Journal of Issues in Nursing*, Vol. #9, no.1. manuscript La.
- Burnhope C. Edmonstone J. Feel the Fear and Do It Anyway: the Hard Business of Developing Collaborative governance, *Journal of Nursing Management.* 2003; 11:147-157.
- Frith, K., Montomery, M. (July-Sept 2006). Perceptions, knowledge and commitment of clinical staff to Collaborative governance. *Nurse Admin. Q*, vol 30, no. 3, pp 273-284
- Hess, R.G., Jr. (Jan. 31, 2004). From Bedside to Boardroom- Nursing Collaborative governance. *Online Journal of Issues in Nursing*, Vol. #9, no.1. manuscript 1.
- Kramer, M., Schmalenberg, C.E. (2003). Magnet Hospital Nurses Describe Control Over Nursing Practice. *Western Journal of Nursing Research*, 35(4), pp. 434-452.
- Porter-O'Grady, T.(October 2001) Is Collaborative governance Still Relevant? *JONA* Vol. 31, no. 10, pp. 468-473
- Scott L, Carees A. Collaborative governance and Shared Leadership: Meeting the challenges of Implementation. Journal of nursing Management. *2005; 13:4-12.*
- *Collaborative governance forum. www.sharedgovernance.org/cgi-bin/newsscript.pl?record=3* What to Do About Petulant Participants.
- Thompson, B., Hateley, P., Molloy, R., Fernandez, S., Madigan, A., Thrower, C., Cain, A. (Jan. 31, 2004). A Journey, Not An Event-Implementation of Collaborative governance in a NHS Trust. *Online Journal of Issues in Nursing.* Vol. #9, #1., manuscript 3.

Responsibility for Review and Maintenance of Policy: **VP of Patient Care Services/CNE**	Original Creation Date: **10/01/2010**
Nursing Management Council Review and Approval: **Not Set**	Last Periodic Review Date: **Not Set**
Senior Management Review and Approval: **Not Set**	Date Revised: **11/25/2019**
Medical Executive Committee Review and Approval: **Not Set**	
Board of Directors Review and Approval: **Not Set**	

SUBJECT: COMPLIANCE HOTLINE	SECTION: Page1 of 3

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

PURPOSE:

Sierra View Medical Center (SVMC) has established a variety of communication channels, including a Compliance Hotline, for the purpose of employees and others reporting problems and concerns. The Hotline allows for telephonic transmission of information concerning suspected or potential violations of regulations, laws and improper or unethical business practices and other wrong doings.

POLICY:

A. SVMC will establish, maintain, and operate a telephone Hotline as a communication channel to report concerns, known/suspected misconduct, individual actual or potential violations of laws, rules, regulations, contract provisions, policies and procedures, and our Code of Conduct.

1. Employees or other interested parties may call the Hotline to report problems and concerns anonymously.
2. To the extent practicable or allowed by law, the Compliance Officer (CO) and Compliance personnel will, when requested, maintain the confidentiality or anonymity of an employee reporting compliance-related concerns.
3. Employees are encouraged to use the Hotline to report problems or concerns in the event other resolution channels are ineffective or the individual wishes to remain anonymous. SVMC is committed to the timely identification and resolution of all issues that may adversely affect employees, physicians, volunteers, or contracted employees of the organization.
4. All Hotline calls will be handled in a manner that protects the privacy of the caller to the extent that the law allows.
5. The goal is for all Hotline calls to be investigated within 30 days of receipt.
6. Employees who report problems and concerns via the Hotline in good faith will be protected from any form of retaliation or retribution (See NON RETALIATION-COMPLIANCE ISSUE REPORTING policy).
7. The CO will redirect non-compliance-related issues to the appropriate leader(s) for resolution, as appropriate.

AFFECTED PERSONNEL/AREAS: ALL EMPLOYEES, CONTINGENT WORK FORCE, MEDICAL STAFF MEMBERS, VOLUNTEERS AND OTHERS IN OUR WORKPLACE

EQUIPMENT: Analog telephone.

PROCEDURE:

A. An employee or other interested party who wishes to report a suspected compliance related concern via the Hotline will access it by calling (559) 497-4777 or extension 4777.

B. Every attempt will be made by Compliance personnel to answer Hotline calls during Compliance personnel working hours. If the call is anonymous, the caller will be instructed to give as much

detail as possible to allow for an adequate investigation. The anonymous caller will be asked to call back in 2-3 days during normal business hours to provide additional details if needed.

C. The Hotline will maintain a voice mail box for times that Compliance personnel are not immediately available to answer during normal business hours, and for calls received outside of normal business hours. The caller will be instructed to leave a message and a description of the compliance-related concern. The caller will also be asked to call back in 2-3 days during normal business hours to provide additional details if needed.

D. Callers to the Hotline should be prepared to report:

1. Name and contact information (unless caller wishes to remain anonymous)
2. Department or location of event
3. Any relevant information concerning the allegations, including the date of the event, the departments involved and the names of employees who can provide additional information.

E. The CO is responsible for ensuring the operation and integrity of the Hotline which includes ensuring all calls are addressed in an appropriate and timely manner as well as in accordance with this and all related policies and procedures. Other responsibilities include:

1. Ensuring proper functioning of the Hotline
2. Establishing reporting and records maintenance procedures
3. Conducting appropriate inquiries, investigations, and follow-up
4. Referring calls to Human Resources, other management and staff, or entities when appropriate.
5. Providing feedback to callers when necessary and/or appropriate
6. Reporting Hotline activity to the Compliance Committee and the Board of Directors
7. Maintaining security for all calls and related documents.
8. Ensuring Hotline reports are handled with utmost confidence, discretion and integrity in assuring that information received is acted upon in a reasonable and proper manner.
9. Ensuring all allegations and complaints are monitored to final resolution and closure.

F. As part of the ongoing auditing and monitoring of the compliance program effectiveness, the CO will be responsible for ensuring periodic and annual reviews and evaluations of the Hotline operations are conducted and will verify the following:

1. The Hotline number is published in the internal phone directory and posted prominently on the SVMC intranet.
2. The existence of the Hotline is communicated through various channels including the Code of Conduct, at New Hire and Annual orientation and various training.
3. The Hotline has continued accessibility, integrity and effectiveness.
4. Employees are encouraged to use the Hotline anytime they feel it is appropriate.

REFERENCES:

- x U.S. Department of Health and Human Services, Office of Inspector General, General Compliance Program Guidance, November 2023 https://oig.hhs.gov/documents/compliance-guidance/1135/HHS-OIG-GCPG-2023.pdf

- x U.S. Department of Health and Human Services, Office of Inspector General, OIG Supplemental Compliance Program Guidance for Hospitals Published by the Office of Inspector General (OIG) February 23, 1998 Federal Register / Vol. 70, No. 19 / Monday, January 31, 2005 https://www.govinfo.gov/content/pkg/FR-2005-01-31/pdf/05-1620.pdf

- x U.S. Department of Health and Human Services, Office of Inspector General of OIG, Publication of the OIG Compliance Program Guidance for Hospitals, Federal Register / Vol. 63, No. 35 / February 23, 1998 / Notices https://www.govinfo.gov/content/pkg/FR-1998-02-23/pdf/98-4399.pdf

Formatted: Indent: First line: 0.5"

CROSS REFERENCES:

- x Code of Conduct

- x Compliance Issue Reporting

- x Non Retaliation- Compliance Issue Reporting

SUBJECT: COMPLIANCE PROGRAM/PLAN	SECTION: Page1 of 9

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

PURPOSE:

Sierra View Medical Center (SVMC) has established and developed a corporate responsibility program designed to prevent, detect, collaborate, and enforce against fraud, waste, abuse, and illegal, improper or unethical conduct in our business practices. This policy describes a systematic program by which SVMC promotes compliance with government requirements, including encouraging ~~all~~ employees ~~Employees~~, contingent work force, Medical Staff and ~~A~~agents ~~and Professionals~~ to report potential problems, implementing processes of immediate action for questionable situations, and providing early detection for potential issues.

POLICY:

Consistent with its values, SVMC is committed to assuring that ~~all~~ employees, contingent work force, Medical Staff and ~~A~~agents ~~and Professionals~~ conduct themselves ethically and in conformance with all applicable laws and regulations, all policies and procedures of SVMC and the Code of Conduct. SVMC has developed this Compliance Program Policy and Procedure for the purpose of adopting and implementing an effective corporate responsibility program. SVMC has established, through Board Resolution on 03/27/01, a formal Corporate Compliance Program, which encompasses ~~es~~ employees, contingent work force, Medical Staff and ~~A~~agents, ~~and Professionals~~ of SVMC. The SVMC Board of Directors established direct oversight and guidance of the SVMC Compliance Program through Board Resolution on 6/28/16.

DEFINITIONS:

The following definitions apply to this Compliance Plan:

A. Agent means any individual, other than ~~an~~ employee, contingent work force member or Medical Staff member ~~or Professional~~, who is authorized to act on behalf of SVMC.

B. Compliance/Privacy Officer (CPO): means the individual charged with the responsibility of coordinating the implementation of this Policy and Procedure.

C. Compliance Committee (CC) means the ~~Compliance~~ team of department and senior leadership representatives providing diverse knowledge and perspective as the subject matter expert of their respective area ~~charged with the responsibility of~~ to oversee ing the ~~development of the~~ Compliance ~~Policy and Procedure~~ S U R J U D P ¶ V S H U I R U P D Q F H

C.D. Contingent Work Force;

D.E. Employee means an individual employed by ~~in the service of~~ SVMC who is working for salary or wages and the details of whose work SVMC has the authority to control and direct.

Formatted: Font: Times New Roman

Formatted: Font: Times New Roman

Formatted: List Paragraph, No bullets or numbering

Formatted: Font: Bold, Italic

Formatted: Font: Bold, Italic

~~E.~~F. ~~Professionals~~Medical Staff Members mean individuals who are credentialed by SVMC, including physicians, and allied health professionals to the extent that these individuals take actions when they are authorized to act on behalf of SVMC.

~~F.~~G. Program means this Corporate Compliance Program, including the Code of Conduct.

AFFECTED AREAS/PERSONNEL: ALL EMPLOYEES, CONTINGENT WORK FORCE, AGENTS, ~~PROFESSIONALS~~ MEDICAL STAFF, BOARD MEMBERS

OBJECTIVES:

The Program operates under the authority and oversight of the Board of Directors of SVMC and is structured to encourage collaborative participation at all levels of SVMC and to foster a culture of ethical and legal behavior in which ~~E~~employees, contingent work force, ~~A~~agents and ~~Professionals~~ Medical Staff of SVMC may report concerns about business practices without fear of retribution. ~~The Program operates under the authority and oversight of the Board of Directors of SVMC and applies to SVMC and its Employees, Agents and Professionals.~~

To accomplish its goal of promoting legal and ethical standards in the workplace, SVMC has designed its Program to be consistent with the seven key elements described in the United States Department of Health and Human Services, Office of Inspector General, General Compliance Program Guidance, ~~Federal Sentencing Guidelines~~; (1) ~~Standards~~ Code of Conduct/Written Policies and Procedures, (2) Compliance ~~Officer and Committee~~ Leadership and Oversight, (3) ~~Effective~~ Training and Education, (4) Effective Lines of Communication (~~Reporting~~) with the Compliance Officer and Disclosure Program, (5) Enforcing ~~Disciplinary Guidelines~~ Standards: Consequences and Incentives, (6) Risk Assessment, Auditing and Monitoring, and, (7) Responding to Detected Offenses and ~~D~~developing ~~Taking~~ Corrective Action~~s~~ Initiatives. This Compliance Plan sets forth below how the Program will be developed and implemented consistent with those Guidelines:

1. Written Code of Conduct, Policies and Procedures:

   a. Code of Conduct: SVMC has developed an enterprise wide Code of Conduct that provides guidance to ensure that business practices are conducted ethically and in a legal manner. SVMC's Code of Conduct emphasizes the shared common values that guide 6 9 0 & ¶ V D F W L R Q V D Q G V S H F L I L F V W D Q G D U G V U H J D U G L Q J D S S U R S U L D W H conduct in the workplace. The Code of Conduct emphasizes the importance of adhering to values and standards and that violations may lead to disciplinary action including immediate termination.

   b. Written Policies and Procedures: Compliance Policies and Procedures are developed to provide guidelines ~~for Employees, Agents and Professionals of SVMC~~ regarding compliance standards and related activities. These policies and procedures are available on the SVMC intranet, are appropriate reading level and are accessible by all ~~E~~employees, contingent work~~and~~force and ~~Professionals~~the Medical Staff. These S R O L F L H V D Q G S U R F H G X U H V S U R P R W H 6 9 0 & ¶ V F R P P L W P H Q W W R F R P S O L D Q F H D

areas of risk, are clearly defined, and are composed of objective factors. These factors establish no room for varying interpretation, produce predictable and consistent results in employees carrying out their job functions in a manner that ensures compliance with federal and state health care program requirements.

Policies and procedures are established and updated when there is a need for guidance and clarification of standards within the organization. The need for compliance policies and procedures are identified by the CPO, the Compliance Committee, and/or leadership responsible for hospital operations. Risk areas in the health care industry and particularly in the hospital environment, are regularly identified by the Department of Health and Human Services, Office of the Inspector General (OIG) and are addressed in the development of SVMC ¶V SROLFLHV DQG SURFHGXUHV

2. ~~Compliance Officer and Compliance Committee~~ Compliance Leadership and Oversight:

Formatted: Indent: Left: 0", Hanging: 0.5"

The OIG and the Federal Sentencing Guidelines recommend GUG RI 'LUHFWRU¶V RYHUVLJKW WKH designation of compliance professional to serve as the focal point for compliance activities and a Compliance Committee to advise the CPO and assist in the implementation of the program.

a. Board Oversight of Compliance Program

- The CPO shall assist the Board of Directors in their oversight responsibilities for the Program and provide periodic updates. The CPO will provide Compliance education and training to the Board of Directors and quarterly reports on Compliance activ

b. Compliance/Privacy Officer

- The CPO will be charged with the responsibility of implementing and managing the Program, and will have the commitment from the Board of Directors and the Chief Executive Officer (CEO) to develop an efficient and effective Program. The CPO shall report directly to the CEO and have a direct line of access to the Board of Directors as needed, to coordinate SVMC implementation of the Program and bring forward compliance related issues. The CPO should be in a position to exercise independent judgment with respect to compliance activities of SVMC. The Program provides that the CPO will have full authority to access any and all records, billing records, contracts with third parties, agents and any areas of compliance interest. The CPO should have access to review contracts with independent contractors and agents, such as physicians.

- At a minimum, the CPO shall have the following responsibilities:

Make quarterly reports to the CEO and the Board of Directors regarding the operations of the Program.

Organize and chair a Compliance Committee

Coordinate appropriate education and training programs as needed for ~~Employees~~employees, ~~Agents~~agents and ~~Professionals~~professionals, including programs for new employees and regular updates for existing employees, particularly when there are significant changes in the law.

Coordinate a monitoring/auditing process in which MSV¶ V E X V L Q H V V practices are continually evaluated to assure compliance with the Program.

Ensure that appropriate and consistent steps are taken to respond to compliance violations of the Program, to discipline violators and to prevent further violations.

Oversee investigations of violations of the Program to ensure consistency in the enforcement of the Program.

Monitor any changes in the law and changes in MSV¶ V E X V L Q H V V operations, policies and procedures to determine whether such changes impact the Program and if so, coordinate appropriate revisions to the Program.

Compliance Committee (CC)

- The CC serves to advise and assist the CO with implementing and monitoring the Program. The CC is comprised of a group of senior members of the MSV¶ V organization, including representatives from target departments [e.g., Patient Accounting, Financial Services, Medical Staff, IT Security, HIM, ~~Privacy~~, etc.] The CC develops, reviews and implements policies and procedures and develops strategies for promoting and ensuring compliance throughout the organization, including the detection of potential violations.

3. Training and Education

The CO shall be responsible for developing education and training programs addressing basic education about the compliance process under the Program, as well as targeted education which encompasses the specific legal duties applicable to the individual(s) receiving the education. Specific attention will be given to training concerning laws and regulations identified by government agencies as targets for enforcement actions against healthcare organizations. The training for all ~~Employees, Agents and Professionals~~ shall include the following components:

a. Definition of a Compliance Program and Reasons for a Compliance Program;

b. Code of Conduct and other related written guidance;

c. Communication channels (e.g.; Compliance Hotline);

d. Explanation of fraud, waste and abuse;

e. Who the Compliance/Privacy Officer is;

f. Employee Reporting Obligations; and

g. SVMC ¶ V 1 Retaliation for Compliance Issue Reporting policy.

In developing the training program, the CPO shall assure that:

a. All current Employees receive appropriate education and training concerning the Program annually

b. All new Employees receive appropriate education and training concerning the Program as part of orientation to SVMC.

c. A realistic process is followed to educate contingent work force, Agents and ~~Professionals~~ Medical Staff concerning their obligations with respect to the Program.

d. The CPO shall determine and make recommendations for the appropriate method of educating Employees, contingent work force, Agents and ~~Professionals~~ the Medical Staff. The CPO is responsible for overseeing coordinating education and training processes.

Employee Acknowledgement

Each Employee shall be required to sign an attestation indicating that he/she has read and acknowledged the Code of Conduct and agrees to abide by its terms.

4. Effective Lines of Communication ~~(Reporting)~~ with the Compliance/Privacy Officer and Disclosure Programs

Formatted: Indent: Left: 0", Hanging: 0.5"

SVMC is committed to the establishment of a culture that promotes the prevention, detection and resolution of instances of conduct that do not conform to law, regulation, VMCS policies and procedures. SVMC realizes that in order for this commitment to succeed Employees, contingent work force, Agents, and ~~Professionals~~ Medical Staff must be able to communicate their compliance concerns or report instances of misconduct confidentially and without fear of retribution or retaliation. Any one ~~Employee, Agent or Professional~~ who in good faith believes

that an activity may not comply with the laws, regulations, or policies described in the Program shall report such activity without fear of retaliation by any of the following means:

a. Reporting to department or senior leadership;

b. Calling, emailing or speaking directly with the CPO in person; The CP2 ¶V FRQWDFW LQIRUPDWLRQ LV RQ WKH 690& LQWUDQHW RQ WKH &RPSOLDQF page and in the hospital phone roster.

c. Delivering a written report to:

Sierra View Medical Center
Compliance Department
465 W. Putnam
Porterville, CA 93257;

d. Filing a report electronically ~~on~~ via ~~the~~ a Compliance issue report form on the link on the Compliance page on the intranet

e.

~~d.~~f. Submitting ~~or~~ a hardcopy report form in a locked box in the Mailroom 1st floor by the time clock outside of the EVS office or 1st floor at the Medical Office Building by the time clock ~~of Sierra View Medical Center~~; or

~~e~~g. Calling the Compliance Hotline at 559 ~~591~~-4777 or ext. 4777

The CPO shall maintain a database, which records all reports of alleged wrongdoing and describes the manner in which each report was handled, including investigations and any disciplinary actions resulting from the report.

5. Enforcing ~~Compliance~~ Standards Consequences and Incentives

a. Disciplinary Policy

The Program will ensure there are ~~have~~ established policies setting forth disciplinary actions for failure to comply with policies and procedures ~~and procedures for handling disciplinary issues~~ including degrees of disciplinary action if an employee, fails to comply with the Program, including failure to comply with applicable laws and regulations and/or policies and procedures of MSV leadership shall take appropriate disciplinary action up to and including termination of employment.

Circumstances in which disciplinary action may be taken against an employee contingent work force agent or ~~professional~~ recommended for a Medical Staff member include, but are not limited to:

Formatted: Font: Bold

Formatted: Superscript

Formatted: Superscript

Formatted: Highlight

Formatted: Highlight

Formatted: Highlight

- Noncompliance with the laws, regulations, policies or procedures applicable to their work;
- Encouraging or assisting another to engage in noncompliance;
- Failure to report known noncompliance;
- Failure to detect noncompliance by an individual who should have detected such noncompliance;
- Failure to satisfy the education and training requirements of the Program; and
- Retaliation against an employee, contingent work force agent or professional Medical Staff member who reports a concern relating to possible noncompliance.
- Consistent with SVMC ¶V Operation policy, no employee, contingent work force, agent or professional Medical Staff member shall be disciplined or recommended for discipline solely on the basis that he or she reported in good faith what was reasonably believed to be an act of wrongdoing or a violation of the Program. However, an employee, contingent workforce agent or professional Medical Staff member will be subject or recommended to disciplinary action if it is reasonably concluded that the report of wrongdoing was knowingly fabricated or distorted.
- An employee who admits wrongdoing will not be guaranteed protection from disciplinary action. The weight to be given to the admission shall depend on all the facts known to SVMC at the time it makes its disciplinary decision. In determining what, if any, disciplinary action may be taken against the individual, SVMC shall WDNH LQWR DFFRXQW WKH IDFW RI WKH DGPLVVLRQ ZKHWKHU WKH LQGLYLG known to SVMC prior to the admission or its discovery was imminent, and whether the admission was complete and truthful.

b. Screening for Excluded Providers

SVMC has established procedures to prevent hiring, employing, contracting with and/or giving the provision of Medical Staff privileges to anyone excluded from participation in a Federal or State Health Care Program. All current and prospective employees, independent contractors, vendor, supplier, consultant, and Medical Staff members, shall be searched against the Department of Health and Human Services, Office of Inspector *HQHUDO¶V /LVW RI ([FOXGHG ,QGLYLGXDOV (QWLWLHV 2,* WKH *HQHUDO 6\V Administration (GSA) list of Excluded Individuals/Entities and the State Medi Exclusion List based on the frequency as described in the Excluded Individuals/Entities policy.

The Compliance & Privacy Office will check individuals/entities exclusion status as described above, use a third party vendor or verify performance by another department,

Formatted: Highlight
Formatted: Highlight
Formatted: Highlight
Formatted: Highlight
Formatted: Highlight

on a periodic basis, but not less than annually. Pursuant to the Program, any employee, agent or professional located on a federal exclusion list will be immediately suspended from providing services to SVMC pending further inquiry.

6. Risk Assessments Auditing and Monitoring

SVMC recognizes that ongoing auditing and monitoring of its employees, records, and activities is necessary to detect violations of the law, regulations, or SVMC policies and procedures. SVMC shall maintain a structured process to conduct regular risk assessments, monitoring and auditing of compliance activities at least annually. The CEO shall develop protocols for the monitoring and auditing process and report the results to the CEO and/or the Board of Directors. The process may involve the use of sampling protocols by internal and/or external auditors to identify and review variations from established baseline levels of activity. The process should focus on areas that present a potentially high risk of legal exposure for SVMC.

Formatted: Highlight

Formatted: Highlight

Risk Assessments:

Areas to audit may include:

a. Review of coding, billing and documentation practices of the hospital, its providers, and employees;

b. Review of areas of risk identified in the OIG Work Plan and identified through risk assessments;

c. Review of Program processes to assess if the Program works as it was meant to, assess if still meaningful;

d. Review of employee surveys and employee exit interview questionnaires; and

e. Review of potential anti-kick back and self-referral issues and conflicts of interests.

7. Responding to Detected Offenses and ~~Taking~~ Developing Corrective ~~Actions~~ Initiatives

SVMC recognizes that failure to comply with state and federal laws and other types of misconduct damage the status, reputation, and mission of SVMC. To establish a culture that promotes the prevention, detection and resolution of instances of conduct that do not conform to law, regulation, or SVMC policy and procedure, SVMC will investigate all reported concerns regarding potential or actual violations of state, or federal law, or SVMC policies and procedures. The investigation may include employee interviews and review of relevant

documentation, and will require that relevant documents are protected from alteration or disposal.

Where the investigation ultimately identifies that there has been a failure to comply with laws, regulations, or the Program, the CCO shall ensure that timely and effective remedial action/ corrective action is taken by SVMC. Corrective actions may include immediate correction, prompt reporting of violations of law or regulation to appropriate government authorities when so advised by Legal Counsel, identification and return of any overpayments to appropriate government agencies, and the imposition of appropriate disciplinary action, up to and including, termination of employment.

Corrective actions may include revision to a SVMC policy and procedure, additional training and education provided to involved individuals and others to reduce the likelihood of future violations.

REFERENCES:

- U.S. Department of Health and Human Services, Office of Inspector General, General Compliance Program Guidance, November 2023.
- Federal Register / Vol. 70, No. 19 / Monday, January 31, 2005, OIG Supplemental Compliance Program Guidance for Hospitals.
- DHHS, OIG Model Compliance Guidance for Hospitals (63 Fed. Reg. 8987; February 23, 1998), (70 Fed. Reg. 4858; January 31, 2005)

Formatted: Indent: Left: 0.5", No bullets or numbering

CROSS REFERENCES:

- All Compliance Policies
- Code of Conduct

SUBJECT: CRITERIA FOR TRANSFUSION REVIEW	SECTION: Page1 of 3

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

PURPOSE:

Transfusion audits provide reviews of policies and practices to ensure safe and appropriate transfusions

Formatted: No underline

CRITERIA FOR TRANSFUSION REVIEW :

Appropriate Use of Red Blood Cells:

- Hypovolemia due to blood loss evidenced by significant change in blood pressure or pulse, or orthostatic change in blood pressure.
- Symptomatic anemia whatever the cause if no other therapy is likely to correct the anemia.
- Anemia requiring correction perioperatively (hematocrit < 24% or hemoglobin less than 8 gm/d).
- Non-trauma or non-cardiac surgical patient receiving red blood cells when blood loss does NOT exceed 15% 20% of the total blood volume. (Review criteria, refer record to Radiology-Pathology Committee).

Appropriate Use of Fresh Frozen Plasma:

- History or clinical course suggestive of a coagulopathy due to deficiencies of soluble coagulation factors, and prothrombin time (PT) > 18 seconds, partial thromboplastin time (PTT) > 45 seconds or studies pending, in a patient with significant bleeding.
- Intravascular volume depletion due to active bleeding documented by replacement of blood volume once within several hours.
- Antithrombin III deficiency state for patients about to undergo surgery or who require heparin for treatment of thrombosis.
- Immediate reversal of warfarin effect in patients who are actively bleeding or who are about to undergo emergency surgery.
- Inpatients with thrombotic thrombocytopenic purpura.
- Protime and PTT or specific coagulation factor assay to be obtained immediately prior to and within four (4) hours post transfusion.
- Transfusion of fresh frozen plasma units without confirmation of a clotting factor deficiency. (Review criteria - refer record to Rad-Path committee).

Appropriate Use of Platelets:

- Platelet count <20,000/uL with or without active bleeding.
- Platelet count < 50,000/uL with active bleeding consistent with platelet deficit or when patient is receiving chemotherapy with or without active bleeding.
- Platelet count < 50,000/uL in patients undergoing major surgery.
- Transfusion of platelets without first obtaining a platelet count indicating a thrombocytopenia that warrants transfusion. (Review criteria refer to Rad-Path committee).
- Transfusion of platelets in numbers that do not correspond, over a 24 hour period, to the appropriate amount to maintain at least a minimum platelet count. (Review criteria record to physician peer review/committee)

Appropriate Use of Cryoprecipitate:

- Decreased Factor VIII level documented by appropriate laboratory data.
- von Willebrand's disease documented by a positive or suggestive history and appropriate laboratory testing.
- Hypofibrinogenemia <150 documented by history or clinical course suggestive of decreased fibrinogen or history of active bleeding and laboratory documentation of low fibrinogen.

Appropriate Use of Autologous Blood:

- Same as for packed cells, see above, when reasons are documented in the clinical record.
- Transfusion back to patient if Hgb is 11 gm or lower at the discretion of the ordering physician.
- Last phlebotomy at least 72 hours before procedure.
- Documentation that the patient has been placed on oral iron supplement.
- Transfusion of autologous blood resulting in post transfusion CHF. (Review criteria refer record to Rad-Path committee).

Directed Donor Blood Criteria:

- ABO and Rh grouping
- Antibody screening
- Antibody screening for Hepatitis B antigen

- Screening for HIV Antibody

* Directed donor blood collection is not performed at this facility. All directed donor collection is performed through the Central California Blood Bank, with criteria met as stated above.

Specific Blood Use Requiring Review:

1. All transfusions are reviewed with special emphasis on:

   a. Transfusions of more than one (1) platelet aphoresis or 12 single platelet concentrates in a 24 hour period.

   b. Mortality associated with transfusion.

   c. Adverse effects associated with transfusion.

   d. Appropriateness and necessity of transfusion.

AFFECTED AREAS/PERSONNEL: ALL CLINICAL EMPLOYEES

REFERENCES

- Fung, Mark E (2023). Association for the Advancement of Blood & Biotherapies, Technical Manual (21st Edition).
- Association for the Advancement of Blood & Biotherapies (2022). Standards for Blood Banks and Transfusion Services (33rd Edition).
- The Joint Commission (2025). Laboratory Accreditation LD.03.07.01, PI.01.01.01 Joint Commission Resources. Oak Brook, IL.

SUBJECT: FIRE RESPONSE PLAN	SECTION: Life Safety Management Page 1 of 4

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

PURPOSE:

In order to assure the safety of patients, visitors, and staff, a standard response to fire, or to the potential of fire, defined plans are required. This fire plan describes the standard responses for all staff, Volunteers, and Licensed Independent Practitioners within the Sierra View Medical Center inpatient and outpatient buildings to an activation of the Fire Alarm or to conditions that indicate the presence of a fire in the area.

POLICY:

In the event of a fire, the staff, Volunteers, and Licensed Independent Practitioners will follow the basic plan for the building in which they are located. They will use the same plans for fire drills as they do in actual events. Fire drills will be observed to measure the effectiveness of staff response, as well as to measure the response of building fire systems.

AFFECTED PERSONNEL/AREAS: GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, LICENSED INDEPENDENT PRACTICIONERS, SIERRA VIEW COMMUNITY HEALTH CENTER (SVCHC)

PROCEDURE:

1. Code Red In Your Work Area

   Hospital:

   a. An alarm will sound throughout the building and where the pull station was activated or where the automatic sensors have detected smoke or heat.

   b. An overhead page will follow, indicating the location of the fire.

   c. If you discover smoke, fire, or the alarm system is activated in your immediate area, the appropriate response will best be remembered by using the acronym R.A.C.E.:

R- Rescue Remove people

- Remove anyone in immediate danger to a safe area. This may be a patient, visitor, or employee.
- Do Not Use Elevators.

A- Alarm Sound the Alarm

- Go to the nearest pull station and activate. This notifies the Fire Department and mobilizes the Hospital Fire Response Team (Engineering & Security).

- Call 55 to notify the operator of the location of the fire. The operator will then R Y H U K H D & 2 ' $ 5 (3 % X L O G L Q J $ U H D three times at 5 minute intervals until ALL CLEAR.

C- Confine Secure the Area

- Close all doors and windows
- Remove all items from the corridors
- The Safety Officer will assess if oxygen supply to the affected area should be discontinued. Only the Safety Officer or his/her designee and the fire marshal are authorized to order a supply valve closed.

E- Extinguish Attempt to extinguish fire

- Fight the fire only if you are not placing yourself in danger.
- Personnel in the immediate department area should take an extinguisher and proceed to the fire.

All Clear Situation is under control

The Fire Department Incident Commander at the scene verifies that the situation has been resolved. The Incident Commander will notify the L W F K E R D U G R SODE U D W R U D Q RED , 6 $ / / & / ($ 5 will be paged overhead.

2. General Responsibilities for Fire Alarm Activation Above, Below or Adjacent to the Code Area

If your area is above, below, or adjacent to the point of origin, the following procedures should be taken:

i. Close all doors
ii. Remove items from the corridors
iii. Have patients return to their rooms
iv. Remind patients and visitors not to use elevators
v. Listen for overhead pages for status of situation
vi.

3. General Responsibilities for Fire Alarm Activation Remote from Your Work Area

If your area is away from the point of origin (not within your immediate area or above, below or adjacent to that area), the following procedures will need to be implemented:

i. Be ready to accept patients from the point of origin
ii. Remind patients and visitors not to use elevators
iii. Listen for overhead pages for status of situation

4. Evacuation

a. Evacuation will not take place until directed by the Incident Commander and/or Fire Department. At any time, when several patients are in immediate danger, moving them to a safer area can be done without the approvals. Administrator/Administrator-on-Call, Nursing Supervisor, and/or Safety Officer evaluates the situation and determines the need to activate the Emergency Operations Plan.

b. Do Not Use Elevators

c. There are several types of evacuations:

i. Stage I – Horizontal – move into an adjacent smoke compartment.

ii. Stage II – Vertical – move one floor down, taking the exit stairs.

iii. Stage III – Building – all patients and visitors will be moved from the building to alternate care sites.

d. Incident Commander in conjunction with the Porterville Fire Department will determine the need for evacuation beyond horizontal evacuation to an adjacent smoke compartment.

5. Fire Response Team

The fire response team is made up of Facilities/Engineering Department, Security and the Safety Officer. They are responsible for responding to the area when a code red is initiated. The Safety Officer or designee will direct the fire response team once they arrive on the scene.

6. FIRE EXTINGUISHERS

a. Location of Fire Extinguishers:

All Staff, Volunteers, and Licensed Independent Practitioners should be oriented to the location of the fire extinguishers in their respective work area/department. Storage or equipment should never block fire extinguishers. The Facilities/ Engineering Department visually inspects extinguishers every month.

b. Use of Fire Extinguishers:

Select the proper fire extinguisher for the fire. Position yourself as close to the fire as safely possible. Remember to leave a way out.

Use the PASS method to extinguish the fire:

Pull	the pin on the extinguisher.
Aim	the extinguisher nozzle at the base of the flames.
Squeeze	the handle to discharge the extinguisher. Squeeze the handle as the contents are under pressure.

Sweep from side to side at the base of the fire. Remember that the extinguisher will empty quickly. Do not waste the extinguishing agent.

DO NOT ATTEMPT TO EXTINGUISH THE FIRE IF IT IS TOO LARGE OR DANGEROUS. CLOSE THE DOOR, LEAVE THE AREA AND AWAIT ARRIVAL OF THE FIRE DEPARTMENT.

7. Fire Drills Will:

- Be conducted a minimum of once per quarter per shift.
- Be evaluated for performance of fire safety equipment and staff.
- Be reviewed by the Safety Committee on a regular basis.
- Simulate real-life possibilities.
- Be scheduled at varied times.
- Be conducted by the Facilities/Engineering Department.
- Be observed from varied locations.

Evaluation of staff knowledge will include:

- Compartmentalization and containment
- Areas of refuge
- Fire extinguishment
- Fire response duties
- Vertical and horizontal evacuation

Staff response will be observed at the drill location and:

- Adjacent compartment(s).
- The compartment above and below the drill location.

REFERENCES:

- The Joint Commission (2012). EC.02.03.01 EP 9. Hospital accreditation standards. Joint Commission Resources. Oakbrook, IL.

SUBJECT:	SECTION:
INTERIM LIFE SAFETY MEASURES (ILSM)	Life Safety Management Page 1 of 3

POLICY:

Sierra View Medical Center (SVMC) protects occupants during periods when the Life Safety Code is not met or during periods of construction.

Interim life safety measures will be maintained during all phases of construction of

California Hospital
Record and Data Retention Schedule

A guidebook on which records should be kept and for how long

CALIFORNIA HOSPITAL ASSOCIATION

Record and Data Retention Schedule

A guidebook on which records should be kept and for how long

October 2018
9th Edition

CALIFORNIA HOSPITAL ASSOCIATION

CHA Publications

Several helpful publications are available through CHA including:

- *California Health Information Privacy Manual*
- *California Hospital Compliance Manual*
- *California Hospital Survey Manual — A Guide to the Licensing & Certification Survey Process*
- *Consent Manual*
- *EMTALA — A Guide to Patient Anti-Dumping Laws*
- *Guide to Release of Patient Information*
- *Healthcare Workplace Violence Prevention*
- *Hospital Financial Assistance Policies and Community Benefit Laws*
- *Mental Health Law*
- *Minors & Health Care Law*
- *Model Medical Staff Bylaws & Rules*
- *Principles of Consent and Advance Directives*
- *Record and Data Retention Schedule*
- *The Cal/OSHA Safe Patient Handling Regulation*
- *The California Guide to Preventing Sharp Injuries*

Plus numerous human resource and volunteer publications.

Ordering Information

For more information, visit CHA online at www.calhospital.org/publications

Published by the California Hospital Association.
Printed in the United States of America.

Liz Mekjavich, Vice President, Publishing and Education
Lois J. Richardson, Esq., Vice President and Counsel, Privacy and Legal Publications/Education
Bob Mion, Director, Publishing and Marketing
Emily Stone, Publishing Manager

CALIFORNIA HOSPITAL ASSOCIATION

Table of Contents

Preface

Health care providers create volumes of records dealing with a variety of matters. Some concern the corporate, business and administrative aspects of their operations. Others document unique areas, such as medical staff activities at hospitals. Still others trace the course of care given to patients. Providers naturally consider retaining any record that is of more than passing interest. However, as records accumulate, they occupy valuable space that often could be put to better use. Storing records off-site or in electronic form may alleviate the problem. However, these alternatives are likely to be expensive and do not address the basic question of which records should be kept and for how long.

If health care providers are to deal intelligently with the problem, they must base their decisions upon a firm knowledge of legal requirements and policy considerations. This guide discusses those requirements and considerations, and recommends specific periods for the retention of various classes of records.

The guide contains two sections. The first is a discussion of retention considerations as they pertain to various kinds of records. The second section is a Recommended Retention Schedule. It contains tables listing typical records, legal citations applicable to each health care provider type, and recommended retention periods. This schedule does not list every possible record that may be produced or retained by a health care provider but rather provides recommendations and cites legal requirements for the most common documents. For records not specifically addressed in this guide, CHA recommends considering retention periods for records listed that are of a similar nature or purpose and consulting your legal counsel.

The guide is not designed to serve as a substitute for legal counsel. If there are differences of opinion, or where the law is unclear, a provider should consult legal counsel and then make retention decisions based on the law and its own philosophy, mission and purpose.

Lois J. Richardson, Esq.
Vice President and Legal Counsel, Privacy and Legal Publications/Education
California Hospital Association
(916) 552-7611
lrichardson@calhospital.org

Record Retention Considerations

I. INTRODUCTION

Health care providers create volumes of records dealing with a variety of matters. The question naturally arises, which records should be kept and for how long?

This section of the *Record and Data Retention Schedule* discusses why hospitals and other health care providers should have a record retention policy, the pertinent factors that should be considered when determining how long to keep various documents, and considerations regarding record disposal and/or destruction. The second section of the *Record and Data Retention Schedule* (starting on page 21) is a Recommended Retention Schedule. It contains tables listing typical records, provider types, any applicable legal citations, and recommended retention periods.

The information in this manual applies identically to all records, regardless of media (paper, electronic, microfiche, microfilm, video/audio recording, magnetic tape, CD-ROM, USB sticks, etc.).

This guide is intended to be used as a reference document. The information is accurate at the time of publication; however, the guide does not cover every law, rule or regulation concerning record retention — it focuses on the ones most relevant to hospitals. Due to the dynamic nature of the law, information of this kind is subject to change at any time. **Records should never be destroyed without first verifying that retention requirements have not changed and litigation is not pending.**

All of the laws cited in this manual can be found on the Internet. *(See "Where to Find the Laws Referenced in the Manual," page 75, for instructions on finding the exact language of the laws.)*

II. THE IMPORTANCE OF HAVING A RECORDS MANAGEMENT POLICY

Hospitals and other health care providers are advised to establish and implement written policies and procedures regarding the retention and disposal/destruction of records. Doing so will help the provider achieve compliance with state licensure laws, federal health care program (Medicare, Medi-Cal) requirements, contractual obligations, accreditation organization requirements, and other statutes and regulations. Without a written policy, a provider may retain records longer than necessary, which is costly and inefficient, or dispose of records too soon, resulting in the inability to access important documents when needed. Disposing of records too soon may also lead to fines or penalties. On the other hand, keeping documents too long incurs storage fees. In addition, if a record retention policy limits how long information is kept, the hospital will have less information to search and review if served with a subpoena or other document request. This can save the hospital time and money, both employee time looking through documents and attorney time spent reviewing them.

The policies and procedures should be followed consistently to dispute any allegation that the provider withheld, hid, altered or destroyed evidence relevant to a legal proceeding ("spoliation of evidence"). Spoliation of evidence is a crime in California and at the federal level [Penal Code Section 135; 18 U.S.C. Section 1519]. In addition, if a judge believes that a party to a lawsuit has destroyed evidence, the judge may conclude that the evidence would have been unfavorable to the spoliator.

An employee should be designated to be responsible for implementing and updating the policies and procedures, as well as training and monitoring employees to ensure consistent compliance throughout the organization. It may be helpful to establish a records management committee to review and approve additions and updates to the policies and procedures, and to assist in implementation, training and monitoring/auditing.

A record retention and disposal policy should contain at least the following elements:

1. A statement about the purpose of the policy;
2. Whether the policy covers the entire organization or only certain departments;
3. A statement that the destruction of relevant records will be suspended upon receipt of legal process or other notice of pending or reasonably foreseeable investigations or litigation, whether government or private;
4. A list of employees and/or departments responsible for maintaining and updating the policy;
5. A list of employees and/or departments responsible for moving documents to long-term storage and/or destroying documents in accordance with the policy; and
6. A retention period for each type of record.

III. PRIMARY CONSIDERATIONS IN DEVELOPING A RECORD RETENTION SCHEDULE

A record retention schedule that meets the needs of a health care provider should result from an evaluation of several important primary considerations. Providers should pay particular attention to the following:

1. Legal requirements and considerations;
2. Frequency of use of a record;
3. Space constraints; and
4. Historical or research uses for the records.

These considerations are described more fully below.

A. Legal Requirements and Considerations

Specific Statutes and Regulations

The health care industry is highly regulated. The number of state and federal government agencies that regulate hospitals and other health care providers is astonishing.[1] Each of these agencies has the authority to audit hospitals, inspect their records, issue regulations that hospitals must follow, and sanction hospitals for noncompliance.

Many state and federal government agencies have issued regulations that specify how long hospitals and other health care providers must keep certain documents. The Recommended Retention Schedule found in the second section of this manual lists these requirements. Providers are required to comply with these retention periods. However, in many cases, compliance with these minimum retention requirements is inadequate to protect the health care provider in all situations. Additional considerations in determining an optimal record retention period are discussed below.

Hospitals should check with county and local agencies regarding any record retention requirements they may have, such as local water quality protection agencies or county health departments. The CHA Recommended Retention Schedule does not include local government retention requirements.

Medi-Cal Requirements

A state law that took effect on Jan. 1, 2018, requires hospitals and other providers of health care services rendered under Medi-Cal or any other Department of Health Care Services program to keep records for at least 10 years, including:

1. Billings.
2. Treatment authorization requests.
3. Copies of remittance advices that accompany reimbursement to providers for services/supplies provided to beneficiaries.
4. Individual ledger accounts reflecting credit and debit balances for each beneficiary.
5. Copies of original purchase invoices for medication, appliances, and assistive devices.
6. Written requests for laboratory testing and all reports of test results.
7. Book records of receipts and disbursements by the provider.
8. All medical records (including each service rendered, date of service, and identification of the person rendering services), service reports, and orders prescribing treatment plans.
9. Records of medications, drugs, assistive devices, or appliances prescribed, ordered for, or furnished to beneficiaries.

1 For example, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Drug Enforcement Administration, Equal Employment Opportunity Commission, Food and Drug Administration, Internal Revenue Service, Office for Civil Rights, Occupational Safety and Health Administration, U.S. Department of Labor, California Department of Public Health, California Board of Pharmacy, California Department of Health Care Services, Cal/OSHA, Fair Employment and Housing Commission, Franchise Tax Board, etc.

10. For providers of psychiatric and psychological services, patient logs, appointment books or similar documents showing the date and time allotted for appointments of each patient or group of patients, and the time actually spent with the patients.
11. Employment records including shifts, schedules and payroll records of employees.
12. Records of receipts and disbursements of personal funds of beneficiaries held in trust by the provider, if any.

These records must be kept starting from the date the record was created and running for 10 years from the latest of:

1. The final date of the contract period between the plan and the provider,
2. The date of completion of any audit, or
3. The date the service was rendered.

Because most hospitals and other health care providers serve Medi-Cal beneficiaries, and the contract period or audit process may add several years to the 10-year time frame, CHA's Record Retention Schedule shows a 15-year recommended retention period for the records listed above. This recommendation is reflected in the fourth column of the Recommended Retention Schedule. Providers using the Schedule that do not serve Medi-Cal patients may wish to consider a shorter retention period. *(See also "Contracts with Medicare Advantage or Medicare Part D Plans," page 6, and "Accountable Care Organizations," page 7.)*

This law applies to any individual, partnership, group, association, corporation, institution or other entity that provides goods, services, supplies or merchandise, directly or indirectly, including all ordering, referring and prescribing, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program [Welfare and Institutions Code Section 14043.1(o)]. A health facility or other provider that does not treat Medi-Cal patients or provide any other services regulated by the Department of Health Care Services is not required to comply with this law.

[Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]

Statutes of Limitations

Sometimes hospitals and other health care providers will want to be able to produce records to defend themselves in a lawsuit. It is helpful to understand the time period during which various types of lawsuits may be brought in order to develop an effective retention policy. The time period during which a lawsuit may be brought is called the "statute of limitations." After the statute of limitations has run, it is too late for a plaintiff to bring a lawsuit, and related records will thus not be needed to defend any such suit.

This section of the manual describes several statutes of limitations commonly applicable in the California health care industry. However, it is not possible to list every potentially applicable statute of limitations. Legal counsel should be consulted if a question arises regarding the statute of limitations in a particular situation.

Medical Malpractice Action

In California, a medical malpractice lawsuit (also known as a professional negligence action) must be brought within three years after the date of injury, or one year after the patient discovers, or through the use of reasonable diligence should have discovered, the injury,

whichever occurs first. Minors have three years to bring a lawsuit, but a minor under the age of six years has three years or until the eighth birthday, whichever is later. The applicable time period is indefinite in cases of fraud, intentional concealment, or the presence of a foreign body that has no therapeutic or diagnostic purpose. [Code of Civil Procedure Section 340.5]

It is important to note that California courts have interpreted the medical malpractice statute of limitations fairly leniently in favor of the patient, and allowed actions to be brought many years after the medical care at issue was provided.

Personal Injury Action

In California, a personal injury lawsuit must be brought within two years [Code of Civil Procedure Section 335.1]. This type of lawsuit includes slip-and-fall injuries on hospital premises, car accidents by employees in hospital-owned vehicles, etc.

Breach of Contract Action

In California, a lawsuit for breach of contract must be brought within four years if the contract is evidenced by writing [Code of Civil Procedure Section 337]. This does not mean that the contract must be a formal, written contract signed by both parties. It means that there must be some written evidence (a letter, e-mail, purchase order, etc.) regarding the contract. If the contract is not evidenced by writing, the statute of limitations is two years [Code of Civil Procedure Section 339].

Federal Fraud and Abuse Actions

The federal government must bring an action against a health care provider for civil monetary penalties within six years from the date on which the claim at issue was presented, the request for payment was made, or the incident occurred [42 C.F.R. Section 1003.1570]. The statute of limitations for False Claims Act suits is also six years after the violation was committed (or within three years after the date when material facts were known or should have been known by the government, but in no case later than 10 years after the violation was committed) [31 U.S.C. Sections 3729 and 3731].

However, health care providers should be aware that there are many different fraud statutes under which the federal government may bring a lawsuit, and each has its own limitations period — for example, criminal fraud, mail fraud, wire fraud, racketeering, etc. *(see, for example, 18 U.S.C. Sections 1031 and 3282)*. There are circumstances under which the government may bring a lawsuit after more than six years have elapsed. Legal counsel should be consulted if questions arise with respect to fraud and abuse statutes of limitations.

Internal Revenue Service Actions

The IRS must generally bring an action within three years from the date of filing of tax returns. However, if a false or fraudulent return is filed, if a willful attempt to evade tax takes place, or no return is filed, the IRS may bring an action at any time. [26 U.S.C. Section 6501]

Accreditation Requirements

Hospitals and other health care providers should review all relevant accreditation requirements to determine whether they contain any record retention obligations. If they do, the providers' policies and procedures should be reviewed and revised as necessary to maintain compliance.

The Joint Commission (TJC) generally requires that hospitals determine appropriate records retention periods based on applicable laws, as well as anticipated uses for patient care, legal, research, operational and educational purposes. TJC notes that documents such as crash cart daily checks, temperature monitoring logs, and meeting minutes and agendas are examples of documents that are not considered part of a patient's medical record, but are required to document compliance with TJC standards. TJC requires organizations to keep all records needed to document compliance with standards dating back to the last full survey. Because surveys may be no more than 39 months apart, hospitals accredited by TJC should keep these records for at least 39 months.

Contracts and Grants

Health care providers should carefully review their contracts and grants to determine whether they contain any record retention obligations. If they do, the providers' policies and procedures should be reviewed and revised as necessary to maintain compliance with the contractual obligation.

Three common record retention contractual provisions in the health care industry are described below.

Medicare Access Clause

A hospital may be both a Medicare-participating provider and a subcontractor under the Medicare program at the same time, if the hospital accepts Medicare patients and also provides services under a contract with another Medicare-participating provider.

The records a participating hospital must retain are included in the Recommended Retention Schedule *(see, for example, "Medicare cost report records," page 29)*.

A hospital that is a subcontractor, or a hospital that enters into agreements with subcontractors, must include an "access" clause in its contracts that allows federal government agencies to access the subcontractor's books and records. Specifically, contracts for services between a Medicare institutional provider and a subcontractor must contain an access clause if the value of the services is $10,000 or more over a 12-month period. This includes contracts for both goods and services in which the service component is worth $10,000 or more.

The clause must permit the Comptroller General of the United States, the U.S. Department of Health and Human Services, and their duly authorized representatives to access to the subcontractor's contract, books, documents, and records until four years after the services are furnished under the contract or subcontract.

If a contract subject to these requirements does not contain the clause, CMS will not reimburse the provider for the cost of the services furnished under the contract and will recoup any payments previously made for services under the contract.

[42 C.F.R. Section 420.302]

Contracts with Medicare Advantage or Medicare Part D Plans

Federal regulations governing the Medicare Advantage (MA) program and Medicare Part D (Medicare prescription drug benefit) require the plans to include a provision in their contracts with first tier, downstream and related entities to maintain records for a minimum of 10 years from the final date of the contract period or completion of audit, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2)]. This includes books, contracts, computer or

other electronic systems, medical records, patient care documentation, and other records that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract [42 C.F.R. Sections 422.504(e)(2)–(4) and 423.505(e)(2)–(4)]. Under certain circumstances, CMS may notify the contractor that it must keep its records longer. *(See also* Medicare Managed Care Manual*, Pub. 100-16, Chapter 11, Section 100.5.)*

Hospitals and other health care providers that have contracted with MA or Medicare Part D plans should ensure that relevant records are maintained in accordance with contractual obligations.

Accountable Care Organizations

Accountable Care Organizations (ACOs) must agree to retain their records for 10 years after the agreement with the Centers for Medicare & Medicaid Services ends, or 10 years after any audit, evaluation, or inspection is concluded, whichever is later. In addition, the ACOs must require their ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities to do the same. Required records include books, contracts, records, documents, and other evidence (including data related to Medicare utilization and costs, quality performance measures, shared savings distributions, and other financial arrangements related to ACO activities) sufficient to enable the audit, evaluation, investigation, and inspection of the ACO's compliance with program requirements, quality of services performed, right to any shared savings payment, or obligation to repay losses, ability to bear the risk of potential losses, and ability to repay any losses to CMS.

The Centers for Medicare & Medicaid Services (CMS) may notify an ACO that it must keep its records longer. In addition, if there has been a termination, dispute, or allegation of fraud or similar fault against the ACO, its ACO participants, its ACO providers/suppliers, or other individuals or entities performing functions or services related to ACO activities, the ACO must retain records for an additional six years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault. [42 C.F.R. Section 425.314]

U.S. Department of Health and Human Services Grants

Recipients of grants from the U.S. Department of Health and Human Services must retain financial, statistical and nonexpendable property records, and any other records pertinent to the grants, for three years from the submission of the final expenditure report, or until resolution of all litigation and federal audit findings. Records for real property and equipment acquired with federal funds must be retained for at least three years after final disposition. [45 C.F.R. Section 75.361] Subrecipients and contractors are also subject to this record retention requirement. Recipients, subrecipients, and contractors may wish to retain many of these records longer in accordance with the Recommended Retention Schedule.

B. Frequency of Use

When establishing retention periods, providers should consider how often records will be needed. Records that are used more frequently should be retained in a more quickly accessible form for longer periods of time. As the frequency of use declines, providers may transfer more important records to an image storage media or to outside storage, or consider whether the records should be destroyed.

C. Space Constraints

The Schedule acknowledges that most providers have limited storage space, both physical and electronic. The amount of space available will influence whether a record should be purged after the minimum required retention period or whether it should be retained longer.

D. Historical or Research Use of Records

These guidelines generally do not address the retention of records for historical or research purposes. However, these considerations may be important to providers. Therefore, providers should consider whether to keep records for historical documentation and/or research activities. The costs of storage, plus the cost of employee and attorney time to review records if a subpoena is received, should be considered.

IV. MEDICAL RECORDS

A. Retention Period Options

Some California health care providers choose to keep their medical records permanently. However, this is not legally required.

Requirements for Providers That Treat Medi-Cal Patients

Until 2018, hospitals and other health facilities were required by CDPH licensing laws to retain medical records of adults for 7 years after discharge or the last patient encounter, and until the age of 19 but no less than 7 years after discharge or the last patient encounter for minors.

However, a state law that took effect on Jan. 1, 2018, requires hospitals and other providers of health care services rendered under Medi-Cal or any other Department of Health Care Services program to keep all medical records of covered patients for at least 10 years starting from the date the record was created until the latest of:

1. The final date of the contract period between the plan and the provider,
2. The date of completion of any audit, or
3. The date the service was rendered.

Because most hospitals and other health care providers serve Medi-Cal beneficiaries, and the contract period or audit process may add several years to the 10-year time frame, CHA's Record Retention Schedule shows a 15-year recommended retention period for medical records. This recommendation is reflected in the fourth column of the Recommended Retention Schedule. Providers using the Schedule that do not serve Medi-Cal patients may wish to consider a shorter retention period. *(See also "Contracts with Medicare Advantage or Medicare Part D Plans," page 6, and "Accountable Care Organizations," page 7.)*

[Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]

This law applies to any individual, partnership, group, association, corporation, institution or other entity that provides goods, services, supplies or merchandise, directly or indirectly, including all ordering, referring and prescribing, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program [Welfare and Institutions Code Section 14043.1(o)].

Additionally, skilled nursing facilities that participate in Medicare or Medi-Cal must keep records of minors until they reach the age of 21 [42 C.F.R. Section 483.70(i)].

The medical records of patients not covered by Medi-Cal or other Department of Health Care Services programs do not need to be kept for this longer period of time *(see below)*.

Requirements for Providers That Do Not Treat Medi-Cal Patients

State licensing laws govern how long providers must keep medical records for patients not covered by Medi-Cal or other Department of Health Care Services programs.

Health facilities, home health agencies, primary care clinics and psychology clinics [Title 22, California Code of Regulations, Sections 70751(c) (general acute care hospitals), 71551(c) (acute psychiatric hospitals), 72543(a) (skilled nursing facilities), 73543(a) (intermediate care facilities), 74731(d) (home health agencies), 75055(a)(primary care clinics), 73543(a) (psychology clinics), 77143(c) (psychiatric health facilities) and 79351(c) (chemical dependency recovery hospitals)] must keep medical records as follows:

1. **Adults:** 7 years after discharge or the last patient encounter,
2. **Minors:** Until the age of 19 but no less than 7 years after discharge or the last patient encounter. However, skilled nursing facilities that participate in Medicare or Medi-Cal must keep records of minors until they reach the age of 21 [42 C.F.R. Section 483.70(i)].

California law is inconsistent with respect to record retention requirements for individual practitioners. There is no required retention period for medical records maintained by a physician in a private office setting. However, the California legislature has passed legislation requiring other types of individual practitioners to retain medical records for the same length of time as health facilities [Business and Professions Code Sections 2570.185 (occupational therapists), 2620.7 (physical therapists), 2919 (licensed psychologists), 3007 (optometrists) and 3641 (naturopathic doctors)]. Individual practitioners not specified above are advised to retain medical records for at least seven years after the last patient encounter, and until the patient has reached the age of 19 (but no less than seven years after the last encounter) for minors.

There are medical record retention requirements in the Medicare Conditions of Participation and the *Interpretive Guidelines* for various types of facilities and clinics. These retention requirements are shorter than the California requirements, so they are not listed in detail in this manual.

Alternative Retention Period

An alternative option calls for a universal 25-year record retention policy. A 25-year retention policy has several advantages:

It relieves the provider of the need to differentiate between the medical records of adult patients and those of minor patients, and for Medi-Cal patients and other patients, as it satisfies applicable legal requirements for all classes.

It reduces even further the possibility that a lawsuit will be filed after the medical records are destroyed.

It ensures the longer retention of medical records containing information regarding medical treatment or medications received during pregnancy.

Each provider must weigh the appropriate factors and determine whether the simplicity and convenience of a 25-year period outweigh the advantages of a shorter period.

B. Test Results, Tracings and Recordings

Providers regularly accumulate the results of diagnostic tests performed upon patients, including radiological studies, laboratory analyses, and tracings and recordings of various kinds. Most will be the subject of an interpretation or report.

California regulations require most types of health facilities to place reports of test results in medical records [Title 22, California Code of Regulations, Sections 70749(a)(8) and (9) (general acute care hospitals), 71549(a)(10) and (11) (acute psychiatric hospitals), 72547(a)(7) and (8) (skilled nursing facilities), 73547(a)(8) and (9) (intermediate care facilities) and 77141(a)(19), (20) and (21) (psychiatric health facilities)]. Accordingly, reports of all diagnostic test results and clinical laboratory test results must be kept as long as the medical record.

X-Ray Films, CT Scans and MRI Results

Under the regulations governing the licensure of general acute care hospitals and acute psychiatric hospitals, "X-ray films or reproduction thereof" must be preserved for at least seven years after discharge, or one year after a minor reaches the age of 18 (but not less than seven years) [Title 22, California Code of Regulations, Sections 70751(c) (general acute care hospitals) and 71551(c) (acute psychiatric hospitals)]. Similarly, skilled nursing facilities, intermediate care facilities and primary care clinics are required to keep all "exposed X-ray film" for seven years [Title 22, California Code of Regulations, Sections 72543(a) (skilled nursing facilities), 73543(a) (intermediate care facilities) and 75055(a) (primary care clinics)]. Most imaging no longer uses "film," but these regulations are still on the books. Although the law is not clear, all imaging records, including CT, PET and MRI, probably should be saved for the prescribed period. Whether radiological studies are kept for a longer period will depend on the same considerations discussed in III. "Primary Considerations in Developing a Record Retention Schedule," page 2.

Clinical Laboratory Test Results

There are specific federal and state laws covering retention of laboratory test results by clinical laboratories [Title 42, Code of Federal Regulations, Section 493.1105; Business and Professions Code Section 1265(j)]. These regulations apply to freestanding laboratories and laboratories situated in hospitals. The laws require laboratories to retain certain information for minimum periods of time, ranging from two to 10 years. These time periods are described in the Schedule.

When a hospital patient is tested at a hospital laboratory, test results will be placed in the patient's hospital medical record where it will be subject to the longer medical record retention periods. A hospital laboratory, therefore, can dispose of information concerning inpatients and outpatients as soon as the minimum legal periods pass.

The situation is different, however, with information concerning individuals who are tested at freestanding laboratories or are referred to a hospital laboratory just to be tested or when just the specimen goes to the hospital laboratory. These patients have no separate medical record on the premises. Therefore, the laboratory should consider keeping its records for a period longer than the minimum prescribed by the law.

Tracings and Recordings

There are no laws requiring a minimum retention period for tracings or recordings like EKGs, EEGs, EMGs or videotapes of diagnostic tests, surgeries or other procedures. Depending on the test involved, these materials can be quite bulky. Accordingly, it makes sense to have the responsible physician identify the portions that demonstrate significant or unusual results. The provider should keep those portions for as long as it keeps the medical record. The remainder, which most likely would include most of the tracings or recordings, could be disposed of as soon as the patient is discharged or the treatment is complete. If an adverse event takes place, however, the provider may wish to retain the entire tracing or recording.

Fetal Heart Monitor Strips

Hospitals may wish to retain in the medical record just those portions of the fetal heart monitor strips chosen by the physician. Alternatively, hospitals may choose to retain these tracings in their entirety for at least 10 years, or even 25 years. The latter options make it more likely that full monitoring records will be available during the period allowed by the statute of limitations for minors to bring suit.

V. ELECTRONIC RECORDS

Many records created by health care providers formerly stored on paper are now created and stored electronically, and communicated through electronic means both within and beyond the provider's location. Civil Code Section 1633.12 states that if a law requires that a record be retained, the requirement is satisfied by retaining an electronic record, if the electronic record accurately reflects the information set forth when the record was first generated in its final form as an electronic record.

A. Electronic Medical Records Requirements

Providers (including hospitals, clinics and home health agencies) that use electronic systems only must meet the following requirements (these requirements do not apply to medical records if hard copy versions are retained):

1. Any use of electronic record keeping to store medical records must ensure the safety and integrity of those records at least to the extent of hard copy records.
2. The provider must ensure the safety and integrity of all electronic media used to store medical records by employing:
    a. An offsite backup storage system,
    b. An image mechanism that is able to copy signature documents, and
    c. A mechanism to ensure that once a record is input, it is unalterable.
3. Access to electronically stored records must be made available to the Division of Licensing and Certification of CDPH staff promptly, upon request.
4. The provider must develop and implement policies and procedures to include safeguards for confidentiality and unauthorized access to electronically stored medical records, authentication by signature keys and systems maintenance.

Original hard copies of medical records may be destroyed once the record has been electronically stored. The printout of the computerized version is considered the original for

the purposes of providing copies to patients, the Division of Licensing and Certification of CDPH and for introduction into evidence in administrative and court proceedings.

This law does not exempt providers from the requirement of maintaining original copies of medical records that cannot be electronically stored. [Health and Safety Code Section 123149]

(See A. "Change or Deletion of Medical Information: Audit Trails," page 13, regarding the requirement that electronic medical record systems must automatically record and preserve any change or deletion of any electronically stored medical information.)

B. Retention of Electronic Records

Electronic information may be stored in greater quantities, placed in varied configurations and retrieved rapidly when needed. Most importantly for this discussion, there may no longer be as great a need to purge records because of space constraints. Because electronic records require much less space, the temptation is to retain more information for longer periods. However, the question of purging information from an electronic system is identical to that of discarding or destroying hard copy. The same record retention periods apply irrespective of whether a record is electronic, paper, microfiche, microfilm, etc.

Retention policies for electronic records should focus both on transferring information for longer-term storage and on purging information from the system.

VI. DUPLICATE, TRANSITORY AND NONSUBSTANTIVE RECORDS

Health care providers create many duplicate, transitory and nonsubstantive records.

Duplicate records do not need to be retained. Only one version of a record, preferably the original, must be retained. However, providers may prefer to retain electronic versions of records that were originally produced on paper or other hard copy. Records may be transferred from hard copy to electronic format without legal risk, if appropriate backup and other security measures are maintained *(see V. "Electronic Records," page 11)*.

Health care providers also create many transitory and/or nonsubstantive records. These are records that do not establish policy, guidelines, or procedures; do not certify a transaction; do not constitute a receipt; and do not contain final substantive information. Transitory records may include personal notes, meeting notices, cover memos, lunch invitations, preliminary drafts, telephone messages, etc.

Transitory and nonsubstantive records may be discarded when no longer needed, unless there is a legal hold in place *(see VII. "Legal Hold," page 12)*.

VII. LEGAL HOLD

If a hospital or other health care provider has reason to believe that it may be sued or may be the subject of an audit or investigation, legal counsel should be consulted immediately to determine whether to initiate a legal hold. If a legal hold (also called a "litigation hold") is initiated, the usual retention and disposal policies are suspended for records relevant to the potential claim, dispute, lawsuit, audit or investigation. All potentially relevant records (paper and electronic) should be retained in their original form until legal counsel authorizes their destruction or deletion in accordance with the usual record retention schedule.

The occurrence of any of the following should provoke the hospital to consider a legal hold:

1. Service of legal process (subpoena, summons, or the like)
2. Learning of an investigation or audit by a government agency, government contractor, or private entity
3. Receipt of a claim (formal or informal)
4. Receipt of a patient complaint (not including minor complaints)
5. A dispute

All records relevant to the issue should be retained. This includes paper records as well as electronic data and documents (including e-mails). If a medical device, product, equipment, drug, other supply, or patient specimen may be involved, it should be sequestered. Employees and other personnel should be notified to suspend destruction of potentially relevant records, and all steps related to compliance with the legal hold should be documented.

VIII. DELETION, DISPOSAL AND DESTRUCTION OF RECORDS

State and federal privacy laws governing information containing protected health information (e.g., medical records, patient-identifiable billing records, labeled prescription bottles, hospital ID bracelets, etc.) and customer/consumer records impose on providers a duty to ensure that records are properly destroyed and are not improperly disclosed during the destruction process. This portion of the Record and Data Retention Schedule provides a brief, general overview of the laws and recommended procedures surrounding destruction of records. This information applies irrespective of whether the records are in electronic or hard copy form.

A. Change or Deletion of Medical Information: Audit Trails

An electronic health record system or electronic medical record system must automatically record and preserve any change or deletion of any electronically-stored medical information. The record of any change or deletion must include:

1. The identity of the person who accessed and changed the medical information,
2. The date and time the medical information was accessed, and
3. The change that was made to the medical information.

[Civil Code Section 56.101]

For purposes of this requirement, **"electronic medical record"** or **"electronic health record"** means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff [42 U.S.C. Section 17921(5)].

Failure to comply with the above requirements may result in significant financial penalties under the Confidentiality of Medical Information Act (CMIA).

B. Disposal or Destruction of Personal Information

State and federal privacy laws governing individually-identifiable health information and customer/consumer records impose a duty on health care providers to ensure that records

are properly destroyed, and are not improperly disclosed during the destruction process. This portion of the manual discusses the laws and recommended procedures for destruction of records. This information applies to records either in electronic or hard copy form.

Medical Records

The CMIA states that every health care provider, health care service plan, pharmaceutical company, or contractor who creates, maintains, preserves, stores, abandons, destroys or disposes of medical information must do so in a manner that preserves the confidentiality of the information contained therein. [Civil Code Section 56.101]

Failure to comply with the requirements described above may result in penalties under Civil Code Section 56.36, which include civil lawsuits by patients and fines of up to $250,000 per violation. Health care facilities may also be fined up to $250,000 by the California Department of Public Health for a privacy breach [Health and Safety Code Section 1280.15].

The HIPAA regulations do not require any particular method of destruction. However, the Department of Health and Human Services (DHHS) has released guidance stating that if one of the methods of destruction described below is used, and the media containing the PHI is later released to, or accessed by, a third party, it will not be considered a breach under the HITECH regulations. The media on which the PHI is stored or recorded must have been destroyed in one of the following ways:

1. Paper, film, or other hard copy media have been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed. Redaction is specifically excluded as a means of data destruction.
2. Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, “Guidelines for Media Sanitization,” such that the PHI cannot be retrieved.

Providers are not required to follow the guidance. However, if the specified technologies and methodologies are used, no breach notification obligation exists even if a breach occurs. This is referred to as a “safe harbor.”

The Secretary of DHHS must annually update this guidance. The guidance can be found on the DHHS website at https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html. DHHS has also published a document, “Frequently Asked Questions About the Disposal of Protected Health Information,” that may be found at https://www.hhs.gov/hipaa/for-professionals/faq/disposal-of-protected-health-information/index.html.

Federally-Assisted Substance Use Disorder Program Records

Special requirements apply when a federally-assisted substance use disorder program is discontinued or is acquired by another entity [42 C.F.R. Section 2.19]. Legal counsel should be consulted in these circumstances.

Customer Records

The Information Practices Act requires any business that maintains customer records which include personal information to take all reasonable steps to destroy, or arrange for the destruction of, such records by:

1. Shredding;

2. Erasing; or
3. Otherwise modifying the personal information in those records to make it unreadable or undecipherable through any means.

[Civil Code Section 1798.80-1798-84]

This law applies to medical records and other records that could identify a customer, such as records containing a name, Social Security number, contact information, insurance policy number, driver's license number, credit card number, certain passwords and security questions and answers, etc.

Employee Records

The California Constitution has been interpreted to provide employees a right to privacy. It is recommended that records containing employee-identifiable information be treated in the same manner as records containing medical information or customer/consumer information.

Information Derived from Consumer Credit Reports

Regulations adopted under the Fair and Accurate Credit Transactions (FACT) Act of 2003 require businesses that possess consumer information derived from consumer credit reports to properly dispose of the information. A person must take reasonable measures to protect against unauthorized access to or use of the information in connection with the disposal. Compliance with the Information Practices Act (described under "Customer Records," page 14) will likely ensure compliance with the FACT Disposal Rule. However, legal counsel should be consulted if questions arise. [16 C.F.R. part 682]

C. Process

A health care provider may dispose of records itself, or may engage an outside company to dispose of records. Any such company would be acting as the provider's business associate, and a written business associate agreement should be executed. The provider has a duty to ensure the company is competent to perform the task and its proposed method of disposal ensures the confidentiality and security of the records and their ultimate destruction.

A certificate of records destruction should be completed for records destroyed or deleted pursuant to the records management policy. In addition, the disposal of records should be documented in a log. A sample certificate of records destruction that providers may adapt to fit their needs may be found at http://library.ahima.org/doc?oid=105016#.WxceSKrruUk.

IX. CHA'S RECOMMENDED RETENTION SCHEDULE

A. General Retention Period

CHA's Recommended Retention Schedule (starting on page 21) recommends a retention period of six years for general records that might prove valuable for litigation, statistical or business purposes, but are not required to support Medi-Cal or Medicare claims. CHA has chosen this period because the utility of most records declines significantly after six years. The six-year period meets or exceeds the normal statute of limitations for civil actions. However, it would not be sufficient when a claimant alleges fraudulent concealment of a wrongful act, or some other occurrence prolongs the limitation period. CHA's Recommended Retention Schedule recommends a retention period of 15 years for records that support claims for Medi-Cal or Medicare services *(see A. "Legal Requirements and Considerations," page 3)*.

After establishing a general retention period, the Schedule was refined to account for particular demands. For example, it is suggested that providers preserve annual reports and significant statistical compilations longer, as these materials do not demand significant storage space and may be useful for historical, research, or business planning purposes. Additionally, special legal requirements that govern the retention of various records have been taken into account. Also recommended is fairly lengthy retention of credentialing and other medical staff records, as these contain information that is increasingly the subject of litigation. Finally, a two- or three-year retention period is assigned to various other records that are usually of only short-term interest.

NOTE: CHA's Recommended Retention Schedule does not include record retention requirements mandated by the U.S. Securities and Exchange Commission or the Sarbanes-Oxley Act, which applies only to investor-owned organizations that are publicly traded. These organizations should consult legal counsel regarding additional record retention requirements.

B. How to Interpret the Schedule

Column 1: "Record"

This column describes a document, record, or data that a hospital may generate.

Column 2: "Provider Types"

This column describes the types of providers that must comply with the retention requirement described in the row.

Column 3: "Legal Requirements"

This column provides any legal requirements that pertain to the providers listed in column 2 regarding the document described in column 1. The provider is legally required to follow the retention period stated in this column.

Column 4: "Recommended Retention Period"

This column provides CHA's recommendation regarding how long to keep the document described in column 1. Please note that this is only a recommendation, not a legal requirement. A particular provider may wish to keep the document longer than the recommended retention period. On the other hand, a provider may wish to destroy or delete the document sooner than the recommended retention period. Each health care provider should consider the factors described in III. "Primary Considerations in Developing a Record Retention Schedule," page 2, and develop its own retention schedule. It is not mandatory to comply with CHA's recommended retention period.

C. Frequently Asked Questions

Q1: Is every document that a hospital may generate included in the Schedule?

A1: No. It is not possible to list every document that a hospital may generate. The Schedule contains those documents that are commonly used by hospitals and other health care providers, and those documents to which the government has assigned a required record retention period.

Q2: Why is the time period under the fourth column, "Recommended Retention Period," sometimes longer than the legally-required retention period stated in the third column, "Legal Requirements"?

A2: It is common to find that the retention period listed under "Recommended Retention Period" is longer than the legally-required retention period listed in the "Legal Requirements" column. This is because there are other factors to be considered when determining the minimum retention period in addition to the legal requirement that is specific to that document *(see III. "Primary Considerations in Developing a Record Retention Schedule," page 2)*.

Q3: Does the "Legal Requirements" column list all possible laws that apply to the document described in the first column?

A3: No. The "Legal Requirements" column lists only the laws that are specific to the document described in column 1. However, it does not list all of the laws that represent more general retention considerations, such as statutes of limitations. The laws that represent more general retention considerations are discussed under III. "Primary Considerations in Developing a Record Retention Schedule," page 2.

Q4. How long should I keep a document that is not included in the Schedule?

A4. CHA recommends reviewing the Schedule to find a similar document or a document used for a similar purpose, and keeping the document in question for as long as the similar document must be kept.

Record Retention Schedule

Health care providers, particularly hospitals, are among the most heavily regulated entities in the United States. State and federal laws specify who is qualified to deliver safe and effective health care, and under what circumstances that care may be provided. In addition, providers are required to meet standards imposed under corporate, labor, tax, workers' compensation, environmental, and criminal law and many, many others.

In order to show that legally-required standards are being met, facilities must document compliance with the law. Records are required by law to be kept by every department of a California health care provider's facility. Sometimes the government specifies precisely how those records are to be maintained and for how long. Most of the time the government does not.

The Schedule that follows gives recommended retention periods for records that are common to health care providers and have statutorily- or regulatorily-mandated retention periods, or are representative of documents that have no legal retention requirements.

Retention Tip: For a document not listed in the Schedule, CHA recommends using the retention period listed for a similar document or for a document required for a similar purpose.

The Schedule gives recommendations for a wide variety of health care providers. In the "Provider Types" column, the following definitions apply:

1. **"All providers"** includes:
    a. Health facilities, as defined below,
    b. Home health agencies,
    c. Primary care clinics,
    d. Psychology clinics,
    e. Individual practitioners,
    f. Groups of practitioners,
    g. Surgery centers, and
    h. Unlicensed outpatient facilities.

2. **"Health facilities"** means a facility that treats persons who are admitted for a 24-hour stay or longer. The term "health facilities" includes the following types of providers:
    a. General acute care hospitals (GACHs),
    b. Acute psychiatric hospitals (APHs),
    c. Skilled nursing facilities (SNFs),
    d. Intermediate care facilities (ICFs),
    e. Special hospitals,
    f. Congregate living health facilities,
    g. Correctional treatment centers,
    h. Psychiatric health facilities (PHFs), and
    i. Chemical dependency recovery hospitals (CDRHs).

[Health and Safety Code Sections 1250 and 1250.2]

The following acronyms are used in the Schedule:

1. **"C.C.R."** means California Code of Regulations.
2. **"C.F.R."** means Code of Federal Regulations.
3. **"U.S.C."** means United States Code.

Retention Tip: *See "Where to Find the Laws Referenced in the Manual," page 75, for instructions on how to find the exact language of the statutes and regulations on the internet.*

ADMINISTRATIVE RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Accident reports		*See "Incident reports," page 24. If an employee is injured, see "Workers' compensation claims files," page 50.*	
Accountable Care Organization (ACO) utilization, quality and financial records	ACO participants, providers and suppliers	Must keep for at least 10 years from end of contract term or completion of audit, whichever is later [42 C.F.R. Section 425.314]	15 years
Accreditation/licensing surveys and plans of correction (TJC, AOA, DNV, CMS, CDPH, IMQ, CAP, etc.)	All providers		6 years (longer if continuing interest)
Adverse event reports to CDPH	Hospitals		6 years after any appeal is concluded
Aerosol transmissible disease and biosafety plan annual review	All providers	Must keep for at least 3 years [8 C.C.R. Section 5199(j)(3)]. *See regulation for required content of record.*	6 years
Appraisal reports (property, building, equipment, etc.)	All providers		Life of asset plus 10 years
Arbitration resolution documents	SNFs that particfipate in Medicare/Medicaid	When facility and resident resolve a dispute by arbitration, must keep arbitration agreement and arbitrator's decision for at least 5 years [42 C.F.R. Section 493.70(n)].	6 years after discharge of patient, longer if readmission is anticipated.
Birth records to local government	Hospitals, practitioners		Permanent
Cancer/tumor registry	Hospitals, practitioners		Permanent
Census (daily)	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep "patient admission rosters," but do not specify a retention period [22 C.C.R. Sections 70733, 71531, 77127, and 79337].	6 years
Certificate of records destruction	All providers		Permanent
Committee agendas, minutes (not otherwise specified in this retention schedule)	All providers		6 years
Communicable disease reports to state and local health departments	All providers		3 years
Construction project contracts and related documents	All providers		Life of building plus 10 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Contracts, leases, and supporting documentation	All providers	Contracts for services between a Medicare institutional provider and a subcontractor must be kept for the life of the contract, plus 4 years, if the value of the services is $10,000 or more over a 12-month period. This includes contracts for both goods and services in which the service component is worth $10,000 or more [42 C.F.R. Section 420.302(b)]. Contracts required by the HIPAA privacy rule must be kept for 6 years [45 C.F.R. Section 164.530(j)]. Regulations require GACHs, APHs, PHFs and CDRHs to keep contracts that are required by regulation, but no retention period is specified [22 C.C.R. Sections 70733, 71531, 77127, 79337]. Contracts that support claims for services rendered to Medicare or Medi-Cal patients must be kept for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	Life of agreement/lease/equipment, plus 6 years; if the agreement supports Medicare or Medi-Cal claims, then life of agreement/lease/equipment plus 15 years
Corporate records, including the following: Articles of Incorporation or partnership agreement; bylaws and rules and regulations of the governing body; minutes of meetings of the governing body	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep these documents, but do not specify retention periods [22 C.C.R. Sections 70733, 71531, 77127 and 79337].	Permanent
Court orders	All providers		Permanent, unless disposal approved by legal counsel
Death records to local government, death certificates	All providers		Permanent
Deeds or titles to property	All providers		Permanent
Disposal of records log	All providers		Permanent

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Donations, endowments, trusts, bequests, contributions	All providers		6 years. If a condition is attached to the gift, the records should be kept permanently.
EHR Incentive Program data (Medicare or Medicaid)	Hospitals, eligible professionals	Must keep for at least 6 years *(see FAQ No. 7711 under "Audits" on the CMS Promoting Interoperability Programs website at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html.)*	15 years
Grants		*See "Health and Human Services Agency grants," page 23.*	
Grievances and resolution documents	SNFs that participate in Medicare/Medicaid	Must keep for at least 3 years [42 C.F.R. Section 483.10(j)(4)(vii)]	6 years
Health and Human Services Agency grants	Health facilities	Keep financial, statistical and nonexpendable property records, and any other records pertinent to grants, for 3 years from the date of submission of the final expenditure report, or until resolution of all litigation and federal audit findings. Records for real property and equipment acquired with federal funds must be kept for at least 3 years after final disposition. [45 C.F.R. Section 75.361]	6 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
HIPAA privacy-related documents (notice of privacy practices; acknowledgment of receipt of notice of privacy practices; correspondence/ forms related to request for access to and amendment of protected health information (PHI); titles of persons/offices responsible for receiving and processing requests for access and amendment; accountings for disclosures; accountings provided to patients; titles of persons/offices responsible for receiving and processing requests for an accounting, correspondence/forms regarding a special restriction; authorization for use/disclosure of PHI; correspondence/forms related to grievances; business associate agreements; breach investigation and notification reports; etc.)	All providers	Must keep for at least 6 years from the date of creation or the date last in effect, whichever is later [45 C.F.R. Section 164.530(j)].	8 years
Incident reports	All providers	*See also "Unusual occurrence reports to CDPH/public health officer (PHO)," page 28.*	10 years
Inspection and approval by state or local fire control agencies	Medicare particiating hospitals	Regulations require written evidence of regular inspection and approval by fire control agencies to be kept, but no retention period is specified [42 C.F.R. Section 482.41].	6 years
Inspection reports by local, state or federal agents	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep inspection reports, but do not specify retention periods [22 C.C.R. Sections 70733, 71531, 77127 and 79337].	6 years
Inspection reports by local, state or federal agents	ICFs	Must keep the latest report of inspection by state or local health authorities with notations made of the actions taken to comply with any recommendations [22 C.C.R. Section 73515].	6 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Institutional review board (IRB) records	All providers	Must keep until research is completed, plus 3 years [21 C.F.R. Section 56.115]. *See regulation for required content of records. See also 21 C.F.R. Sections 312.62 and 812.140 (2-year retention period for related records).*	Completion of research, plus 10 years
Insurance policies, current and expired, and related claims and correspondence	All providers		Permanent
Intellectual property: copyright, trademark, service mark applications, approvals, and related documents	All providers		Duration of use of mark plus 10 years
Leases		*See "Contracts, leases, and supporting documentation," page 22.*	
Licenses or certificates	All providers		Life of license or certificate, plus 6 years
List of contracted services	Medicare-participating hospitals	Regulations require a list of contracted services to be kept, but do not specify retention periods [42 C.F.R. Section 482.12(e)].	6 years
Master patient index/medical record index number	All providers		Permanent
Meaningful use attestations (Medicare or Medicaid) and supporting data	Hospitals, eligible professionals	Must keep for at least 6 years *(see FAQ No. 7711 under "Audits" on the CMS Promoting Interoperability Programs website at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html)*.	15 years
Medical device reports (MDR) and records of MDR reportable events (MedWatch)	Health facilities, clinics, home health agencies, surgery centers	File relating to an adverse MDR event must be kept at least 2 years from the date of the event [21 C.F.R. Section 803.18(c)].	Life of device, plus 6 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medical device tracking records	Health facilities, clinics, home health agencies, surgery centers	Keep for the period of time the device is in use or in distribution for use. (For example, a record may be discarded if the device is no longer in use, has been explanted, returned to the manufacturer, or the patient has died.) [21 C.F.R. Section 821.60] *See 21 C.F.R. Section 821.30 for a list of information that must be kept in the device tracking record.*	Life of device, plus 6 years
Meeting minutes and agendas needed to document compliance with accreditation requirements	The Joint Commission accreditation organizations	Must keep until next full survey	4 years (unless longer period recommended for specific records elsewhere in this chart)
OSHPD reports (financial, patient discharge data, quality)	Hospitals		20 years
OSHPD reports (seismic)	Hospitals		Permanent
Patient admission roster		*See "Census (daily)," page 21.*	
Patient grievances/complaints — complaint, investigation materials, correspondence	Facilities		6 years after resolution
Patient property: deceased patient's property disposition	Health facilities	Records of disposition of deceased patient's property must be kept for at least 3 years [Probate Code Section 330(d)]. *See chapter 14 of CHA's* Consent Manual *for information about disposition of deceased patient's property.*	5 years after discharge
Patient property: patient cash and valuables receipts, personal property inventory	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	5 years after discharge
Patient property: receipts and disbursements of personal funds of Medi-Cal beneficiaries being held in trust by the provider	Facilities		15 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Permits	All providers		Life of permit, plus 6 years
Policies and procedures	GACHs, APHs, PHFs	Regulations require these facilities to keep policy and procedure manuals, but do not specify retention periods [22 C.C.R. Sections 70733, 71531 and 77127]. Policies and procedures required by the HIPAA privacy and security rules must be kept for at least 6 years [45 C.F.R. Sections 164.316(b) and 164.530(j)].	Life of policy or procedure, plus 6 years. Must be kept longer for transplant services.
Real estate transaction records, deeds, easements, zoning permits, building permits	All providers		Permanent
Reports, memos, correspondence (not otherwise specified in this retention schedule)	All providers		6 years (unless desired longer for trending or business planning purposes)
Safe patient handling-related documents	GACHs	Must keep for at least 1 year [8 C.C.R. Sections 3203(b) and 5120(e)(1)(B)]	6 years (may also wish to document attendance at training in employee's personnel file)
Statistical data/reports regarding admissions, discharges, outpatient visits, services rendered, transfers, etc. (not otherwise specified in this retention schedule)	All providers		6 years (unless desired longer for trending or business planning purposes)
Statistics on admissions and services	All providers		6 years (longer if needed for business planning purposes)
Summary record of decisions not to transfer a patient to another facility for airborne infection isolation for medical reasons	All providers	Must keep for at least 3 years [8 C.C.R. Section 5199(j)(3)]. *See regulation for required content of record.* The information must also be documented in the patient's medical record.	6 years
Survey, certification and complaint investigation reports; plans of correction	SNFs that participate in Medicare/Medicaid	Must keep at least 3 years [42 C.F.R. Section 483.10(g)(11)]	6 years
Survey reports		*See "Accreditation/licensing surveys and plans of correction (TJC, AOA, DNV, CMS, CDPH, IMQ, CAP, etc.)," page 21.*	

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Training records — employees (not otherwise specified in this retention schedule)	All providers	Regulations require GACHs to keep documentation as described in 22 C.C.R. Section 70214(d), but do not specify a retention period.	6 years after date of training (may also wish to document attendance in employee's personnel file)
Treatment authorization requests (TARs)	Hospitals	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Unavailability of airborne infection isolation rooms/areas	All providers	Must keep for at least 3 years [8 C.C.R. Section 5199(j)(3)]. *See regulation for required content of record.*	6 years
Unusual occurrence reports to CDPH/public health officer (PHO)	GACHs, APHs	Must keep for at least 2 years [22 C.C.R. Sections 70733 and 71531]. The report made to CDPH/PHO should include only factual information that CDPH/PHO must have. These reports may be obtained by plaintiffs' attorneys from CDPH/PHO by use of a subpoena. The facility likely will also complete an incident report, root-cause analysis, etc. that may be protected from discovery. *See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Unusual occurrence reports to CDPH/public health officer (PHO)	SNFs, primary care clinics	Must keep for at least 1 year [22 C.C.R. Sections 72541 and 75053]. The report made to CDPH/PHO should include only factual information that CDPH/PHO must have. These reports may be obtained by plaintiffs' attorneys from CDPH/PHO by use of a subpoena. The facility likely will also complete an incident report, root-cause analysis, etc. that may be protected from discovery. *See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years
Unusual occurrence reports to CDPH/public health officer (PHO)	PHFs and CDRHs	Must keep for at least 3 years [22 C.C.R. Sections 77137 and 79339]. The report made to CDPH/PHO should include only factual information that CDPH/PHO must have. These reports may be obtained by plaintiffs' attorneys from CDPH/PHO by use of a subpoena. The facility likely will also complete an incident report, root-cause analysis, etc. that may be protected from discovery. *See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years
Workplace violence prevention records: hazard identification, evaluation and correction	Health facilities, HHAs, hospices	Must keep for at least 1 year [8 C.C.R. Sections 3203(b), 3342 and 5120(e)(1)(B)]	6 years

ADMITTING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Admission and discharge records	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep "patient admission rosters," but do not specify a retention period [22 C.C.R. Sections 70733, 71531, 77127 and 79337].	6 years
Advance Beneficiary Notice	Hospitals	Must keep for at least 5 years from discharge or completion of delivery of care [*Medicare Claims Processing Manual*, Publication 100-04, Chapter 30, Section 50.6.4]. However, the original ABN must be retained in the medical record; thus, California hospitals should retain the ABN in accordance with medical record retention requirements.	File in patient's medical record
Conditions of admission agreements	Health facilities		File in patient's medical record
Emergency department log (must include name; date, time and means of arrival; age; sex; record number; nature of presenting complaint; disposition; time of departure; and names of patients who are dead on arrival)	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	6 years
Emergency department transfer records (medical and other records related to individuals transferred to or from the hospital, including "Transfer Summary" required by Health and Safety Code Section 1317.2(f))	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	Medical records: 15 years — adults 25 years — minors Other records: 6 years
Medicare secondary payer beneficiary questionnaire	All providers	Must keep for 10 years after date of service [*Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.2].	15 years

BUSINESS AND FINANCE RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Accountable Care Organization (ACO) utilization, quality and financial records	ACO participants, providers and suppliers	Must keep for at least 10 years from end of contract term or completion of audit, whichever is later [42 C.F.R. Section 425.314]	15 years
Audit reports	All providers		7 years
Bank deposits	All providers		7 years
Bank statements	All providers		15 years
Bond records (including how bond-financed investments are used and disposed of; investment and expenditure of bond proceeds)	Tax-exempt facilities	Must keep for 3 years after final redemption *(see IRS webpage at https://www.irs.gov/tax-exempt-bonds/tax-exempt-bond-faqs-regarding-record-retention-requirements#6)*.	15 years after final redemption
Budgets	All providers		7 years
Cash receipts	All providers	Medi-Cal regulations require that "book records of receipts and disbursements" be retained for 10 years from the date of service, end of Medi-Cal contract period, or audit completion, whichever is later [Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]. A similar timeframe exists for records needed to support claims to certain Medicare patients. [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2)]. It is unclear what "book records of receipts" means.	15 years
Cashiers' tapes from bookkeeping machines	All providers		2 years
Chargemaster	Hospitals		15 years
Check registers	All providers		15 years
Checks — canceled • Payroll • Taxes, capital, purchases, important contracts • Other	All providers		 15 years Permanent 15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Claims, billings, and charges to patients, fiscal intermediaries, third-party payers, etc.	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Depreciation schedules — equipment	All providers		Life of equipment, plus 15 years
Disbursements — unclaimed/returned	All providers	Unclaimed checks and disbursements escheat to state after 3 years; the state then attempts to notify recipients [Code of Civil Procedure Section 1510 *et seq.*].	7 years
Employee expense reports	All providers		15 years
Employment tax records (federal)	All providers	Must keep for at least 4 years after due date of tax, or date tax is paid, whichever is later [26 C.F.R. Section 31.6001–1 *et seq.*].	15 years
Exempt Organization Annual Information Returns (IRS Form 990, State Form 199)	Tax-exempt organizations		Permanent
Financial statements (year-end)	All providers		Permanent
Income — daily summary	All providers		7 years
Income tax returns	All providers		Permanent
Invoices — accounts receivable/payable	Providers that participate in Medicare Advantage, Medi-Cal, accountable care organizations, or Medicare Part D	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Invoices documenting purchase or lease of clinical laboratory equipment and test kits, reagents, or media	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *(See "Invoices — accounts receivable/payable" above.)*	15 years
Invoices — fixed assets, equipment	All providers		Permanent/life of asset or equipment, plus 15 years
IRS rulings, audit records	All providers		Permanent
Journals — general	All providers		15 years
Ledgers — general	All providers		15 years
Ledgers — individual ledger accounts reflecting credit and debit balances for each Medi-Cal beneficiary	Facilities	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Medi-Cal remittance advices	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Medicare Advantage-related documents	All providers that contract with a Medicare Advantage plan	Must keep for at least 10 years after end of contract term or audit, whichever is later. [42 C.F.R. Section 422.504(i)(2)]. *See "Contracts with Medicare Advantage or Medicare Part D Plans," page 6.*	15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medicare cost report records	Hospitals	Must keep for at least 5 years after the cost report is filed with the intermediary. The records that must be retained are: 1. Billing material: copies of claim forms, supporting documents and forms (e.g., charge slips, daily patient census records, and other business and accounting records referring to specific claims). 2. Cost report material: all data necessary to support the accuracy of entries on annual cost reports including original invoices, cancelled checks, copies of material used in preparing annual cost reports, and other similar cost items, schedules and related worksheets, and contracts or records of dealings with outside sources of medical supplies and services or with related organizations. 3. Medical record material: utilization review committee reports, physicians' certification and recertifications, discharge summaries, clinical and other medical records relating to health insurance claims. 4. Provider physician material: provider physician agreements on which Part A and Part B allocations are based. [*Medicare Claims Processing Manual*, Publication 100-04, Chapter 1, Section 110.3] *See also 42 C.F.R. Sections 413.20 and 413.24. (See also "Resident rotation schedules — location, nature of assignment, vacation, leave of absence, sick time, orientation time, classroom time, etc.," page 64.)*	15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medicare Part D-related documents (prescription drug benefit)	All providers that contract with a Medicare Part D plan	Must keep for at least 10 years after end of contract term or audit, whichever is later [42 C.F.R. Section 423.505(i)(2)]. *See "Contracts with Medicare Advantage or Medicare Part D Plans," page 6.*	15 years
Medicare secondary payer beneficiary questionnaire		*See "Medicare secondary payer beneficiary questionnaire," page 30.*	
Patient accounting files	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Payment receipt books	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Payroll records		*See "Human Resources Records," page 45.*	
Property tax payment records	All providers		Permanent
Purchase orders	All providers		Life of item, plus 7 years
Request for payment	Medicare provider or supplier of DMEPOS, lab, imaging, or home health services	Must keep at least 7 years [42 C.F.R. Section 424.516(f)]	15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Returned goods credits	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Tax bills, statements, payments, receipts	All providers		Permanent
Tax-exempt status application, supporting documentation, determination letters from IRS and FTB	Tax-exempt organizations		Permanent
Tax returns	All providers		Permanent
Unemployment tax records	All providers	Must keep for at least 4 years after due date of tax, or the date tax is paid, whichever is later [26 C.F.R. Section 31.6001-1; 22 C.C.R. Section 1085–2(c)].	7 years
Volunteer funds raised		*See "Donations, endowments, trusts, bequests, contributions," page 30.*	
Wage and tax statements (W-2 forms)	All providers	Must keep for at least 4 years after due date of tax, or the date tax is paid, whichever is later [26 C.F.R. Section 31.6001–1].	7 years
Withholding allowance certificates (W-4 forms)	All providers	Must keep for at least 4 years after due date of tax, or the date tax is paid, whichever is later [26 C.F.R. Section 31.6001–1].	7 years after termination of employment or new certificate completed

DEPARTMENT RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Ambulance replenishing records (other than linens)	Facilities	Must keep for at least 5 years [42 C.F.R. Sections 1001.952(v)]	15 years
Appointment books, patient logs, or similar documents showing date and time allotted for appointment of each Medi-Cal patient or group of patients, and time actually spent with such patients	Psychiatric and psychological service providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Appointment calendars (patients' appointments), sign-in sheets	All providers except providers of psychiatric and psychological services to Medi-Cal patients		6 years
Birth records to local government		*See "Birth records to local government," page 21.*	
Compliance audits/ investigations (internal)	All providers		6 years
Compliance hotline log (annual)	All providers		6 years
Crash cart daily records	The Joint Commission accredited organizations	Must keep until next full survey	4 years
Dialysis — hemodialyzer reuse records (procedure, training, equipment, audit records)	Dialysis clinics	Regulations require these documents to be kept, but do not specify a retention period [22 C.C.R. Section 75198]. *See 22 C.C.R. Sections 75189 and 75198 for details about content of required records.*	Life of dialyzer, plus 6 years
Dialysis — dialyzer reuse records (device history records, including patient name, dates of treatment, dates of disinfectant rinsing, type and model, reuse number, results of performance tests, initials or other ID of reprocessing technician, reason for dialyzer failure and subsequent acceptance)	Dialysis clinics	Must keep for at least 6 months after last reprocessing of dialyzer [22 C.C.R. Section 75198(b)(5)]. *See 22 C.C.R. Sections 75189 and 75198 for details about content of required records.*	Life of dialyzer, plus 6 years

DEPARTMENT RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Emergency department log (must include name; date, time and means of arrival; age; sex; record number; nature of presenting complaint; disposition; time of departure; and names of patients who are dead on arrival)	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	6 years
EMTALA-related records, including records of patients transferred in or out, emergency department log, policies and procedures, etc.	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	6 years
Hardware and software operating instructions, warranties, system requirements, configurations, etc.	All providers		Life of product, plus 2 years
Human tissue intended for transplantation (records regarding donor screening and testing; records regarding supplier, donor and lot identification, receipt, name(s) of recipient(s), storage temperatures, distribution, destruction, disposition of human tissue, expiration dates of all tissues, etc.)	GACHs	Must keep at least 10 years after the date of transplantation (if known), distribution, disposition, or expiration of the tissue, whichever is latest [21 C.F.R. Section 1270.33].	Permanent
Infection control committee, minutes and reports of	GACHs, APHs	Regulations require these facilities to keep their documents, but do not specify retention periods [22 C.C.R. Sections 70733 and 71531].	6 years
Labor room log books	Hospitals	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)].	6 years

DEPARTMENT RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medical transportation records (must include time and date of service for each Medi-Cal beneficiary; odometer readings at each pick-up and delivery location; provider-assigned vehicle ID code; name of operator providing the service, names of beneficiaries transported in total or partial group runs)	Medical transportation providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Meeting minutes and agendas needed to document compliance with accreditation requirements	The Joint Commission accreditation organizations	Must keep until next full survey	4 years (unless longer period recommended for specific records elsewhere in this chart)
Motor vehicle maintenance records	All providers		Life of vehicle, plus 6 years
Policy and procedures manuals		*See "Policies and procedures," page 27.*	
Requisitions (internal)	Health facilities		Discretionary
Surgical privileges list	Hospitals	The surgical service of hospitals that participate in Medicare must keep a roster of practitioners specifying the surgical privileges of each practitioner, but no retention period is specified [42 C.F.R. Section 482.51].	Each physician's surgical privileges should be kept in his or her medical staff file *(see "Medical Staff Records," page 63)*. The lists provided to the surgical service should be retained for at least 6 years.
Surgery • Register of operations • Operating room logs	GACHs	Regulations require hospitals to keep a register of operations, but do not specify retention periods [22 C.C.R. Section 70223(f)].	6 years
Temperature monitoring logs	The Joint Commission accredited organizations	`Must keep until next full survey	4 years

NOTE: Individual departments may wish to keep copies of the original records, which are kept at the administrative offices. The department should keep duplicate records only as long as the records are used on a regular basis.

DIETARY DEPARTMENT RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Bacteriological testing of ice	Health facilities		2 years
Dietetic service personnel (number of)	GACHs, APHs	Regulations require these facilities to keep records listing the number of dietetic service workers and their job titles and hours worked, but do not specify retention periods [22 C.C.R. Sections 70275 and 71245].	2 years
Food costs	Health facilities		6 years
Food purchased	GACHs, APHs, SNFs, ICFs	Must keep records of food purchased for at least 1 year [22 C.C.R. Sections 70273(g)(6), 71243(g)(6), 72341(h) and 73333(g)].	3 years
In-service training records for dietetic services personnel (subject areas covered, date and duration of each session, attendance list)	GACHs, APHs, ICFs	Regulations require these facilities to keep these records, but do not specify retention periods [22 C.C.R. Sections 70273(j), 71243(j) and 73335].	6 years after date of training (may also wish to document attendance in employee's personnel file)
Meal counts	Health facilities		2 years
Menus	GACHs, APHs, SNFs, ICFs	Must keep for at least 30 days [22 C.C.R. Sections 70273(g)(5), 71243(g)(5), 72341(g) and 73333(f)].	3 months
Recipes, including ingredients, portion size, nutritional analysis	Health facilities		2 years after discontinuation

ENGINEERING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Autoclaves and sterilizers: thermometer charts (daily checking of recording and indicating thermometers) and monthly bacteriological tests (including the bacterial organism used) (ICFs only: recording thermometers are not required on portable sterilizers and autoclaves)	GACHs, APHs, SNFs, ICFs	Must keep for at least 1 year [22 C.C.R. Sections 70833, 71637, 72619 and 73677].	Life of equipment, plus 6 years
Building blueprints, plans, specifications, inspections	All providers		Permanent (or until property is sold)
Calibration records (all gauging and measuring equipment must be regularly calibrated as specified by the manufacturer)	GACHs, APHs	Must keep for at least 2 years [22 C.C.R. Sections 70837 and 71641].	Life of equipment, plus 6 years
Emergency generator records — inspection, performance, exercising period and repairs	GACHs, APHs, SNFs, ICFs	Regulations require these facilities to keep these records, but do not specify retention periods [22 C.C.R. Sections 70841(e), 71645(e), 72641(f) and 73639(f)].	Life of generator, plus 6 years
Equipment records (purchase, operating instructions, maintenance, inspection, repairs, calibrations)	All providers		Life of equipment, plus 6 years
HVAC air filter maintenance records (record of inspection, cleaning, replacement, including static pressure drop. Record must include a description of filters originally installed, ASHRAE atmospheric dust spot test efficiency rating, and criteria established by manufacturer or supplier to determine when replacement or cleaning is necessary. If filter maintenance is performed by an outside company, the hospital may retain a certification from the company stating that these requirements have been met.)	GACHs, APHs, SNFs, ICFs	Regulations require these facilities to keep these records, but do not specify retention periods [22 C.C.R. Sections 70839(b), 71643(b), 72639(b) and 73637(b)].	Life of air filter, plus 6 years
Inspection reports of grounds and buildings	All providers		6 years

ENGINEERING RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Maintenance logs and manuals (heating, air conditioning, ventilation)	GACHs, APHs, SNFs, ICFs, PHFs	Regulations require health facilities to keep maintenance logs and a written maintenance manual, but do not specify retention periods [22 C.C.R. Sections 70837(d), 71641(d), 72655(b), 73653(b) and 77155(b)].	Life of equipment, plus 6 years
Records of inspection, testing and maintenance of non-disposable engineering controls including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems (include name and affiliation of person performing the test/ inspection/maintenance, date, significant findings, actions)	All providers	Must keep for at least 5 years [8 C.C.R. Section 5199(j)(3)(F)].	Life of equipment, plus 6 years
Work orders	All providers		2 years

HOUSEKEEPING/ENVIRONMENTAL SERVICES RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Checkout, transfer, isolation records	All providers		2 years
Cleaning records (rooms, equipment, work surfaces, etc.)	All providers		2 years
Environmental exposure analysis using exposure or medical records	All providers	Must keep for at least 30 years [8 C.C.R. Section 3204(d)(1)(C)]	30 years
Environmental (workplace) monitoring or measuring regarding toxic substances or harmful physical agents (including personal, area, grab, wipe, or other form of sampling; collection and analytical methodologies, calculations, and other background data; and analyses)	All providers	Must be kept for at least 30 years [8 C.C.R. Section 3204]. However, background data to environmental monitoring or measuring, such as laboratory reports and worksheets, need only be kept for 1 year.	30 years
Inspection reports of grounds and buildings	All providers		6 years
Hazardous waste (that is not medical waste) — reports, test results, waste analyses, manifests	All providers that generate hazardous waste	Must keep for at least 3 years from due date of report or date waste accepted by transporter [22 C.C.R. Section 66262.40].	30 years
Material Safety Data Sheets	All providers	Must keep for as long as a material is used or stored at a workplace [8 C.C.R. Sections 3204(d)(1)(B)(2) and 5194]. Once the material is no longer used or stored, if the MSDS is destroyed, a record of the identity of the substance or agent, where it was used, and when it was used must be kept for at least 30 years. MSDSs must be immediately accessible to employes during each work shift.	30 years
Medical waste treatment and tracking documents	Small quantity generators of medical waste	Must keep for at least 3 years [Health and Safety Code Section 117943]. *See Health and Safety Code Section 118040 for required content of records.*	30 years
Medical waste treatment and tracking documents	Large quantity generators of medical waste	Must keep for at least 2 years [Health and Safety Code Section 117975]. *See Health and Safety Code Section 118040 for required content of records.*	30 years

HOUSEKEEPING/ENVIRONMENTAL SERVICES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Pesticide handling training programs	All providers	Must keep for at least 2 years after training program is discontinued [3 C.C.R. Section 6724(a)]. *See regulation for required content of training.* When antimicrobial agents are used only as sanitizers, disinfectants, or medical sterilants, the employer is exempt from complying with this requirement, and instead must comply with Cal/OSHA requirements [3 C.C.R. Section 6720], which require records to be kept for at least one year [8 C.C.R. Section 3203(b)].	6 years after date of training (may also wish to document attendance in employee's personnel file)
Pesticide Safety Information Series leaflets, MSDSs, pesticide use records, employee exposure records, work practice reviews	All providers	Regulations require these records to be kept, but no retention period is specified [3 C.C.R. Section 6723]. When antimicrobial agents are used only as sanitizers, disinfectants, or medical sterilants, the employer is exempt from complying with this requirement, and instead must comply with Cal/OSHA requirements [3 C.C.R. Section 6720]. *See "Material Safety Data Sheets," page 43, and "Employee health (medical) records — Employees subject to OSHA regulations," page 46.*	30 years

HUMAN RESOURCES RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Aerosol transmissible disease training	All providers	Must keep for at least 3 years after date of training [8 C.C.R. Section 5199)(j)(2)]. *See regulation for required content of record.*	6 years after date of training (may also wish to document attendance in employee's personnel file)
Affirmative action program records	All providers subject to affirmative action requirements	Life of program, plus 1 year [41 C.F.R. Section 60-1.12]	Life of program, plus 6 years
Applications for employment		*See "Employee and applicant records ...," below.*	
Bloodborne pathogen training	All providers	Must keep for at least 3 years [8 C.C.R. Section 5193(h)]	6 years (may also wish to document attendance in employee's personnel file)
Collective bargaining agreements and related documents	All providers	Must keep for at least 3 years [29 C.F.R. Section 516.5].	Life of agreement, plus 10 years
Employee acknowledgment of child abuse and neglect reporting requirement, elder and dependent adult abuse and neglect reporting requirement	All providers		File in employee's personnel file
Employee and applicant records required by the California Fair Employment and Housing Act, Title VII of the Civil Rights Act, the Americans with Disabilities Act, the Genetic Information Nondiscrimination Act, and the Age Discrimination in Employment Act — any personnel or employment record made or kept by an employer, including application forms and resumes submitted by applicants; requests for reasonable accommodation; records relating to recruitment, testing, hiring, promotion, demotion, transfer, recall, layoff, termination, rate of pay and other terms of compensation, garnishment, and selection for training or apprenticeship programs	All providers	Health facilities and primary care clinics must keep for at least 3 years after termination of employment [22 C.C.R. Sections 70725, 71525, 72533, 73527, 75052, 77119, 79333 and 87866]. Other providers must keep for at least 2 years from date of making record or personnel action involved, whichever is later [Government Code Section 12946]. *See also 29 C.F.R. Sections 1602.14 (one year retention period required) and 1627.3(b) (3 years).* Longer if a charge of discrimination has been filed [29 C.F.R. Section 1602.14]	Duration of employment, plus 10 years

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Employee benefit plans — pension and insurance plans	All providers	Must keep for 1 year after termination of plan [29 C.F.R. Section 1627.3].	Permanent
Employee exposure records, including audiometric test results	All providers	Must keep for at least 30 years [8 C.C.R. Sections 3204(d)(1)(B) and 5100(d)]	Duration of employment plus 30 years
Employee handbook	All providers		Permanent
Employee health (medical) records — Employees *not subject* to OSHA regulations	Health facilities, clinics, HHAs	Must keep these records for at least 3 years after termination of employment [22 C.C.R. Sections 70723, 71523, 72535, 73525, 74723, 75052, 77121 and 79331].	Duration of employment, plus 30 years
Employee health (medical) records — Employees *subject* to OSHA regulations	All providers	Federal and California OSHA regulations require that medical records be kept for the duration of employment plus 30 years for all employees who are exposed, *or potentially exposed*, to hazardous substances (including chemical substances, biological agents, and bloodborne pathogens) or to a hazardous environment [29 C.F.R. Sections 1910.1020(d)(1)(i), and 1910.1030(h); 8 C.C.R. Sections 3204(c)(5), 3204(d)(1), 5193(h) and 5199(j)(1)]. *See regulations for required content of records.* Hazardous substances include those listed in the latest edition of the Registry of Toxic Effects of the National Institute for Occupational Safety & Health. Hazardous environments include noise, heat, cold, vibration, repetitive motion, ionizing and nonionizing radiation, and hypo- and hyperbaric pressure. *See also "Noise exposure records," page 47.*	Duration of employment, plus 30 years
Employee polygraph records	All providers	Must keep for at least 3 years [29 C.F.R. Section 801.30]. See regulation for required content of report. *See also Labor Code Section 432.2 for retrictions on employee polygraphs.*	Duration of employment, plus 10 years
Employer Information Report EEO-1	Employers subject to Title VII of the Civil Rights Act of 1964 that have 100 or more employees	Must keep the most recent annual report [29 C.F.R. Section 1602.7].	30 years

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Employment Eligibility Verification Form (INS Form I-9)	All providers	Must keep for at least 3 years after date of hire or 1 year after termination of employment, whichever is later [8 C.F.R. Section 274a.2].	Duration of employment, plus 10 years
Equal Pay Act records — records that relate to payment of wages, wage rates, job evaluations, job classifications, job descriptions, merit systems, seniority systems, other matters that explain the basis for payment of any wage differential to employes of the opposite sex in the same establishment	All providers	Must keep for at least 2 years [29 C.F.R. Section 1620.32]. (Copies of seniority systems and merit systems must be kept for at least 1 year after termination of the system under the Age Discrimination in Employment Act [29 C.F.R. Section 1627.3(b)(2)]).	Records about specific employees: File in employees personnel file. Other records: 30 years
Family Medical Leave Act records — dates of leave, hours of leave, employee notices, employer policies and practices, records of disputes, premium payments	Providers subject to FMLA	Must keep for at least 3 years [29 C.F.R. Section 825.500]. *See also Government Code Section 12946 (2-year retention period required, longer if ongoing litigation).*	Records about specific employees: File in employees personnel file. Other records: 30 years
Garnishment records	All providers		7 years
Labor/management reporting records to Office of Labor-Management Standards	All providers	Must keep for at least 5 years after filing [29 U.S.C. Section 436; 29 C.F.R. Section 405.9].	6 years after filing report
Log of temporary health services personnel	SNFs	Must keep for at least 3 years [22 C.C.R. Section 72533].	6 years
Mammography personnel qualification records		*See "Mammography personnel qualifications for physicians, mammographic radiologic technologists, medical physicists," page 52*	
Material Safety Data Sheets	All providers	Must keep while chemical is being used by employees. When safety data sheets are destroyed, must keep a record of the identity (chemical name, if known) of the substance, where it was used, and when it was used for at least 30 years. [8 C.C.R. Section 3204(d)(1)(B)]	6 years after use of chemical discontinued
Noise exposure records	All providers	Noise exposure measurement records must be kept for at least 2 years [8 C.C.R. Section 5100].	30 years
Orientation and competency validation	GACHs	Must retain in employee's file for the duration of employment [22 C.C.R. Section 70214(a)(4)]	Duration of employment plus 6 years

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
OSHA logs, summaries and reports; OSHA forms 300, 300A, 301 Incident Reports, privacy case list	All providers	Must keep for at least 5 years following the end of the calendar year that the records cover [29 C.F.R. Section 1904.33; 8 C.C.R. Section 14300.33].	6 years
Payroll records, including: • Employee deduction authorizations • Hours worked (daily) • Leaves of absence • Overtime, vacation and sick leave accruals and entries • Time cards • Wage rates and wages paid • Wage statements, itemized	All providers	Retention of comprehensive payroll records is required under numerous federal and state laws, including the Fair Labor Standards Act, Equal Pay Act, Age Discrimination in Employment Act, Title VII of the Civil Rights Act, Americans with Disabilities Act, California Fair Employment & Housing Act, California Unemployment Insurance Code, ERISA and Medi-Cal/Medicare requirements. Although most of the acts require retention for a period no longer than 4 years, ERISA requires current availability of all payroll records necessary to determine entitlement to pension benefits. It is therefore recommended that payroll records be permanently retained. *(See also Labor Code Sections 226(a) and 247.5.)* (As ERISA requirements vary according to the type of pension plan, facilities may wish to have their attorneys review their plans to determine whether a shorter retention period may be appropriate and to determine which payroll records should be retained.) *See also Labor Code Section 1174; 29 C.F.R. Sections 516.5 and 516.6; 22 C.C.R. Sections 70725, 71525, 72533, 73527, 75052, 77119 and 79333.*	Employees not entitled to pension: 15 years Employees entitled to pension: life of employee plus 6 years
Pension records	All providers	*See box immediately above.*	Permanent

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Pesticide training program records	All providers	Must keep for at least 2 years [3 C.C.R. Section 6724]. *See regulation for required content of training.* When antimicrobial agents are used only as sanitizers, disinfectants, or medical sterilants, the employer is exempt from complying with this requirement and instead must comply with Cal/OSHA requirements [3 C.C.R. Section 6720], which require records to be kept for at least one year [8 C.C.R. Sections 3203, 5194].	6 years after date of training (may also wish to document attendance in employee's personnel file)
Respirator fit-testing	All providers	Must keep until another fit-testing is performed on the employee [8 C.C.R. Section 5144(m)]. *See regulation for required content of record.*	6 years
Sharps injury log	All providers	Must keep for at least 5 years [8 C.C.R. Section 5193(h)]. *See regulation for required content of log.*	10 years
Sharps injury training	All providers	Must keep for at least 3 years [8 C.C.R. Section 5193(h)]. *See regulation for required content of record.*	6 years (may also wish to document attendance in employee's personnel file)
Unavailablility of vaccine for employees who may be exposed to an aerosol transmissible disease	All providers	Must keep for at least 3 years [8 C.C.R Section 5199(j)(3)]. *See regulation for required content of record.*	6 years
Volunteer personnel records	All providers		6 years after termination of volunteer status
Volunteer sign-in sheets, hours worked, assignments	Facilities		6 years
W-2, W-4 forms		*See "Business and Finance Records," page 31.*	

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Workplace violence prevention records: iolent incident log, reports to Cal/OSHA and injury investigations	Health facilities, HHAs, hospices	Must keep for at least 5 years [8 C.C.R. Section 3342(h)(3)]	6 years
Workplace violence prevention training	Health facilities, HHAs, hospices	Must keep for at least 1 year [8 C.C.R. Section 3342(h)]	6 years after date of training (may also wish to document attendance in employee's personnel file)
Workers' compensation claims files	All providers	Must keep for the latest of: 5 years from date of injury; 1 year from date compensation last provided; until all compensation due or which may be due has been paid; or, if an audit has been conducted within 5 years from the date of injury, until the findings are final [8 C.C.R. Section 10102]. *See 8 C.C.R. Section 10101.1 for required content of file.*	6 years after all compensation paid
Workers' compensation claims log	All providers	Must keep for 5 years from the end of the year to which the log relates [8 C.C.R. Section 10103.2]. *See regulation for required content of log.*	6 years
Workers' compensation self-insureds' claims files	All providers	Claim files must be kept for at least 5 years from date of injury or date on which last compensation benefit paid, whichever is later. Must keep indefinitely if open future medical benefits due. Must be kept in California unless written permission is obtained to retain the records out-of-state. [8 C.C.R. Section 15400.2]	6 years after all compensation paid

IMAGING/RADIOLOGY RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Dose surveys, air sampling, bioassays, measurements to evaluate release of radioactive effluents	Health facilities and imaging centers	Must keep for duration of license [10 C.F.R. Section 20.103; 17 C.C.R. Section 30275]. *See 10 C.F.R. Section 20.2103 for required surveys and measurements.*	Duration of license plus 30 years. Must keep any records showing potential employee exposures for at least 30 years *(see "Environmental (workplace) monitoring or measuring regarding toxic substances or harmful physical agents (including personal, area, grab, wipe, or other form of sampling; collection and analytical methodologies, calculations, and other background data; and analyses)," page 43)*.
Dose to individual member of public	Health facilities and imaging centers	Must keep for the duration of license [10 C.F.R. Section 20.2107; 17 C.C.R. Section 30275].	Duration of license, plus 30 years
Equipment inspection records	Health facilities and imaging centers		Life of equipment, plus 6 years
Fluoroscopy monitoring readings	Imaging facilities	Must keep at least 3 years [17 C.C.R. Section 30307(b)(2)] *(See regulation for required content of logs.)*	6 years
Mammograms and reports	Mammography facilities	Must keep in patient's medical record for not less than 7 years, or not less than 10 years if no subsequent mammograms of the patient are performed at the facility, unless the original mammogram is transferred to the patient's health care provider or to the patient [42 U.S.C. Section 263b(f)(1)(G)(i); 21 C.F.R. Section 900.12(c); 17 C.C.R. Section 30317.50].	File in patient's medical record
Mammography consumer complaints	Mammography facilities	Must keep for at least 3 years [21 C.F.R. Section 900.12(h)]	6 years

IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Mammography personnel qualifications for physicians, mammographic radiologic technologists, medical physicists	Mammography facilities	Must keep for at least 2 years after termination of employment/ medical staff membership [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30315.52, 30315.50 and 30455.1 for required qualifications.* In addition, records of personnel no longer employed must be kept until the next annual inspection has been completed and the FDA has determined that the facility is in compliance with MQSA personnel requirements [21 C.F.R. Section 900.12].	File in employee's personnel file
Mammography quality assurance records — records concerning mammography technique and procedures, quality control (including monitoring data, problems detected, corrective actions, effectiveness of corrective actions), safety and protection	Mammography facilities	Must keep until the next annual inspection has been completed and the FDA has determined that the facility is in compliance with the quality assurance requirements, or, for quality control test records, until the test has been performed two additional times at the required frequency, whichever is longer [21 C.F.R. Section 900.12(d)].	Until next inspection, plus 6 years
Mammography records — calibrations, maintenance, machine modifications (must include date of calibration, maintenance, or modification; name of individual making the record; manufacturer's model number, facility's radiation machine ID number)	Mammography facilities	Must keep for at least 3 years [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	Life of equipment, plus 6 years
Mammography records — processor film strips, phantom images, fixer retention test films, darkroom test films, screen-film contact test films	Mammography facilities	Must keep for at least 1 year [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	6 years

IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Mammography records — QA logs, phantom image score sheets, fixer retention log sheets, repeat analyses, darkroom fog log sheets, screen-film contact log sheets, compression test log sheets, darkroom cleaning logs, intensifying screen cleaning logs, view box cleaning logs, medical physicist survey reports, evaluations and instrument calibration reports, evaluations of new/repaired equipment, medical outcomes audit analyses, consumer complaints, mobile service provider documents	Mammography facilities	Must keep for at least 3 years [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	6 years/Life of equipment, plus 6 years
Mammography records — receipt, transfer, and disposal of radiation machines (must include date of receipt, transfer, or disposal; name and signature of individual making the records; manufacturer's model number; facility's radiation machine ID number)	Mammography facilities	Must keep until facility ceases use and disposes of the machine [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	Life of equipment, plus 6 years
Manifests	Health facilities and imaging centers		30 years
NRC Form 4 — prior occupational dose	Health facilities and imaging centers	Must keep for 3 years [10 C.F.R. Section 20.2104(f); 17 C.C.R. Section 30275].	Duration of employment, plus 30 years
NRC Form 5 — occupational monitoring	Health facilities and imaging centers	Must keep for the duration of license [10 C.F.R. Section 20.2106(f); 17 C.C.R. Section 30275]. Keep also in employee health record. *(See "Employee health (medical) records — Employees subject to OSHA regulations," page 46.)*	Duration of license, plus 30 years
Planned special exposure	Health facilities and imaging centers	Must keep for duration of license [10 C.F.R. Section 20.2105; 17 C.C.R. Section 30275].	Duration of license, plus 30 years
Radiation protection program	Health facilities and imaging centers	Must keep for the duration of license [10 C.F.R. Section 20.2102; 17 C.C.R. Section 30275].	Duration of license, plus 30 years

IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Radiation protection program — audits and reviews of content and implementation	Health facilities and imaging centers	Must keep for at least 3 years [10 C.F.R. Section 20.2102; 17 C.C.R. Section 30275].	30 years
Radiation source records: disposal	Health facilities and imaging centers	Must keep for duration of license [17 C.C.R. Sections 30275 and 30293, 10 C.F.R. Section 20.2108].	Duration of license, plus 30 years
Radiation source records: receipt and transfer	Health facilities and imaging centers	Must keep for 3 years following transfer [17 C.C.R. Section 30293].	30 years following transfer
Radiology reports, printouts, films, scans, and other imaging records	Health facilities and imaging centers	Hospitals that participate in Medicare must keep for at least 5 years [42 C.F.R. Section 482.26].	File in patient's medical record
Radioisotopes — receipt, transfer, use, storage, delivery, disposal and reports of overexposure	Health facilities and imaging centers	Must keep for at least 3 years after transfer or disposal of the material. Disposal records must be kept for duration of license. [10 C.F.R. Section 30.51]	30 years
Reports to CDPH of unplanned contamination events involving licensed radioactive material, failure of equipment designed to prevent releases, event requiring unplanned medical treatment, fire or explosion damaging licensed material, etc.	Health facilities and imaging centers	Must keep for duration of license [17 C.C.R. Section 30293]. *See 17 C.C.R. Section 30295 regarding reporting requirements.*	Duration of license plus 30 years. Must keep any records showing potential employee exposures for at least 30 years *(see "Environmental (workplace) monitoring or measuring regarding toxic substances or harmful physical agents (including personal, area, grab, wipe, or other form of sampling; collection and analytical methodologies, calculations, and other background data; and analyses)," page 43)*.
Requests for tests, procedures	Health facilities and imaging centers	Medicare-participating facilities and imaging centers must keep for at least 7 years [42 C.F.R. Section 424.516(f)]	15 years

IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Surveys and calibrations	Health facilities and imaging centers	Must keep for at least 3 years [10 C.F.R. Section 20.2103; 17 C.C.R. Section 30275]. *See 10 C.F.R. Section 20.2103 for required surveys and calibrations.*	Life of equipment, plus 6 years.
Tests of residual fixer level, darkroom fog, corrective actions	Imaging facilities (other than mammography or dental)	Must keep for at least one year from date of test [17 C.C.R. Section 30308.1]	6 years
X–rays, other imaging data and studies	Health facilities and imaging centers	Must keep for time prescribed for retention of medical records. *See "Medical Records," page 61.*	15 years – adults 25 years – minors

LABORATORY RECORDS AND SPECIMENS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Analytic system records: • Quality control and patient test records, including instrument printouts, if applicable; • Records documenting all analytic systems activities specified in CLIA, 42 C.F.R. Sections 493.1252-493.1289; and • Records of quality control procedures in use, including results on standards and reference materials and action limits when appropriate	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	6 years
Analytic system records — records of test system performance specifications that the laboratory establishes or verifies under 42 C.F.R. Section 493.1253	Freestanding and health facility laboratories	Must keep for the period of time the laboratory uses the test system, but no less than 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	Life of system, plus 6 years

LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Blood and blood component records (documentation regarding collection processing, testing, storage, distribution, complaints, adverse reaction and quality control records)	Blood banks, freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep for at least 10 years after processing or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d)] *See 21 C.F.R. Section 606.160(d) for further information about required record contents. See also 42 C.F.R. Sections 482.27 and 493.1105.*	15 years after expiration date, unless indefinite retention required *(see remarks to the left)*
Blood donor histories and pertinent records	Blood banks, freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep for at least 10 years after processing or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d)] *See 21 C.F.R. Section 606.160(d) for further information about required record contents.*	15 years after expiration date, unless indefinite retention required *(see remarks to the left)*
Blood: sample of transfused blood	Health facilities	Must keep for further testing in the event of a transfusion reaction [42 C.F.R. Section 493.1271(d)	2 weeks after last transfusion
Blood transfusion records (including source and disposition)	Freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep for at least 10 years after processing or distribution or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d)] *See also 42 C.F.R. Sections 482.27 and 493.1105.*	15 years after expiration date, unless indefinite retention required *(see remarks to the left)*
Blood transfusion-related records for which there is no expiration date	Freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep indefinitely [21 C.F.R. Section 606.160].	Permanent
Correspondence with clinician about malignant neoplasms	Freestanding and health facilities labs	Must keep at least 5 years [Business and Professions Code 1274(a)]	File in patient's medical record

LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Cytology lab — records of the total number of slides examined by each employee during each 24-hour period and the number of hours spent examining slides in the 24-hour period irrespective of the site or laboratory	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Sections 1265(j) and 1271]. *See also 42 C.F.R. Sections 493.1105 and 493.1274(d)(3).*	10 years
Cytology reports	Freestanding and health facility laboratories	Must keep for at least 10 years [Business and Professions Code 1271(g)].	File in patient's medical record.
Cytology slides and cell blocks	Freestanding and health facility laboratories	Must keep for at least 5 years from date of examination [Business and Professions Code 1271(g)]. *See also 42 C.F.R. Sections 493.1105 and 493.1274(f).* (Slides may be loaned to proficiency testing programs in lieu of keeping them for the required time period, provided the laboratory receives written acknowledgment of the receipt of slides by the proficiency testing program and keeps the acknowledgment.)	5 years
Equipment inspection, validation, calibration, repair and replacement records	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. If the records relate to equipment used to process blood or blood components, *see "Blood and blood component records (documentation regarding collection processing, testing, storage, distribution, complaints, adverse reaction and quality control records)," page 56, for applicable retention period.*	Life of equipment, plus 6 years
Histopathology slides	Freestanding and health facility laboratories	Must keep for at least 10 years from date of examination [42 C.F.R. Section 493.1105(a)(7)].	10 years
Human tissue intended for transplantation		*See "Human tissue intended for transplantation," page 61.*	

LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Immunohematology records and reports	Freestanding and health facility laboratories	Must keep for at least 10 years after processing or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d); 42 C.F.R. Section 493.1105]	Reports about individual patients: file in patient's medical record. Otherwise, keep 15 years unless indefinite retention required *(see remarks to the left)*
Invoices		*See "Invoices documenting purchase or lease of clinical laboratory equipment and test kits, reagents, or media," page 33.*	
Nuclear medicine reports	GACHs, APHs	Must keep for at least 5 years [42 C.F.R. Section 482.53(d)]	File in patient's medical record
Pathology test reports	Freestanding and health facility laboratories	Must keep for at least 10 years [42 C.F.R. Section 493.1105(a)(6)(ii)].	File in patient's medical record
Pathology specimen blocks	Freestanding and health facility laboratories	Must keep for at least 2 years from date of examination. [42 C.F.R. Section 493.1105]	2 years
Patient specimen testing records (including personnel performing the test and, if applicable, instrument printouts)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Sections 493.1105 and 493.1283.*	6 years
Procedure manuals; method of validation (manuals, card files, or flow charts for each procedure performed, including at least: name of procedure, source or reference for the test method, date procedure last reviewed/modified by the director/supervisor, current specific instructions for test performance, standards and controls required, and instructions for collecting and handling specimens to insure test reliability)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)].	Life of manual/ method, plus 6 years

LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Proficiency testing records	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Sections 493.801 and 493.1105*.	6 years
Quality control/assessment documentation (documentation regarding calibration, control procedures, maintenance and function tests, test result comparison activities, workload limit records, alarm system checks, proficiency testing, corrective actions, etc.)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section1265(j)]. However, quality control records for blood and blood components and immunohematology must be kept for at least 10 years after processing or 6 months after expiration date, whichever is later. [21 C.F.R. Section 606.160; 42 C.F.R. Section 493.1105] *See also 42 C.F.R. Part 493.*	6 years
Registers of tests — logbooks (chronological), accession logs	Freestanding and health facility laboratories		6 years
Report of imminent life-threatening result or panic value (including name of person contacted)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)].	File in patient's medical record
Requests for tests/test requisitions (patient ID, name of submitter, dates of receipt and report, type of test performed, test results).	Freestanding and health facility laboratories	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); 42 C.F.R. Section 424.516(f) (7-year retention period); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Specimen records	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)].	6 years

LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Test procedures (must include dates of initial use and discontinuance)	Freestanding and health facility laboratories	Must keep for at least 3 years after a procedure has been discontinued [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	6 years after procedure discontinued
Test reports not otherwise specifically mentioned (final, preliminary and corrected)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	File in patient's medical record
Tissue specimens	Freestanding and health facility laboratories	Preserve remnants of tissue for pathology examination until a diagnosis is made on the specimen [42 C.F.R. Section 493.1105].	Until diagnosis is made. May wish to keep longer depending upon type of tissue, how it is preserved, and clinical indications.

NOTE: State and federal laws contain detailed requirements regarding the information to be included in various documents. Laboratories should carefully review Business and Professions Code Section 1265(j) and 42 C.F.R. Section 493.1105 (which requires documentation of compliance with CLIA, 42 C.F.R. Sections 1252-1289) to be sure all required information is captured in the appropriate documents, and retained for the required period of time. Laboratories should also review 21 C.F.R. Section 606.160 if blood or blood components are involved. *(See "Where to Find the Laws Referenced in the Manual," page 75, for instructions on where to find the exact text of each statute and regulation.)*

The College of American Pathologists (CAP) has developed a recommended retention schedule that addresses many records and items not covered in this manual. Hospitals and other providers may wish to consult the CAP schedule.

MEDICAL RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Anatomical gift	Hospital		Permanent
Birth certificates	All providers		Permanent
Birth room record	All providers		Permanent
Cancer/tumor registry files	All providers		Permanent
Death certificates	All providers		Permanent
Electrocardiograms (EKGs)	All providers	Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Electroencephalograms (EEGs)	All providers	Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Electromyograms (EMGs)	All providers	Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Fetal heart monitor strips		Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Human tissue intended for transplantation		*See "Human tissue intended for transplantation (records regarding donor screening and testing; records regarding supplier, donor and lot identification, receipt, name(s) of recipient(s), storage temperatures, distribution, destruction, disposition of human tissue, expiration dates of all tissues, etc.)," page 38.*	
Index to patients' medical records		*See "Master patient index/medical record index number," page 25.*	
Orders and certifications	Medicare provider or supplier of DMEPOS, lab, imagery or home health services	Must keep at least 7 years [42 C.F.R. Section 424.516(f)]	File in patient's medical record

MEDICAL RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Patient medical records, including: • Admission records • Autopsy reports (and consents for autopsy) • Consent forms • Consultation reports • Diagnoses • Discharge summary • Imaging/radiology reports • Labor and delivery records • Laboratory reports • Medication records • Nurses' notes • Patient histories • Patient identification information • Patient's principal spoken language • Physical examination notes • Physical therapy notes • Physicians' orders • Progress notes • Psychiatric records • Reports of all other tests: EKG, EEG, etc. • Surgical records, complete with: – Anesthesia records – Findings – Operative report – Pathology report – Postoperative diagnoses – Preoperative diagnoses • Vital signs sheets	All providers	Various types of health facilities, home health agencies and individual practitioners are required to keep medical records for at least the following periods: • Adults and emancipated minors — 7 years • Unemancipated minors — 1 year after the minor has reached age 18, and in no event less than 7 years [Business and Professions Code Sections 2570.185 (occupational therapists), 2620.7 (physical therapists), 2919 (psychologists), 4980.49 (marriage and family therapists), 4989.51 (educational psychologists), 4993 (clinical social workers), 4999.75 (professional clinical counselors); Health and Safety Code Section 123145; 22 C.C.R. Sections 70751(c), 71551(c), 72543(a), 73543(a), 74731(d), 75055(a), 75343(a), 77143(c) and 79351(c)] Records that support claims for services rendered to Medicare or Medi-Cal patients must be kept for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476] SNFs that participate in Medicare/Medicaid must keep records of minors until they reach the age of 21 [42 C.F.R. Section 483.70(i)]. Prescribers of controlled substances must keep specified records at least 3 years [Health and Safety Code Sections 11190-11191].	15 years — adults 25 years — minors

MEDICAL RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Resident assessments	SNFs that participate in Medicare/Medicaid	Must keep for at least 15 months [42 C.F.R. Section 483.20(d)]	File in patient's medical record
Video records of diagnostic tests (e.g., arthroscopies)	All providers	Keep only those portions that are specifically selected by the physician to accompany the report in the patient's medical record.	File in patient's medical record

NOTE: *See "Human Resources Records," page 45, for information about employee health records.*

MEDICAL STAFF RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Bylaws and rules and regulations of the medical staff	GACHs, APHs, PHFs, CDRHs	Regulations require hospitals to keep these records, but do not specify retention periods [22 C.C.R. Sections 70703, 70733, 71503, 71531, 77127, 79303, and 79337].	Permanent
Bylaws, rules and regulations, and minutes of meetings of the professional and other staff	PHFs, CDRHs	Regulations require PHFs and CDRHs to keep these records, but do not specify retention periods [22 C.C.R. Sections 77127 and 79337].	Permanent
Call schedules	Hospitals	Hospitals that participate in Medicare must keep ED call schedules for at least 5 years [42 C.F.R. Section 489.20(r)].	6 years
Medical staff committee records, including minutes, reports and other records	GACHs, APHs, PHFs, CDRHs	Regulations require hospitals to keep these records, but do not specify retention periods [22 C.C.R. Section 70703, 70733, 71503, 71531, 79303 and 79337].	Permanent
Medical staff files (credentialing files) for allied health providers (non-employees), physicians, residents, interns, fellows, impaired practitioners — including applications (accepted and rejected), credentials, complaints, CME records, etc.	Hospitals		Length of practitioner's career, plus 6 years

MEDICAL STAFF RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Peer review records	Hospitals		Records regarding individual practitioners: length of practitioner's career, plus 6 years. Other records: 6 years
Quality assurance records, incident reports, root-cause analyses, etc.	Facilities	*See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years (unless desired longer for trending purposes)
Resident rotation schedules — location, nature of assignment, vacation, leave of absence, sick time, orientation time, classroom time, etc.	Resident employers	Must keep for at least 5 years after the cost report is filed with the intermediary. *See "Medicare cost report records," page 29.*	15 years
Surgical privileges list		*See "Surgical privileges list," page 39.*	

NUCLEAR MEDICINE RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Calibration records (including the model and serial number of the instrument, date of calibration, results of calibration, and the name of the individual who performed the calibration)	All providers	Must keep for at least 3 years [10 C.F.R. Section 35.2060].	Life of equipment, plus 6 years
Exposure records		*See "Employee health (medical) records — Employees subject to OSHA regulations," page 46.*	
Interpretations, consultations, and procedures reports	GACHs, APHs	Medicare-participating hospitals must keep for at least 5 years [42 C.F.R. Section 482.53].	File in patient's medical record
Receipt and disposition of radiopharmaceuticals	All providers	Regulations require Medicare-participating hospitals to keep these records, but do not specify a retention period [42 C.F.R. Section 482.53].	10 years

NOTE: *See "Imaging/Radiology Records," page 51, for additional information.*

NURSING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Nurse staffing data	SNFs that participate in Medicare/Medicaid	Must keep at least 18 months [42 C.F.R. Section 483.35(g)(4)]	15 years
Orientation and competency validation	GACHs	Must retain in employee's file for the duration of employment [22 C.C.R. Section 70214(a)(4)]	Duration of employment plus 4 years
Staff assignment records (including licensing/certification status of staff, patient census for each shift, staff assignment records, posted nurse staffing data)	SNFs	Must keep for at least 3 years [22 C.C.R. Section 72329.1(h)]. *See also 42 C.F.R. Section 483.35.*	15 years
Staffing patterns, including methodology used	APHs	Must keep for at least 6 months [22 C.C.R. Section 71213(i)].	6 years
Staffing plan for each patient care unit, including patient care requirements, staffing levels for registered nurses, and other licensed and unlicensed personnel. Must also record: 1. Staffing requirements as determined by the patient classification system for each unit, documented on a day-to-day, shift-by-shift basis; 2. The actual staff and staff mix provided, documented on a day-to-day, shift-by-shift basis; 3. The variance between required and actual staffing patterns, documented on a day-to-day, shift-by-shift basis; 4. The actual registered nurse, licensed vocational nurse and licensed psychiatric technician assignments to individual patients by licensure category, documented on a day-to-day, shift-by-shift basis.	GACHs	Must keep records of staffing patterns for the time period between licensing surveys. Must keep records of actual RN, LVN, and LPT assignments for at least 1 year. [22 C.C.R. Section 70217(d)(2)]	6 years

PHARMACY RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Alcohol (tax-free), used for medicinal, mechanical (analysis or test), or scientific purposes for patient treatment (records of receipt, shipments, use, destruction, and claims; include date of transaction, quantity and proof)	Hospitals, blood banks, and sanitariums	Must keep for at least 3 years following date of transaction. Must keep records at permit premises. [27 C.F.R. Section 22.164] *See also 27 C.F.R. Sections 22.161 and 22.162 for required content of records.*	6 years
Automated delivery device policies and procedures	Pharmacies	Must keep for at least 3 years after last use [16 C.C.R. Section 1713].	6 years
Chemicals and products used for compounding (records of acquisition, storage, destruction)	Pharmacies	Must keep for at least 3 years [16 C.C.R. Section 1735.3].	6 years
Compounded drug records	Pharmacies	Must keep for at least 3 years. Records to be kept include the master formula; date; personnel who compounded; pharmacist reviewing final product; quantity of each ingredient; manufacturer, expiration date and lot number of each component; equipment used; pharmacy-assigned reference or lot number; expiration date; and quantity compounded. Some exceptions for products compounded on a one-time basis for administration to an inpatient. [16 C.C.R. Section 1735.3]	6 years

PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Controlled substances dispensed, prescriptions	Health facilities, pharmacies	Must keep for at least 2 years records showing the kind and quantity of controlled substances dispensed or administered, the date of dispensing, the names and addresses of persons to whom controlled substances were dispensed or administered, and the names or initials of persons who dispensed or administered the controlled substance [21 C.F.R. Sections 1304.04 and 1304.22]. Prescriptions must be kept for at least 3 years [Business and Professions Code Section 4333; Health and Safety Code Sections 11179 and 11205]. Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)]. *See 21 C.F.R. part 1304 for required content of records.*	6 years
Controlled substances inventories and records (by registered location)	Pharmacies	Must keep for at least 3 years [16 C.C.R. Sections 1707 and 1718; 21 C.F.R. Section 1304.04(a)]. Some records may be kept at a central location if DEA and Board of Pharmacy is properly notified [21 C.F.R. Section 1304.04(a); 16 C.C.R. Section 1707]. Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)]. *See also 21 C.F.R. part 1304.11 for required inventory content and procedure.*	6 years
Controlled substance prescription forms (to whom issued, number issued, etc.)	Health facilities, specified clinics	Must keep at least 3 years [Health and Safety Code Section 11162.1]	6 years after last form used or destroyed

PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Controlled substances records	Prescribers	Must keep for at least 3 years [Health and Safety Code Section 11191]. *See Health and Safety Code Section 11190 for specific information that must be documented.* Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)].	6 years
Dialysis drugs and devices for home dialysis patients (prescriptions, invoices showing name of drugs/ devices, quantities, manufacturer, lot number, date, pharmacist)	Pharmacies	Must keep for at least 3 years [16 C.C.R. Sections 1787 and 1790].	6 years
Drugs provided to health care facility or prehospital EMS provider for use by EMS provider	Pharmacy, prehospital EMS provider	Must keep for at least 3 years [Business and Professions Code Section 4119].	6 years
Epinephrine auto-injectors furnished to school districts,county offices of education (records regarding acquisition and disposition)	Pharmacies	Must keep for at least 3 years [Business and Professions Code Section 4119.2].	6 years
Inspection reports by pharmacist of emergency drug supplies in nursing units (must be inspected at least monthly)	GACHs, APHs	Must keep for at least 3 years [22 C.C.R. Sections 70263(f) and 71233(f)].	6 years
Invoices		*See "Business and Finance Records," page 31.*	
Log of destruction of discontinued individual patient's drugs not supplied by the hospital which remain at the hospital after the patient is discharged (must include name of patient, name and strength of drug, prescription number, amount destroyed, date of destruction, signature of witness(es))	GACHs, APHs	Must keep for at least 3 years. Alternatively, the information may be kept in the patient's medical record. [22 C.C.R. Sections 70263 and 71233]	6 years

PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medicare Part D-related documents (prescription drug benefit)	All providers that contract with a Medicare Part D plan	Must keep for at least 10 years [42 C.F.R. Section 423.505(i)(2)]. *See "Contracts with Medicare Advantage or Medicare Part D Plans," page 6.*	15 years
Order form DEA 222 (Copy 3 for filled orders; also copies returned as unaccepted or defective)	Pharmacies	Must keep for at least 2 years [21 C.F.R. Section 1305.17]. *See 21 C.F.R. Sections 1305.03, 1305.13 and 1305.15 for required content of records.*	6 years
Patient medication profile (patient name, address, phone, date of birth, gender, allergies, current medications, medical conditions, etc.; prescription and prescriber information)	Pharmacies	Must keep for at least 1 year from the date the last prescription filled [16 C.C.R. Section 1707.1].	15 years — adults 25 years — minors
Prescriptions and prescription records	Pharmacies	Must keep for at least 3 years [Business and Professions Code Section 4333; Health and Safety Code Section 11179; 16 C.C.R. Section 1707 and 1717(f)]. Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)].	6 years
Quality assurance reviews (investigation and analysis of medication errors)	Pharmacies	Must keep for at least 1 year [16 C.C.R. Section 1711].	10 years
Quality assurance review required by Board of Pharmacy	Pharmacies	Must keep for at least one year [16 C.C.R. Section 1711(f)]	6 years
Recall records — records regarding manufacturer's recall of drugs and records evidencing removal of drugs from all nursing units, satellite pharmacies, etc.	Health facilities		6 years
Records of sale, acquisition, receipt and disposition of drugs (including DEA Form 222, theft and loss reports)	Health facilities, pharmacy	Must keep for at least 3 years [Business and Professions Code Sections 4081, 4105, 4190 and 4333]. Must be kept on the licensed premises unless a written waiver is granted by the Board of Pharmacy. *See also 42 C.F.R. Section 482.25; 21 C.F.R. Section 1304.22.*	6 years

PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Records regarding prescriptions purposely mislabeled (as part of a research study or by order of prescriber)	Pharmacies	Must keep for at least 3 years [Business and Professions Code Section 4078].	Research: 30 years after completion of research Order of prescriber: 15 years — adults 25 years— minors
Returned drugs — credit memo	Health facilities, pharmacies	A facility's return of a drug to the manufacturer is exempt from legally-prohibited sale/resale if a credit memo is created, sent to the manufacturer, and retained [21 C.F.R. Section 203.23]. The credit memo must be kept for at least 3 years [21 C.F.R. Section 203.60]. *See 21 C.F.R. Section 203.23 for required content of credit memo.*	6 years
Self-assessment required by Board of Pharmacy	Pharmacies	Must keep for at least 3 years [16 C.C.R. Section 1715]	6 years
Sterile compounding records	Pharmacies	Must keep for at least 3 years [16 C.C.R. Section 1751.1]. *See regulation for required content of records.*	6 years
Sterile injectable product records: name, lot number, amount, date, compounding information.	Pharmacies	Must keep for at least 3 years. For sterile products compounded from one or more nonsterile ingredients, must also keep training and competency evaluation of employees in sterile product procedures, refrigerator and freezer temperatures, certification of sterile compounding environment, other facility quality control logs, inspection for expired or recalled products, preparation records (including master work sheet, preparation work sheet, and end-product evaluation results). [16 C.C.R. Section 1751.1]	6 years
Temperature monitoring logs	The Joint Commission accredited organizations	`Must keep until next full survey	4 years

PUBLIC RELATIONS RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Advertisements (print, radio, television, etc.)	All providers		10 years; may wish to retain those of historical interest permanently
Authorization to use/disclose protected health information (media interviews, etc.)	All providers	HIPAA regulations require authorizations to be kept for at least 6 years [45 C.F.R. Section 164.530(j)].	8 years
Consent to photograph	All providers	HIPAA regulations require authorizations to be kept for at least 6 years [45 C.F.R. Section 164.530(j)]. Thus, if the photograph depicts a patient (as opposed to an employee, volunteer, or model) and is used for purposes other than treatment, payment or health care operations, the consent to photograph must comply with HIPAA authorization requirements and must be kept for at least 6 years.	8 years after discontinuing use of photograph
Marketing materials	All providers		10 years; may wish to retain those of historical interest permanently
Newspaper and magazine clippings (historical)	All providers		10 years; may wish to retain those of historical interest permanently
Photographs — institutional	All providers		10 years; may wish to retain those of historical interest permanently
Press releases	All providers		10 years; may wish to retain those of historical interest permanently
Publications (in-house)	All providers		10 years; may wish to retain those of historical interest permanently

PURCHASING AND RECEIVING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Invoices		*See "Business and Finance Records," page 31.*	
Packing slips	All providers		Providers may wish to match packing slips with invoices/ purchase orders and retain together.
Purchase orders		*See "Business and Finance Records," page 31.*	
Purchase requisitions (internal documents)	All providers		2 years
Receiving reports	All providers		2 years
Returned goods credits	All providers	*See "Business and Finance Records," page 31.*	

RESEARCH RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Contracts with study sponsors and principal investigators, including related documentation	All providers		30 years after completion of the research
Human subject research records	All providers	Retained records should include medical records.	30 years after completion of the research
Institutional Review Board (IRB) records (research proposals and scientific evaluations; approved sample consent documents; progress reports submitted by investigators; reports of injuries to subjects; minutes of IRB meetings; records of continuing review activities; correspondence between the IRB and investigators; list of IRB members, including name, degrees, representative capacity, experience; any employment or other relationship with the institution; written procedures for the IRB as required by 21 C.F.R. Section 56.108 (a) and (b); statements of significant new findings provided to subjects, as required by 21 C.F.R. Section 50.25)	IRBs	Must keep for at least 3 years after completion of the research [21 C.F.R. Section 56.115; 45 C.F.R. Section 46.115].	Records regarding particular research projects: 30 years after completion of the research General IRB records: 6 years
Other research reports	All providers		6 years (longer if continuing interest)
Research papers published	All providers		10 years; may wish to retain those of historical interest permanently
Research regarding prescriptions purposely mislabeled (as part of a research study)		*See "Records regarding prescriptions purposely mislabeled (as part of a research study or by order of prescriber)," page 71.*	

Where to Find the Laws Referenced in the Manual

All of the laws discussed in the manual can be found on the Internet.

FEDERAL LAW

A federal statute is written by a United States Senator or Representative. It is voted on by the United States Senate and the House of Representatives, and then signed by the President. A federal statute is referenced like this: 42 U.S.C. Section 1395. "U.S.C." stands for "United States Code." Federal statutes may be found at www.gpo.gov/fdsys or at www.law.cornell.edu.

A federal regulation is written by a federal agency such as the U.S. Department of Health and Human Services or the U.S. Food and Drug Administration. The proposed regulation is published in the Federal Register, along with an explanation (called the "preamble") of the regulation, so that the general public and lobbyists may comment on it. The federal agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. The final regulation is also published in the *Federal Register*. A federal regulation is referenced like this: 42 C.F.R. Section 482.1 or 42 C.F.R. Part 2. "C.F.R." stands for "Code of Federal Regulations." Federal regulations may be found at www.ecfr.gov. The preamble, however, is only published in the Federal Register and not in the Code of Federal Regulations. The Federal Register may be found at www.federalregister.gov.

The Centers for Medicare & Medicaid Services (CMS) publishes its *Interpretive Guidelines* on the internet. The *Interpretive Guidelines* include information for surveyors on how CMS interprets the Conditions of Participation, and instructions for surveyors on how to assess hospitals' compliance with the Conditions of Participation. They may be found at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html (click on Publication 100-07, "State Operations Manual, then "Appendices Table of Contents"). There are several appendices that hospitals will find useful, for example, A (hospitals), AA (psychiatric hospitals), V (EMTALA), and W (critical access hospitals).

A federal law must be obeyed throughout the United States, including in California, unless the federal law expressly states otherwise. As a general rule, if a federal law conflicts with a state law, the federal law prevails, unless the federal law expressly states otherwise.

If there is no conflict, such as when one law is stricter but they don't actually conflict with each other, both laws generally must be followed. For example, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal law states that providers must conform to whichever provision of federal or state law provides patients with greater privacy protection or gives them greater access to their medical information.

STATE LAW

A state statute is written by a California Senator or Assembly Member. It is voted on by the California Senate and Assembly, and then signed by the Governor. A state statute is referenced like this: Civil Code Section 56 or Health and Safety Code Section 819. State statutes may be found at www.leginfo.legislature.ca.gov. Proposed laws (Assembly Bills and Senate Bills) may also be found at this website.

A state regulation is written by a state agency such as the California Department of Public Health or the California Department of Managed Health Care. A short description of the proposed regulation is published in the California Regulatory Notice Register, more commonly called the Z Register, so that the general public and lobbyists may request a copy of the exact text of the proposed regulation and comment on it. The state agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. A notice that the final regulation has been officially adopted is also published in the Z Register. The Z Register may be found at www.oal.ca.gov/notice_register.htm.

A state regulation is referenced like this: Title 22, C.C.R., Section 70707. "C.C.R." stands for "California Code of Regulations." State regulations may be found at https://govt.westlaw.com/calregs/Search/Index.

A state law must be obeyed in California only. As a general rule, if a California law conflicts with a federal law, the federal law prevails, unless the federal law expressly states otherwise. (If there is no conflict, such as when one law is stricter but they don't actually conflict with each other, both laws generally must be followed.)

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	09/03/2025
BOARD OF DIRECTORS APPROVAL	
	09/23/2025
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
September 23, 2025 BOARD APPROVAL

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

		Pages	Action
I.	**Policies**:		**APPROVE**
	• Administration of Pneumococcal Vaccine to Inpatients	1-6	
	• Alteplase Protocol for Dialysis Catheters	7-8	
	• Neutral Zone and Operative Sharps Safety Practices	9	
	• Steam Sterilization	10-20	
	• Sterile Hazardous Drug Handling	21-40	
II.	**Forms:**		
	• CDI Pamphlet – SVMC Clinical Documentation Tips	41-42	
	• Outpatient Infusion Orders	43-44	
	• Refusal to Permit Medical Treatment	45-46	

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

POLICY

PURPOSE

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

BACKGROUND

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

A. PREREQUISITES

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

   i. Patients age 65 years or older

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

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

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

B. PRECAUTIONS

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

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

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

C. CONTRAINDICATIONS AND RISKS

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

   i. The patient has received two pneumococcal vaccine doses

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

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

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

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

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

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

   viii. The patient refused vaccination (notify the physician)

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

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

D. RESPONSIBILITIES

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

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

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

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

E. PROCEDURE

a. Treatment

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

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

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

TABLE 1: Recommendations for use of PCV15 or PCV20 in pneumococcal conjugate vaccine – naïve adults aged ≥ 19 years. Advisory Committee on Immunization Practices, United States, 2023

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

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

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

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

b. Education

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

c. Follow-up

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

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

1. Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). VAERS for reporting only, no medical advice is available. Contact VAERS at **www.vaers.hhs.gov** or call **1-800- 822-7967** (verified on 11-22-23)

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

a. A written emergency protocol specifically for vaccination reactions

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

d. Documentation

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

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

F. DEVELOPMENT & APPROVAL OF THE STANDARDIZED PROCEDURE

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

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

REFERENCES:

CDC: Advisory Committee on Immunization Practices (ACIP). GRADE: 20-valent pneumococcal conjugate vaccine (PCV20) for adults aged ≥65 years. (2021) Page last reviewed September 9, 2024, Accessed July 29, 2025 from: https://www.cdc.gov/acip/grade/pneumo-pcv20-age-based.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/acip/recs/grade/pneumo-PCV20-age-based.html

CDC: Advisory Committee on Immunization Practices (ACIP). Pneumococcal ACIP Vaccine Recommendations. Page last reviewed January 8, 2025, Accessed July 29, 2025 from: https://www.cdc.gov/acip-recs/hcp/vaccine-specific/pneumococcal.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html

CDC: Epidemiology and Prevention of Vaccine-Preventable Diseases – Chapter 17: Pneumococcal Disease (The Pink Book). Hall E., Wodi A.P., Hamborsky J., et al., eds. 14th ed. Washington, D.C. Public Health Foundation, 2021. Updated May 1, 2024, Accessed July 29, 2025 from https://www.cdc.gov/pinkbook/hcp/table-of-contents/?CDC_AAref_Val=https://www.cdc.gov/vaccines/pubs/pinkbook/index.html

CDC: Pneumococcal Vaccine Timing for Adults, Informational Sheet. Last reviewed July 24, 2024, accessed July 29, 2025 from https://www.cdc.gov/acip-recs/hcp/vaccine-specific/pneumococcal.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html

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

Kobayashi, M, Pilishvili, T, Farrar, JL, et al. Pneumococcal Vaccine for Adults Aged ≥ 19 Years: Recommendations of the Advisory Committee on Immunization Practices, United States, 2023. MMWR Recomm Rep 2023;72(No. RR-3):1-39 Accessed July 29, 2025 from http://dx.doi.org/10.15585/mmwr.rr7203a1

SUBJECT: **ALTEPLASE PROTOCOL FOR DIALYSIS CATHETERS**	SECTION: *[Enter manual section here]* **Page 1 of 2**

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

Recombinant tissue plasminogen activator (TPA or Alteplase) will be tried as an alternative to urokinase to restore function to clotted dialysis catheters. Alteplase has been used successfully and safely for this purpose in central vein catheters in much larger doses than we will be instilling in catheters.

It should be noted that TPA is indicated primarily as a thrombolytic agent in the setting of cerebrovascular accidents and coronary artery occlusion.

PURPOSE:

To restore function to thrombosed dialysis catheters by using Alteplase.

AFFECTEDAREAS/PERSONNEL: NURSING PERSONNEL/DIALYSIS

PROCEDURE:

1. Alteplase will only be used on poorly functioning dialysis catheters unable to maintain at least a blood flow rate of 200 ml/min.

2. After verifying that there are no obvious mechanical causes for inadequate flow, notify Physician. Obtain order for administration of Cathflo® Activase® into one or both catheter limbs.

3. **Preparation of Solution**
   - Check medication vial for expiration date and make sure seal is not broken.
   - Using aseptic technique, withdraw 2.2 ml's of sterile water for injection from the vial. **Do not use Bacteriostatic water for injection** per the manufacturer's package insert. (Reconstitute Cathflo® Activase® to a final concentration of 1 mg per ml).
   - Inject the 2.2 ml of sterile water for injection into the Cathflo® Activase® vial, directing the diluents stream into the powder. Mix by gently swirling until the contents are completely dissolved. **DO NOT SHAKE**. Complete dissolution should occur within three minutes. Slight foaming is not unusual, let the vial stand undisturbed to allow large bubbles to dissipate.
   - The solution may be used for intra catheter instillation within eight hours following reconstitution when stored at 2-30°C (36-86°F). No other medications should be added to solutions containing Cathflo® Activase®.
   - Inspect the vial for foreign matter and/or discoloration. After reconstitution, the solution should be colorless to pale yellow transparent solution.
4. Wash your hands. Put on your PPE and have patient place their mask on.
5. Note the priming volume of each catheter limb. If catheter volume is greater than 2ml's, complete the fill volume using normal saline behind the Cathflo® Activase®.
6. Wipe the top of the Cathflo® Activase® using an alcohol prep pad or swab. Aseptically withdraw 2 ml's of solution from the vial.

7. Attach the syringe containing Cathflo® Activase® to the catheter limb. Unclamp the catheter line and slowly instill the appropriate volume of Cathflo® Activase® into the catheter. **DO NOT USE EXCESSIVE PRESSURE.** Clamp the line and replace 3cc syringe with 10cc syringe. Label the catheter Cathflo® instilled, **DO NOT FLUSH.**
8. Document instillation of the medication into your treatment flowsheet.
9. After 30 minutes of dwell time, assess catheter function by attempting to aspirate Cathflo® from the catheter limbs containing the medication by gently pulling back on the 10 cc syringe.
    a. If patency is successful, using the attached 10 cc's syringe , aspirate 10 cc's from each limb. Clamp line and remove syringe. Attach a 10 cc syringe containing saline to each limb and genly irrigate catheter.
    b. If patency is Unsuccessful, allow Cathflo® to dwell another 30-60 minutes then repeat steps 9 and 9a.
10. **MD may send patient home with Cathflo® Activase® remaining in one or both catheter limbs as an interdialytic dwell solution. Patency is to be evaluated prior to the next scheduled dialysis treatment.**

11. If the second instillation of Alteplase is unsuccessful, contact the MD for possible catheter change in Interventional Radiology.

12. If the catheter function has been restored, the dialysis treatment will proceed per routine.

REFERENCE:

Cathflo Activase Dosing and Administration, Genentech Inc. 2017, San Francisco, Ca

CROSS REFERENCE: N/A

SUBJECT: **NEUTRAL ZONE AND OPERATIVE SHARPS SAFETY PRACTICES**	SECTION: **Page 1 of 1**

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

PURPOSE:

To provide guidance to perioperative personnel for identifying potential sharps hazards and developing and implementing best practices, including use of a neutral zone during operative and other invasive procedures, to prevent sharps injuries and reduce bloodborne pathogen exposure to perioperative patients and personnel. The expected outcome is that patients and personnel are free from sharps injury related to perioperative equipment, medical supplies, or instrumentation.

POLICY:

- Surgical team members will establish a neutral zone and use a hands-free technique for passing sharp instruments, blades, needles, and devices.
- A modified hands-free technique will be used during operative or other invasive procedures if use of a hands-free technique compromises safety.

AFFECTED AREAS/ PERSONNEL: *SURGICAL SERVICES, MATERNAL CHILD HEALTH, REGISTERED NURSES, SURGICAL TECHNICIANS; REGISTERED NURSE FIRST ASSISTANTS, CARDIAC CATHETERIZATION LAB, INTERVENTIONAL RADIOLOGY*

PROCEDURE:

1. Use of a neutral zone during operative or other invasive procedures will include
2. identifying the neutral zone before the first sharp is passed;
3. using a manufactured neutral zone device, instrument mat, magnetic pad, basin, or designated area as the neutral zone that provides a sturdy and adequately sized space for sharps;
4. giving verbal notification when a sharp is in the neutral zone;
5. placing one sharp at a time in the neutral zone;
6. orienting the sharp for easy retrieval by the surgeon or first assistant;
7. handling of a sharp item by only one team member at a time; and
8. placing sharp items in the neutral zone after use.
9. Use of a neutral zone with a modified hands-free technique during operative or other invasive procedures will include
10. the scrub person placing the sharp into the surgeon's hand and
11. the surgeon returning the sharp to the designated neutral zone.

REFERENCES:

Guideline for sharps safety. In: *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc.

SUBJECT: **STEAM STERILIZATION**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 1 of 11**

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

PURPOSE:

To provide guidelines for steam sterilization and monitoring of the processes throughout the Sierra View Medical Center (SVMC) facilities.

POLICY:

All steam processing at Sierra View Medical Center will be performed in a manner that provides the highest level of assurance that an object is free of viable microbes.

AFFECTED AREAS/ PERSONNEL:

MAIN OR, CPD (CENTRAL PROCESSING DEPARTMENT), SURGERY STAFF, CPD STAFF

DEFINITIONS:

Immediate use sterilization: Process designed for the steam sterilization of patient care items for immediate use (ANSI/AAMI ST79: 2010).

Biological indicator: A device intended for use by a health care provider to monitor adequacy of sterilization. This device consists of a known number of microorganisms, of known resistance to the mode of sterilization, in or on a carrier and enclosed in a protective package. Subsequent growth or failure of the microorganisms to grow under suitable conditions indicates the adequacy of sterilization [FDA, 21 CFR 880.2800(a)(1)].

Bowie-Dick test: Diagnostic test of a dynamic-air-removal steam sterilizer's ability to remove air from the chamber and prevent air re-entrainment (ANSI/AAMI ST79: 2010). Also known as "DART" test.

Chemical integrating indicators: Devices used to monitor the presence or attainment of one or more of the parameters required for a satisfactory sterilization process, or are used in specific tests of sterilization equipment (ANSI/AAMI ST79: 2010).

Decontamination: The use of physical and/or chemical means to remove, inactivate or destroy blood-borne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal [OSHA, 29 CFR 1910.1030].

Dynamic-air-removal steam sterilization: One of the two types of steam sterilization cycles in which air is removed from the chamber and the load by means of a series of pressure and vacuum excursions (prevacuum cycle) or by means of a series of steam flushes and pressure pulses above atmospheric pressure. It is generally preferred to a gravity-displacement cycle because of more efficient air removal, a shorter exposure time at higher temperatures, and a vacuum drying phase, resulting in an overall reduction in cycle time (ANSI/AAMI ST79: 2010).

Gravity-displacement steam sterilization: Type of sterilization in which incoming steam displaces residual air through a port or drain in or near the bottom of the sterilizer chamber (ANSI/AAMI ST79: 2010).

Presoaking: This is the process that begins at the point of use. It is recommended that instruments be kept as free as possible of blood and saline. Pre-treating instruments with an entity approved product (e.g. an enzymatic solution) is recommended. In lieu of this pre-treating, instruments may be rinsed and/or soaked in water prior to transport to the CPD Decontamination unit (ANSI/AAMI ST79: 2010).

Process challenge device (PCD): A challenge test pack or tray that contains a biological indicator plus a Class 5 integrating indicator or an enzyme-only indicator (ANSI/AAMI ST79: 2010).

PROCEDURE:

A. Assembly

1. Containers or baskets must be large enough to allow the metal mass of instruments and devices to be distributed evenly.

2. Total weight of an instrument set should not exceed 25 pounds.

3. Before assembly, instruments will be inspected and tested to assure patient safety and ultimate performance of the devices.

4. Instruments are to be positioned to allow the sterilant to come into contact with all surfaces.

5. A class 5 chemical integrating indicator should be placed in the areas of the package or tray that is considered least acceptable to steam penetration. For multiple layered trays, the indicators should be placed at opposite corners of each layer and/or where the instrument(s) are the most dense.

6. All jointed/hinged instruments should be in the open or unlocked position with ratchets not engaged to ensure that the sterilant comes into contact with all surfaces.

7. Instruments composed of more than one part or with sliding pieces or removable parts should be disassembled unless the device manufacturer provides specific instructions, supported by test data, to the contrary.

8. Instruments are not to be held together with rubber bands.

9. Perforated instrument tip protectors or foam instrument pouches may provide protection to sharp or delicate instrument tips in accordance with instrument manufacturer instructions for sterilization.

10. Any stylets, caps or plugs should be removed from devices with lumens, such as catheters, needles and tubing.

11. Items with concave surfaces and/or broad, flat surfaces that will retain water should be placed on edge so that these surfaces will drain water or condensate.

12. Heavy instruments should be placed on the bottom or sides of the trays so that they do not damage more delicate items. Lighter instruments should be positioned to protect tips and to prevent damage from changes in position.

13. Complex instruments (e.g., air-powered instruments, endoscopes, and instruments with lumens or channels) should be prepared and sterilized according to the device manufacturers' written instructions. When combining complex instruments in a set, the effectiveness of sterilization and drying should be tested.

14. Judicious use of tray liners or lint-free absorbent material may be used to alleviate drying problems.

15. If a rigid sterilization container is used, the manufacturer's instructions regarding set preparation and assembly should be followed.

B. Packaging

1. Selection of packaging, including rigid container systems, is based on manufacturers' recommendations for specific sterilization methods and cycles to be used.

2. Packaging techniques should be consistent with manufacturers' recommendations.

3. All packaging materials, including filters, must be examined for defects before using.

4. Packages/containers are to be labeled with name of item, date sterilized and initials of person who wrapped the item.

   a. If a marking pen is used to label wrapped packs, the ink should be non-toxic and the labeling information should be written on the indicator tape or affixed label.

5. Paper-plastic pouches should be used for small, light-weight items.

a. Double-packaging should not be performed without documentation from the manufacturer that the plastic-paper pouches have been validated for this use.

b. If the item is to be double-pouched, two sequentially-sized pouches should be used so that the sealed inner pouch fits inside the outer pouch without folding. The envelopes must be large enough to allow the hinged instruments to remain open during processing and storage. The pouches should be positioned so that the plastic faces plastic and the paper faces paper.

c. More than one instrument may be packaged together but must be placed so that all surfaces are exposed for adequate sterilant penetration.

d. Paper-plastic pouches are not to be used within wrapped sets or rigid containers.

C. Loading the Sterilizer

1. Similar items requiring the same cycle parameters (i.e., sterilization exposure time and temperature, cycle drying time and/or cooling time) should be grouped together. Rigid sterilization container systems can be sterilized in the same load as other supplies that require a common exposure cycle.

2. Load configuration should ensure adequate air removal, penetration of steam into each package and steam evacuation.

3. Paper-plastic pouches should stand on edge in relation to the cart or shelf, with the paper side of one pouch next to the plastic side of the next pouch; holding racks or baskets specifically designed for pouches can be used.

4. Wrapped instrument sets or rigid container sets should be placed on the sterilizer carriage rack so that the bottom of the tray or container system is parallel to the shelf.

5. Wrapped or rigid containers are not to be stacked.

6. Do not overload shelves or compress packages. Do not allow wrapped packages to make contact with the sterilizer chamber wall. Provide at least 3 inches between the sterilizer chamber ceiling and the topmost package of the load. Never place packages on the chamber floor.

7. The medical device and sterilizer manufacturers' guidelines as listed in the on-line "OneSource" program will be consulted before selecting cycle parameters (temperature and time of exposure and drying time) for all instrumentation and medical devices being wrapped or flash sterilized. If the information is not found on the "OneSource" site, the manufacturer will be contacted for clarification.

D. Sterilization of Wrapped Instrumentation/Devices:

1. Specific pre-programmed cycles that have been set to meet the medical device manufacturers' guidelines will be selected when sterilizing instrumentation.

2. Any differences between the sterilizer's programmed cycle parameters and the device manufacturer's recommended parameters should be investigated and resolved before the items are sterilized. For certain devices, the exposure or dry time might have to be extended, at which time the device manufacturer's written instructions must be consulted and followed.

3. To avoid wet packs, evaluation of drying time should be repeated any time that there is an addition of instruments or change of configuration to a set.

4. Following steam sterilization, the contents of the sterilizer should be removed from the chamber and left untouched for a period of 15 minutes to 2 hours depending on the load of contents. These contents must remain untouched until the equalization of the temperature differential between the chamber and outside environment has occurred and cooling/drying process has begun.

5. Warm or hot items should not be placed on cool or cold surfaces to prevent moisture condensation. (Sterilized packages or containers that have formed condensate should be considered unsterile and none of the contents used.)

E. Immediate Use Sterilization:

1. Immediate use steam-sterilization should be kept to a minimum and should be used only when there is insufficient time to process by the preferred wrapped/container method or when sufficient instrumentation does not exist for back to back case turnover and all options have been eliminated.

2. Specific pre-programmed cycles have been set to meet the medical device manufactures' guidelines and will be selected, as appropriate, when immediate use sterilization is necessary.

3. Dynamic-air removal cycles for unwrapped porous and non-porous items: The minimum exposure time and temperature for nonporous items is 3 minutes at 132 C (270 F) to 135 C (275 F).

4. The same decontamination and cleaning processes will be used on immediate use items as those that are processed in CPD.

5. Immediate use items are to be used immediately and not stored for later use.

6. Packaging and wrapping, such as textiles, paper/plastic pouches, non-woven wrappers are not to be used in rapid cycle sterilization.

7. Immediate use sterilization process:

   a. Place all items to be sterilized in a metal basket and place this basket inside the appropriate sized "Flash Pak".

   b. Place a class 5 indicator with the items to be sterilized.

   c. Close door securely.

   d. Select appropriate cycle for item to be sterilized according to manufacturers' specifications.

   e. When sterilization cycle is completed, open door with caution to prevent injury from exhaust of excess steam and heat.

   f. Measures are taken to prevent contamination during transfer of sterilized instruments to the sterile field. The sterilization container, when used, is carried to the OR by the circulating nurse using insulated gloves or towels to protect their hands. The circulator places the sterilization container on stable surface, opens the sterilization container. Both the circulator and scrub technician will check the indicator for correct exposure before transferring the inner basket to the sterile field. The scrub technician will retrieve instruments using sterile technique.

   g. The person opening the door to the sterilizer will verify that the cycle parameters were met by signing the autoclave printout and stapling the printout to the sterilizer log.

F. MONITORING OF STEAM STERILIZATION PROCESSES:

1. Physical monitoring devices, such as printouts, graphs and gauges, verify cycle time and temperature parameters for each load.

2. Chemical Integrators (CI) respond with a chemical or physical change to help detect potential sterilization failures from incorrect packaging, incorrect loading of the sterilizer or malfunctions of the sterilizer. The "pass" indicator does not prove that the item has been sterilized. The CIs must be used in conjunction with physical and biological monitors to demonstrate efficacy of the sterilization process.

a. An internal CI is to be placed within each package, tray, or rigid sterilization container system to be sterilized.

b. The CI is to be placed in the area of the package, tray or containment device that is considered to be least accessible to steam penetration (of greatest challenge to the sterilization process).

c. If the interpretation of the CI shows inadequate steam processing, the contents of the package are not to be used. The decision to recall the entire load should be based on the result of physical monitoring (time and temperature), results of other CIs in the load, and (if possible available) the results of the process challenge device biological indicator run in that load.

3. A process challenge device (PCD), which contains a biological and a CI indicator, is used to assess the effective performance of a sterilization process required for the most difficult item routinely processed.

a. PCDs are run with the first sterilizer loads each day in CPD and with each load sterilizing wrapped sets containing implants.

b. The PCD is placed on the bottom shelf of the chamber close to or over the drain where it is least favorable to sterilization (referred to as the "cold point" of the autoclave).

c. Loads should be quarantined until the results of the tests are read.

d. If the results are positive, the contents are not to be considered sterile.

e. Immediately hang a sign on the autoclave that it is out of service.

f. Notify the Engineering Department and the Steris technician for repair.

g. Notify the Department Manager.

h. After the malfunctioned autoclave is repaired, the sterilizer must have qualification testing performed before being placed back into service (see Autoclave Qualification Testing policy.)

4. A Bowie-Dick (DART) Test is used to test proper functioning of the vacuum pump by indicating if all air is being removed from the chamber.

a. Bowie-Dick test is required on all dynamic-air-removal or prevacuum sterilizers and is performed every day before the first load is run.

b. Place test pack on the bottom shelf close to or over the drain in the sterilizer.

c. Run the autoclave for 3 minutes with zero drying time or select the DART test setting from the cycle selections on the autoclave.

d. Satisfactory test results will show a black uniform coloring of the paper in the test pack.

e. Light areas denote the presence of air pockets within the test pack, and therefore, signal a problem with the vacuum pump.

f. Immediately hang a sign on the autoclave that it is out of service.

g. Notify Engineering and/or the Steris service department for repair.

h. Notify the Department Manager.

i. After the malfunctioned autoclave is repaired, the sterilizer must have qualification testing before being placed back into service (see Autoclave Qualification Testing policy.)

5. Biological (vial) indicators vials are run daily in the flash autoclave and with each implant load to monitor sterilizer efficacy and to validate the lethality of sterilization cycles.

   a. 3M Attest 1492V biological indicator (brown top – Geocillus stearothermophilus) is to be used with dynamic air-removal or prevacuum autoclave cycles.

6. Biological testing of the autoclave:

   a. Identify each test indicator by writing the sterilizer number, the load number and the processing date on the label.

   b. Place test indicator in a tray into the autoclave.

   c. Run the test indicator for 3 minutes on a normal flash cycle.

   d. At the end of the cycle, remove the tray and allow the indicator sufficient time to cool.

e. Close the cap, crush the indicator in the crusher well, tap it on a hard surface and place into a well of the incubator. This indicator is the testing indicator. Label the autoclave number on the indicator for identification purposes.

f. Incubation: Label a biological that has not been run with the same manufacture date and lot number as the testing indicator. Place in a well in the incubator. This indicator is the control indicator. Label "C" on the indicator for identification purpose. This indicator will show a positive result due to no "kill" exposure of the sterilizing process.

g. Interpretation: Rapid read-out of biological indicator is completed after 1 hour of incubation of 3M Attest 1492V

- A minus sign means a negative result (spore kill) and is safe to use the autoclave.
- A "plus" sign means positive result of bacterial growth and the contents of the load are not sterile.
- If a positive result is noted, immediately hang a sign on the autoclave that it is out of service. Communicate this to the Charge Nurse and/or appropriate personnel.
- Notify Engineering Department and the Manager or Director of Surgery of the malfunctioning autoclave which caused the positive test.
- After the malfunctioned autoclave is repaired, the sterilizer must have qualification testing performed before being placed back into service (see Autoclave Qualification Testing policy).

7. Documentation of cycle information and monitoring results of Bowie-Dick and biological testing should be maintained in a log to provide tracking of the sterilized loads. This enables personnel to retrieve items in the event of a recall and to trace problematic loads. The log must include:

a. Assigned lot number, including sterilizer identification and cycle number

b. Load content

c. Duration and temperature of exposure phase of the cycle

d. Signature or other identifier of the operator

e. Date and time of cycle

f. Results of biological testing, if applicable

G. Handling and inspection of wrapped sterilized items

1. As sterilized items are removed from the sterilizer cart or shelves, they should be visually inspected for packaged integrity.

2. Care should be taken to avoid dragging, sliding, crushing, bending, compressing or puncturing the packaging.

3. Any items with torn packaging or packaging that appears to be wet should not be used.

4. If an item is dropped on the floor and the integrity or sterility of the packaging is compromised, it should be returned to the decontamination area for reprocessing.

H. Storage of sterilized instruments

1. Shelf life of a packaged, sterilized item is considered event-related; i.e., package integrity, moisture exposure, storage conditions and the amount of handling

2. Sterile packages should be stored under environmentally controlled conditions to reduce the risk of contamination.

a. Temperature in the sterile storage areas should not exceed 75° F (24° C).

b. Relative humidity should not exceed 60%.

c. Supplies should be stored in a manner that allows adequate air circulation, ease of cleaning and compliance with fire codes. (8 inches above the floor, 18 inches below sprinkler heads.)

d. Stock should be rotated according to the principle, "first in-first out".

I. Documentation

1. Records of all cycles run in the CPD, Main OR and the ASD will be maintained for 3 years.

2. Records of all cycles run will be collected daily and stored by date for ease of tracking.

3. CPD:

a. At the end of each cycle, the person who cracks open the autoclave door will check the printout of the cycle to assure that the correct temperature and time parameters were met.

b. The printout is removed from the sterilizer, signed by the technician and attached to the "Load List – Process Documentation System" form to be completed for that load.

c. The form is completed to include:

- Date Load number
- Sterilizer number
- Load number
- List of contents
- If test load or if implants are included in the load, the biological indicator lot number

d. If test loads, the Bowie/Dick (Dart) readout and the Class 5 Chemical Integrator (CI) from the PCD are also attached to the Load List Documentation Form.

e. The BI vial removed from the PCD is placed in the incubator and recorded as mentioned earlier in this policy.

J. Quality Monitoring:

1. The Director of Surgical Services will be responsible for collection of data, analysis and actions pertaining to steam sterilization when applicable.

EVIDENCE-BASED REFERENCES:

- American National Standard Institution/ Association for the Advancement of Medical Instrumentation. 2017. Comprehensive guide to steam sterilization and sterility assurance in health care facilities. Arlington VA. Association for the Advancement of Medical Instrumentation. ST79:2017

- Association of Perioperative Registered Nurses. Instrument Cleaning. Retrieved October 12, 2020, from https://aornguidelines.org/guidelines/content?sectionid=173736661&view=book#173736661.

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

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

PURPOSE:

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

DEFINITIONS:

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

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

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

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

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

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

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

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

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

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

POLICY:

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

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

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

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

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

A. PERSONNEL PREPARATION:

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

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

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

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

   c. Utilize bactericidal soap.

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

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

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

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

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

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

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

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

   c. Don protective chemotherapy-approved gown.

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

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

   f. Extend outer glove over the cuff of gown.

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

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

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

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

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

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

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

B. CHEMOTHERAPY PREPARATION TECHNIQUE:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. INSPECTION OF FINAL PRODUCT:

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

D. LIST OF HAZARDOUS DRUGS

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

E. RESPONSIBILITIES OF PERSONNEL HANDLING HAZARDOUS DRUGS

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

a. Program integrity will be assured through the following:

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

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

F. FACILITIES AND ENGINEERING CONTROLS

1. Designated areas for handling HDs

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

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

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

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

c. Storage at Cancer Treatment Center

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

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

e. Designated Administration Areas

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

G. RECEIPT

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

a. If the shipping container appears damaged:

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

b. If a damaged shipping container must be opened:

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

H. STORAGE

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

I. COMPOUNDING

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

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

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

c. Utilize bactericidal soap.

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

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

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

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

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

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

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

b. Sanitize HD gloves with 70% isopropyl alcohol.

c. Don protective chemotherapy-approved gown.

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

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

f. Extend outer glove over the cuff of gown.

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

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

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

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

4. Head, Hair, and Shoe Covers

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

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

5. Doffing of PPE after HD compounding

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

6. Eye and Face Protection

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

   b. Goggles must be used, not eye glasses.

   c. Goggles plus face shield provide full protection.

7. Respiratory Protection

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

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

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

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

      - Deactivating, decontaminating, and cleaning underneath work surfaces.

- Known or suspected airborne exposure to powders or vapors.

8. Engineering Controls

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

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

9. CACI/BSC

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

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

10. STERILE COMPOUNDING

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

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

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

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

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

A. TRANSPORT OF HDs

1. LABELING

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

2. PACKAGING

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

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

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

B. ADMINISTERING

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

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

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

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

C. DISPOSAL

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

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

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

D. DISPENSING OF FINAL DOSAGE FORMS

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

E. DEACTIVATING, DECONTAMINATION, CLEANING, AND DISINFECTING

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

   a. Trained annually

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

2. CACI/BSC MAINTENANCE

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

   b. Disposal meets FDA regulations.

   c. All cleaning activities will be documented.

3. Deactivation

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

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

4. Decontamination

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

      - Removal of HD residue
        - Sterile Alcohol 70%

5. Cleaning

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

      - Removal of organic and inorganic material

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

6. Disinfecting

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

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

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

7. Spill Control

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

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

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

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

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

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

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

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

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

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

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

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

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

   a. 2 pairs of disposable HD gloves

   b. Low permeability gown and shoe covers

   c. Goggles or face shield

   d. Respirator mask (unless included in face shield)

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

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

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

h. Disposable scoop for collecting glass fragments

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

j. Cleaning solution for cleaning and decontamination of area

k. Instructions on the management of a cytotoxic chemotherapy spill

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

F. General clean-up procedure:

1. Assess the size and scope of the spill.

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

3. Post signs to limit access to spill area.

4. Obtain spill kit.

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

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

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

8. Absorb liquids with spill pads.

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

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

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

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

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

hazardous waste.

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

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

16. Wash hands thoroughly with soap and water.

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

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

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

2. If the spill is on an employee:

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

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

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

H. DOCUMENTATION AND STANDARD OPERATING PROCEDURES

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

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

I. MEDICAL SURVELLIANCE

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

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

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

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

4. ACTIONS IN RESPONSE TO EXPOSURE-RELATED HEALTH CHANGES

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

   b. Compare performance of controls with recommended standards.

   c. Conduct environmental wiping samples.

   d. Verify that all engineering controls are operating properly.

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

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

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

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

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

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

J. TRAINING

1. Personnel will be trained annually

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

   b. USP 797

   c. USP 800

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

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

f. Chemo Check Workbook ™

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

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

K. QUALITY ASSURANCE PROGRAM

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

a. Personnel Performance

b. Equipment and Facilities

c. Product and Environment

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

L. HAZARD COMMUNICATION PROGRAM

1. Standards of handling HDs shall be implemented and evaluated thru annual employee competencies.
2. All containers of HDs shall be labeled with the identity of the material and appropriate hazard warning.
3. Material Data Sheets are available for all employees 24 hours a day via the SVMC intranet.
4. Personnel shall receive training on exposure prior to handling HDs or when there are hazard changes.
5. Personnel of reproductive capability shall confirm in writing that they understand the risk of handling HDs.

M. CONTAINMENT REQUIREMENTS

1. For dosage forms (tablets or capsules, solid intact medications) that are administered to patients without modification shall be handled as per assessment of risk.
2. The selected containment strategy (handling precautions) will be communicated to staff via Electronic Medical Record and auxiliary stickers or pharmacy labels.
3. The facility risk assessment shall be reevaluated annually.
4. All HD API's and antineoplastic HD's will be transported in an imperious plastic container and labeled as HD on the outside of the container.

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

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

P. Documentation Retention

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

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

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

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

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

REFERENCES:

- USP 800 Hazardous Drugs- Handling in Healthcare Settings (2017). Retrieved from http://www.usp.org/sites/default/files/usp/document/our-work/healthcare-quality-safety/general-chapter-800.pdf. Accessed 6/24/2020.
- "ASHP Guidelines on Handling Hazardous Drugs." *American Journal of Health-System Pharmacy* 63, no. 12 (June 15, 2006): 1172–1191. doi:10.2146/ajhp050529. Accessed: November 6, 2018.
- Occupational Safety and Health Administration (OSHA) Guidelines for Controlling Occupational Exposure to Hazardous Drugs Accessed 6/24/20.https://www.osha.gov/SLTC/hazardousdrugs/index.html.
- 2025 Lawbook for Pharmacy. Business and Professions Code 4000. https://www.pharmacy.ca.gov/laws_regs/lawbook.pdf.

CROSS REFERENCES:

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

❖ **HEART FAILURE**: Always document if it is **acute, chronic**, or **acute on chronic** (exacerbation). Always document if it is **systolic, diastolic**, or **systolic and diastolic.**

Cardiogenic pulmonary edema = heart failure

❖ **SYMPTOMS:** Try to link to a diagnosis, whether confirmed or suspected.

❖ **RESPIRATORY FAILURE:** should document evidence of increased work of breathing! Mechanical vent **not** required. Supplemental oxygen administered by venture mask, non-rebreather,CPAP/BiPAP or high flow NC. Consider when patient is hypoxemic, hypercapneic, tachypneic, acidotic. ABG's. **Acute, chronic, Acute on chronic**

❖ **SEPSIS/SIRS: SIRS** = body's systemic response to infections and noninfectious causes (continue to use the SIRS parameters)

Bacteremia = nonspecific lab finding

Sepsis/Severe sepsis = infection with ACUTE organ dysfunction (must link the infection to the organ dysfunction)

Clinical Indicators:

- **Respiratory** (Pa02/FiO2 <400)
- **Coagulation** (platelets <150)
- **Liver** (Bilirubin >1.2)
- **Cardiovascular** (Map <70 &/or vasopressors)
- **Central Nervous System** (Glasgow Coma Scale <14)
- **Renal** (Creatinine >1.2, or urine ouput <500 mL/day)

Septic shock = severe sepsis

hypotension, not reversed w/fluid resuscitation

***Sepsis resolved=sepsis treated and resolved*

***Sepsis ruled-out=worked up/initially but was later ruled out*

***Include sepsis resolved or ruled-out on discharge summary*

❖ **RENAL DISEASE**: Document the stage of CKD per National Kidney Guidelines. CKD = kidney damage or GFR < 60 x 3+ months

- **Stage I**- Slight kidney damage with normal kidney function- **GFR >90**
- **Stage II**- Kidney damage with mildly decreased kidney function- **GFR 60-89**
- **Stage III**- moderately decreased kidney function- **3a-GFR 45-59; 3b-GFR 30-44**
- **Stage IV**- severely decreased kidney function- **GFR 12-29**
- **Stage V**- Kidney Failure- **GFR <15**
- **End Stage Renal Disease – GFR<15**

○ **RENAL FAILURE:** Renal insufficiency is insufficient. If you document acute renal insufficiency when your patient is in **acute renal failure**, you will not capture severity of illness!

○ **Acute kidney injury** and **acute renal failure** can be documented interchangeably. Don't abbreviate "AKI" as it can mean insufficiency

○ **Please consider KDIGO criteria for acute kidney injury. Any of the following 3 criteria**

KDIGO defines AKI as any of the following:

-Increase creatinine**>= 0.3 mg/dl from baseline within 48 hours;** or
-Increase in creatinine level to **>= 1.5x baseline**, which is known or presumed to have occurred within the prior 7 days:or
-Urine output< 0.5 ml/kg/hr for 6 hours

❖ **Malnutrition**: **2** of the following **6** criteria, **NOT albumin/pre-albumin.**
Insufficient energy intake, weight loss, loss of muscle mass, loss of subQ fat, decrease grip strength, fluid accumulation masking wt loss
*** Please review Dieticians(RD) Assessment

020981

Sierra View Medical Center

CLINICAL DOCUMENTATION PHYSICIAN TIPS

Your Clinical Documentation Improvement Specialists are:

Melissa Cabeje, RN, CCDS (559) 791-4755	Sherri Gray, RN, CDS (559) 791-4799

- **Always document the reason for admission, including possible or suspected diagnoses**
- **Always document the disposition of each diagnosis, whether confirmed, ruled out, remains possible, etc.**
- **Always carry through to the discharge summary diagnoses that have not been ruled out**
- **Always document all conditions that affect the patient's stay, including chronic conditions for which medications have been ordered**
- **Always document the clinical significance of any abnormal labs, radiology reports, and pathology findings**
- **Always document adherence to core measures and quality standards**

❖ **PRESENT ON ADMISSION (POA):**

- **Ulcers: identify type, location, and stage**
- **Sepsis if identified after study and not noted on admission**
- **Catheter-associated UTI, central line associated bloodstream infection**
- **Deep vein thrombosis**
- **If currently treating a condition, document it as current and not just "history of"**

❖ **LINK!!**

- **Link conditions to underlying cause**
- **Link infections to organisms**

Neurology	
Instead of	.....think about documenting....
Altered mental status (**Document suspected or known cause**)	▪ Metabolic, toxic, hepatic, infectious encephalopathy ▪ Drug-induced delirium ▪ Dementia with delirium
Mass effect	▪ Cerebral edema ▪ Brain compression
CVA (Please note if Ruled in or out)	▪ Left or right sided hemiparesis/ hemiplegia, dominant/nondominant
TIA/CVA (Review MRI & neurologist notes)	▪ Cerebral thrombus/embolus without infarct ▪ Note Ruled in or out

Cardiology	
Instead of	.....think about documenting....
CHF	▪ Acute (systolic, diastolic)heart failure ▪ Chronic (systolic, diastolic) heart failure ▪ Acute on chronic (exacerbation or decompensated is ok) (systolic, diastolic) heart failure
ACS	▪ NSTEMI ▪ Unstable angina
Cardiomyopathy	▪ If there is a component of heart failure
Troponin leak	▪ NSTEMI, demand ischemia ▪ Source of leak
Chest pain	▪ Suspected or known cause
Syncope	▪ Suspected or known cause

Pulmonary	
Instead of	think about documenting....
Respiratory distress/hypoxia/ SOB	▪ Respiratory failure (specify acute or chronic), with or without hypoxia/hypercapnia
Pneumonia	▪ Type of pneumonia: aspiration, viral, bacterial, CAP, HCAP. ▪ Type of organism: OK to use likely/suspected/ possible/probable.
Pulmonary edema	▪ Acute pulmonary edema ▪ If cardiogenic, document heart failure (see heart failure tips)

GI/GU	
Instead of	.....think about documenting....
Urosepsis (Not codeable)	▪ Sepsis due to UTI ▪ UTI (if no sepsis)
Renal insufficiency	▪ ARF/AKI (if acute) ▪ CKD with stage (if chronic)
+ UA	▪ UTI ▪ Catheter-associated infection
GI bleed	▪ GI bleed linked to specific cause

Metabolic	
Instead of	.....think about documenting....
Cachexia, wt loss, muscle wasting	▪ Malnutrition – mild, moderate or severe
IDDM or NIDDM	▪ Type 1 or type 2, out of control, poorly or inadequately controlled ▪ Any link between DM and PVD, osteomyelitis, gastroparesis, retinopathy, neuropathy, ulcers, etc.

Fluid overload	▪ Heart failure (see heart failure tips)

Integumentary	
Instead of	.....think about documenting....
I&D	▪ Debridement: excisional or nonexcisional ▪ Include instruments used, tissue debrided, depth reached
Pressure ulcer	▪ Location and stage

Hepatobiliary	
Instead of	.....think about documenting....
Obstructive jaundice	▪ Bile duct obstruction
Hepatitis	▪ Type and acuity

Hematology/Oncology	
Instead of	.....think about documenting....
Leukopenia, thrombocytopenia & anemia in pt on chemo	▪ Pancytopenia due to medications
Anemia	▪ Anemia of acute/chronic blood loss ▪ Anemia due to chemotherapy ▪ Anemia of chronic disease ▪ Anemia due to (specified) nutritional deficit

A few last words:

Acuity! If it can be described as acute, chronic, or acute on chronic, please do so.

Laterality! If it can be described as left, right or bilateral, please do so.

Specificity! If a site can be described down to a more exact location, please do so. If a condition can be described with more details, please do so.

SIERRA VIEW MEDICAL CENTER **OUTPATIENT INFUSION PHYSICIAN ORDERS**

TREATMENT

ALL ORDERS MUST BE DATED, TIMED AND SIGNED BY THE PRESCRIBING PHYSICIAN

Physicians: Please indicate your orders by checking the boxes or filling in the blank spaces below

PATIENT NAME: _____ **DOB** _____

DIAGNOSIS – Primary _____

DIAGNOSIS – Secondary _____

ALLERGIES: _____

ACTIVE MEDICATIONS _____

SIGNIFICANT SURGICAL/INVASIVE PROCEDURES: _____

PREMEDICATIONS:

Drug	Dose	Route	Frequency	Total Treatments

MEDICATIONS:

Order (check)	Drug	Dose (circle one)	Route (circle one)	Frequency	Total Treatments	Supporting Documentation (required)
	Iron Sucrose	200 mg	IVP over 5 minutes		x5	
	Feraheme	510 mg			Two	Informed Consent
	Ferrlecit	125 mg				Informed Consent
	Immune Globulin		IVPB			Informed Consent
	Reclast	5 mg	IVPB	Once	One	Informed Consent, Bone density, BMP (**Within 30 days.**)
	Solumedrol		IV			Informed Consent
	Vitamin B-12		IM			

Order (check)	Drug	Dose	Route	Frequency	Total Treatments
	Prolia: Denosumab	60mg	SUBQ	once every 6 months	x2
	Inflectra	5mg/kg	IV	0,2, and 6 weeks and every 8 weeks thereafter	x8
	Inflectra Maintenance	5mg/kg	IV	Every 8 weeks	x6
	Vedolizumab	300mg	IV	0, 2, and 6 weeks and then every 8 weeks thereafter	x8
	Vedolizumab Maintenance	300mg	IV	8 weeks thereafter	x6

PATIENT'S LABEL

SIERRA VIEW MEDICAL CENTER — OUTPATIENT INFUSION PHYSICIAN ORDERS

PROCEDURES:

Procedure	Dose/Units	Frequency	Total Treatments	Supporting Documentation (required)
Type & Cross Match	_____	_____	_____	
Blood Transfusion				Transfusion Informed Consent
Phlebotomy				Informed Consent
Flush Portacath	NA			
Blood Draw from portacath	NA			Labs:

POST MEDICATIONS:

Drug	Dose	Route	Frequency	Total Treatments

PHYSICIAN SIGNATURE:_____ **DATE:**_____ **TIME:**_____

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

OUTPATIENT INFUSION ORDERS

Form # 016917 REV. 5/25

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

PATIENT'S LABEL

REFUSAL TO PERMIT MEDICAL TREATMENT

My doctor (physician name)_____,

has advised the following medical treatment:_____

_____.

My doctor has informed me of the following:

1. The nature and advisability of this medical treatment.
2. The risks and complications of this medical treatment.
3. The expected benefits of this medical treatment.
4. The alternatives to this medical treatment and their risks and benefits.
5. The probable consequences of not receiving this medical treatment.

I understand that the doctor named above and other doctors who provide services to me are not employees or agents of the hospital. They are independent medical practitioners.

Notwithstanding the recommendation of my doctor, I hereby request that this medical treatment not be administered to me during my stay at(name of hospital)_____.

I hereby release the hospital, its personnel, my doctor, and any other persons participating in my care from any responsibility whatsoever for any injury or unfavorable consequences which may occur as a result of my refusal to permit this medical treatment.

Date:_____ Time:_____ AM / PM

Signature:_____
(patient/legal representative)

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

Print name:_____
(legal representative)

PATIENT'S LABEL

Negativa a Permitir Tratamiento Médico

Mi médico (nombre del médico)_____ ha aconsejado el siguiente tratamiento médico: _____

_____

Mi médico me ha informado lo siguiente:

1. La naturaleza y la conveniencia de este tratamiento médico.
2. Los riesgos y las complicaciones de este tratamiento médico.
3. Los beneficios que se esperan de este tratamiento médico.
4. Las alternativas a este tratamiento médico y sus riesgos y beneficios.
5. Las consecuencias probables de no recibir este tratamiento médico.

Entiendo que el médico antes nombrado y otros médicos que me prestan servicios no son empleados ni agentes del hospital, son médicos independientes.

Sin perjuicio de la recomendación de mi médico, por la presente, solicito que no se me administre este tratamiento médico durante mi permanencia en el (nombre del hospital) _____ .

Por la presente eximo al hospital, a su personal, a mi médico y a otras personas que participen en mi atención de toda responsabilidad, sea cual fuere, por cualquier lesión o consecuencia adversa que se pueda producir debido a mi negativa a permitir este tratamiento médico.

Fecha:_____ Hora:_____ AM / PM

Firma:_____
(paciente/representante legal)

En caso de que lo firmase una persona que no sea el paciente, indique la relación:_____

Nombre en letra de imprenta: _____
(representante legal)

PATIENT'S LABEL

SIERRA VIEW
MEDICAL CENTER

MEETING MINUTES

MINUTES FROM PREVIOUS MEETING SUBMITTED FOR APPROVAL

MEETING MINUTES

BOARD OF DIRECTORS REGULAR MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly **August 26, 2025 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman Lomeli called the meeting to order at 5:01 p.m.

Board Attendance:

- Liberty Lomeli, Chair - Present
- Bindusagar Reddy, Vice Chair - Present
- Areli Martinez, Secretary – Present
- Hans Kashyap, Director – Absent
- Gaurang Pandya, Director - Present

Others Present: Donna Hefner, President/Chief Executive Officer, Craig McDonald, Chief Financial Officer, Melissa Crippen, Vice President of Quality and Regulatory Affairs, Ron Wheaton, Vice President of Professional Services & Physician Reruitment, Tracy Canales, Vice President of Human Resources & Marketing, Jeff Hudson, Patient Care Services Strategy Advisor, Brandy Irwin, Interim Chief Nursing Officer, Whitney Watts, Accreditation and Regulatory Affairs, Coordinate, Kim Pryor-DeShazo, Director of Marketing and Communications, Silvia Roberts, Director of Care Integration, John Lee, Project Manager, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff, Michael Nelson, Associate at Darden Architects.

I. Approval of Agenda:

Chair LOMELI motioned to approve the Agenda. The motion was moved by Director PANDYA, seconded by, Vice Chair REDDY and carried to approve the agenda. The vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:02 p.m. to discuss the following items:

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

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

1. Evaluation – Quality of Care/Peer Review/Credentials

2. Quality Division Update – Quality Report

3. Compliance Report – Quarter 4

E. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation; Anticipated Litigation: BETA Claim 25-0015272 Conference with Legal Counsel.

Closed Session Items C, D, F and G were deferred to the conclusion of Open Session, as there was not sufficient time to address these items prior to the scheduled start of Open Session.

III. Open Session: Chair LOMELI adjourned Closed Session at 5:35 p.m., reconvening in Open Session at 5:35 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report.
Information Only; No Action Taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – Quality of Care/Peer Review/Credentials

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ and carried to approve the Evaluation – Quality of Care/Peer Review/Credentials as presented. The vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Yes
PANDYA	Yes
REDDY	Abstain
LOMELI	Yes

2. Quality Division Update – Quality Report

Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Director PANDYA, and carried to approve the Quality Division Update – Quality Report as presented. The vote of the Board is as follows:

KASHYAP Absent

MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

3. Compliance Report – Quarter 4

Following review and discussion, it was moved by Vice Chairman REDDY seconded by Director PANDYA, and carried to approve the Quarter 4 Compliance Report as presented. The vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

E. Discussion Regarding Significant Exposure to Litigation; Anticipated Litigation

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ, and carried to reject BETA CLAIM 25-001572 . The vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

IV. Public Comments

None

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). Following review and discussion, it was moved by Director MARTINEZ, seconded by Director PANDYA, and carried to approve the Consent Agenda. The vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes

LOMELI Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director MARTINEZ and seconded by Vice Chairman REDDY to approve the July 22, 2025 Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

KASHYAP Absent
MARTINEZ Yes
PANDYA Yes
REDDY Yes
LOMELI Yes

VII. Business Items

A. July 2025 Financials

Craig McDonald, CFO presented the Financials for July 2025.

Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Director PANDYA and carried to approve the July 2025 Financials as presented. The vote of the Board is as follows:

KASHYAP Absent
MARTINEZ Yes
PANDYA Yes
REDDY Yes
LOMELI Yes

B. Notice of Resignation of Zone 2 Board Member Gaurang Pandya Effective September 1, 2025

The Board thanked Director Pandya for his service and advocacy for advancing education and quality within the hospital. Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman REDDY and carried to approve the plan to obtain applicants to fill the vacancy by Appointment by the November 25, 2025 Regular Meeting.

KASHYAP Absent
MARTINEZ Yes
PANDYA Yes
REDDY Yes
LOMELI Yes

VIII. SVLHCD Board Chair Report

Board Chair Lomeli thanked Director Pandya for his services not only in the hospital but in the community.

IX. CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View.

IX. Announcements:

A. Regular Board of Directors Meeting – September 23, 2025 at 5:00 p.m.

X. Closed Session: Chairman LOMELI adjourned Open Session at 5:57 p.m., reconvening in Closed Session at 6:07 p.m.

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning (3 Items). Estimated date of disclosure July 1, 2026.

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

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning. Estimated date of disclosure January 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 Item).

XI. Open Session: Chairman LOMELI adjourned Closed Session at 7:15 p.m., reconvening in Open Session at 7:15 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

C. Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning (3) Items

Following review and discussion, it was moved by Director PANDYA, seconded by Director Martinez and carried to approve to authorize plan development drawings for the Distinct Part Skilled Nursing Facility, Nuclear Medicine and Graduate Medical Education. The vote of the Board is as follows:

KASHYAP	Absent
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
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

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

XII. Adjournment

The meeting was adjourned at 7:16 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

SIERRA VIEW MEDICAL CENTER

FINANCIALS

FINANCIAL REPORTS FROM THE PREVIOUS MONTH

FINANCIAL PACKAGE
Aug-25

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
August 2025

Statistic	Aug-25 Actual	Aug-25 Budget	Aug-25 Over/ (Under)	Aug-25 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 25 YTD	Increase/ (Decrease) Aug-24	% Change
Utilization											
SNF Patient Days											
Total	27	-	27	0.0%	27	-	27	0.0%	62	(35)	-56.5%
Medi-Cal	27	-	27	0.0%	27	-	27	0.0%	62	(35)	-56.5%
Sub-Acute Patient Days											
Total	1,063	1,067	(4)	-0.3%	2,132	2,162	(30)	-1.4%	2,066	66	3.2%
Medi-Cal	469	551	(82)	-14.8%	965	1,134	(169)	-14.9%	1,083	(118)	-10.9%
Acute Patient Days	1,639	1,746	(107)	-6.2%	3,392	3,365	27	0.8%	3,185	207	6.5%
Acute Discharges	472	463	9	1.9%	952	892	60	6.7%	892	60	6.7%
Medicare	174	174	-	0.0%	358	344	14	4.1%	344	14	4.1%
Medi-Cal	229	236	(7)	-3.0%	471	427	44	10.3%	427	44	10.3%
Contract	65	51	14	27.5%	116	113	3	2.7%	113	3	2.7%
Other	4	2	2	100.0%	7	8	(1)	-12.5%	8	(1)	-12.5%
Average Length of Stay	3.47	3.77	(0.30)	-7.9%	3.56	3.77	(0.21)	-5.5%	3.57	(0.01)	-0.2%
Newborn Patient Days											
Medi-Cal	155	195	(40)	-20.4%	345	342	3	0.8%	339	6	1.8%
Other	40	44	(4)	-9.5%	82	78	4	5.6%	81	1	1.2%
Total	195	239	(44)	-18.4%	427	420	7	1.7%	420	7	1.7%
Total Deliveries	105	110	(5)	-4.5%	224	202	22	10.9%	204	20	9.8%
Medi-Cal %	74.77%	83.43%	-8.67%	-10.4%	78.51%	83.43%	-4.92%	-5.9%	84.31%	-5.80%	-6.9%
Case Mix Index											
Medicare	1.5677	1.6368	(0.0691)	-4.2%	1.4520	1.6368	(0.1848)	-11.3%	1.6578	(0.2058)	-12.4%
Medi-Cal	1.1409	1.1975	(0.0566)	-4.7%	1.0934	1.1975	(0.1041)	-8.7%	1.1854	(0.0920)	-7.8%
Overall	1.2712	1.3724	(0.1012)	-7.4%	1.2176	1.3724	(0.1548)	-11.3%	1.3777	(0.1601)	-11.6%
Ancillary Services											
Inpatient											
Surgery Minutes	7,307	7,621	(314)	-4.1%	15,294	15,725	(431)	-2.7%	15,331	(37)	-0.2%
Surgery Cases	89	95	(6)	-6.2%	186	184	2	1.2%	182	4	2.2%
Imaging Procedures	1,558	1,437	121	8.4%	3,296	3,012	284	9.4%	2,992	304	10.2%
Outpatient											
Surgery Minutes	15,033	13,476	1,557	11.6%	31,053	28,236	2,817	10.0%	29,367	1,686	5.7%
Surgery Cases	195	187	8	4.4%	400	391	9	2.2%	384	16	4.2%
Endoscopy Procedures	201	178	23	12.9%	394	373	21	5.6%	385	9	2.3%
Imaging Procedures	4,309	4,004	305	7.6%	8,505	8,388	117	1.4%	7,672	833	10.9%
MRI Procedures	313	290	23	8.0%	654	607	47	7.7%	595	59	9.9%
CT Procedures	1,494	1,204	290	24.0%	2,888	2,524	364	14.4%	2,511	377	15.0%
Ultrasound Procedures	1,441	1,298	143	11.0%	2,921	2,719	202	7.4%	2,720	201	7.4%
Lab Tests	34,199	30,839	3,360	10.9%	70,139	64,615	5,524	8.5%	64,957	5,182	8.0%
Dialysis	5	3	2	55.4%	12	7	5	78.0%	4	8	200.0%

Sierra View Medical Center
Financial Statistics Summary Report
August 2025

	Aug-25				YTD						
Statistic	**Actual**	**Budget**	**Over/ (Under)**	**% Var.**	**Actual**	**Budget**	**Over/ (Under)**	**% Var.**	**Fiscal 25 YTD**	**Increase/ (Decrease) Aug-24**	**% Change**
Cancer Treatment Center											
Chemo Treatments	2,006	1,922	84	4.4%	4,131	4,027	104	2.6%	4,576	(445)	-9.7%
Radiation Treatments	1,585	1,833	(248)	-13.5%	2,765	3,840	(1,075)	-28.0%	4,397	(1,632)	-37.1%
Cardiac Cath Lab											
Cath Lab IP Procedures	19	13	6	42.3%	35	28	7	25.1%	17	18	105.9%
Cath Lab OP Procedures	31	32	(1)	-2.5%	64	67	(3)	-3.9%	53	11	20.8%
Total Cardiac Cath Lab	50	45	5	10.8%	99	95	4	4.7%	70	29	41.4%
Outpatient Visits											
Emergency	3,596	3,506	90	2.6%	6,839	6,880	(41)	-0.6%	6,874	(35)	-0.5%
Total Outpatient	14,720	13,663	1,057	7.7%	29,829	28,627	1,202	4.2%	28,072	1,757	6.3%
Staffing											
Paid FTE's	887.85	900.16	(12.31)	-1.4%	898.62	900.16	(1.54)	-0.2%	883.71	14.91	1.7%
Productive FTE's	765.40	772.13	(6.73)	-0.9%	743.86	772.13	(28.27)	-3.7%	743.86	-	0.0%
Paid FTE's/AOB	5.22	5.10	0.12	2.3%	5.10	5.21	(0.10)	-2.0%	5.30	(0.20)	-3.7%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,652	10,443	1,208	11.6%	11,226	11,033	193	1.8%	11,209	17	0.1%
Cost/Adj.Patient Day	2,984	2,783	201	7.2%	2,794	2,858	(64)	-2.2%	2,710	84	3.1%
Revenue/Adj. Discharge	53,634	51,421	2,213	4.3%	52,538	54,987	(2,449)	-4.5%	53,052	(513)	-1.0%
Cost/Adj. Discharge	13,736	13,705	31	0.2%	13,076	14,245	(1,169)	-8.2%	12,825	251	2.0%
Adj. Discharge	1,146	1,111	35	3.2%	2,334	2,151	183	8.5%	2,186	148	6.8%
Net Op. Gain/(Loss) %	1.13%	-3.86%	4.99%	-129.3%	1.21%	-1.63%	2.84%	-174.5%	-3.17%	4.38%	-138.4%
Net Op. Gain/(Loss) $	180,106	(566,081)	746,187	-131.8%	375,086	(491,521)	866,607	-176.3%	(860,180)	1,235,266	-143.6%
Gross Days in Accts Rec.	94.97	95.03	(0.06)	-0.1%	94.97	95.03	(0.06)	-0.1%	97.82	(2.85)	-2.9%
Net Days in Accts. Rec.	42.74	57.75	(15.01)	-26.0%	42.74	57.75	(15.01)	-26.0%	50.53	(7.79)	-15.4%

Sierra View Local Health Care District
Balance Sheet

	Aug-25	Jul-25
Assets		
Current Assets:		
Cash & Cash Equivalents	15,171,943	20,639,841
Short-Term Investments	3,175,489	1,499,446
Assets Limited As To Use	1,538,380	1,062,085
Patient Accounts Receivable	188,043,447	176,718,952
Less Uncollectables	(19,158,327)	(13,692,139)
Contractual Allowances	(147,611,420)	(143,913,973)
Other Receivables	26,493,197	21,954,330
Inventories	4,490,351	4,513,125
Prepaid Expenses and Deposits	2,723,239	3,202,007
Less Receivable - Current	301,020	301,020
Total Current Assets	**75,167,319**	**72,284,694**
Assets Limited as to use, Less		
Current Requirements	32,371,168	32,368,359
Long-Term Investments	137,081,220	137,671,971
Property, Plant and Equipment, Net	70,501,162	71,023,281
Intangible Right of use Assets	255,062	267,111
SBITA Right of use Assets	2,903,840	3,053,267
Lease Receivable - LT	657,400	682,053
Other Investments	250,000	250,000
Prepaid Loss on Bonds	1,216,818	1,237,797
Total Assets	**320,403,988**	**318,838,533**
Liabilities and Funds Balances		
Current Liabilities		
Bond Interest Payable	202,942	101,471
Current Maturities of Bonds Payable	4,235,000	4,235,000
Current Maturities of Long Term Debt	769,718	854,806
Account Payable and Accrued Expenses	5,090,024	5,157,286
Accrued Payroll and Related Costs	7,080,821	6,453,485
Estimated Third-Party Payor Settlements	4,577,456	4,772,037
Lease Liability - Current	134,353	136,088
SBITA Liability - Current	1,413,910	1,415,949
Total Current Liabilities	**23,504,224**	**23,126,121**
Self-Insurance Reserves	2,122,259	2,115,953
Capital Lease Liab LT	0	0
Bonds Payable, Less Curr Reqt	29,040,000	29,040,000
Bonds Premium Liability - LT	1,987,536	2,033,056
Lease Liability - LT	143,765	154,274
SBITA Liability - LT	1,901,710	2,019,464
Other Non Current Liabilities	-	-
Deferred Inflow - Leases	897,036	921,533
Total Liabilities	**59,596,530**	**59,410,401**
Unresticted Fund	258,897,667	258,897,667
Profit or (Loss)	1,909,791	530,465
Total Liabilities and Fund Balance	**320,403,988**	**318,838,533**
	-	-

Sierra View Local Health Care District
Income Statement

For Period **Aug-25**

	ACTUAL	BUDGET	VARIANCE	% VARIANCE	ACTUAL YTD	BUDGET YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	5,610,431	5,444,722	165,709	3%	11,461,632	10,723,044	738,588	7%
Inpatient - Ancillary	19,758,425	18,363,042	1,395,383	8%	38,659,901	38,325,594	334,307	1%
Total Inpatient Revenue	**25,368,856**	**23,807,764**	**1,561,092**	7%	**50,121,533**	**49,048,638**	**1,072,895**	2%
Outpatient - Ancillary	36,100,200	33,315,607	2,784,593	8%	72,483,006	69,226,277	3,256,729	5%
Total Patient Revenue	**61,469,057**	**57,123,371**	**4,345,686**	8%	**122,604,538**	**118,274,915**	**4,329,623**	4%
Medicare	(16,821,291)	(18,653,537)	1,832,246	(10%)	(37,471,478)	(38,893,629)	1,422,151	(4%)
Medi-Cal	(18,864,336)	(17,683,164)	(1,181,172)	7%	(41,723,312)	(36,468,310)	(5,255,002)	14%
Other/Charity	(4,201,079)	(6,699,274)	2,498,195	(37%)	(7,506,354)	(13,889,429)	6,383,075	(46%)
Discounts & Allowances	(171,391)	(17,877)	(153,514)	859%	(275,733)	(37,015)	(238,718)	645%
Bad Debts	(6,176,292)	(228,493)	(5,947,799)	2,603%	(6,158,942)	(473,099)	(5,685,843)	1,202%
Total Deductions	**(46,234,389)**	**(43,282,345)**	**(2,952,044)**	7%	**(93,135,820)**	**(89,761,482)**	**(3,374,338)**	4%
Net Service Revenue	**15,234,667**	**13,841,026**	**1,393,641**	10%	**29,468,718**	**28,513,433**	**955,285**	3%
Other Operating Revenue	687,894	818,039	(130,145)	(16%)	1,421,100	1,636,078	(214,978)	(13%)
Total Operating Revenue	**15,922,561**	**14,659,065**	**1,263,496**	9%	**30,889,819**	**30,149,511**	**740,308**	2%
Salaries	6,205,658	6,024,633	(181,025)	(3%)	12,385,756	12,096,159	(289,597)	(2%)
S&W PTO	644,057	715,549	71,492	10%	1,338,029	1,431,037	93,008	6%
Employee Benefits	1,472,620	1,460,204	(12,416)	(1%)	2,938,407	2,920,408	(17,999)	(1%)
Professional Fees	2,222,982	1,910,870	(312,112)	(16%)	3,697,086	3,800,696	103,610	3%
Purchased Services	989,357	908,417	(80,940)	(9%)	1,640,448	1,820,160	179,712	10%
Supplies & Expenses	2,283,833	2,218,465	(65,368)	(3%)	4,709,650	4,597,234	(112,416)	(2%)
Maintenance & Repairs	286,431	303,754	17,323	6%	497,037	607,508	110,471	18%
Utilities	319,983	306,217	(13,766)	(4%)	586,460	612,434	25,974	4%
Rent/Lease	36,729	30,041	(6,688)	(22%)	66,925	60,082	(6,843)	(11%)
Insurance	115,299	122,727	7,428	6%	260,107	245,454	(14,653)	(6%)
Depreciation/Amortization	828,635	811,079	(17,556)	(2%)	1,640,657	1,622,158	(18,499)	(1%)
Other Expense	336,872	413,190	76,318	18%	754,170	827,702	73,532	9%
Impaired Costs	-	-	-	0%	-	-	-	0%
Total Operating Expense	**15,742,455**	**15,225,146**	**(517,309)**	(3%)	**30,514,733**	**30,641,032**	**126,299**	0%
Net Gain/(Loss) From Operations	**180,106**	**(566,081)**	**746,187**	**(132%)**	**375,086**	**(491,521)**	**866,607**	**(176%)**
District Taxes	138,477	138,477	-	0%	276,954	276,954	-	0%
Investment Income	331,909	488,226	(156,317)	(32%)	841,845	976,452	(134,607)	(14%)
Other Non - Operating Income	28,089	40,308	(12,219)	(30%)	57,146	80,616	(23,470)	(29%)
Interest Expense	(72,647)	(70,649)	(1,998)	(3%)	(148,267)	(141,298)	(6,969)	(5%)
Non-Operating Expense	(21,315)	(39,852)	18,537	47%	(84,173)	(79,706)	(4,467)	(6%)
Total Non-Operating Income	**404,513**	**556,510**	**(151,997)**	(27%)	**943,505**	**1,113,018**	**(169,513)**	(15%)
			-				-	
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	**584,619**	**(9,571)**	**594,190**	**(6,208%)**	**1,318,591**	**621,497**	**697,094**	**112%**
Net Incr/(Decr) in the Fair Value Invstmt	794,706	162,500	632,206	389%	591,199	325,000	266,199	82%
Net Gain/(Loss)	**1,379,325**	**152,929**	**1,226,396**	802%	**1,909,791**	**946,497**	**963,294**	102%

-

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
August-25

	Current Month	YTD
Cash flows from operating activities:		
Operating Income/(Loss)	180,106	375,086
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation/Amortization	828,635	1,640,657
Provision for bad debts	5,466,189	4,937,530
		-
Change in assets and liabilities:		-
Patient accounts receivable, net	(7,627,048)	(6,814,888)
Other receivables	(4,538,867)	(6,224,742)
Inventories	22,775	2,560
Prepaid expenses and deposits	478,768	(103,321)
Advance refunding of bonds payable, net	20,980	41,959
Accounts payable and accrued expenses	(67,262)	(407,924)
Deferred inflows - leases	(24,497)	(48,994)
Accrued payroll and related costs	627,337	554,105
Estimated third-party payor settlements	(194,581)	168,743
Self-insurance reserves	6,306	(6,830)
Total adjustments	(5,001,267)	(6,261,145)
Net cash provided by (used in) operating activities	(4,821,161)	(5,886,059)
Cash flows from noncapital financing activities:		
District tax revenues	138,477	276,954
Noncapital grants and contributions, net of other expenses	(9,047)	(61,551)
Net cash provided by (used in) noncapital financing activities	129,430	215,403
Cash flows from capital and related financing activities:		
Purchase of capital assets	(294,467)	(670,298)
Proceeds from sale of assets	-	-
Proceeds from debt borrowings	-	-
Proceeds from lease receivable, net	24,653	49,235
Principal payments on debt borrowings	-	(4,235,000)
Interest payments	(876)	(695,366)
Issuance of bonds payable and bond premium liability	-	-
Net change in notes payable and lease liability	(67,696)	(134,801)
Net changes in assets limited as to use	(479,105)	3,868,575
Net cash provided by (used in) capital and related financing activities	(817,490)	(1,817,656)
Cash flows from investing activities:		
Net (purchase) or sale of investments	1,385,457	2,565,707
Investment income	331,909	841,845
Net cash provided by (used in) investing activities	1,717,367	3,407,552
Net increase (decrease) in cash and cash equivalents:	(3,791,855)	(4,080,759)
Cash and cash equivalents at beginning of month/year	22,139,287	22,428,191
Cash and cash equivalents at end of month	18,347,432	18,347,432
	18,347,432	18,347,432
	0.00	0.00

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
August 2025

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Sep-24	12,800,001	1,611,606	14,411,607
Oct-24	14,933,404	1,420,062	16,353,466
Nov-24	11,872,571	1,402,779	13,275,350
Dec-24	13,002,191	6,026,303	19,028,494
Jan-25	12,353,155	4,293,154	16,646,309
Feb-25	9,516,870	8,335,277	17,852,147
Mar-25	13,111,820	451,259	13,563,079
Apr-25	13,460,422	8,143,789	21,604,211
May-25	12,344,513	9,292,615	21,637,128
Jun-25	10,549,177	4,753,556	15,302,733
Jul-25	13,219,919	932,239	14,152,158
Aug-25	**9,922,993**	**1,161,531**	**11,084,524**

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 2025 Summary of Other Activity:

354,485	M-Cal DHDP FY25 Phase 1
340,372	M-Care Temporary Allowance Cost Report
253,428	M-Care interim payments
213,246	Miscellaneous
1,161,531	08/25 Total Other Activity