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

AGENDA
April 22, 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):

1. Evaluation – Quality of Care/Peer Review/Credentials

2. Quality Division Update – Quality Report

C. Pursuant to Gov. Code Section 54954.5(c) and 54956.9(d): Conference with Legal Counsel Regarding Existing Litigation: SVLHCD vs. Dr. Snyder; Tulare County Superior Court Case # VCU308242

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

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2027

F. Pursuant to Gov. Code Section 54957(b)(1): Public Employee Annual Performance Evaluation of Hospital CEO. Estimated date of disclosure April 23, 2025

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).

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

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

B. Quality Review

1. Evaluation – Quality of Care/Peer Review/Credentials
   Recommended Action: Approve/Disapprove Report as Given

2. Quality Division Update – Quality Report
   Recommended Action: Approve/Disapprove Report as Given

C. Conference with legal counsel regarding Existing Litigation:
SVLHCD vs. Dr. Snyder; Tulare County Superior Court Case # VCU308242
Recommended Action: Information Only; No Action Taken

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

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

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

G. 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 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. February 25, 2025 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove February 25, 2025 Minutes of the Regular Meeting of the Board of Directors

B. March 25, 2025 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove March 25, 2025 Minutes of the Regular Board Meeting

C. April 10, 2025 Minutes of the Special Meeting of the Board of Directors
Recommended Action: Approve/Disapprove April 10, 2025 Minutes of the Special Board Meeting

IX. Business Items

A. March 2025 Financials
Recommended Action: Approve/Disapprove Report as Given

B. Capital Report – Quarter Ending March 31, 2025
Recommended Action: Approve/Disapprove Report as Given

C. Investment Report – Quarterly Ending March 31, 2025
Recommended Action: Approve/Disapprove Report as Given

D. Formation and Appointment of Operational Efficiency Ad Hoc Advisory Committee
Recommended Action: Approve/Disapprove

X. CEO Report

XI. Announcements:

Regular Board of Directors Meeting – May 27, 2025 at 5:00 p.m.

XII. 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.

Senior Leadership Team	4/22/2025
Board of Director's Approval	
Liberty Lomeli, Chairman	4/22/2025

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
APRIL 22, 2025
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	Action
Policies:		Approve ↓
• Disruption of Services – Air Conditioning	1-2	
• Employee Parking	3-4	
• SVLHCD Investment Policy	5-31	
Reports:		
• Human Resources Report 2025 – Quarter 1	32-68	
• Marketing Report 2025 – Quarter 1	69-93	

SUBJECT:	SECTION:
DISRUPTION OF SERVICES - AIR CONDITIONING	***Resource Management and Preparation*** **Page 1 of 2**

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

PURPOSE:

To maintain a good working system to enable provision of desired temperature, humidity and air purity for the health, safety, and comfort of patients and employees.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

The Engineering Department will determine the cause of failure (faulty motor, dirty filters, grounded compressor, frozen unit, etc.) The time required for repair will be estimated. If the repair of the air conditioning system cannot be made in a timely manner or is beyond the capabilities of the Engineering Department:

Call: Patton Control (559) 486-5222

In addition, notify any Department Heads that are affected and the approximate down time of the system. Upon completion of repair, let department heads know that system is again operational.

In the event of prolonged failure, the Engineering Department will coordinate with affected units to mitigate temperature extremes.

1. In hot weather - use of fans and channeling of air from working units to maintain patient comfort.

2. In cold weather – channeling of air from working units, procurement of extra blankets to maintain patient comfort.

In the Operating Room, unit(s) can only be repaired or evaluated after first checking to see that there are no surgeries and/or treatments taking place in the operating room pertaining to the unit in question. Clearance must be received from the Operating Room (OR) Clinical Coordinator.

Location:

Air Handler units are located throughout the facility and chillers are located in the Central Utility Plant (CUP). The Emergency Power (EP) panel is located in the switchgear room of the Central Utility Plant.

REFERENCES:

- Title 22: Section 70741, 70743, 70745, 70746. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- The Joint Commission (2025). Hospital accreditation standards. EC.02.05.01, EP.10, EP.13. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **EMPLOYEE PARKING**	SECTION: ***Security Management*** **Page 1 of 2**

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

PURPOSE:

To identify and define appropriate locations to be used for employee parking so as to maintain adequate parking for patients and visitors. For purposes of this policy, contingent workforce will follow employee designated parking areas.

POLICY:

1. Employees, travelers/registry will park in employee designated locations at all SVMC properties.

2. Employees shall not park in reserved spaces, red curbed fire lanes, loading zones or spaces identified for patient and visitor use. Examples of reserved spaces include Physician, CTC, SLT and Contractor parking.

3. Employees who have a valid State of California Handicap/Disabled parking permit may utilize designated Handicap parking spaces after approval by Employee Health Services.

4. Employees who fail to park appropriately as defined in this policy will be subject to the District's progressive disciplinary process.

5. Employees who park in Red Fire Lanes and Handicap reserved spaces without a valid permit may receive a non-moving traffic violation citation by the City of Porterville Police Department.

AFFECTED PERSONNEL/AREAS: *GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, CONTINGENT WORKFORCE*

PROCEDURE:

1. Employees will only park in designated employee parking locations.

    a. Employees who work in the Main Facility will park in the parking lot across the street from the facility.

    b. Employees are not to park their vehicle on surface streets in residential areas as a courtesy to our neighbors.

    c. Employees may also park in the designated parking lot on Pearson Street.

2. Under certain circumstances, employees will be permitted to park in visitor parking.

    a. This will require approval from HR and their respective Vice President.

    b. Once approved, a parking permit will be issued by Human Resources (HR).

c. The employee is responsible to hang their parking permit from their rearview mirror and they may not park in designated spaces for Physicians, SLT, CTC or Contractor parking or they will be subject to the District's progressive disciplinary process.

3. Employees on-call must park in employee designated parking during their regular shift.

4. Employees who work offsite but may come to the main campus for business purposes must park in the employee designated parking areas.

PLEASE NOTE SVMC does not have a designated charging station for EV, therefore no one is permitted to utilize SVMC electricity to charge EV's.

CROSS REFERENCE:

- *PERSONAL CONDUCT* – SVMC Policies and Procedures

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1. POLICY STATEMENT

Sierra View Local Health Care District ("District") is a California Health Care District formed by resolution of the Tulare County Board of Supervisors. The District was created pursuant to the California Health and Safety Code §32000 to address health care needs in the southeast portion of Tulare County. It is governed by an elected five-member board of directors.
All funds of the District shall be invested in accordance with principles of sound treasury management and in accordance with the provisions of the California Government Code §53600 et seq., (the Municipal Code), which sets forth the investment parameters for local agencies (including districts) in California, and guidelines established by the California Municipal Treasurer's Association, and this Investment Policy ("Policy").

2. INVESTMENT POLICY OBJECTIVES

A. Overall Risk Profile

The objectives of the District's Investment Program are, in order of priority:

1. Safety of principal of invested funds;
2. Maintenance of Sufficient Liquidity to Meet Cash Flow Needs; and
3. Attainment of the Maximum Yield Possible Consistent With the First Two Objectives.

To achieve these objectives, The District shall consider the following when making an investment:

1. Safety of Principal of Invested Funds

The District shall mitigate the risk to the principal of invested funds by limiting credit and interest rate risks. Credit Risk is the risk of loss due to the failure of a security's issuer or backer. Interest Rate Risk is the risk that the market value of the District's portfolio will fall due to an increase in general interest rates.

a) Credit risk will be mitigated by:

(i) Limiting investments to only the most creditworthy types of securities defined as "investment grade" by a Nationally Recognized Statistical Rating Organization (NRSRO) including (a). Standard and Poor's Rating Service, (b). Moody's Investors Service and (c). Fitch Ratings.
(ii) By pre-qualifying the financial institutions with which it will do business; and

(iii) By diversifying the investment portfolio so that the potential failure of any one issue or issuer will not place an undue financial burden on the District.

b) Interest rate risk will be mitigated by:

(i) Structuring the District's portfolio so that securities mature to meet the District's cash requirements for ongoing obligations, thereby avoiding the possible need to sell securities on the open market at a loss prior to their maturity to meet those requirements; and

(ii) Investing primarily in shorter term securities.

2. Liquidity

The District's investment portfolio shall be structured in a manner which emphasizes that securities mature at the same time the cash is needed to meet anticipated demands (Static Liquidity). Additionally, since all possible cash demands cannot be anticipated, the portfolio should consist of securities with active secondary markets (Dynamic Liquidity). The maximum percentage of different investment instruments and maturities is described in Appendix A of this Policy.

3. Yield

Yield on the District's investment portfolio is of secondary importance compared to the safety and liquidity objectives described above. Investments are limited to relatively low risk securities in anticipation of earning a fair return relative to the risk being assumed. While it may occasionally be necessary or strategically prudent for the District to sell a security prior to maturity to either meet unanticipated cash needs or to restructure the portfolio, this policy specifically prohibits trading securities for the sole purpose of speculating on the future direction of interest rates.

B. Basic Investment Strategy

The District shall pursue a "passive" strategy of investment under which investments shall be of "laddered" maturities, facilitating a "buy and hold" process where financial instruments are held until maturity rather than actively bought and sold at various times. An "active" strategy of market timing, sector rotation, indexing to a benchmark and similar strategies are considered inappropriate for the size of the District's portfolio. It is understood that it may be appropriate to sell a particular security prior to maturity to meet unanticipated cash needs. Any such transaction will be reported to the Board of Directors at its next regularly scheduled meeting.

The District's investment portfolio shall be structured to provide that sufficient funds from investments are available each month to meet the District's anticipated cash needs. Subject to the objectives stated above, the choice in investment instruments and maturities shall be based upon an

analysis of future anticipated cash needs, existing and anticipated revenues, interest rate trends and specific market opportunities. No investment may have a maturity of more than five (5) years from its date of purchase without receiving prior Board of Directors approval. After approval by the Board, reserve funds associated with bond issues may have a maturity of more than five (5) years, up to the earliest date the bonds may be redeemed or mature.

3. INVESTMENTS

This section of the Investment Policy identifies the types of investments in which the District will invest its idle or surplus funds.

A. Standard of Prudence

The District operates its investment portfolio under the Prudent Investor Standard (California Government Code §53600.3) which states, in essence, that "when investing, reinvesting, purchasing, acquiring, exchanging, selling or managing public funds, a trustee shall act with care, skill, prudence and diligence under the circumstances then prevailing, including, but not limited to, the general economic conditions and the anticipated needs of the District, that a prudent person in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the District".

This standard shall be applied in the context of managing the overall portfolio. Investment officers, acting in accordance with written procedures and this investment policy and exercising the above standard of diligence shall be relieved of personal responsibility for an individual security's credit risk or market price changes, provided deviations from expectations are reported in a timely fashion and appropriate action is taken to control adverse developments.

B. Allowable Investments

Investment of District funds is governed by California Government Code §53600 et seq. See Appendix A for a listing of Allowable Investments.

The District may choose to restrict its permitted investments to a smaller list of securities that more closely fits the District's cash flow needs and requirements for liquidity. If a type of investment is added to California Government Code §53600, it will not be added to the District's listing of Allowable Investments until this policy is amended and approved by the Board of Directors. If a type of investment permitted by the District should be removed from California Government Code §53600, it will be deemed concurrently removed from the District's listing of Allowable Investments, but existing holdings may be held until they mature.

A thorough investigation of any pool or fund is required prior to investing and on a continual basis. The investigation will, at a minimum, obtain the following information:

- A description of eligible investment securities, and a written statement of investment policies and objectives.
- A description of interest calculations and how it is distributed, and how gains and losses are distributed.
- A description of how securities are safeguarded (including the settlement process) and how often the securities are marked to market and how often an audit is conducted.
- A description of who may invest in the program, how often, what size deposits and withdrawals are permitted.
- A schedule for receiving statements and portfolio listings.
- Does the pool/fund maintain a reserve or retain earnings or is all income after expenses distributed to participants?
- A fee schedule which also discloses when and how fees are assessed.
- Is the pool or fund eligible for bond proceeds and/or will it accept such proceeds?

The purpose of this investigation is to determine the suitability of a pool or fund and evaluate the risk of placing funds with that pool or fund.

The District will generally avoid "Brokered CD's" pools in which brokers arrange for deposits (usually $250,000 each to obtain federal deposit insurance). Such brokered CD's are frequently issued by failing or marginal institutions whose safety is derived almost exclusively by the existence of federal insurance rather than by the strength of the issuing institution.

One of the purposes of this Investment Policy is to define what investments are permitted. If a type of security is not specifically authorized by this policy, it is not a permitted investment.

C. Qualification of Brokers, Dealers and Financial Institutions

The District's Chief Financial Officer (CFO) or designee will (1) establish and maintain a list of the financial institutions and broker/dealers authorized to provide investment and depository services to the District, (2) perform an annual review of the financial condition and registrations of the qualified bidders, and (3) require annual audited financial statements to be on file for each approved company. The District shall annually send a copy of its current Investment Policy to all financial institutions and broker/dealers approved to do business with the District. Receipt of the Policy and Enabling Resolution, including confirmation that it has been received and reviewed by the person(s) handling the District's account, shall be acknowledged in writing within thirty (30) days.

All broker-dealers and financial institutions that desire to become qualified bidders for investment transactions must submit a "Broker-Dealer Application" and related documents relative to eligibility. This includes a current audited financial statement, proof of state registration, proof of NASD registration and a certification they have received and reviewed the District's Investment Policy and agree to comply with the provisions outlined in the Investment Policy. The District's CFO or designee may establish any additional criteria deemed appropriate to evaluate and approve any financial services provider. The selection process for broker- dealers shall be open to both "primary dealers" and "secondary/regional dealers" that qualify under Securities and Exchange Commission Rule 15c3-1 (Uniform Net Capital Rule). The provider must have an office in California and the provider's representative must be experienced in institutional trading practices and familiar with the California Government Code as it relates to investments by a Special District. The current form of the Broker Dealer Questionnaire appears as Appendix B of this policy.

D. Collateralization Requirements

Uninsured Time Deposits with banks and savings and loans shall be collateralized in the manner prescribed by state law for depositories accepting municipal investment funds.

E. Diversification

The District will diversify its investments by security type and investment. The District's CFO or designee will adopt a strategy that combines current market conditions with the District's cash needs to maintain the maximum degree of safety of principal and liquidity throughout market and budgetary cycles. This strategy will include diversification by investment type and maturity allocations and will be included in the regular quarterly reports to the Board. This strategy will be reviewed quarterly and can be changed accordingly.

F. Confirmations

Receipts for confirmation of purchases or sales of authorized securities shall include at a minimum the following information: trade date, settlement date, description of the security, par value, interest rate, price, yield to maturity, District's name, net amount due and third party custodial information.

4. SAFEKEEPING OF SECURITIES

The District shall contract with a bank or banks for the safekeeping of securities that are owned by the District as a part of its investment portfolio.

All securities owned by the District shall be held in safekeeping by a third party bank trust department acting as agent for the District under the terms of a custody agreement executed by the

bank and the District. All securities will be received and delivered using standard delivery versus payment (DVP) procedures. The third party bank trustee agreement must comply with Section 53608, which states, in essence, the legislative body of a local agency may deposit its securities for safekeeping with a bank, of the California Government Code. No outside broker/dealer or advisor may have access to District funds, accounts or investments and any transfer of funds must be approved by the District's Chief Executive Officer or Chief Financial Officer.

The District's current custodian for General Fund investments is Fidelity Investments.

Certificates of Deposit purchased directly from local financial institutions may be maintained by the District in a safe deposit box at a local financial institution.

5. STRUCTURE AND RESPONSIBILITIES

This section of the policy defines the overall structure and areas of responsibility within the investment management program.

A. Responsibilities of the District's CFO

The District's CFO is charged with responsibility for maintaining custody of all public funds and securities belonging to or under the control of the District, and for the deposit and investment of those funds in accordance with principles of sound treasury management, applicable laws, ordinances and this Investment Policy. This includes establishing written procedures for the operation of the investment program consistent with this policy. The procedures should include reference to safekeeping, master repurchase agreements, wire transfer agreements, banking services contracts and depository agreements. Such procedures shall also include explicit delegation of authority to persons responsible for investment transactions. No person may engage in an investment transaction except as provided under the terms of this policy and the procedures established by the Board of Directors.

The Board has made a delegation of authority to the Chief Executive Officer and Chief Financial Officer, as set forth in Appendix D.

The current delegation of authority will be provided to all approved financial institutions. They will be notified of any changes to this delegation in a timely fashion and acknowledge receipt.

B. Responsibilities of the Chief Executive Officer and Chief Financial Officer

The Chief Executive Officer and Chief Financial Officer are responsible for keeping the Board of Directors fully advised as to the financial condition of the District.

C. Responsibilities of the Board of Directors

The Board shall consider and adopt a written Investment Policy. As provided in that policy, the Board shall receive, review and accept quarterly investment reports.

D. Ethics and Conflicts of Interest

All District officers and employees involved in the investment process shall refrain from personal business activity that could conflict with the proper execution of the investment program, or that could impair their ability to make impartial investment decisions. Those employees and investment officials shall disclose in their Annual Statement of Economic Interests (Form 700) any material financial interests in financial institutions that conduct business within the District, and they shall further disclose any large personal financial/investment positions that could be related to the performance of the District's investments.

The District has adopted a Conflict of Interest Code applicable to all elected officials and designated positions as set forth in the District's Conflict of Interest Code (Compliance With The Political Reform Act of 1974) policy.

6. REPORTING

The District's CFO shall prepare a quarterly investment report, including a succinct management summary that provides a clear picture of the status of the current investment portfolio and transactions made. This management summary shall be prepared in a manner that will allow the Chief Executive Officer and the Board to ascertain whether investment activities during the reporting period have complied with the District's Investment Policy.

The quarterly report shall include the following:

- A list of individual securities held at the end of the reporting period.
- Unrealized gains or losses resulting from amortization or accretion of principal versus market value changes by listing the cost and market value of securities owned by the District.
- Expected yield for the next 12 month period
- Maturity schedule by type, of each of the District's investments.
- Statement of compliance of the District's Investment Policy with California Government Code §536000 et seq.
- Statement as to ability to meet all scheduled expenditure requirements for the next six months.
- Market value, book value, par value and cost basis of all investments.

7. PERFORMANCE STANDARDS

The investment portfolio will be managed in accordance with the standards established within this Investment Policy and should obtain a market rate of return throughout budgetary and economic cycles.

8. REVIEW OF INVESTMENT POLICY

A. Policy Review

This Investment Policy shall be reviewed annually by the Board in accordance with State law to ensure its consistency with respect to the overall objectives of safety, liquidity and yield. Proposed amendments to the policy shall be prepared by the Chief Financial Officer and forwarded to the Board for its consideration and adoption in a public meeting.

B. Internal Control and Review

The external auditors shall annually review the investments and general activities associated with the investment program to ensure compliance with this Investment Policy. This review will provide internal control by assuring compliance with policies and procedures established by this Investment Policy.

9. DEFINITIONS

The District has adopted its definitions of terms as published by the California Debt and Investment Advisory Commission in its updated *Local Agency Investment Guidelines.* Definitions are included as Appendix E of this policy.

10. ADOPTION OF POLICY

This Policy was duly adopted by the Board of Directors of the Sierra View Local Health Care District on the 28th day of May, 2024

APPENDIX A ALLOWABLE INVESTMENTS

ALLOWABLE INVESTMENT INSTRUMENTS PER STATE GOVERNMENT CODE (AS OF JANUARY 1, 2024) APPLICABLE TO ALL LOCAL AGENCIES

See "Table of Notes for Figure 1" on the next page for footnotes related to this figure.

INVESTMENT TYPE	MAXIMUM MATURITY[C]	MAXIMUM SPECIFIED % OF PORTFOLIO[D]	MINIMUM QUALITY REQUIREMENTS	GOV'T CODE SECTIONS
Local Agency Bonds	5 years	None	None	53601(a)
U.S. Treasury Obligations	5 years	None	None	53601(b)
State Obligations–CA And Others	5 years	None	None	53601(c) 53601(d)
CA Local Agency Obligations	5 years	None	None	53601(e)
U.S Agency Obligations	5 years	None	None	53601(f)
Bankers' Acceptances	180 days	40%[E]	None	53601(g)
Commercial Paper–Non-Pooled Funds[F] (under $100,000,000 of investments)	270 days or less	25% of the agency's money[D]	Highest letter and number rating by an NRSRO[H]	53601(h)(2)(c)
Commercial Paper–Non-Pooled Funds (min. $100,000,000 of investments)	270 days or less	40% of the agency's money[D]	Highest letter and number rating by an NRSRO[H]	53601(h)(2)(c)
Commercial Paper–Pooled Funds[I]	270 days or less	40% of the agency's money[D]	Highest letter and number rating by an NRSRO[H]	53635(a)(1)
Negotiable Certificates of Deposit	5 years	30%[J]	None	53601(i)
Non-negotiable Certificates of Deposit	5 years	None	None	53630 et seq.
Placement Service Deposits	5 years	50%[K]	None	53601.8 and 53635.8
Placement Service Certificates of Deposit	5 years	50%[K]	None	53601.8 and 53635.8
Repurchase Agreements	1 year	None	None	53601(j)
Reverse Repurchase Agreements and Securities Lending Agreements	92 days[L]	20% of the base value of the portfolio	None[M]	53601(j)
Medium-Term Notes[N]	5 years or less	30%	"A" rating category or its equivalent or better	53601(k)
Mutual Funds And Money Market Mutual Funds	N/A	20%	Multiple[P,Q]	53601(l) and 53601.6(b)
Collateralized Bank Deposits[R]	5 years	None	None	53630 et seq. and 53601(n)
Mortgage Pass-Through and Asset-Backed Securities	5 years or less	20%	"AA" rating category or its equivalent or better	53601(o)
County Pooled Investment Funds	N/A	None	None	27133
Joint Powers Authority Pool	N/A	None	Multiple[S]	53601(p)
Local Agency Investment Fund (LAIF)	N/A	None	None	16429.1
Voluntary Investment Program Fund[T]	N/A	None	None	16340
Supranational Obligations[U]	5 years or less	30%	"AA" rating category or its equivalent or better	53601(q)
Public Bank Obligations	5 years	None	None	53601(r), 53635(c) and 57603

LOCAL AGENCY INVESTMENT GUIDELINES

TABLE OF NOTES FOR FIGURE 1

[A] *Sources: Sections 16340, 16429.1, 27133, 53601, 53601.6, 53601.8, 53630 et seq., 53635, 53635.8, and 57603.*

[B] *Municipal Utilities Districts have the authority under the Public Utilities Code Section 12871 to invest in certain securities not addressed here.*

[C] *Section 53601 provides that the maximum term of any investment authorized under this section, unless otherwise stated, is five years from the settlement date. However, the legislative body may grant express authority to make investments either specifically or as a part of an investment program approved by the legislative body that exceeds this five year remaining maturity limit. Such approval must be issued no less than three months prior to the purchase of any security exceeding the five-year maturity limit.*

[D] *Percentages apply to all portfolio investments regardless of source of funds. For instance, cash from a reverse repurchase agreement would be subject to the restrictions.*

[E] *No more than 30% of the agency's money may be in bankers' acceptances of any one commercial bank.*

[F] *Applies to local agencies, other than counties or a city and county, with less than $100 million of investment assets under management. Includes agencies defined as a city, a district, or other local agency that do not pool money in deposits or investment with other local agencies, other than local agencies that have the same governing body.*

[G] *Local agencies, other than counties or a city and county, may purchase no more than 10% of the outstanding commercial paper and medium-term notes of any single issuer.*

[H] *Issuing corporation must be organized and operating within the U.S., have assets in excess of $500 million, and debt other than commercial paper must be in a rating category of "A" or its equivalent or higher by a nationally recognized statistical rating organization, or the issuing corporation must be organized within the U.S. as a special purpose corporation, trust, or LLC, have program wide credit enhancements, and have commercial paper that is rated "A-1" or higher, or the equivalent, by a nationally recognized statistical rating organization.*

[I] *Applies to counties or a city and county, and the City of Los Angeles that have $100 million or more of investment assets under management.*

[J] *Includes agencies defined as a county, a city and county, or other local agency that pools money in deposits or investments with other local agencies, including local agencies that have the same governing body. Local agencies that pool exclusively with other local agencies that have the same governing body must adhere to the limits set forth in Section 53601(h)(2)(C).*

[K] *No more than 30% of the agency's money may be in negotiable certificates of deposit that are authorized under Section 53601(i).*

[L] *Effective January 1, 2020, no more than 50% of the agency's money may be invested in deposits, including certificates of deposit, through a placement service as authorized under 53601.8 (excludes negotiable certificates of deposit authorized under Section 53601(i)). On January 1, 2026, the maximum percentage of the portfolio reverts back to 30%. Investments made pursuant to 53635.8 remain subject to a maximum of 30% of the portfolio.*

[M] *Reverse repurchase agreements or securities lending agreements may exceed the 92-day term if the agreement includes a written codicil guaranteeing a minimum earning or spread for the entire period between the sale of a security using a reverse repurchase agreement or securities lending agreement and the final maturity dates of the same security.*

[N] *Reverse repurchase agreements must be made with primary dealers of the Federal Reserve Bank of New York or with a nationally or state chartered bank that has a significant relationship with the local agency. The local agency must have held the securities used for the agreements for at least 30 days.*

[O] *"Medium-term notes" are defined in Section 53601 as "all corporate and depository institution debt securities with a maximum remaining maturity of five years or less, issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States."*

[P] *No more than 10% invested in any one mutual fund. This limitation does not apply to money market mutual funds.*

[Q] *A mutual fund must receive the highest ranking by not less than two nationally recognized rating agencies or the fund must retain an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of $500 million, and has at least five years' experience investing in instruments authorized by Sections 53601 and 53635.*

[R] *A money market mutual fund must receive the highest ranking by not less than two nationally recognized statistical rating organizations or retain an investment advisor registered with the SEC or exempt from registration and who has not less than five years' experience investing in money market instruments with assets under management in excess of $500 million.*

[S] *Investments in notes, bonds, or other obligations under Section 53601(n) require that collateral be placed into the custody of a trust company or the trust department of a bank that is not affiliated with the issuer of the secured obligation, among other specific collateral requirements.*

[T] *Security types authorized under Section 53601(o) that are issued or guaranteed by an issuer identified in subdivisions (b) or (f), are not subject to the limitations placed on privately issued securities authorized in Section 53601(o)(2)(A)(B).*

[U] *A joint powers authority pool must retain an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of $500 million, and has at least five years' experience investing in instruments authorized by Section 53601, subdivisions (a) to (o).*

[V] *Local entities can deposit between $200 million and $10 billion into the Voluntary Investment Program Fund, upon approval by their governing bodies. Deposits in the fund will be invested in the Pooled Money Investment Account.*

[W] *Only those obligations issued or unconditionally guaranteed by the International Bank for Reconstruction and Development (IBRD), International Finance Corporation (IFC), and Inter-American Development Bank (IADB), with a maximum remaining maturity of five years or less.*

APPENDIX B
SIERRA VIEW LOCAL HEALTH CARE DISTRICT BROKER/DEALER QUESTIONNAIRE

1. **Name of Firm:** _____
2. **Address:** _____
3. **Telephone:** _____
4. **Principal(s)/Manager(s)/Partner(s): Name:**_____ **Title:** _____
   Name:_____ **Title:** _____
5. **Is your firm:**

   Broker? Yes □ No □ (a firm that does not own the securities being offered) Dealer? Yes □ No □ (a firm that owns a position in the securities being offered)
6. **Year founded:** _____
7. **Firm's total volume of U.S. government securities traded in most recent fiscal year:**

   $ _____
8. **Financial instruments most regularly offered:** _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
9. **References: (Public sector clients in the local geographical area are preferred):**

Name:_____ Title:_____
Telephone:_____Address:_____

Name:_____ Title:_____
Telephone:_____ Address:_____

Name:_____ Title:_____
Telephone: _____ Address: _____

10. **Local office and representative assigned to the Sierra View Local Health Care District account**: Address: _____
Name:_____Title: _____

11. **Has any client sustained a loss on a securities transaction arising from a misunderstanding or misrepresentation of the risk characteristic of the financial instrument?**

Yes □ No □

If yes, please explain: _____

_____

12. **Has your firm, its employees, or local office been the subject of a state or federal investigation for alleged unfair, illegal, or fraudulent activities?**

Yes □ No □

If yes, please explain: _____

_____

13. **Please explain your usual custody or delivery process. Who audits these fiduciary systems?**

_____

_____

_____

14. **Describe the capital line and trading limits imposed on the office that would service the account and conduct business with the Sierra View Local Health Care District.**

_____

_____

15. **Please enclose recent financial statements and/or other indications of your firm's capitalization.**

16. **Please describe the limits of insurance (Securities Investor Protection Corporation, excess SIPC, etc.) available:**

_____

_____

_____

17. **Please provide proof of National Association of Securities Dealers (NASD) certification.**

18. **Please provide proof of registration with the State of California.**

19. **Please provide proof that your firm is qualified under SEC Rule 15c3-1 (Uniform Net Capital Rule).**

20. **What information do you require of the Sierra View Local Health Care District?**

_____

_____

21. **What transaction documents can the Sierra View Local Health Care District expect to receive from you?**

_____

_____

22. **Please confirm that your representatives have read and understand the Sierra View Local Health Care District Investment Policy and that they are familiar with Government Code §53600 et seq.**

Attach resumes of all persons receiving a copy of our investment policy:

Name:_____ **Title:** _____

Name:_____ **Title:** _____

Name:_____ **Title:** _____

APPENDIX C

Annual Broker Certification for (year)_____

I hereby certify that the preceding is true and correct to the best of my knowledge and that I am authorized to execute this request for information on behalf of the broker/dealer Firm. I further agree to notify the Sierra View Local Health Care District (the District) immediately in the event of a material adverse change in the Firm's financial condition.

The Firm has in place reasonable procedures and a system of controls designed to preclude imprudent investment activities arising out of transactions conducted between the Firm and the District.

All individuals assigned to the District's account have read the District's Investment Policy for the current fiscal year, understand the objectives and constraints set forth by the Policy, agree to disclose potential conflicts or risks to public funds that might arise out of business transactions between the Firm and the District, and will incorporate due diligence in conforming to the provisions of the Policy as well as all applicable state and federal regulations as they apply to the investment activities of California special districts.

The Firm shall be provided annually the District's Investment Policy and shall be informed of any changes to the policy. The undersigned certify that no securities will be sold to the District which are in violation of State Code or the District's Investment Policy; however, the District shall be responsible for ensuring compliance with percentage limits established by State Code and the District's Investment Policy.

The Firm and the broker are in receipt of the District's Investment Policy for (Year)_____.

Firm Name:_____ Signature: _____

Broker assigned to City:_____ Date: _____

Name of Principal:_____ Manager Title: _____

Signature:_____ Date:
_____

APPENDIX D
DELEGATION OF AUTHORITY

The following named individuals are hereby designated authority to act as authorized agents of the Sierra View Local Health Care District including the purchase and sale of public funds and securities:

Donna J. Hefner, President/Chief Executive Officer
Craig P. McDonald, Chief Financial Officer

This designation shall remain valid until May 31, 2025 or until rescinded or superseded.

Executed this 28th day of May, 2024

_____

Areli Martinez
Secretary, Sierra View Local Health Care District Board of Directors

APPENDIX E GLOSSARY

A

ACCRUED INTEREST

Coupon interest accumulated on a bond or note since the last interest payment or, for a new issue, from the dated date to the date of delivery.

ASSET ALLOCATION

The division of an investment portfolio among different asset categories, such as stocks, bonds, and cash.

ASSET-BACKED SECURITIES

Securities that are supported by pools of assets, such as installment loans or leases, or by pools of revolving lines of credits. Asset-backed securities are structured as trusts in order to perfect a security interest in the underlying assets.

B

BANK DEPOSITS

Deposits in banks or other depository institutions that may be in the form of demand accounts (checking) or investments in accounts that have a fixed term and negotiated rate of interest.

BANKERS' ACCEPTANCE

A draft or bill or exchange accepted by a bank or trust company. The accepting institution, as well as the issuer, guarantees payment of the bill.

BASIS POINTS

Refers to the yield on bonds. Each percentage point of yield in bonds equals 100 basis points (1/100% or 0.01%). If a bond yield changes from 7.25% to 7.39% that is a rate of 14 basis points.

BENCHMARK

A passive index used to compare the performance, relative to risk and return, of an investor's portfolio.

BONDS

A debt obligation of a firm or public entity. A bond represents the agreement to repay the debt in principal and, typically, interest on the principal.

BOOK VALUE

The value at which an asset is carried on a balance sheet.

BROKER

A person or firm that acts as an intermediary by purchasing and selling securities for others rather than for its own account.

BUY AND HOLD STRATEGY

A strategy based on holding all securities until maturity, regardless of fluctuations in the market.

C

CALL OPTION

The terms of the bond contract giving the issuer the right to redeem or call an outstanding issue of bonds prior to its stated date of maturity.

CALL RISK

The risk to a bondholder that the bond issuer will exercise a callable bond feature and redeem the issue prior to maturity.

CALLABLE SECURITIES

An investment security that contains an option allowing the issuer to retire the security prior to its final maturity date.

CASH FLOW

A comparison of cash receipts (revenues) to required payments (debt service, operating expenses, etc.).

CERTIFICATE OF DEPOSIT

A short-term, secured deposit in a financial institution that usually returns principal and interest to the lender at the end of the loan period. Certificates of Deposit (CDs) differ in terms of collateralization and marketability. Those appropriate to public agency investing include:
Negotiable Certificates of Deposit

Generally, short-term debt instrument that usually pays interest and is issued by a bank, savings or federal association, state or federal credit union, or state-licensed branch of a foreign bank. The majority of negotiable CDs mature within six months while the average maturity is two weeks. Negotiable CDs are traded in a secondary market and are payable upon order to the bearer or initial

depositor (investor). Negotiable CDs are insured by FDIC up to $250,000, but they are not collateralized beyond that amount.

Non-Negotiable Certificates of Deposit

CDs that carry a penalty if redeemed prior to maturity. A secondary market does exist for non- negotiable CDs, but redemption includes a transaction cost that reduces returns to the investor. Non- negotiable CDs issued by banks and savings and loans are insured by the Federal Deposit Insurance Corporation up to the amount of $250,000, including principal and interest. Amounts deposited above this amount may be secured with other forms of collateral through an agreement between the investor and the issuer. Collateral may include other securities including Treasuries or agency securities such as those issued by the Federal National Mortgage Association.

COLLATERALIZATION OF DEPOSITS

Process by which a bank or financial institution pledges securities, or other deposits for the purpose of securing the repayment of deposited funds.

COMMERCIAL PAPER

An unsecured short-term promissory note issued by corporations or municipalities, with maturities ranging from 2 to 270 days.

COUNTY POOLED INVESTMENT FUNDS

The aggregate of all funds from public agencies placed in the custody of the county treasurer or chief finance officer for investment and reinvestment.

COUPON

The annual rate of interest that a bond’s issuer promises to pay the bondholder on the bond’s face value; a certificate attached to a bond evidencing interest due on a payment date.

CREDIT RATING

The three most commonly used nationally recognized statistical rating organizations (NRSROs) are Standard & Poor's, Fitch Ratings, and Moody's.

Moody's		S&P		Fitch		Rating description	
Long-term	Short-term	Long-term	Short-term	Long-term	Short-term		
Aaa	P-1	AAA	A-1+	AAA	F1+	Prime	Investment-grade
Aa1		AA+		AA+		High grade	
Aa2		AA		AA			
Aa3		AA-		AA-			
A1		A+	A-1	A+	F1	Upper medium grade	
A2		A		A			
A3	P-2	A-	A-2	A-	F2		
Baa1		BBB+		BBB+		Lower medium grade	
Baa2	P-3	BBB	A-3	BBB	F3		
Baa3		BBB-		BBB-			
Ba1	Not prime	BB+	B	BB+	B	Non-investment grade speculative	Non-investment grade aka high-yield bonds aka junk bonds
Ba2		BB		BB			
Ba3		BB-		BB-			
B1		B+		B+		Highly speculative	
B2		B		B			
B3		B-		B-			
Caa1		CCC+	C	CCC	C	Substantial risks	
Caa2		CCC				Extremely speculative	
Caa3		CCC-				Default imminent with little prospect for recovery	
Ca		CC					
		C					
C		D	/	DDD	/	In default	
/				DD			
				D			

Source: benzinga.com

CREDIT RISK

The chance that an issuer will be unable to make scheduled payments of interest and principal on an outstanding obligation. Another concern for investors is that the market's perception of an issuer/borrower's credit will cause the market value of a security to fall, even if default is not expected.

CUSIP NUMBER

The Committee on Uniform Security Information Procedures (CUSIP) Number refers to a security's identification number assigned to each publicly traded security by the CUSIP Service Bureau operated

by Standard & Poor's for the American Bankers Association. The CUSIP Number is a nine-character identifier unique to the issuer, the specific issue and the maturity, if applicable (the first six characters identifying the issuer, the next two identifying the security and the last digit providing a check digit to validate the accuracy of the preceding CUSIP number).

CUSTODIAN

A bank or other financial institution that keeps custody of stock certificates and other assets.

D DEALER

Someone who acts as a principal in all transactions, including underwriting, buying, and selling securities, including from his/her own account.

DEFAULT RISK

The risk that issuers/borrowers will be unable to make the required payments on their debt obligations.

DELIVERY VS. PAYMENT (DVP)

The payment of cash for securities as they are delivered and accepted for settlement.

DERIVATIVE

Securities that are based on, or derived from, some underlying asset, reference date, or index.

DISCOUNT

Discount means the difference between the par value of a security and the cost of the security, when the cost is below par. Investors purchase securities at a discount when return to the investor (yield) is higher than the stated coupon (interest rate) on the investment.

DIVERSIFICATION

The allocation of different types of assets in a portfolio to mitigate risks and improve overall portfolio performance.

F FIDUCIARY

An individual who holds something in trust for another and bears liability for its safekeeping.

FLOATING RATE SECURITY

A security that has a variable or "floating" interest rate.

G

GOVERNMENT ACCOUNTING STANDARDS BOARD (GASB)

A standard-setting body, associated with the Financial Accounting Foundation, which prescribes standard accounting practices for governmental units.

GUARANTEED INVESTMENT CONTRACT (GIC)

An agreement acknowledging receipt of funds for deposit, specifying terms for withdrawal, and guaranteeing a rate of interest to be paid.

I

INTEREST RATE RISK

Interest rate risk is the risk that an investment's value will change due to a change in the absolute level of interest rates, spread between two rates, shape of the yield curve, or any other interest rate relationship.

INSTITUTIONAL ACCOUNT

As defined by the Financial Industry Regulatory Authority (FINRA), an institutional account includes one of the following: (1) a bank, savings and loan association, insurance company or registered investment company; (2) an investment adviser registered either with the SEC under Section 203 of the Investment Advisers Act or with a state securities commission (or any agency or office performing like functions); or (3) any other person (whether a natural person, corporation, partnership, trust or otherwise) with total assets of at least $50 million.

L

LIQUIDITY

The measure of the ability to convert an instrument to cash on a given date at full face or par value.

LIQUIDITY RISK

The risk that a security, sold prior to maturity, will be sold at a loss of value. For a local agency, the liquidity risk of an individual investment may not be as critical as how the overall liquidity of the portfolio allows the agency to meet its cash needs.

LOCAL AGENCY INVESTMENT FUND (LAIF)

A voluntary investment fund open to government entities and certain non-profit organizations in California that is managed by the State Treasurer's Office.

M

MARKET RISK

The chance that the value of a security will decline as interest rates rise. In general, as interest rates fall, prices of fixed income securities rise. Similarly, as interest rates rise, prices fall. Market risk also is referred to as systematic risk or risk that affects all securities within an asset class similarly.

MARKET VALUE

The price at which a security is trading and presumably could be purchased or sold at a particular point in time.

MATURITY

The date on which the principal or stated value of an investment becomes due and payable.

MEDIUM-TERM NOTE

Corporate or depository institution debt securities meeting certain minimum quality standards (as specified in the California Government Code) with a remaining maturity of five years or less.

MONEY MARKET MUTUAL FUNDS

MMF's are mutual funds that invest exclusively in short-term money market instruments. MMF's seek the preservation of capital as a primary goal while maintaining a high degree of liquidity and providing income representative of the market for short-term investments.

MORTGAGE BACKED SECURITIES

Mortgage-backed securities (MBS) are created when a mortgagee or a purchaser of residential real estate mortgages creates a pool of mortgages and markets undivided interests or participations in the pool. MBS owners receive a prorata share of the interest and principal cash flows (net of fees) that are "passed through" from the pool of mortgages. MBS are complex securities whose cash flow is deter- mined by the characteristics of the mortgages that are pooled together. Investors in MBS face prepayment risk associated with the option of the underlying mortgagors to pre-pay or payoff their mortgage. Most MBS are issued and/or guaranteed by federal agencies and instrumentalities (e.g., Government National Mortgage Association (GNMA), Federal National Mortgage Association (FNMA), and Federal Home Loan Mortgage Corporation (FHLMC)).

MORTGAGE PASS-THROUGH OBLIGATIONS

Securities that are created when residential mortgages (or other mortgages) are pooled together and undivided interests or participations in the stream of revenues associated with the mortgages are sold.

MUNICIPAL NOTES, BONDS, AND OTHER OBLIGATIONS

Obligations issued by state and local governments to finance capital and operating expenses.

N

NET ASSET VALUE

Net asset value (NAV) is a term used in the mutual fund industry to determine the average price per share of a pool or mutual fund. How this measure varies over time provides information on whether the pool is stable or variable. NAV is the market value of all securities in a mutual fund, less the value of the fund's liabilities, divided by the number of shares in the fund outstanding. Shares of mutual funds are purchased at the fund's offered NAV.

NEW ISSUE

Securities sold during the initial distribution of an issue in a primary offering by the underwriter or underwriting syndicate.

NOTE

A written promise to pay a specified amount to a certain entity on demand or on a specified date. Usually bearing a short-term maturity of a year or less (though longer maturities are issued— see "Medium-Term Note").

P

PAR AMOUNT OR PAR VALUE

The principal amount of a note or bond which must be paid at maturity. Par, also referred to as the "face amount" of a security, is the principal value stated on the face of the security. A par bond is one sold at a price of 100 percent of its principal amount.

PORTFOLIO

Combined holding of more than one stock, bond, commodity, real estate investment, cash equivalent, or other asset. The purpose of a portfolio is to reduce risk by diversification.

PREMIUM

Premium means the difference between the par value of a security and the cost of the security, when the cost is above par. Investors pay a premium to purchase a security when the return to the investor (yield) is lower than the stated coupon (interest rate) on the investment.

PRINCIPAL

The face value or par value of a debt instrument, or the amount of capital invested in a given security.

PRUDENT INVESTOR STANDARD

A standard of conduct where a person acts with care, skill, prudence, and diligence when investing, re-investing, purchasing, acquiring, exchanging, selling, and managing funds. The test of whether the standard is being met is if a prudent person acting in such a situation would engage in similar conduct to ensure that investments safeguard principal and maintain liquidity.

R

REINVESTMENT RISK

The risk that interest rates may be lower than the yield on a fixed income security when the investor seeks to reinvest interest income or repaid principal from the security.

REPURCHASE AGREEMENTS

An agreement of one party (for example, a financial institution) to sell securities to a second party (such as a local agency) and simultaneous agreement by the first party to repurchase the securities at a specified price from the second party on demand or at a specified date.

REVERSE REPURCHASE AGREEMENTS

An agreement of one party (for example, a financial institution) to purchase securities at a specified price from a second party (such as a public agency) and a simultaneous agreement by the first party to resell the securities at a specified price to the second party on demand or at a specified date.

RISK

The uncertainty of maintaining the principal or interest associated with an investment due to a variety of factors.

S

SAFEKEEPING SERVICE

Offers storage and protection of assets provided by an institution serving as an agent.

SAFETY

In the context of investing public funds, safety relates to preserving the principal of an investment in an investment portfolio; local agencies address the concerns of safety by controlling exposure to risks.

SECURITIES AND EXCHANGE COMMISSION (SEC)

The federal agency responsible for supervising and regulating the securities industry.

SUPRANATIONAL INSTITUTIONS

International institutions formed by two or more governments that transcend boundaries to pursue mutually beneficial economic or social goals. There are three supranational institutions that issue obligations that are eligible investments for California local agencies: the International Bank for Reconstruction and Development (IBRD), International Finance Corporation (IFC), and Inter- American Development Bank (IADB).

T

TRUSTEE, TRUST COMPANY OR TRUST DEPARTMENT OF A BANK

A financial institution with powers to act in a fiduciary capacity for the benefit of the bondholders in enforcing the terms of the bond contract.

U

U.S. TREASURY OBLIGATIONS

Debt obligations of the U.S. Government sold by the Treasury Department in the forms of bills, notes, and bonds. Bills are short-term obligations that mature in one year or less and are sold at a discount. Notes are obligations that mature between one year and ten years. Bonds are long-term obligations that generally mature in ten years or more.

Y

YIELD

The current rate of return on an investment security generally expressed as a percentage of the securi- ties current price.

YIELD CURVE

A graphic representation that shows the relationship at a given point in time between yields and maturity for bonds that are identical in every way except maturity.

YIELD-TO-CALL

The rate of return to the investor earned from payments of principal and interest, with interest compounded semi-annually at the stated yield when the security is redeemed on a specified call date. In addition, if the security is redeemed at a premium call price, the amount of the premium is also reflected in the yield.

YIELD-TO-MATURITY

The rate of return to the investor earned from payments of principal and interest, with interest compounded semi-annually at the stated yield as long as the security remains outstanding until the maturity date.

YIELD-TO-WORST

For a given dollar price on a municipal security, the lowest of the yield calculated to the pricing call, par option or maturity.


SIERRA VIEW
MEDICAL CENTER
HR Report 2025 QTR 1

Dashboard

Measurement	QTR 1	QTR 2	QTR 3	QTR 4	YTD	Annualized	Goal	Variance
EE Referral Rate	10%				10%	10%	NA	NA
Geofencing Rate	0%				0%	0%	NA	NA
Timely Eval	63%				63%	63%	90%	-27.4%
Turnover	3.9%				4%	16%	10%	-5.3%
RN Turnover	5.3%				5%	21%	11%	-10.3%
Employee Retiention >5 Years	45%				45%	45%	50%	-5.0%

SVMC RECRUITMENT

Recruitment Update – Q1

64

Full Time Positions Filled

20

Per Diem Positions Filled

28

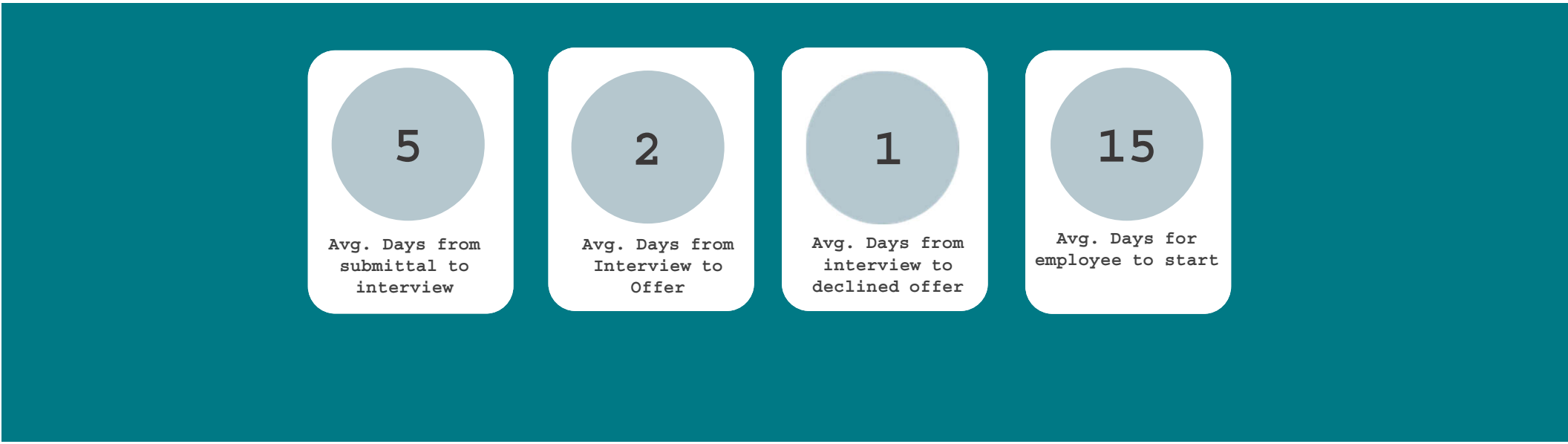
RNs Hired

*Includes 16 internal transfers

92

Total positions filled **including transfers**

Candidate Activity Metrics



Recruitment Metrics

94	92	1269	146	8
Jobs Opened	Total Accepted Offers	Total Applications Screened	Scheduled Interviews	Declined Offers

*Top reason for candidate decline: Hourly Rate/Internal Equity

Quarter 1

Recruitment Events/Projects

- Feb 25 – Unitek Bakersfield Meet N Greet
- Feb 26 – PC Meet n Greet / Luncheon Invite
- March 6 – Fresno state Career Fair
- March 20 – TCWIB Event for High Schoolers
- March 25 – PC luncheon

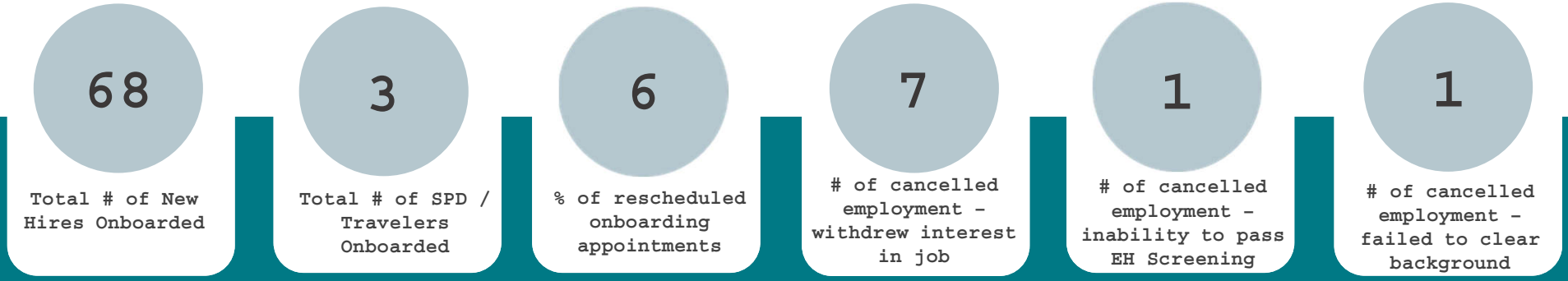
Upcoming Quarter 2 (2025)

Recruitment Events/Projects

- April 14 – New Grad Interview Day (PC)
- April 15 – New Grad Interview Day (Unitek)
- April 23 – Visalia Adult School Career Fair
- April 29 – COS Career Fair

ONBOARDING UPDATE

Onboarding Stats



EMPLOYEE RELATIONS

Employee Relations Activity

Human Resources

Performance Management Activities

INVESTIGATIONS CONDUCTED

33

PACPs SUPPORTED

0

EXIT INTERVIEWS CONDUCTED

4

GRIEVANCES MANAGED

2

Progressive Disciplinary Action

36
Attendance NOCAs

9
Performance NOCAs

43
Terminations Processed

0
Suspension Letters Pending Investigation

Unemployment Insurance Activity

19	Submitted UI Claims
1	Appeal Hearings Attended
80%	Traditional Claims Win Ratio
0	Hearings Won
$7,136	Savings
1	Hearings Pending

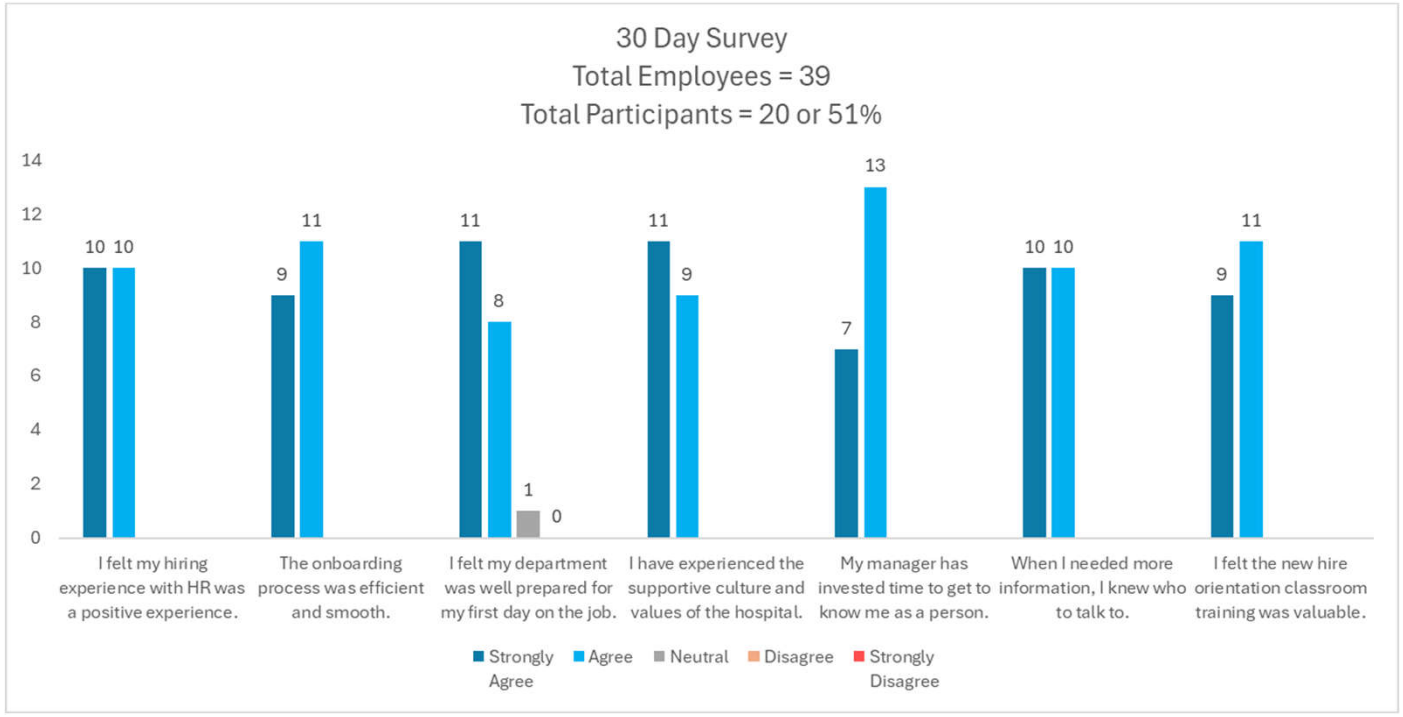
SIERRA VIEW MEDICAL CENTER

Training & Development

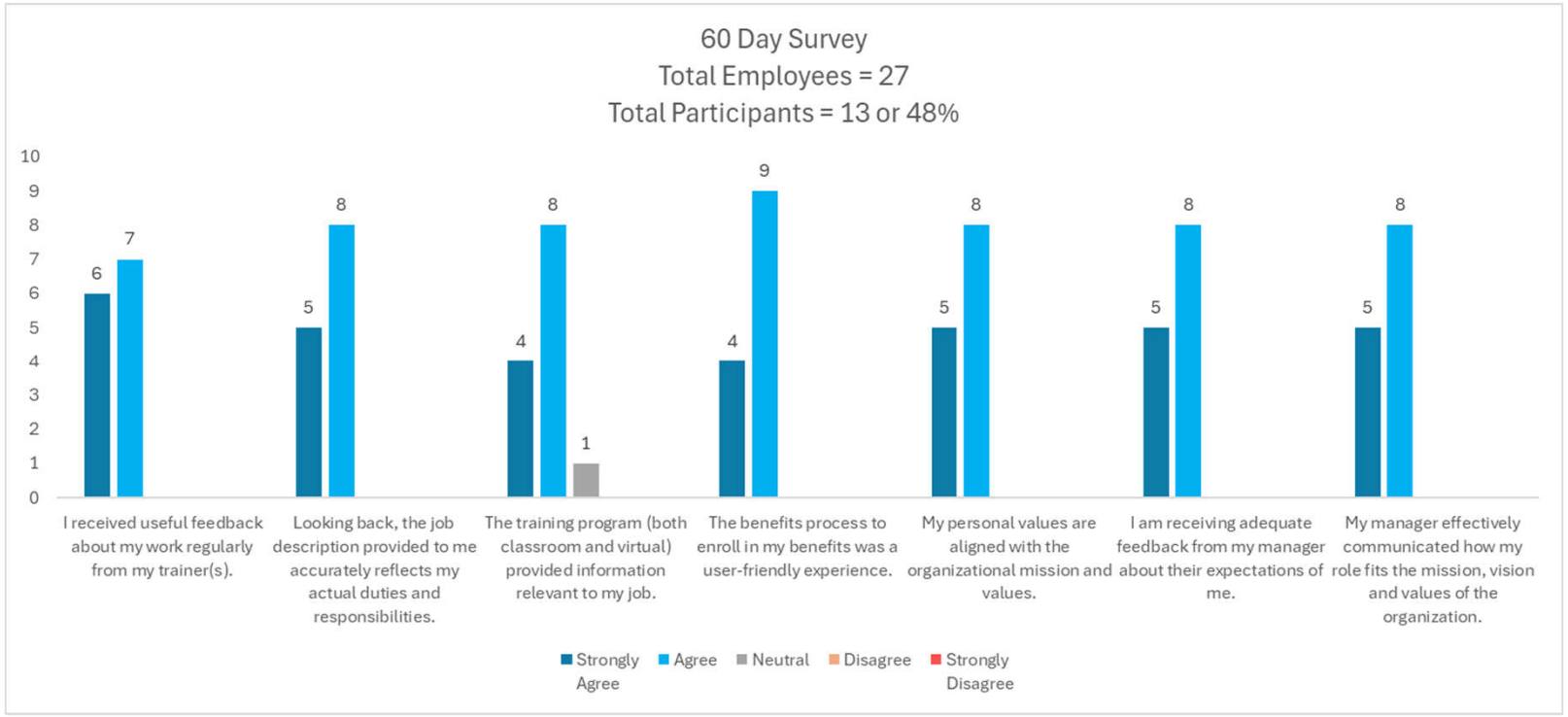
- ✓3 NHO Sessions Facilitated
- ✓50 New Hires Trained

EMPLOYEE ENGAGEMENT

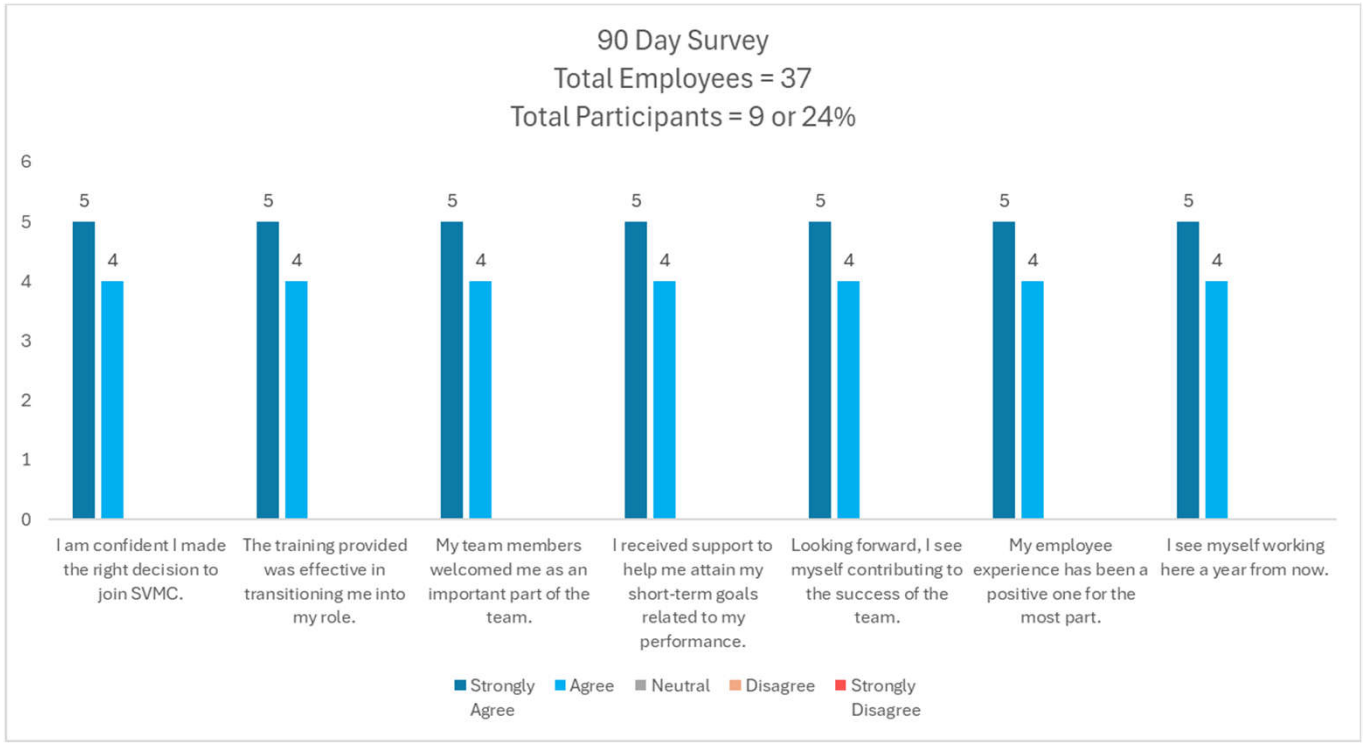
New Hire Survey



New Hire Survey



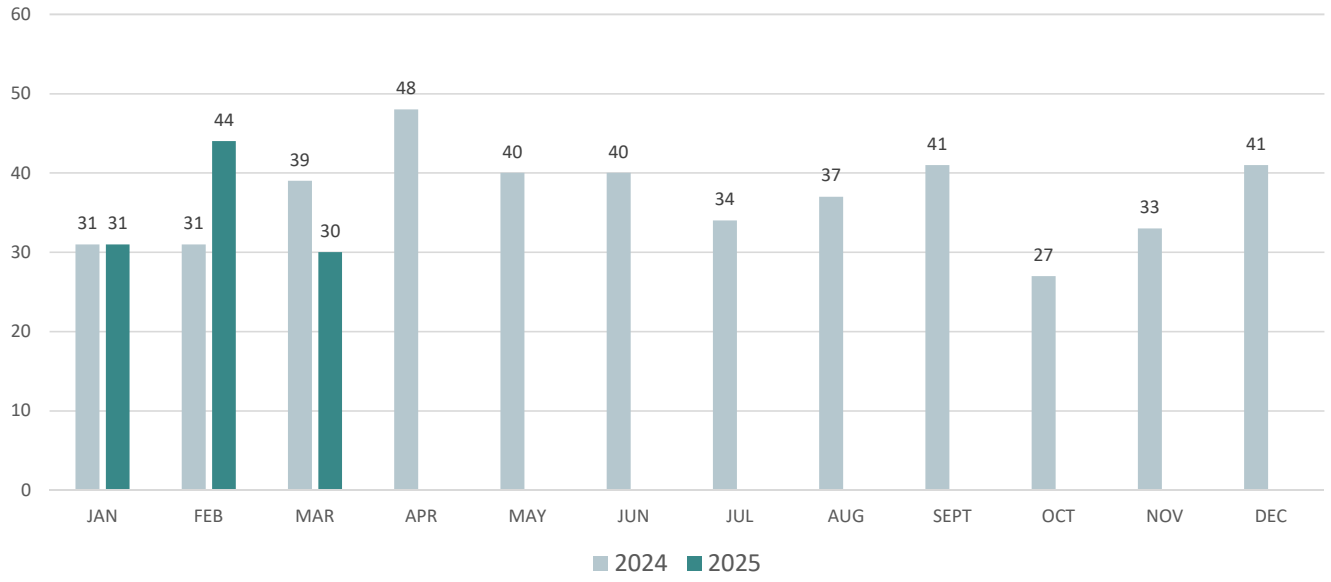
New Hire Survey



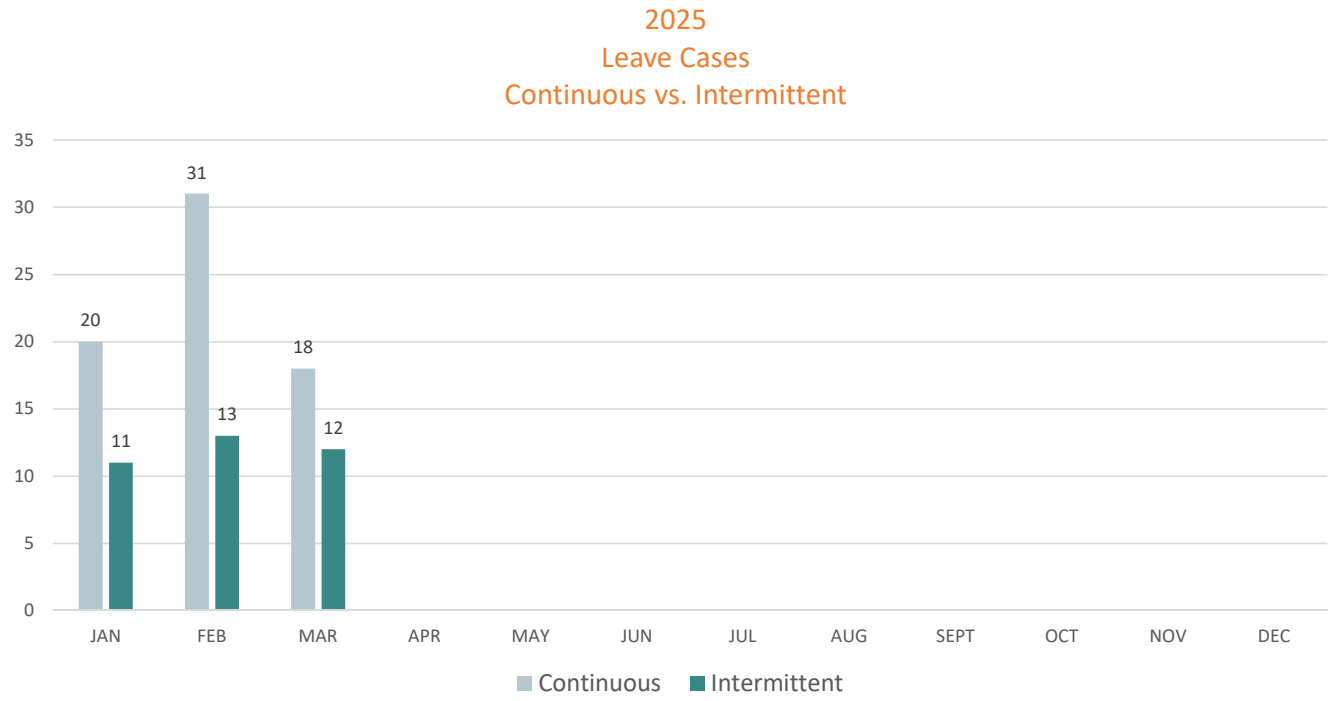
LEAVE OF ABSENCE UPDATE

Leave of Absence Update

Leave Cases
2024 vs. 2025
CY25: Q1 = 105 | Q2 = | Q3 = |Q4 =



Leave of Absence Update



Leave of Absence & Accommodations

Leave Designation & Totals

- FMLA- **53**
- FMLA Intermittent- **36**
- ADA Accommodation- **8**
- Personal- **0**
- Administrative- **8**
  - Expired licensure/certification- **7**
  - Expired I-9 documentation- **1**
- Workers Compensation- **10**
- Extensions- **44**
- Return to Work- **74**
- Total of ALL Leaves- **105**

Accommodations Requests

- Light Duty/Modified Duty- **6**

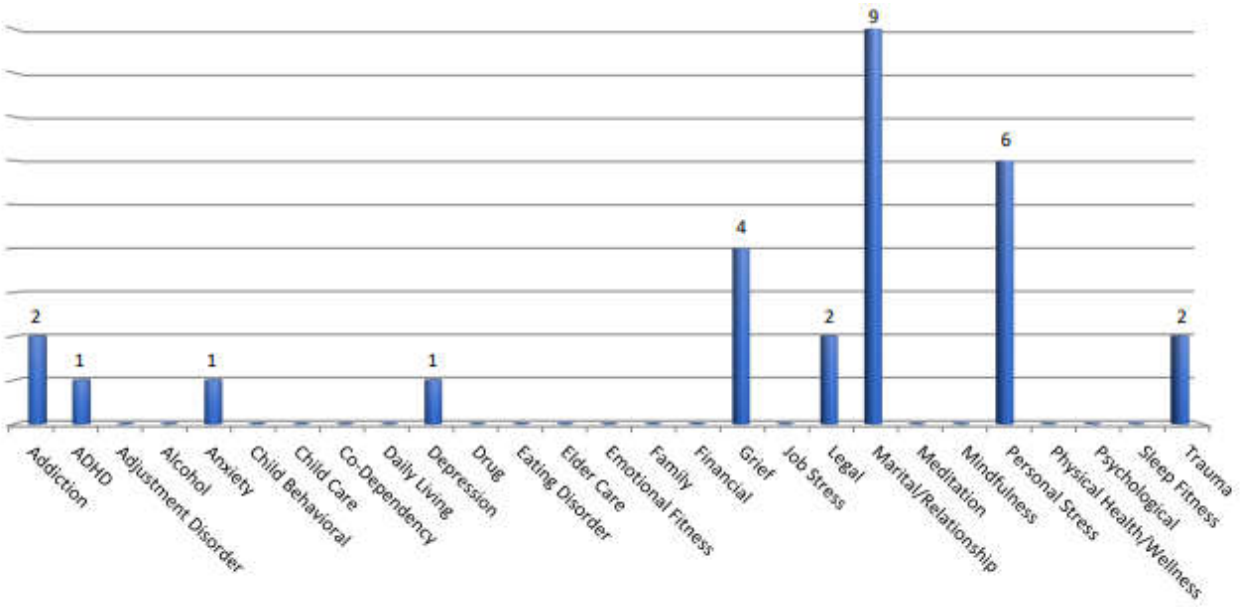
Consultations with Benefits/Leave Coordinator

Q4 Total= 352

BENEFITS UPDATES

01/01/2025 thru
03/31/2025
* Always a QTR behind

Simple Therapy- EAP



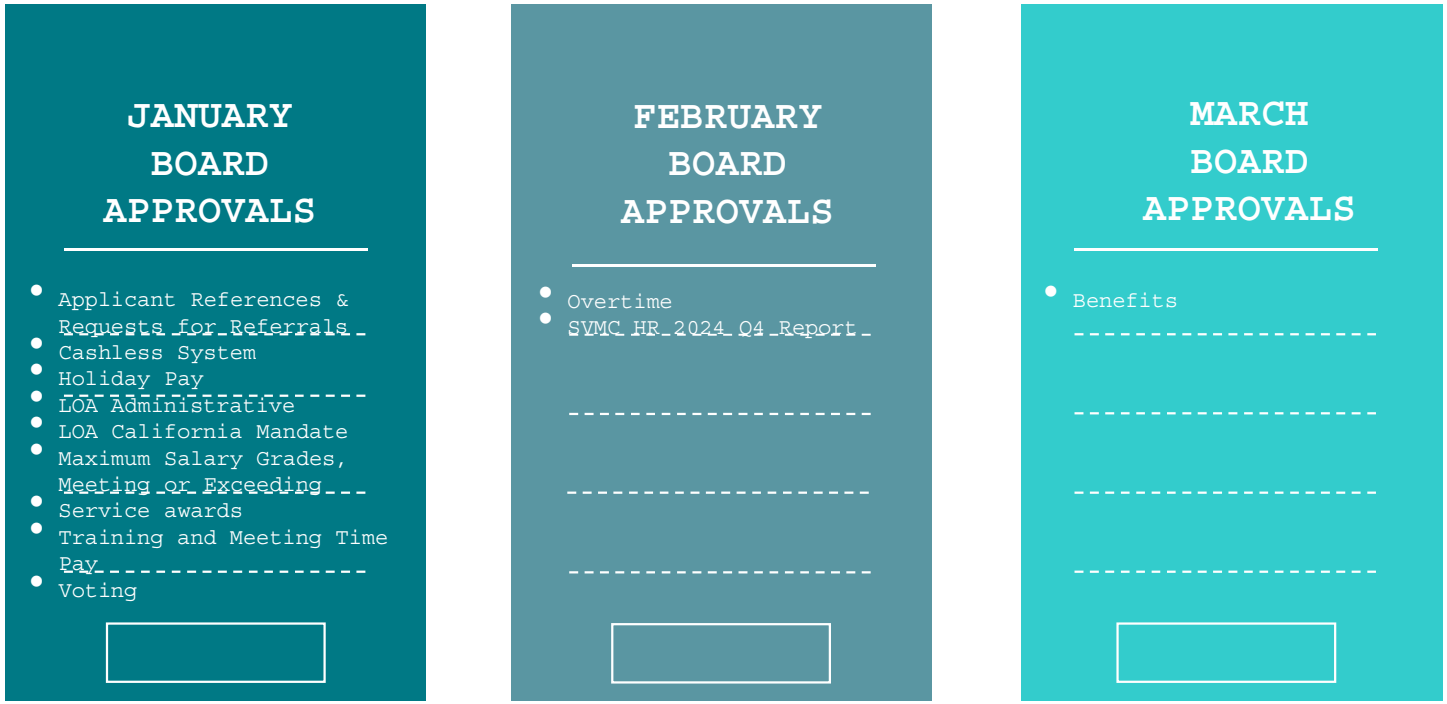
Benefits Conversational Report

* Always a QTR behind

HR POLICY REVIEW

Infographic

HR Policies



REGULATORY COMPLIANCE AUDIT UPDATES

Regulatory Audits/Internal Audits

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

INTERNAL AUDITS CONDUCTED

- NONE this QTR

REGULATORY SURVEYS CONDUCTED

- CDPH Validation Survey- March 2025

Regulatory Compliance

224
License and Certification Renewals Processed

82
Employment Verifications

258
Evaluations Processed

113
Employee Change Notices


HR PROJECT
UPDATES

HRIS Project Update

- **Performance Management**
  - Implementation in progress, completion in April 2025
- **ACA Hours Integration**

  Interface file created, pending validation

Report Requests

15

Total Report Requests

4

Total analyses

11

Total staff support reports

HR KEY ACCOMPLISHMENTS

- Implemented ChatGPT
- UKG Job Group Assignment
- Completion of FY 25-26 Salary Administration
- Annual Benefit Enrollment Record Update
- Review Employee Handbook
- Implemented Shift Diff for 10 Hour shift employees
- Trialed & Implemented AI Receptionist for HR


Marketing Report
Quarter 1
SIERRA VIEW
MEDICAL CENTER

Social Media

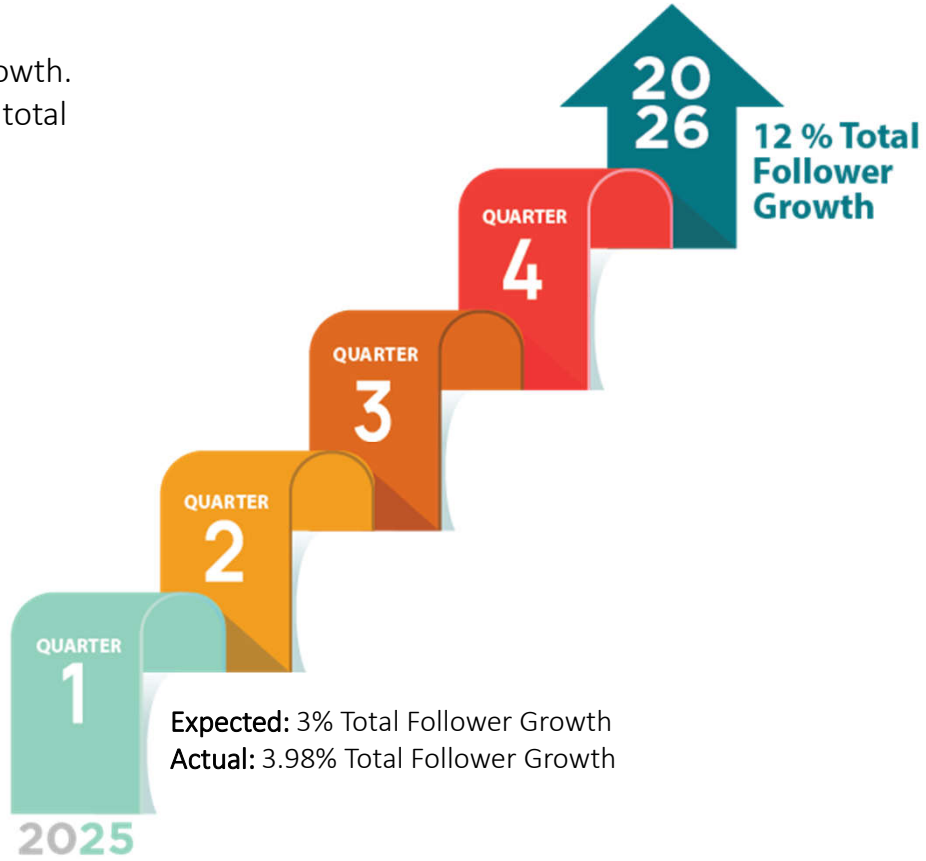
SIERRA VIEW
MEDICAL CENTER

Quarter 1

Social Media Growth

SVMC social media platforms continue to experience a steady growth. Average growth for Q1 was 3.98% in overall audience net gain. A total of 380 new followers was gained across the three platforms.

Followers by Platform				
Platform	2024 Q4	2025 Q1	Followers Gained	Growth Percentage
Facebook	5,351	5,387	36	0.67%
Instagram	1,996	2,042	46	2.3%
LinkedIn	2,055	2,347	295	14.2%



Expected: 3% Total Follower Growth
Actual: 3.98% Total Follower Growth

Quarter 1

Social Media Analytics

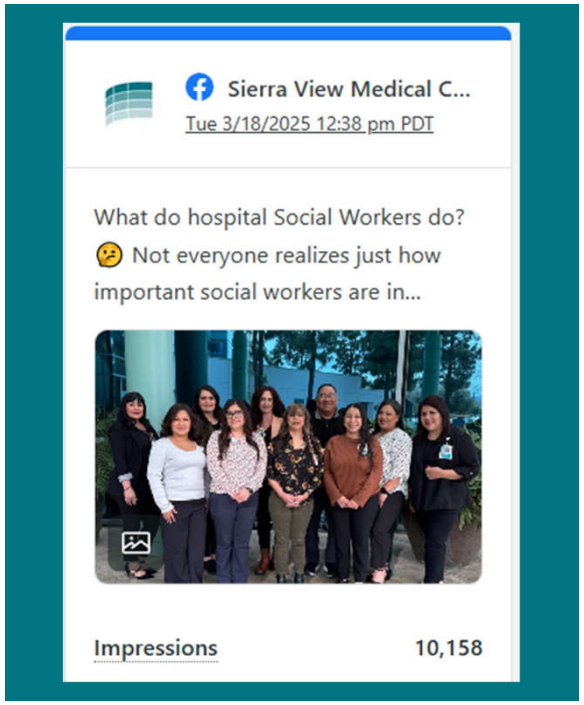
	Facebook	Instagram	LinkedIn	Overall Total for Q1	Social Media Quarterly Goals
# of Posts	80	118	55	253 	250 per quarter
Impressions	485,632	121,616	45,363	652,611 	625,603
Engagements	34,986	3,287	9,972	48,245 	48,587
Engagement Rate	7.2%	2.7%	22%	10.633% 	8.4%

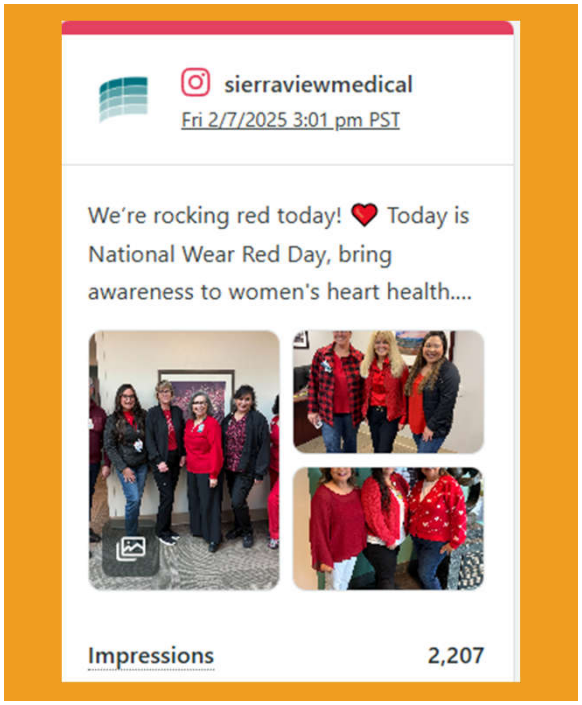
Social Media Quarterly Goals Explained:

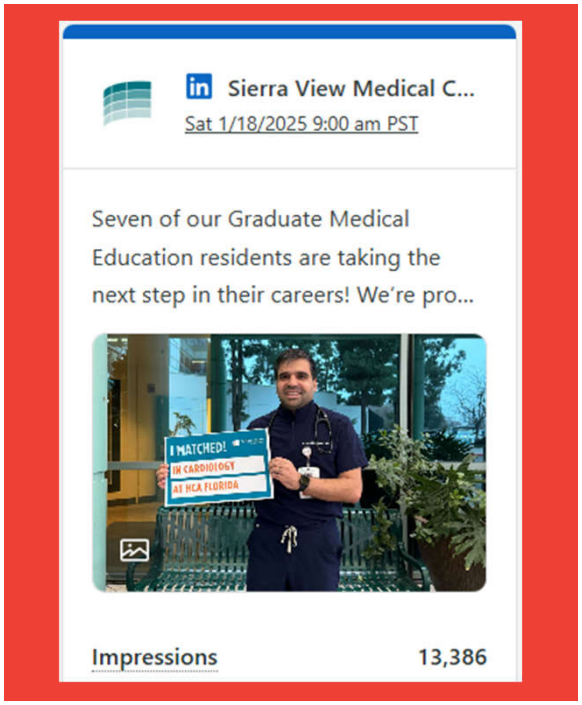
- **# of Posts (250 per quarter):** Realistic goal for SVMC that keeps up with industry standards
- **Impressions Goal (625,603 per quarter):** 10% growth from previous year-to-date
- **Engagements Goal (48,587 per quarter):** 10% growth from previous year-to-date
- **Engagement Rate Goal (8.4% per quarter):**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

Quarter 1

Top Three Stories By Platform (Impressions)







Quarter 1

Top Three Stories By Platform (Engagements)

Sierra View Medical C...
Wed 1/15/2025 3:46 pm PST

Congratulations to our newest Employee of the Month, Reina, Emergency Department RN! ...

Total Engagements	**2,522**
Reactions	266
Comments	62
Shares	2

sierraviewmedical
Wed 1/15/2025 1:11 pm PST

Congratulations to our newest Employee of the Month, Reina, Emergency Department RN! Reina's kindness...

Total Engagements	**121**
Likes	112
Comments	3
Saves	1

Sierra View Medical C...
Sat 1/18/2025 9:00 am PST

Seven of our Graduate Medical Education residents are taking the next step in their careers! We're pro...

Total Engagements	**5,348**
Reactions	166
Comments	5
Shares	6
Post Clicks (All)	5,171

Quarter 1

Top Paid Advertisements

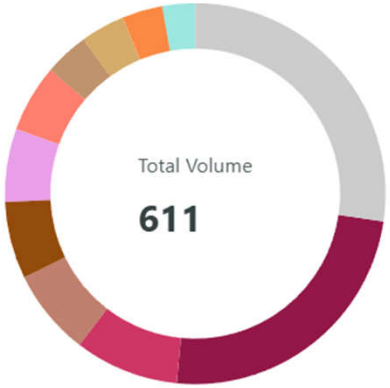
Platform	Post	Date	Link Clicks	Reach
Facebook	Registered Nursing	February 27 for 45 days at $250	478	28,872

*Ad is still running until April 13

Quarter 1

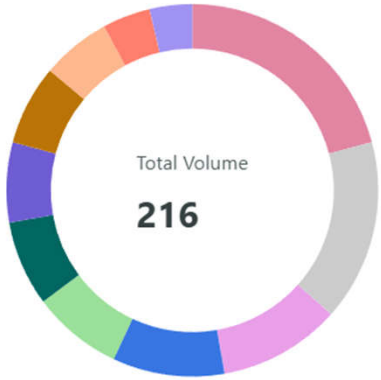
Category Breakdown for Social Media Posts

All Tags



Employees	24.2%
Awards	8.8%
Senior Team	7.4%
events	6.5%
partnerships	6.2%
Holiday & Observances	5.7%
recruitment	3.8%
SV Foundation	3.8%
CTC	3.4%
SVLHCD Board	2.8%
All Other Tags	27.3%

Service Lines Only



Senior Team	20.8%
SV Foundation	10.6%
CTC	9.7%
SVLHCD Board	7.9%
GME	7.4%
ASD	6.9%
Physical Therapy	6.9%
Terra Bella Rural Health Center	6%
Nursing Services	4.2%
Hip & Knee Center	3.7%
All Other Tags	15.7%

Quarter 1

Competitive Analysis

Facebook	Kaweah Health	Sierra View Medical Center
# of Posts	79	79
Follower Growth	-2	+36
Engagements Per Post (Average)	44.28	67.43
Published photos	72	69

Instagram	Kaweah Health	Sierra View Medical Center
# of Posts	83	79
Follower Growth	+136	+46
Engagements Per Post (Average)	84.90	38.53
Published photos	39	48

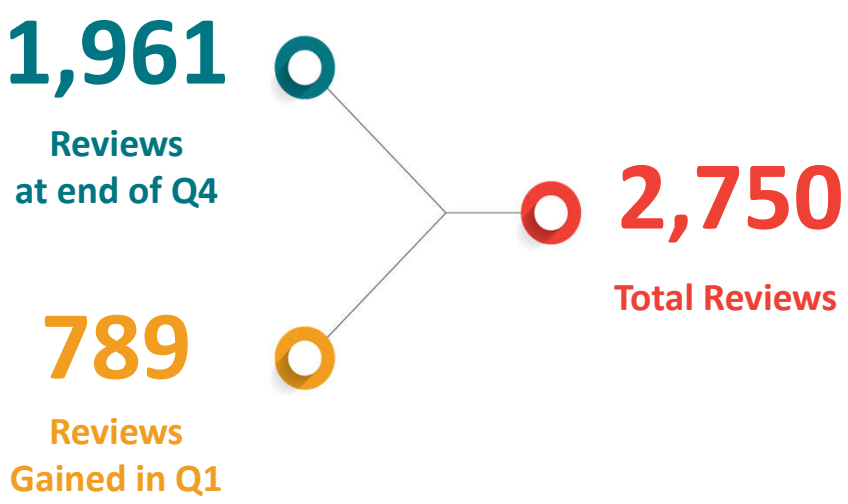
Reputation Management

SIERRA VIEW MEDICAL CENTER

Quarter 1

Reputation Management

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



Google Star Rating by Location	
Sierra View Medical Center	3.6 Stars
SVMC Urology Clinic	4.4 Stars
SVMC Medical Office Building	4.5 Stars
Sierra View Hip & Knee Center	4.7 Stars
SVMC Physical Therapy	4.7 Stars
Sierra View Community Health Center – Terra Bella	4.8 Stars
Roger S. Good Cancer Treatment Center	4.8 Stars
SVMC Ambulatory Surgery Center	4.8 Stars
SVMC Wound Healing	4.9 Stars

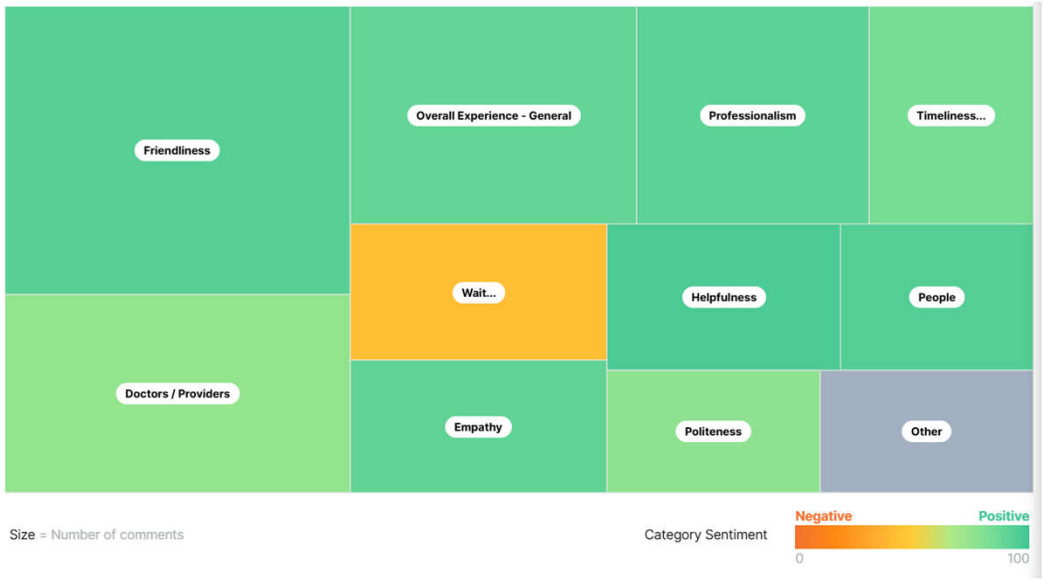
Quarter 1

What Our Patients Are Saying

Word Cloud

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

Sentiment Map



Quarter 1

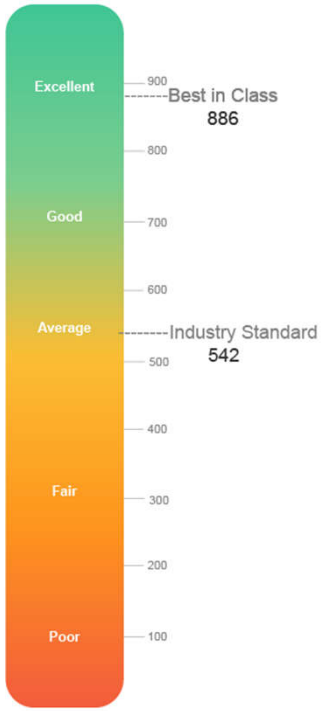
Reviews & Average Ratings

Location (9)	Total Reviews	Average Rating
Sierra View Medical Center (SVMC)	292 20% | 7% | 73%	3.9 /5
Sierra View Community Health Center – Terra Bella (SVMC_Terra_Bella_Clinic)	12 8% | 0% | 92%	4.6 /5
SVMC Medical Office Building (SVMC_MOB)	320 5% | 6% | 89%	4.6 /5
Sierra View Hip & Knee Center (SVMC_Hip_Knee)	33 3% | 9% | 88%	4.7 /5
Sierra View Medical Center Urology Clinic in alliance with Keck Medicine of USC (SVMC_Urology_Clinic)	23 4% | 0% | 96%	4.7 /5
SVMC Ambulatory Surgery Center (SVMC_ASC)	31 0% | 0% | 100%	4.8 /5
Sierra View Physical Therapy (SVMC_PT)	18 0% | 0% | 100%	4.8 /5
SVMC Roger S. Good Cancer Treatment Center (SVMC_CTC)	44 0% | 0% | 100%	4.9 /5
SVMC Wound Healing Center (SVMC_Wound_Healing)	16 0% | 0% | 100%	4.9 /5

SIERRA VIEW MEDICAL CENTER

Quarter 1

Reputation Scores



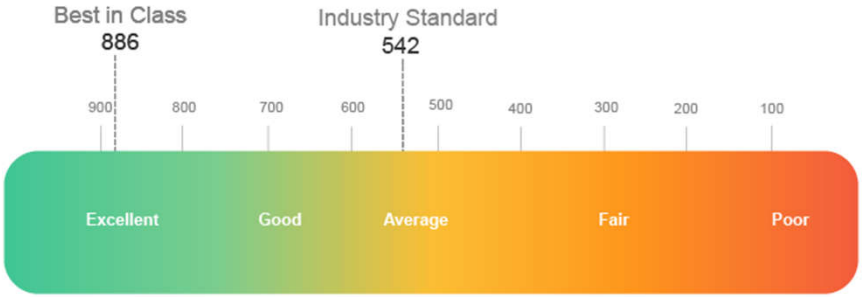
Location (9)	Reputation Score	Review Sentiment	Review Volume	Review Recency	Review Quality	Review Spread	Review Response	Search Impressions	Listing Completeness
Sierra View Medical Center (SVMC)	605	39%	52%	100%	69%	52%	100%	74%	92%
Sierra View Medical Center Urology Clinic in alliance with Keck Medicine of USC (SVMC_Urology_Clinic)	747	85%	52%	100%	32%	52%	100%	31%	84%
SVMC Medical Office Building (SVMC_MOB)	755	79%	52%	100%	61%	52%	100%	74%	80%
Sierra View Community Health Center – Terra Bella (SVMC_Terra_Bella_Clinic)	782	88%	52%	100%	26%	52%	100%	59%	84%
Sierra View Physical Therapy (SVMC_PT)	820	93%	52%	100%	38%	52%	100%	74%	84%
SVMC Ambulatory Surgery Center (SVMC_ASC)	820	92%	52%	100%	60%	52%	100%	74%	84%
SVMC Roger S. Good Cancer Treatment Center (SVMC_CTC)	844	97%	52%	100%	51%	52%	100%	74%	84%
SVMC Wound Healing Center (SVMC_Wound_Healing)	846	98%	52%	100%	39%	52%	100%	74%	84%
Sierra View Hip & Knee Center (SVMC_Hip_Knee)	858	95%	52%	100%	70%	52%	97%	91%	95%

SIERRA VIEW MEDICAL CENTER

Quarter 1

Competitive Analysis of Patient Reviews

Location (4)	Total Reviews	Average Rating	Reputation Score
Adventist Health Hanford	314 9% | 3% | 88%	4.5 /5	857
Sierra View Medical Center (SVMC)	292 20% | 7% | 73%	3.9 /5	631
Dignity Health - Memorial Hospital	126 14% | 3% | 83%	4.3 /5	704
Kaweah Health Medical Center	37 43% | 3% | 54%	3.2 /5	581

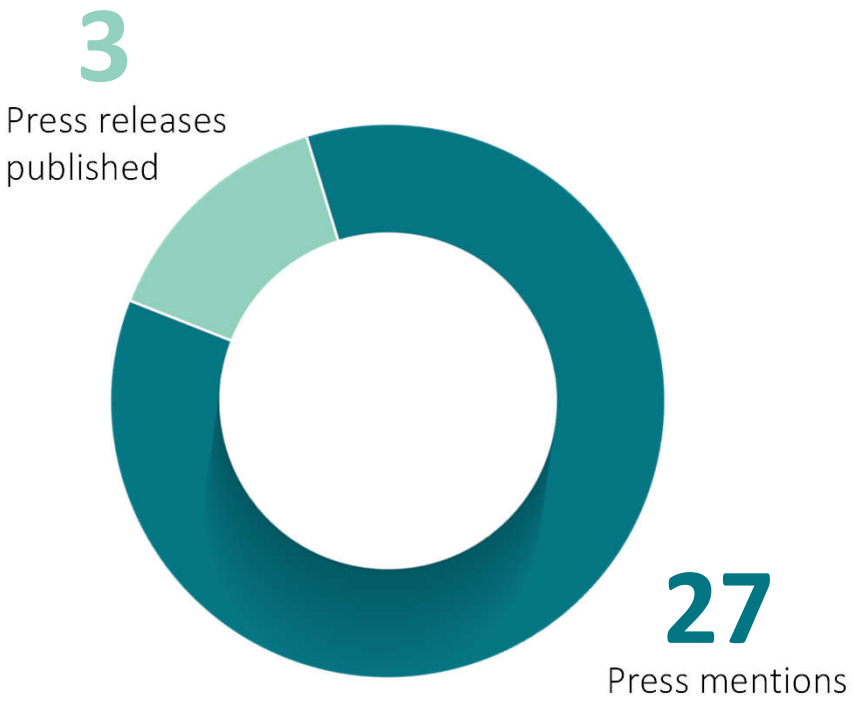


Public & Media Relations

SIERRA VIEW MEDICAL CENTER

Quarter 1

SVMC In the Headlines



Top Articles

1. Sierra View Medical Center New Year's Baby
2. Porterville Breakfast Rotary CTC Donation
3. SVMC CEO Appointed to American Hospital Association Regional Board
4. Fellowship Match Day
5. 2024 Leadership Award Recipients
6. 3 Retirement Stories
7. Infection Prevention in Action

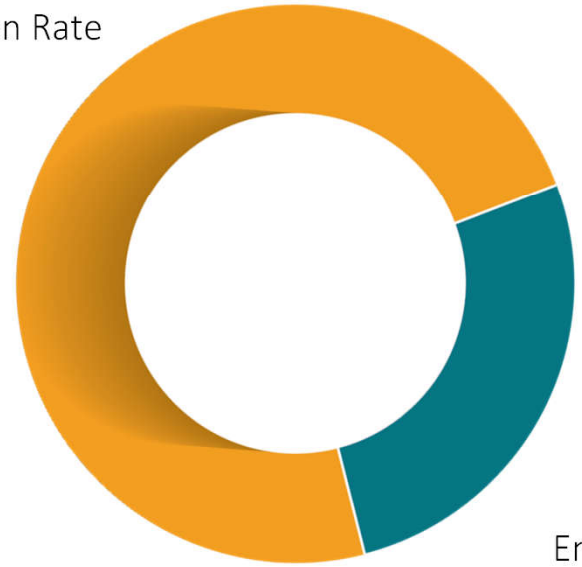
Quarter 1

SIERRA VIEW MEDICAL CENTER

INSIDE View

SIERRA VIEW MEDICAL CENTER

64%
Open Rate



3
Emails Sent

Sierra View Medical Center delivered 3 installments of our digital newsletter Inside View to those who sign up. This publication gives an Inside View of everything happening at and around our hospital. Our monthly emails will keep you up-to-date on the latest Sierra View news, events, career openings, and more.

Community Relations, Events, & Fundraising

SIERRA VIEW MEDICAL CENTER

Quarter 1

Community Events

In quarter three, Sierra View hosted, sponsored or was present at the following community events:

January

February

- National Wear Red Day
- Porterville Breakfast Rotary Check Donation to the CTC
- Summit Charter Intermediate Academy Greeting Card Donation to the CTC

March

- First Friday Coffee with Porterville Chamber
- Doctor's Day Dinner
- 13th Annual Growing Leaders Conference
- Read Across America at Belleview Elementary

Quarter 1

Community Relations Outreach

January

- ABC 30 Advisory Council Meeting
- TKHCC Advisory Committee Meeting

February

- TKHCC Networking Luncheon
- MTA Pathway Meeting
- Access To Care Committee Meeting (Tulare County)
- ACNL Conference (CNO)

March

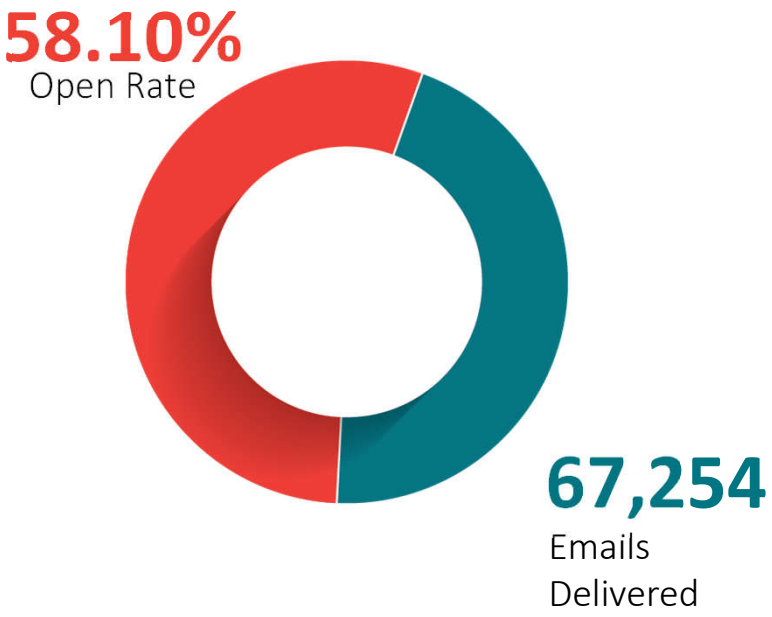
- Vizient Inc. / American Association of College of Nursing Conference
- AHA Regional Policy Board 9 Conference (CEO)
- Porterville College Nursing Luncheon
- GAC Meeting
- TKHCC Networking Luncheon

Internal Communication Strategy

SIERRA VIEW MEDICAL CENTER

Quarter 1

Internal Communications



Email	Open Rate
2/3 HR Leadership Quiz Reminder	95.74% Open Rate
1/16 Leadership Team Bi-Weekly Update	91.84% Open Rate

Types of Internal Communication:

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

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

Get In Touch With Marketing

Address

444 West Putnam Avenue

Porterville, CA 93257

General Email

Marketing@sierra-view.com

General Line

(559)791-3922

Thank You

SIERRA VIEW
MEDICAL CENTER

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MEDICAL EXECUTIVE COMMITTEE	04/02/2025
BOARD OF DIRECTORS APPROVAL	
	04/22/2025
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
April 22, 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**
• Admission Process	1-2	
• Appointment Process	3-4	
• Blanket Warmer	5	
• Business Hours	6	
• Care of Residents with Dementia on the DP/SNF Unit	7-10	
• Changing a Trach Tube on Subacute	11-14	
• Closed Office Coverage, Notices and Signage	15-16	
• Closets – Organizing/Cleaning	17	
• Communication Barriers, Reduction of	18	
• DP/SNF Room Change	19	
• Documentation Nursing DPSNF	20-23	
• Downtime of Electronic Health Record	24-25	
• Drug/Nutrient Interactions and Enteral Tube Feeding Drug/Nutrient Interaction	26-28	
• Earthquake or Weather Disaster	29-30	
• Equal Access to Quality of Care	31	
• Examination/Treatment of Disrobed Patient	32	
• Fire Safety – General Instructions	33	
• GME – Moonlighting	34-36	
• Hand Rolls	37	
• Hepatitis Infection Control Procedures	38-42	
• Influx of Infectious Patients Contingency Plan	43-70	
• Initiation of Hemodialysis Using Dual Lumen Catheter	71-73	
• Laryngeal Mask Airway; Newborn Respiratory Care Service Medications	74-76	
• Linen and Laundry	77	
• Maintaining Patency of Feeding Tube	78-79	
• Mattress – Air	80	
• Mattress – Alternating Air	81-82	
• Measurement of Bicarb and Dialysate Conductivity and PH	83-85	
• Measurement of Recirculation in the Vascular Access	86-87	
• Medical Advice via Telephone	88	
• Medical Assistant Scope of Practice	89-96	
• Medication Administration: Medical Assistant	97-98	
• Medication Administration Through a Feeding Tube	99-100	
• Neonatal Intensive Care Unit Scope of Patient Care/Staffing Guidelines	101-110	

• Nourishments	111-112	**APPROVE**
• Nursing Care, Restorative and Supportive	113-114	
• Nursing Weekly Summary	115-116	
• Oral Nutrition Supplement	117-119	
• Orders – Physician Noting	120	
• Orders – Physician Recapping	121	
• Outpatient – Fall Risk Identification and Mitigation	122	
• Overlapping Operations/Flipping Rooms	123	
• Pandemic Covid-19 Management Plan	124-139	
• Patient Assessment and Reassessment – Acute Renal Services	140-142	
• Precautions for Antibiotic-Resistant Microorganisms	143-148	
• Preventative Maintenance for Fresenius Dialysis Machines	149	
• Quality Assurance/Performance Improvement – DP/SNF	150-153	
• Razor Cleaning – Electric	154-155	
• Recirculation of Blood in Extracorporeal Circuit – Acute Renal Services	156-157	
• Residents' Personal Clothing	158	
• Residents' Personal Refrigerator	159	
• Restraints, Chemical	160-165	
• Scope of Service – Renal Services	166	
• Shared Bathrooms	167	
• Siderails	168	
• Skin Integrity Team Guidelines	169-170	
• Standard Maintenances of Water Treatment System	171-172	
• Sterile Products: Education and Competency	173-179	
• Sterile Products: Sterile Product Quality Assurance	180-194	
• Suctioning – Naso-Orpharyngeal	195-197	
• Swallowing Assessment and Residents' Rights – DP/SNF	198-199	
• Tablo Pro+ in the Acute Care Setting	200-201	
• Theft and Loss	202-205	
• Transfer of Resident To – From Bed	206-208	
• Trapeze – Overbed	209	
• Urology Clinic – Urine Specimen Collection and Testing	210-211	
II. <u>Forms</u>:		
• Respiratory PFT Requisition	212	

SUBJECT: **ADMISSION PROCESS**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose of this policy is to ensure equal access to care and facilitate the admission process according to state and federal guidelines.

POLICY:

The Unit Director, R & Q RN, Support Staff (IP, SSD), or Support Registered Nurse (RN) will assess referrals for admission possibility, using criteria set forth by state and federal guidelines for Distinct Part Skilled Nursing Facility (DP/SNF). Assessed referrals are to be submitted to the Medical Director for approval. Upon selection by the medical director, coordination of disciplines and between facilities is maintained by the Director of the DP/SNF or Admissions Case Manager (if applicable) with the aim of expediting a safe and timely admission into the DP/SNF.

AFFECTED PERSONNEL/AREAS:

MEDICAL DIRECTOR, ANCILLARY STAFF, UNIT DIRECTOR, SUPPORT RN

EQUIPMENT:

- Fax machine
- Computer
- Telephone

PROCEDURE:

1. Receive, assess and catalog prospective referrals. Obtain information as needed from submitting facility. Assess prospective resident in person if possible.

2. Utilize Minimum Adult Eligibility Criteria:

   a. Stable with no acute care needs

   b. 24/hour RN nursing care required

   c. Any one of the following four items:

      - A tracheostomy with continuous ventilation >50% of the day
      - Tracheostomy care and at least one of the six treatment procedures of section "D"
      - SNF residents: any one of the six in Section D

d. **Treatment Procedures:**

- Inpatient Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) for a minimum of 2 hours/day, 5 days/week
- Total Parenteral Nutrition
- Nasogastric tube/gastric tube (NGT/GT)
- Respiratory Therapy (RT) minimum 4 times a day
- Intravenous (IV) therapy
- Wound debridement

3. Eliminate referrals that do not fall within criteria and/or facility capability, i.e. dialysis needs, under age of 21, or severe psychiatric diagnosis in an alert resident. Notify submitting facility of inability to provide care.

4. Submit referrals to the Medical Director, taking into consideration the type of available accommodation such as male or female, shared bath and/or isolation needs.

5. Notify sending facility of acceptance and arrange for admit with the time, date and specific resident needs.

6. Notify disciplines of acceptance and impending admit to include the Unit Director, Medical Director, Nursing, Respiratory Services, Social Services, Infection Control Officer, Registration and the Billing Department.

7. Maintain contact with sending facility as needed until the admit process is complete. Maintain referral pack for future reference.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 72315 (a, b, c) San Francisco, California, Title 22.
- Med Pass, Inc.,(updated February 6, 2015) Facility Guide to OBRA Regulations, 483.12 (D) United States of America, Med Pass Inc.

SUBJECT:	SECTION:
APPOINTMENT PROCESS - SC	***Multispecialty Clinic***
	Page 1 of 2

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

PURPOSE:

To provide patient appointments at the Sierra View Multispecialty Clinic.

POLICY:

It is the policy of Sierra View Multispecialty Clinic to provide continuity of care, promote efficient operation of the Clinic, and to support quality customer service.

AFFECTED PERSONNEL/AREAS: *SURGERY CLINIC PERSONNEL, ACADEMIC HEALTH CENTER, OB/GYN CLINIC AND MEDICAL STAFF*

PROCEDURE:

A. PATIENT REMINDER OF SCHEDULED APPOINTMENT

1. Patients scheduled to be seen in the Multispecialty Clinic within the next 1-3 days will be contacted via phone to confirm the appointment.

2. Patients will be asked to confirm the time and date of the appointment. In the event that the patient would like to reschedule the appointment, a notation of the change will be made in the patient's Electronic Health Record.

3. In the event an appointment is canceled, that appointment will be made available for other patients who may need to see the Physician.

4. The Physician will be notified if the patient has cancelled and has not rescheduled the appointment; if follow up is required the Physician will provide instructions on next steps. Next steps may include direct contact from the Physician, follow up call from clinical staff, follow-up letter or no action. All contact with the patient will be noted in the Electronic Health Record (EHR).

5. Notations will be made in the Electronic Health Record documenting appointment confirmations and attempts.

B. PRACTICE NEED/PHYSICIAN AVAILABILITY:

1. When it is determined that physician availability has changed or other circumstances have arisen that require a revision of the patient schedule, a list of patients scheduled for the identified time frame will be obtained.

2. Designated staff will contact the patient by telephone in an effort to reschedule the affected appointment(s).

3. When reached, the patient will be told that there has been an unplanned change in the physician's schedule or, where an operational issue is the cause of the change, that explanation (i.e., power failure).

4. A new appointment will be made for the soonest possible date convenient to both the patient and the practice by revising the appointment in the Electronic Health Record (EHR) and a notation of the original date/time will be made in the notes section.

5. Health Insurance Portability and Accountability Act (HIPAA) guidelines will be followed when leaving a telephone message for the patient.

    a. Messages may be left on answering machines, a family member or caregiver to include the patient name, appointment date and time and name of doctor.

C. PATIENT NO SHOW

1. The patient's health record will be marked NO SHOW for the missed appointment.

2. A No-Show letter will be generated and documented in the Electronic Record.

    a. The Physician will review charts of patients that did not show up to their appointment. If additional follow up is required, the Physician will provide instructions on next steps. Next steps may include direct contact from the Physician, follow up call from clinical staff, a certified follow up letter in addition to the standard no show letter or no additional action. All contact with the patient will be noted in the Electronic Health Record.

3. The designated staff member will contact the patient by telephone and offer alternate appointment dates and times with sensitivity to any timeframe considerations based on insurance authorization.

4. HIPAA guidelines will be followed when leaving a telephone message for the patient.

    a. Messages may be left on answering machines, a family member or caregiver to include the patient name, appointment date and time and name of doctor.

5. Results of attempted contact with the patient will be recorded in the Electronic Health Record (EHR). A minimum of three attempts to contact the patient will be documented.

REFERENCES:

- U.S. Department of Health & Human Services. HHS.GOV "198- May Providers leave messages for patient at their homes to remind them of appointments" (12/19/2002). Retrieved 10/12/20 from https://www.hhs.gov/hipaa/for-professionals/faq/198/may-health-care-providers-leave-messages/index.html.

- Woodcock, Elizabeth, MBA, FACMP, PCP "Mastering Patient Flow 4th Edition". MGMA published excerpt 7/9/10 retrieved 3/11/15 from http://www.mgma.com.

SUBJECT: **BLANKET WARMER**	SECTION: **Page 1 of 1**

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

PURPOSE:

To provide guidelines for ensuring the proper functioning of the Blanket Warmer on the DP/SNF Unit.

POLICY:

The facility will utilize the blanket warmer for the residents' comfort, to provide them with warm gowns, blankets, towels as per request of the resident and/or after their shower or bath. The DP/SNF unit will maintain safe usage of the blanket warmer at all times.

AFFECTED PERSONNEL/AREAS: *DIRECTORS, CLINICAL MANAGERS, REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA), ENVIRONMENTAL SERVICES (EVS), AND BIOMED*

PROCEDURE:

1. The blanket warmer will be stocked on a daily basis by EVS staff or nursing when needed.

2. The RN on the unit will monitor the temperature of the unit each shift and log on the *Blanket Warmer Log Sheet* the actual temperature and the set point temperature of 125 degrees Fahrenheit. MIFU will be reviewed to its updated guidelines.

3. Each shift, the RN will monitor that the actual reading of the temperature on the unit does not read above the set point temperature of 125 degrees Fahrenheit.

4. The RN will notify Bio Med if the temperature reads above the set point and tag the unit "Out of Order" until evaluated and cleared by Bio Med.

REFERENCE:

- Venture Medical (2019). Blanket Solution Warming Cabinets. Retrieved from https://www.venturemedical.com/knowledge-center/medical-warming-cabinets/.

SUBJECT: **BUSINESS HOURS - SC**	SECTION: ***Multispecialty Clinic*** **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 Multispecialty Clinic.

POLICY:

The Multispecialty Clinic will maintain posted hours of operation.

AFFECTED PERSONNEL/AREAS: *ALL SURGERY CLINIC PERSONNEL, OB/GYN CLINIC, ACADEMIC HEALTH CENTER, AND MEDICAL STAFF*

PROCEDURE:

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

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

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

C. Signage

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

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

D. Unplanned Closing/Change of Schedule

   1. 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.

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

CROSS REFERENCES:

- HUMAN RESOURCES: EMPLOYEE HANDBOOK

SUBJECT:	SECTION:
CARE OF RESIDENTS WITH DEMENTIA ON THE DP/SNF UNIT	***Provisions of Care***

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

PURPOSE:

To provide guidelines used to enhance the quality of life care to residents with the diagnosis of dementia in the DP/SNF unit by individualizing the residents' care to meet physical, spiritual and psychosocial needs.

DEFINITIONS:

Dementia: A syndrome or a group of symptoms that occur together; an umbrella term describing a set of memory and cognitive decline symptoms; many different conditions lead to these symptoms.

POLICY:

It is the DP/SNF unit staff's responsibility to provide a resident with dementia, a therapeutic living environment with regards to what constitutes quality of life most affected by the disease process

AFFECTED PERSONNEL/AREAS: *ANCILLARY STAFF, REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), CERTIFIED NURSING ASSISTANT (CNA), RESPIRATORY THERAPIST (RT), AND ENVIRONMENTAL SERVICES (EVS).*

PROCEDURE:

A. Obtain an initial assessment with details of the residents' cognitive and physical function before admission, if possible. Obtain input from the resident, and their family or guardian, if applicable. Some pertinent questions:

   1. What changes have been noticed with memory?
   2. Can he/she remember at intervals; is it getting worse or does it remain the same?
   3. Have there been changes in personality or behavior?
   4. Have there been declines in personality or behaviors?
   5. Have there been declines in personal care/hygiene?
   6. Is he/she a fall risk?

B. Monitor resident for episodes of dementia-related behavioral problems or changes in behavior such as:

   1. Repetitive vocalizations
   2. Psychomotor hyperactivity
   3. Physical aggression

4. Self-neglect
5. Resisting help with personal care
6. Anger and irritability
7. Manic-like behavior
8. Disturbance of sleep cycle
9. Psychosis
10. Depression
11. Inappropriate sexual behavior
12. Pacing or wandering

C. For changes in or new dementia-related behaviors, collaborate with the physician to determine the need for the following interventions:

1. Psychiatric evaluation as needed.
2. Physical restraints for resident safety, if needed, with MD order and consent.
3. The order for restraint will include the type and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. As needed (PRN) restraint orders will be neither issued nor accepted.
4. Initiation without Physicians Order: If a physician is not available, an RN may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the resident's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 12 hours of its initiation.
5. Initial In-Person Physician Assessment Within 24-hours of Initiation: The treating physician will perform an in-person assessment of the restrained resident within 24-hours of initiation to verify that restraint is needed and that less-restrictive means are not appropriate.
6. Residents on the DP/SNF unit will be taken to the Emergency Room for full evaluation before Violent Self Destructive restraints are used, especially if the resident has a diagnosis of dementia, and/or has become violent and can harm self or others. The resident will not remain on the DP/SNF unit if Violent Self Destructive restraints are used.

7. Antidepressant/antipsychotic medications per MD order

8. Monitor/discuss the use of antipsychotic/psychotropic medications weekly in the Interdisciplinary Team (IDT) meetings and reduce medications as able.

9. Monitor resident closely while on antipsychotic medications using the Abnormal Involuntary Movement Scale (AIMS) tool initially. Re-evaluate using AIMS every 6 months and as indicated.

10. Pharmacy to review issues of adverse medication effects that may cause cognitive impairments and may be mistaken as worsening dementia.

D. Activities should be directed towards managing residents with all stages of dementia. These may include:

1. Reducing long periods of isolation

2. Using distractions

3. Talking/interacting frequently with resident

4. Predictable routines, avoiding frequent or sudden changes

5. Frequent reassurance, calmness

6. Structured environment

7. Orienting stimuli

8. Adequate daylight lighting, night lights, supporting normal wake/sleep cycles

E. If resident is a fall risk/wanderer, place in a low bed if available, place bed in lowest position, assign room closest to nurses' station to be monitored at all times, and place fall mats on the floor next to the bed if indicated. Complete the Bed Assessment for side rail use.

F. Monitor resident routinely for hyperglycemia, dysphasia, weight gain/ weight loss, Parkinsonism, or excessive sedation.

G. Assess resident's decision-making capacity routinely, based on degree/stages of dementia.

REFERENCES:

- Annals of Long Term Care, Consuelo H. Wilkins, MD, 2022 HMP Global, *Diagnosis and Management of Dementia in Long Term Care*. http://www.hmpgloballearningnetwork.com
- Healthcare Brands (n.d.). Dementia.org. *The Difference Between Alzheimer's and Dementia*. Retrieved from http://www.dementia.org/types/the-difference-between-alzheimers-and-dementia.

California Department of Public Health (Feb 28, 2024). All Facilities Letter (AFL-24-07). *Verifying informed consent for psychotherapeutic drugs before transferring patients to Skilled Nursing Facilities*

- California Association of Health Facilities (February 2020). *Guide to Long Term Care*. https://www.cahf.org/About/Consumer-Help/Guide-to-Long-Term-Care.

- Centers for Disease Control and Prevention (Updated May 12, 2020). *Considerations for Memory Care Units in Long-term Care Facilities*. https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html.

- Centers for Medicare & Medicaid Services (February 27, 2020). National Partnership- Dementia Care Resources. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-Dementia-Care-Resources.

CROSS REFERENCES:

- DP/SNF Policy and Procedure – RESTRAINTS, CHEMICAL

- DP/SNF Policy and Procedure – RESTRAINT USE – NON-VIOLENT, NON SELF-DESTRUCTIVE (NVNSD) AND EMERGENCY-VIOLENT SELF DESTRUCTIVE (VSD)

SUBJECT: **CHANGING A TRACH TUBE ON SUBACUTE**	SECTION:

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

PURPOSE:

To define a consistent method for changing a tracheostomy tube while ensuring resident safety and welfare.

POLICY:

The Respiratory Care Practitioner and/or Registered Nurse will be responsible for changing the tracheostomy tube once per month and prn. A Portex D.I.C. non-fenestrated cuffed tracheostomy tube will be used unless another is indicated by the MD. Any resident not utilizing this brand of tracheostomy tube on the DP/SNF Unit must be changed within 48 hours, unless the tracheostomy is less than 30 days old or the MD may have ordered a specialized type of tracheostomy tube for certain residents. Then, the Respiratory Care Practitioner and/or the Registered Nurse will wait 30 days prior to changing the tracheostomy tube. All residents will have the same size or one size smaller tracheostomy tube at his/her bedside.

AFFECTED PERSONNEL/AREAS: *RESPIRATORY CARE PRACTITIONER, REGISTERED NURSE*

PROCEDURE:

1. Wash hands thoroughly and wear gloves.

2. Place all necessary pieces of equipment at the resident's bedside.

3. Remove the replacement tracheostomy tube from its packaging. Take care not to cause any damage to the cuff, the tubing used to inflate the cuffs, or to the control balloon.

4. Remove the inner cannula (if supplied).

5. If a cuffed tracheostomy tube is being inserted, use a clean dry syringe to inflate the cuff up to the right volume for the leak test. You will find this volume listed in the package leaflet enclosed with the tube. The air volume can be read off the markings on the syringe.

6. Using the syringe, release all the air again. While doing so, push the cuff carefully off the end of the tube in the direction of the neck flange. Make sure that you remove all air. (This makes it easier to insert the tube.)

7. Thread the tube holder through one of the openings on the neck flange. If appropriate, insert the obturator in the tube (carry out this step before you insert the tube); have a new tracheal compress ready at hand.

8. Coat the trach with a thin layer of water-soluble lubricant.

9. Hyperextend the residents' neck by placing a folded towel under the neck or remove pillow from behind the head.

10. Suction the tracheostomy tube until clear.

11. Using the syringe, release all air from the cuff on the old tube that is still in the trachea. Now remove the tube. If you are not able to remove the old tube, consult your doctor. *Never apply force.*

12. Manually ventilate the resident (if on Continuous Mechanical Ventilation). At the end of their inhalation, remove the tube carefully; insert the new tube into the stoma.

13. Carefully insert the new tube while the patient is inhaling. Advance the tube with an arching motion first towards the back and then downwards. While doing this, insert the tube at an angle and push it with a slight turning movement into a central position. Positioning the patient with the neck extended to bring trachea forward should be done on all patients unless contraindicated (ie cervical spine injury).

14. Remove the obturator immediately while holding the tube in place with your fingers.

15. Tie the trach tube with trach collar around the resident's neck, leaving room for the insertion of two fingers between the resident's neck and trach collar. This is a safety check procedure to assure that the tie is not too tight.

16. Inflate the cuff to the correct pressure using a cuff pressure monitor (cpm). You may also use the minimal leak technique (MLT) or minimal occlusion volume (MOV). Recommended value: 25 mmHg, do not exceed 30 mmHg.

17. Carry out stoma care as usual; perform suctioning once more as required.

18. Document the trach change in the EMR.

EQUIPMENT:

- Tracheostomy tube (similar size or one size smaller)
- Tracheostomy tube ties/trach collar
- Water soluble jelly
- Sterile gloves
- Suction catheter
- Resuscitation bag with trach tube connection and mask on standby
- 5cc syringe

SPECIAL CONSIDERATION:

The resident has a right to refuse monthly tracheostomy changes. When this occurs, document the patient's refusal in the Electronic Medical Record (EMR).

CONTRAINDICATIONS:

- The tracheostomy tube should not be changed when the resident's condition is too unstable to warrant this procedure.
- The tracheostomy tube should not be changed when there is existence of neck and facial edema sufficient to make the reinsertion of the new tracheostomy tube very difficult.

ASSESSMENT OF THERAPY:

- Breath sounds should be assessed immediately after replacing the tube to determine proper tracheostomy tube placement.
- Heart rate, respiratory rate, and SpO2 will be monitored before and after the procedure.
- Make sure there is another tracheostomy tube (same size or one size smaller) at resident's bedside.

HAZARDS:

- Bleeding
- Tracheostomy tube may not be easily reinserted
- Hypoxia
- Paroxysmal coughing
- Pneumothorax
- Cardiopulmonary arrest
- Infection

REFERENCES:

- Johnson, William A., MD. (2020, February 14) *Clinical Procedures, Tracheostomy Tube Change*. Medscape WebMD. Retrieved from https://emedicine.medscape.com.
- American Association for Respiratory Care (2010). *Endotracheal Suctioning of Mechanically Ventilated Patients With Artificial Airways 2010*. AARC Clinical Practice Guidelines. Retrieved from http://rc.rcjournal.com/content/respcare/55/6/758.full.pdf.

- Tracheostomy education: Tracheostomy tube changes. (2019, June 5). Retrieved from https://www.tracheostomyeducation.com/tracheostomy-tube-changes/

- **National Institutes of Health, 2025, Tracheostomy Tube Change, StatPearls Publishing LLC. Retrieved from: www.ncbi.nlm.nih.gov https://powerdms.com/docs/1578668/revisions/3944050?workflowid=1088385&tab=workflow**

SUBJECT: **CLOSED OFFICE COVERAGE, NOTICES, SIGNAGE**	SECTION: *Multi – Specialty Clinic* **Page 1 of 2**

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

PURPOSE:

To ensure proper, timely communication of both planned and unplanned changes in the clinic's operating schedule.

POLICY:

Clinic staff will post signs and/or notices when both planned and unplanned changes in the Clinic's posted operating schedule occur.

AFFECTED PERSONNEL/AREAS: *MULTI-SPECIALTY CLINIC, OB/GYN CLINIC, ACADEMIC HEALTH CENTER, AND MEDICAL STAFF*

PROCEDURE:

A. Telephone coverage

1. During the course of regular Clinic hours, if the telephone is not being answered by Clinic staff, the phones will automatically be sent to a pre-recorded message where patients may leave a message. The staff will be responsible to check the messages and return a call to the patient as quickly as possible.

2. After hours the phone system will automatically be directed to the pre-recorded message; alerting patients that if they have a medical emergency, they should dial 9-1-1 or go to the nearest emergency department. The Clinic Staff will be responsible to check the messages and get back to patients as soon as possible.

3. Approved pre-recorded message should be recorded in English and Spanish:

   Hello, you have reached the after-hours voicemail for [Department Name].
   If this is a medical emergency, please hang up and dial 911 or go to the nearest emergency room.

   For non-emergency medical inquiries, our office is open to patients Monday - Friday from [Opening Time] to [Closing Time]. Please leave a message with your name, phone number, and the reason for your call. A member of our team will return your call on the next business day.

   Thank you for calling [Department Name]. We appreciate your patience and will assist you as soon as possible.

B. Planned closing/change of schedule

1. If a Clinic closing is planned (i.e.: holiday, vacation), advance notice of the closing will be posted, using the attached format, at least one week prior to the planned closing.

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

C. Unplanned closing/change of schedule

1. 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.

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

3. Upon re-opening the Clinic, all notices will be removed and appropriately disposed.

REFERENCES:

- The Joint Commission, PC.04.01.01, Hospital, Provision of Care, Treatment, and Services

CROSS REFERENCES:

- BUSINESS HOURS – MULTI-SPECIALTY CLINIC

SUBJECT: **CLOSETS- ORGANIZING/CLEANING**	SECTION: **Page 1 of 1**

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

PURPOSE:

To control infection and to enable residents and staff access to personal belongings stored in resident closets.

POLICY:

It is the policy of this facility to maintain the organization and cleanliness of the resident closets.

AFFECTED PERSONNEL/AREAS: *CERTIFIED NURSING ASSISTANTS (CNA), LICENSED VOCATIONAL NURSES (LVN)*

PROCEDURE:

1. The Nurse Aides/ Shower Team will organize and clean the resident's closets on a daily basis.
2. Reorganization and cleaning shall include proper hanging of resident clothing, shoes stored appropriately, and the removal of inappropriately stored items from the closet.
3. The Nurse Aide will monitor that laundry hampers for personal clothing laundered by families are clean and have tightly sealed lids. Those requiring cleaning or lids shall be reported to the Charge Nurse for communication to Social Services for family notification.
4. The Nurse Aide will ensure that only personal laundry hampers and resident shoes/slippers are stored on the floor of the closet.
5. The Nurse Aide on duty at the time of a resident's transfer/discharge will empty the resident's belongings from the closet and follow facility policy and procedures for the care of the residents' belongings during transfer/discharge.
6. Housekeeping will provide terminal unit cleaning upon transfer/discharge of a resident, per housekeeping policies and procedures

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.70(1) (2) (iv) United States of America, Med Pass Inc.

SUBJECT: **COMMUNICATION BARRIERS, REDUCTION OF**	SECTION: **Page 1 of 1**

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

PURPOSE:

To assist residents in communicating their needs.

POLICY:

Residents will be provided methods of communication to ensure adequate communication between residents and staff.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICES, ANCILLARY STAFF*

PROCEDURE:

1. The facility will make arrangements for interpreters or alternate means of communication, such as pictures, sign language, Braille, etc., to enhance communication between residents and staff.

2. Certified bilingual employees, HCIN, TDD phone for the deaf and disabled family members, clergy, or other outside resources may be used in this capacity to reduce communication barriers.

3. Methods instituted to assist residents in communicating their needs will be identified in the residents' plan of care.

4. A list of facility interpreters will be maintained on the unit.

5. Telephone and mail service are available to all residents

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 (1) United States of America, Med Pass Inc.

- Thompson, S. (2017). Overcoming Communication Barriers to Healthcare for Culturally and Linguistically Diverse Patients. Retrieved from https//www.sth.nhs.uk.

SUBJECT: DP/SNF ROOM CHANGE	SECTION:

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

PURPOSE:

To define the process of notification of change of room or roommate.

POLICY:

The resident's right to notification of any change in room assignment or roommate will be respected.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICE*

PROCEDURE:

1. A written notification form will be completed by the Social Service Designee to notify the Resident or responsible party that there will be a change in room or roommate.

2. The form must be acknowledged by the resident or responsible party signature or telephone consent prior to the change occurring.

3. The form is filed in the resident's medical record.

REFERENCE:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, Appendix PP 483.15 (e) (2) United States of America, Med Pass Inc.

SUBJECT: **DOCUMENTATION NURSING DPSNF**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide guidelines for appropriate use of nursing and interdisciplinary documentation.

POLICY:

Documentation will provide an accurate description of a patient's condition, clear and concise communication between healthcare disciplines and meet legal requirements through proper use of nursing and interdisciplinary forms in the Electronic Medical Records Interventions.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSES VOCATIONAL NURSE (LVN), CERTIFIED NURSING ASSISTANT (CNA), LICENSED TRAVELERS AND REGISTRY STAFF, RESTORATIVE NURSING AID, UNIT CLERKS, RESPIRATORY THERAPY, NUTRITIONAL SERVICES, PHYSICAL THERAPY, SOCIAL SERVICES, SPEECH THERAPY, OCCUPATIONAL THERAPY.*

PROCEDURE:

INITIAL ASSESSMENT FORMS:

1. The initial assessment documentation will be completed on all patients at the time of admission.

    a. The Registered Nurse (RN) will complete the DP/SNF General Admission Questions and Past Medical History if able (family or history available if resident unable to speak) in Meditech (EMR).

    b. All screenings will be completed upon admission and the appropriate referrals made as applicable. The unit clerk will enter into Meditech as applicable. (i.e., Physical Therapy, Registered Dietitian, Speech Therapy, Occupational Therapy.)

    c. The RN is responsible for documenting the date and time once all data is collected and the RN has assessed the patient. The RN will document the RN Assessment, Fall Risk and Skin Risk in Meditech.

INTERDISCIPLINARY PLAN OF CARE:

1. Upon completion of the Initial Assessment, the RN or LVN will initiate the appropriate Baseline Care Plan and then the Comprehensive Person Centered Care Plans will be initiated within 48 hours after admission. A copy of the Baseline Care Plan will be reviewed with the family, significant other, or whomever is the guardian.

2. Other healthcare providers involved in the patient's care may also initiate the initial assessments and their corresponding care plans as they deem necessary for the current condition of the patient. These providers include; Respiratory Therapists, Activity Director, Physical Therapists, Speech Therapists, Physicians, Occupational Therapists, Social Service Workers, and Dietitians. It is the responsibility of the healthcare providers to communicate and collaborate with the RN on those care plans they initiated.

3. The Plan of Care will be based upon the age and developmental needs of all residents, and will be consistent with the therapies of other disciplines. Communication among disciplines may occur by review of documentation, referrals via Meditech, interdisciplinary meetings, direct conversation(s) or other appropriate me

Once a problem is resolved the Care Plan will be discontinued in the EMR with a stop date.

4. All healthcare providers that document on the Interdisciplinary Plan of Care will date, initial, and sign the form.

5. The Person Centered Plan of Care is reviewed, updated and/or revised monthly and as the patient's condition warrants in the EMR.

NURSING EVENT NOTES IN MEDITECH SYSTEM

1. The Notes section in the EMR allows for the documentation of events that requires additional narration. When an event occurs, the RN or LVN must document an entry in Notes, including an assessment of the problem, the interventions that were done to correct or help the problem, and the patient outcome and the notification of the MD and family/significant other.

2. The RN or LVN will document appropriate assessment, interventions followed and the patient outcome using brief and concise wording for each event/problem that occurs during their shift.

3. Sometimes the patient outcome from a previous problem may not be known for some period of time. In this instance, a patient outcome may not be documented with the problem entry. Once the outcome is known, the RN or LVN will document the time and what the outcome was for the previous problem.

4. Pain is an event that will be documented in the EMR. If pain medication is administered and will be monitored in the nurses Pain Assessment Intervention in the EMR three times a shift.

5. The pain assessment on the Medication Administration Record (MAR) in the EMR will include:

   a. Initials

   b. Location

   c. Time/Date

   d. Description

   e. Pain Scale Number (0-10)

   f. Intervention

   g. Time of Reassessment (after intervention)

   h. Response after intervention (0-10)

RN ASSESSMENT AND DOCUMENTATION

1. The RN will document the Weekly Summary and update the Care Plans of scheduled residents per the Weekly Summary Calendar each shift.

LVN NOTES/ASSESSMENT IN PCS

1. The LVN Shift Evaluation in Meditech is for documenting the routine shift assessments performed by the nurse. The LVN is responsible for completing this section every 12 hours.

CNA DOCUMENTATION IN MEDITECH

1. The CNA will document in Meditech, the CNA ADL Record- once a shift, Positioning- in real time, Activities of Daily Living (oral care, baths/showers, peri care ability as indicated) and Elimination Record each time of occurrence.

MEDITECH DOWNTIME

1. In the event of an EMR downtime, follow the policy: Meditech Downtime-Clinical documentation.

REFERENCES:

- Thomson Reuters: (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, §70213, §72547, San Francisco, California.

CROSS REFERENCES:

- MEDITECH DOWNTIME - CLINICAL DOCUMENTATION

SUBJECT: **DOWNTIME OF ELECTRONIC HEALTH RECORD**	SECTION: ***Multi – Specialty*** **Page 1 of 2**

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

PURPOSE:

To ensure documentation of patient care in the event of a disruption of access to the Electronic Health Record (EHR).

POLICY:

When access to the Electronic Health Record (EHR) is not possible, practitioners and staff will document patient care using approved downtime paper forms.

AFFECTED PERSONNEL/AREAS: *ALL MULTI-SPECIALTY CLINIC PERSONNEL, OB/GYN CLINIC, ACADEMIC HEALTH CENTER AND MEDICAL STAFF*

PROCEDURE:

A. Approved downtime paper forms will be utilized to document patient care.

B. Any disruption of access to the EHR will be reported to the Information Technology (IT) Department via the Support Website and/or via telephone.

C. Approved downtime paper forms (including administrative and patient care documentation) will be maintained in a central location in a binder or file marked "Downtime Forms".

D. Clinic leadership or designee will access the paper forms, making sufficient copies of the appropriate documents to accommodate patients currently being examined and/or treated and those scheduled to be seen in the Clinic through the balance of the Clinic day.

E. Paper forms will be utilized to capture patient demographics and payor information required to successfully complete patient intake.

F. Paper forms will be provided to all practitioners and will be marked with the patient's name, birth date, medical record number, and visit date.

G. Patients requesting appointments will be listed, along with their phone number and the purpose of the visit/visit type. After the system has been restored, patients on the list will be contacted and appointments scheduled in the Electronic Health Record scheduling module.

H. When access to the Electronic Health Record is restored, completed paper documents will be scanned into the electronic chart.

I. After confirming that the scanned documents have been placed appropriately in the Electronic Health Record, the documents will be sent to the Health Information Management (HIM) Department to be destroyed to protect patient privacy.

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **DOWNTIME OF ELECTRONIC HEALTH RECORD**	SECTION: ***Multi – Specialty*** **Page 2 of 2**

CROSS REFERENCES:

- MEDICAL RECORD RETENTION AND DESTRUCTION: DISPOSAL OF PROTECTED HEALTH INFORMATION

SUBJECT:	SECTION:
DRUG/NUTRIENT INTERACTIONS AND ENTERAL TUBE FEEDING DRUG/NUTRIENT INTERACTION	***Assessment of Patients (PE)*** **Page 1 of 3**

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

PURPOSE:

To discourage food and drug interaction when the patient is receiving enteral tube feedings. Section B seeks to define drug-nutrient interaction education process for patients on potential drug-nutrient interaction medications.

POLICY:

To provide guideline for nursing staff to hold tube feeding when appropriate. Enable the collaboration of Food and Nutrition service, nursing and pharmacy departments in providing patients with educational information about potential drug-nutrient interactions during hospitalization and prior to discharge from hospital.

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

PROCEDURE:

- All patients receiving medication via enteral feeding tube shall be monitored for potential drug food interactions by nursing staff. (Section A)
    - For medications that may have significant drug food interaction, tube feeding will be held for 1 hour before and after the administration of each dose.
- A diet aide will print a daily report from Meditech of patients on selected medications targeted for drug-nutrient interactions (Section B)

Section A
ORAL MEDICATIONS THAT SHOULD BE HELD INCLUDE:

- Phenytoin (Dilantin) (all ORAL formulations)
- Levothyroxine
- Warfarin (only when unable to obtain a therapeutic INR)
- Carafate (Sucralfate)
- Cipro and Levaquin
- Carbidopa/Levodopa (Sinemet)

- Tube feedings may be continued with the use of these medications if the Physician has adjusted the doses to compensate for reduced bioavailability and explicitly states that in his/her notes. Otherwise tube feeds should be held.

- Continuous enteral feedings may be changed to bolus feedings/per physician order when the listed medications are being used, if feasible to discourage potential drug and food interaction.

- In summary, unless the physician orders otherwise, Nursing will hold tube feedings for 1hour before and after administration of one of the medications listed above.

- Nursing can request Dietitian consult as needed to address type of feeding modalities.

Section B

MEDICATIONS TARGETED FOR DRUG-NUTRIENT INTERACTIONS CONSULTATION:

A. Coumadin
B. Theophylline
C. MAOI's, Linezolid
D. Tetracycline, Doxycycline, Minocycline
E. Indinavir
F. Quinolones
    a. Ciprofloxacin, Levofloxacin, Moxifloxacin
G. Itraconazole
H. Carbidopa/Levodopa
I. Levothyroxine
J. Sucralfate
K. Statins
    a. Atorvastatin, Fluvastatin, Lovastatin, Pravastatin, Simvastatin, Rosuvastatin
L. Bisphosphonates
    a. Alendronate, Risedronate
M. Digoxin
N. Metronidazole
O. Ethambutol, Rifampin, Isoniazid
P. Divalproex
Q. Lithium
R. Lamotrigine
S. Carbamazepine

1. The dietitian will provide individualized counseling regarding the potential drug/nutrient interaction with the patient when consultation is ordered.

2. All drug-nutrient interaction consultation will be documented in the patient's medical record.

3. Discharge Education:

   a. a. Nursing will be responsible for dispensing drug-nutrient interaction information to patients who have not been counseled by the dietitian.

   b. Drug-nutrient interaction information will be available on all nursing units via Krames on demand located on the intranet. Upon discharge, nursing will provide the patient with a drug information handout that includes drug-nutrient information. Nursing will provide a brief explanation regarding drug-nutrient interaction.

   c. When members of the nursing staff give information and education to patient's regarding drug-nutrient interaction, this is to be documented in the patient's medical record.

REFERENCES:

- Guidelines for the Provision and Assessment of Nutrition Support Therapy in the Adult Critically Ill Patient:Society of Critical Care Medicine (SCCM) and American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.)JPEN J Parenter Enteral Nutr February 2016 40: 159-211, doi:10.1177/0148607115621863

- The Joint Commission (2025). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- Lexicomp Online®, Lexi-Drugs®, Hudson, Ohio: Lexi-Comp, Inc.; January 13th, 2025.

SUBJECT: **EARTHQUAKE OR WEATHER DISASTER**	SECTION: *Multi – Specialty Clinic* **Page 1 of 2**

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

PURPOSE:

To ensure the safety of patients, personnel, and visitors in the event of an earthquake or weather-related disaster.

POLICY:

Clinic personnel shall be prepared to follow a planned course of action in the event of an earthquake or weather-related disaster.

AFFECTED PERSONNEL/AREAS: *ALL MULTI-SPECIALTY CLINIC PERSONNEL, OB/GYN CLINIC, ACADEMIC HEALTH CENTER AND MEDICAL STAFF*

PROCEDURE:

A. In the event of an earthquake or weather-related disaster:
   1. Patients and visitors will be moved to the safest location(s) within the Clinic as follows:
      a. Earthquake
         i. Structurally strong interior spaces, including, but not limited to, doorways.
         ii. Away from objects on shelves that may fall on them and cause injury.
         iii. Exterior areas which are not under trees, near power poles, or other tall structures (North West parking lot, as designated).

      b. Weather-related disaster

         i. In the case of a high wind storm/tornado, people will be moved to interior rooms without windows.
         ii. In the case of a rainstorm causing flooding, people will be moved to rooms that are dry and/or have furniture that will allow the person to be up and away from the water.
         iii. If required, utilities will be terminated at the source:

Service Type	Source Location
Natural gas	Meter, control valve (exterior)
Electrical service	Electrical panel (supply room)
Water	Main service valve (exterior)

         iv. Clinic leadership or designee will contact 911 if assistance is required to evacuate or render care to patients, visitors, and/or personnel.
         v. Clinic leadership or designee will contact SVMC Operator to advise emergency situation and request support from Engineering Department if required.

         vi. Clinic leadership or designee will meet emergency personnel when they arrive.
         vii. Clinic leadership or designee will record all actions taken and include that information in their Incident Report.
         viii. Clinic will contact Engineering to identify damage to the premises and coordinate arrangements for the repair and replacement of damaged facilities and/or equipment.

ix. SVMC designee will notify Administrative Director of General Services or designee, Administrative Director of Quality and Care or designee, as well as any other appropriate agencies, should operations be curtailed due to the emergency situation. Notification will specifically indicate whether the Clinic is safe for continued use, and if not, what alternate arrangements have been made so that care of the patients may continue.

CROSS REFERENCES:

- EARTHQUAKE PROCEDURES

SUBJECT: **EQUAL ACCESS TO QUALITY OF CARE**	SECTION: **Page 1 of 1**

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

PURPOSE:

- To ensure all residents are treated alike when the facility is making transfer and discharge decisions.
- To ensure the facility does not distinguish between residents based on their source of payment when providing services that are required to be provided under the law.

POLICY:

The facility will maintain identical policies and procedures regarding transfer, discharge, and the provision of services under the state plan for all individuals regardless of payer source. The facility may charge any amount for services furnished to non-Medi-Cal residents consistent with the notice requirements in the Resident Rights (42 C.F.R. – 483.10(b)(5)(i) and (b)(6) describing the charges. The State is not required to offer additional services on behalf of the resident other than services provided in the State plan.

AFFECTED PERSONNEL/AREAS: *DIRECTOR OF NURSING, REGISTERED NURSES, PHYSICIANS, SOCIAL SERVICES, BUSINESS OFFICE*

PROCEDURE:

1. At the time of admission, the Social Worker or Designee will inform the resident/responsible party of their rights concerning equal access to care, statement of services provided, and the facilities' policies for handling transfer and discharge processes.

2. The Director of Nursing will oversee the IDT processes and will ensure that all Nursing Services, Specialized Rehabilitative Services, Social Services, Dietary Services, Pharmaceutical Services, or Activities that are mandated by law will be provided to residents according to their individual needs, as determined by assessments and care plans.

3. The RN and Social Worker or Designee will coordinate the reporting of changes in resident care status/needs through daily census reporting and accounts tracking systems, and will coordinate all transfers, discharges, and services according to facility policies and procedures.

4. The Director of Nursing and/or Social Worker or Designee will ensure the resident is informed by appropriate disciplines/departments of changes in care, discharge plans and services provided under the State plan or current payer source.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 United States of America, Med Pass Inc..

SUBJECT:	SECTION:
EXAMINATION/TREATMENT OF DISROBED PATIENT	***Multi - Specialty***

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

PURPOSE:

To provide a consistent, standard and safe care environment, utilizing Medical Assistants as chaperones when the patient is disrobed during sensitive examinations.

This policy promotes respect for patient dignity and the professional nature of the examination.

The Medical Assistants presence may also provide protection to the practitioner against unfounded allegations of improper behaviors. A practitioner may request a Medical Assistant chaperone for any examination or procedure.

POLICY:

A Medical Assistant (MA) will be in the patient's examination room at all times when the patient is disrobed and being treated by a practitioner.

AFFECTED PERSONNEL/AREAS: *ALL MULTI-SPECIALTY CLINIC PATIENT CARE PERSONNEL, OB/GYN CLINIC, ACADEMIC HEALTH CENTER, AND MEDICAL STAFF*

PROCEDURE:

A. If a patient will be receiving treatment in the Clinic, the Medical Assistant will provide the patient with a gown and/or drape and will advise the patient to disrobe.

B. The Medical Assistant will be present in the examination/treatment room during the course of the procedure and will serve as a physician assist and chaperone during the course of the procedure.

C. The Medical Assistant will document in the medical record that they were present during the procedure, indicating time in and time out, as well as the procedure completed.

REFERENCES:

- The American College of Obstetricians and Gynecologists. Retrieved 1/3/2020 from https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/01/sexual-misconduct.

SUBJECT: **FIRE SAFETY - GENERAL INSTRUCTIONS**	SECTION: ***Multi – Specialty Clinic*** **Page 1 of 1**

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

PURPOSE:

To ensure the proper staff response in the event of a fire emergency.

POLICY:

Staff will follow approved processes in order to ensure patient, staff, and visitor safety in the event of a fire emergency.

AFFECTED PERSONNEL/AREAS: *ALL MULTI-SPECIALTY CLINIC PERSONNEL, OB/GYN CLINIC, ACADEMIC HEALTH CENTER, AND MEDICAL STAFF*

EQUIPMENT:

- Fire extinguisher.

PROCEDURE:

A. The proper response to fire or smoke is R.A.C.E.

R = Rescue patients immediately from fire or smoke area
A = Alarm (call 911 and give exact location)
C = Contain the smoke or fire by closing all doors to rooms and corridors
E = Extinguish the fire (when/if safe to do so)

B. Rescue individuals from the immediate fire or smoke area. If necessary, evacuate patients, guests, and staff to the designated evacuation area located in the northwest corner of the Clinic parking lot.

C. Call 911 and report the fire.

D. Contain the fire and smoke by closing all doors in the area.

E. If safe, attempt to extinguish the fire.

F. Notify adjoining medical offices of the emergency.

G. Call the SVMC Engineering Department to report the fire.

REFERENCES:

- The Joint Commission (2022). Hospital Standards Manual. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- FIRE SAFETY

SUBJECT:	SECTION:
GME - MOONLIGHTING	***Institutional - GME***
	Page 1 of 3

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

PURPOSE:

The ACGME has adopted the position that moonlighting by Residents is permitted with prior permission of the DIO and/or Program Director excluding first year residents. "Moonlighting" refers to a service performed by a resident in the capacity of an independent physician, completely outside the scope of his/her residency training program. A resident shall not engage in moonlighting or other remunerative activities (outside work) other than work performed pursuant to the RESIDENT AGREEMENT, without obtaining the prior consent of the Program Director and the DIO/Department of Graduate Medical Education.

PROCEDURE:

1. The resident must be in good standing within the residency program. A resident/fellow who is on formal academic remediation or probation is prohibited from engaging in any moonlighting activities during the period of remediation or probation.

2. The resident must have the appropriate California unrestricted physician and surgeon's license.

3. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. All residency requirements, institutional requirements, logs, evaluations and medical records must be kept current and up-to-date and maintained as such.

4. PGY-1 residents are not permitted to moonlight.

5. Residents are not required or encouraged to engage in moonlighting. Residents are not obligated to be involved in internal hospital moonlighting activities.

6. Residents must have written permission from their program director to moonlight. It is imperative that the DIO and Program Director be notified in writing of any and all moonlighting that the resident undertakes (Form to be completed is available in Medical Education Department). This documentation will be filed in the resident's file. If the resident is granted permission to participate in moonlighting or outside work, the resident shall do so subject to his/her own legal responsibility. The resident acknowledges and agrees that any outside work the resident does during the term of his/her RESIDENT AGREEMENT, shall be deemed to be outside the provisions of the RESIDENT AGREEMENT. Failure to report and receive prior approval may be grounds for termination from the residency training program, subject to the Due Process provisions as noted in policy for Due Process.

7. It is up to the discretion of the Program Director and DIO to determine if the moonlighting or outside work interferes in any way with the resident's responsibility to the training program. If it is deemed to interfere, the Program Director and DME may require the resident to stop this moonlighting practice or outside work.

8. All approved moonlighting hours must be counted towards the 80-hour Maximum Weekly Hour Limit under ACGME policy and are monitored by the Graduate Medical Education Committee and are to be recorded by the resident in the New Innovations Duty Hours Log within 24 hours of completing a shift or worked hours outside of the residency program. A resident shall provide a monthly schedule and also report any and all moonlighting, outside work or any outside professional activities to the Program Director on a monthly basis. The Program Director must put in writing awareness of the resident's moonlighting and will note the place of moonlighting and the hours. This information will be provided to the Department of Graduate Medical Education on a monthly basis and a permanent copy will placed in the resident's folder both in the respective department and in Department of Graduate Medical Education. Failure to record moonlighting duty hours or to report any outside work or professional activities on an ongoing basis may be grounds for termination from the residency program, subject to the Due Process provisions as noted in the policy for Due Process.

9. Sierra View Medical Center does not provide medical malpractice coverage for Residents during moonlighting. Professional insurance provided to the resident by the hospital is rendered exclusively for services provided in the residency training program. Coverage shall not extend for any other circumstance other than the resident's professional services provided under the residency training program and subject to the RESIDENT AGREEMENT. If the resident engages in the practice of medicine outside of work, resident must provide written documentation to the Program Director and the DIO/Department of Graduate Medical Education that a current policy of professional liability insurance covering the resident's outside work on an occurrence basis has been obtained, with limits of at least One Million Dollars (1,000,000) per occurrence and Three Million Dollars (3,000,000) in the aggregate from a carrier rated at least B+ by A.M. Best or its equivalent, that all times applies to resident's services. It will be the responsibility of the employer for moonlighting to provide the Program Director a description of the duties required for the position and the Program Director to verify the ability of the resident to meet those requirements.

10. The residency Program Evaluation Committee and/or Graduate Medical Education Committee will monitor the effect of moonlighting activities or outside work or professional activities on a resident's performance in the program, including that adverse effects that may lead to withdrawal of permission to moonlight.

11. Residents/fellows working under J-1 sponsorship are prohibited from engaging in moonlighting. Visa sponsorship issued by ECFMG, authorizes a specific training activity and associated financial compensation. Federal regulations do not permit activity and/or financial compensation outside of the defined parameters of the training program. Therefore, employment outside of approved residency or fellowship training (or "moonlighting") is not permitted.

12. Residents cannot moonlight in any clinical setting where Sierra View residents rotate for training and they cannot supervise other residents while moonlighting. By ACGME definition, internal moonlighting includes all moonlighting that occurs at any Sierra View

owned and operated hospital, clinical or related sites, and at affiliated institutions where our residents rotate to as part of their training program.

REFERENCE:

- Accreditation Council for Graduate Medical Education (ACGME) (July 1, 2019). ACGME Common Program Requirements (Residency). Retrieved from https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf.

SUBJECT: **HAND ROLLS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To help maintain correct hand position of residents suffering loss of hand sensation, loss of hand mobility, or a resident who is in a persistent vegetative state or loss of use of an extremity.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to provide for the use of hand rolls for those residents assessed as needing them.

AFFECTED PERSONNEL/AREAS: *RNA, CNA*

EQUIPMENT:

- Factory manufactured hand rolls, either hard or soft, with or without straps
- Improvised hand roll, made of rolled washcloth

PROCEDURE:

1. Explain the procedure to the resident.
2. Wash hands thoroughly. Wear gloves.
3. Wash and dry resident's affected hand/hands.
4. Provide range of motion to affected hand/hands.
5. Position hand roll within affected hand/hands. Ensure that Velcro strap holding hand roll in place is not binding the skin or impairing skin or circulation if used.
6. Record the use and effectiveness of assistive devices in the medical record, the resident's electronic health record (EMR) each shift, and in their person centered care plan. Evaluate the effect of these on the resident care goals.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, §72315, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **HEPATITIS INFECTION CONTROL PROCEDURES**	SECTION: 5 **Page 1 of 6**

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

PURPOSE:

To decrease the chances of cross contamination of hepatitis between staff and patients.

POLICY:

Hepatitis infection Control Procedures

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

PROCEDURE:

HEPATITIS - PATIENT ISOLATION:

- All patients whose HBsAg results are positive, will be isolated to a machine until the physician has given the order to discontinue these measures.
- Dialyzers are single use only and will be changed with every procedure.
- Standard Precautions will be observed by all staff members when giving care to patients with hepatitis or suspected hepatitis.
- Equipment used for patients with hepatitis or suspected hepatitis, must be thoroughly cleaned with an approved germicidal disinfectant before being used again.
- All contaminated disposable supplies will be "red bagged" in biohazardous waste trash liners.

HEPATITIS ISOLATION - INITIATION DIALYSIS:

1. Purpose:
   a. To initiate dialysis on a patient designated to be dialyzed in the isolation area and reduce the chance of exposure of staff and other patients to the communicable disease.
2. Equipment:
   a. Nonsterile Gloves
   b. Disposable Gown, Goggles, Mask
   c. Blood Pressure Cuff
   d. All equipment needed to initiate dialysis
3. Procedure:

a. Standard Precautions will be followed at all times.

b. Check chart for any special treatment or blood work orders.

c. Wash hands and dry thoroughly to decrease surface bacteria on the skin.

d. Put on a disposable gown, being certain to cover all clothing and using all closures, to protect from contamination. Put on clean disposable gloves, goggles and mask.

e. Rinse machine and set up for dialysis initiation with new dialyzer

f. Prime dialyzer

g. Carefully evaluate dry weight, vital signs, and physical assessment.

h. Remove gloves and put on a new pair.

i. Set up and organize all equipment.

j. Proceed to cannulate vessel access or use catheter for attachment to blood lines

k. Initiate dialysis according to procedure. Tape needle (or catheter) and blood lines securely to patient's extremity.

l. Avoid touching anything in the area with the contaminated gloves used to initiate the treatment. REMOVE GLOVES! Put on clean non-sterile gloves.

m. Take patient's vital signs. Set all dialysis machine alarms.

n. Hand the patient the TV set control and nurse call button.

o. Before leaving the area, remove protective clothing and deposit directly into the biohazardous waste container.

p. Wash hands thoroughly. Dry hands. Use a paper towel to turn off the water faucet if sink is not equipped with foot pedal water control.

q. After washing hands, complete documentation

4. Equipment Care:

a. Discard all disposable equipment properly.

b. Do not remove any equipment from the isolation area.

HEPATITIS ISOLATION - PATIENT CARE DURING DIALYSIS:

1. Purpose:

   a. To reduce the chances of exposure of staff and other patients to the hepatitis virus when performing patient care procedures during dialysis.

2. General Protocol:

   a. Patient care procedures which routinely do not involve handling of contaminated material (i.e., taking a blood pressure), requires handwashing before and after leaving the room.

3. Procedure:

   a. Minor blood spills:

   - Clean up immediately (wearing all appropriate PPE).
   - Wipe up with absorbent towel and place in biohazardous waste containers.
   - Pour germicidal cleaning agent over area and wipe dry with second towel.

   b. Drawing blood specimens:

   - Label all tubes. Two (2) specimen bags are needed.
   - Put on gloves, gown, mask and goggles and enter room with blood drawing equipment and one (1) specimen bag.
   - Draw blood from arterial blood port, fill specimen tube; place tube in specimen bag and close; discard the needle in rigid sharps container.
   - Remove gloves, gown, goggles and mask and wash hands before and after leaving the room.

<u>HEPATITIS ISOLATION - DISCONTINUING DIALYSIS:</u>

1. Purpose:

   a. To discontinue dialysis on a patient designated to be dialyzed in the "Hepatitis Isolation" area and reduce the chance of exposure of staff and other patients to the hepatitis virus.

2. Equipment:

   a. Sterile and Nonsterile Gloves

   b. Disposable Gown

c. Disposable Shoe Covers

d. Gown, Goggles, Mask

e. Blood Pressure Cuff

f. Stethoscope

(All equipment needed to discontinue the dialysis treatment)

3. Procedure:

a. Before entering the area, check for any post dialysis blood work or medications that need to be given.

b. Wash hands and dry thoroughly.

c. Put on gown, gloves, goggles and mask.

d. Enter isolation area and set up all equipment needed.

e. Using designated blood pressure cuff, stethoscope and thermometer, take the patient's vital signs.

f. Proceed to discontinue dialysis

g. After needle sites are clotted or catheter care completed, remove gloves and put on nonsterile gloves.

h. Take post dialysis vital signs and weight.

4. Documentation:

a. Complete documentation.

HEPATITIS ISOLATION - POST DIALYSIS CLEANING OF EQUIPMENT AND WASTE DISPOSAL:

1. Purpose:

a. In an efficient and organized manner and without exposing the staff or other patients to the hepatitis virus, clean the outside of the dialysis machine, consolidate trash and linen and remove from the isolation area.

b. To clean, sterilize and store the dialysis machine between treatments, destroying the hepatitis virus and preventing bacterial growth.

2. Equipment:

a. Trash Bags

b. Gloves

c. Disposable Gowns, Goggles, Mask

d. Bleach Bottle Filled with 250mL 5% Sodium Hypochlorite (Household Bleach)

e. Cleaning Cloth

f. Vinegar

g. Chlorine Test Strips

3. Procedure:

a. Gown, glove, goggles, and mask

b. Before removing any clamps, make a closed system with blood lines by inserting arterial line into arterial transducer protector and venous line into pressure transducer protector.

c. Proceed with procedure to clean and disinfect equipment.

REFERENCE:

- Recommendations for preventing transmission of infections among chronic hemodialysis patients. (2001). https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5005a1.htm

- Garthwaite, E., Reddy, V., Douthwaite, S. et al. (2019). Clinical practice guideline management of blood borne viruses within the hemodialysis unit. *BMC Nephrol 20*, 388. doi:10.1186/s12882-019-1529-1

SUBJECT:	SECTION:
INFLUX OF INFECTIOUS PATIENTS CONTINGENCY PLAN	**Page 1 of 28**

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INTRODUCTION

Natural disaster, man-made disasters, bioterrorism events, influenza and other infectious pandemics have the potential to introduce microorganisms into the environment that threaten health. The illnesses and conditions caused by these microorganisms can disrupt patient care activities and the healthcare environment. Ensuring the safety of healthcare providers, patients, and visitors is a high priority. Infection prevention and control measures must be an integral part of the emergency management plan for any institution.

This plan was developed to address infection control issues that will arise during pandemics, bioterrorism events, and disasters. This plan is an essential component of the hospital's existing emergency management plan. As information related to recognizing, diagnosing, treating, and preventing infectious disease events is updated at the federal, state and local levels, this response plan will be modified accordingly.

PURPOSE:

- To authorize the Infection Prevention Manager, or designee to rapidly implement prevention and control measures in response to a suspected outbreak.
- To outline appropriate measures and actions regarding management of infections as a result of pandemics, disasters, or bioterrorism events.
- To describe processes to ensure the safety of patients, visitors, volunteers, and healthcare personnel in the event of an unusual increase in patients presenting with infectious conditions.

POLICY:

The hospital keeps abreast of infectious diseases that are occurring locally, nationally or worldwide that could potentially affect our local community and result in an influx of patients with infectious conditions.

AFFECTED PERSONNEL/AREAS: *ALL HEALTH CARE WORKERS*

PREPARATION & IDENTIFICATION

Potential influx triggers include:

- A local or state health department alert of an increase in admissions of infectious patients requiring isolation.
- A rapidly increasing disease incidence within hours or days in a normally healthy population.
- Emergency Department (ED) report of an increase in patients with potentially infectious symptoms/conditions.

- Infection Control, Nursing Supervisors or Emergency Department personnel note an unusual increase in the number of people seeking care, especially with fever, respiratory, or gastrointestinal complaints.
- Clusters of patients arriving from a single location.
- Any patient presenting with a disease that is relatively uncommon and has bioterrorism potential.
- Lower attack rates among people who have been indoors, especially in areas with filtered air or closed ventilation systems, compared with people who had been outside.
- Large numbers of rapidly fatal cases.

COMMUNICATION

If the potential for an influx of infectious patients is identified:

- The VP of Patient Care Services, the Chief of Staff, the Safety Officer, Infection Prevention Manager/Nurse, the Hospital Supervisor and other appropriate individuals will review the available information and determine whether additional action is needed.
- Current resource availability will be assessed using the Surge Capacity Management Plan.
- The VP of Patient Care Services, Chief of Staff, or other designee, will determine if the facility's Hospital Incident Command Center (HICS) Plan needs to be activated, and if so, will notify the Safety Officer and other appropriate individuals.

Ongoing communication considerations will include the needs for:

- Frequent updates for managers, physicians, and other hospital personnel.
- Infection Prevention Nurse visits to units to assess their situation and offer assistance regarding infection prevention and control issues.
- Initial notification and communication with local Public Health Services.
- Requests for assistance from the local or state health departments and/or other support agencies.

EVALUATION

The VP of Patient Care Services, Chief of Staff, Safety Officer, Infection Prevention Nurse, Chair of Infection Prevention/Control Committee and other appropriate individuals will evaluate the situation on an ongoing basis to determine:

- If other patient admissions need to be suspended.
- If elective procedures, including surgery, need to be cancelled.
- If the facility's visiting policy needs to be temporarily revised, or suspended.
- If appropriate patient placement, including alternative sites for patient holding, triage, treatment and morgue facilities is needed.
- When the Influx Contingency Plan is no longer needed and may be discontinued.

PATIENT MANAGEMENT

A. **Initial Management of Persons with Infectious Conditions**

To aid in the detection of persons entering the facility who may have an infectious condition, the following interventions will be implemented:

1. Visual alerts, in appropriate languages, will be posted at all appropriate entrances to the facility instructing all persons with signs/symptoms of infectious disease, especially respiratory, to:

   a. Inform reception and healthcare personnel when they first register for care that they may be infectious.

   b. Practice respiratory hygiene/cough etiquette.

2. Patients calling Sierra View Medical Center (SVMC) for advice will be discouraged from making unnecessary visits to the hospital.

3. As the number of infectious patients increases, measures will be implemented to reduce the spread of infection within the facility:

   a. A triage officer will be assigned responsibility for managing patient flow, including deferral of patients who do not need emergency care.

   b. The waiting area will be set up to enable patients with respiratory symptoms to sit at least 3 feet away from other patients and visitors. The patient will be required to wear an approved surgical mask, or placed in a single patient room.

4. Signs that promote respiratory hygiene/cough etiquette will be placed in areas such as Emergency Room, entrances to the Main Hospital, and Medical Office Building (MOB) waiting areas, where they can serve as reminders to all persons in the facility. The signs will instruct persons to:

a. Cover the nose/mouth when coughing or sneezing.

b. Use tissues to contain respiratory secretions.

c. Dispose of tissues in the nearest waste receptacle immediately after use.

d. Patients will be given masks upon entry to the facility with instructions to wear them until they have been evaluated and admitted or discharged, if the symptoms/syndrome suggest that airborne transmission is a possibility.

e. Perform hand hygiene after contact with respiratory secretions.

5. Sierra View Medical Center (SVMC) will facilitate adherence to respiratory hygiene/cough etiquette by ensuring the availability of appropriate materials in waiting areas for patient and visitors:

a. Tissues and no touch waste receptacles for used tissue disposal.

b. Conveniently located dispensers of alcohol hand sanitizers.

c. Soap and disposable towels for hand washing where sinks are available.

6. Visitors will be screened for signs/symptoms of infectious disease before entry into the facility:

a. Symptomatic visitors will be excluded from the facility.

b. Family members who accompany patients with infectious illness to the hospital will be assumed to have been exposed to the infectious condition and will be asked to don masks if the condition is respiratory in nature.

c. Visitors will be limited to persons who are necessary for the patient's emotional well-being and care.

d. Visitors will be required to wear appropriate Personal Protective Equipment (PPE) while visiting an infected patient.

e. Visitors will be instructed on hand hygiene practices.

B. **Isolation Precautions and PPE**

In the early stages of an influx of patients, it may not be clear that patients have been exposed to an infectious condition. Therefore, precautions consistent with all possible etiologies must be implemented. Standard precautions, combined with contact, droplet and/or airborne precautions will be implemented until a diagnosis is established.

Staff will be instructed to carefully don PPE before patient contact to avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE will also be stressed.

1. GLOVES

   a. Wear disposable gloves when contact with visible blood and body fluids is anticipated. Gloves should also be worn when touching environmental surfaces and patient care articles visibly soiled with blood or body fluids.

   b. Gloves should be put on just prior to performing a patient care task that involves contact with blood or body fluids and removed immediately, without touching non-contaminated surfaces, when the task is complete.

   c. When performing multiple procedures on the same patient, gloves should be changed after contact with blood and body fluids that contain high concentrations of microorganisms (e.g., feces, wound drainage or oropharyngeal secretions) and before contact with a clean body site such as non-intact skin and vascular access sites.

   d. Remove and dispose of gloves after use on a patient. Furthermore, if gloves are in short supply,
      - Priority will be given to high-risk units such the Emergency Department, etc.
      - Oversee strict adherence to hand hygiene as mandatory in these situations.

   e. Staff will be reminded to avoid touching their eyes, nose or mouth with contaminated hands, gloved or ungloved.

2. FACIAL PROTECTION

   a. If an airborne pathogen is suspected of causing the infectious condition, staff will be required to wear either an N-95 respirator or a mask when entering a patient's room. The facility's Infection Preventionist (IP) will decide which is most appropriate.

      - Masks/respirators will be worn once and then discarded.
      - Masks/respirators will be changed when they become moist or soiled.
      - Personnel are not to leave masks/respirators dangling around their neck.
      - Hand hygiene must be performed upon touching or discarding a used mask.

b. Wear disposable, fluid-resistant masks and eye shields (goggles with side-shields) or a face shield if the patient is coughing or when performing patient care tasks likely to generate splashing or spraying of blood and body fluids onto the mucous membranes of the face.

3. GOWNS

a. Don a disposable, fluid-repelling gowns to protect skin and clothing when performing procedures likely to generate splashing or spraying of blood and body fluids.

b. Plastic aprons may be worn for procedures likely to soil clothing but are unlikely to generate splashing or spraying of blood or body fluids (e.g., cleaning incontinent patients).

c. Remove soiled gowns after patient contact (Use appropriate doffing technique).

d. Reusable cloth gowns may be used for patient contacts, if splashing or spraying of blood and body fluids is unlikely. If soiled, then only wear once and place in holding receptacles for laundering.

e. Disposable gowns should only be worn once and then discarded.

4. PPE FOR SPECIAL CIRCUMSTANCES

a. During aerosol generating procedures (e.g. endotracheal intubation, nebulizer treatment, bronchoscopy, suctioning, etc.) personnel will wear gloves, gown, face/eye protections and an N-95 respirator.

b. If feasible, all aerosol generating procedures will be conducted in an airborne isolation room (negative pressure room or use a private room with an appropriately placed High Efficiency Particulate Air filter, (HEPA)).

5. HANDWASHING

a. Wash hands with soap and water after protected (gloved) and unprotected (ungloved) contact with visible blood, body fluids (including secretions and/or excretions such as urine and feces), wound drainage or when skin is visibly soiled.

b. Wash hands before leaving the immediate vicinity of patient contact (patient room, cubicle, or bathroom).

c. After hand washing, avoid touching the patient and surfaces or items in the immediate vicinity of the patient (bedpans, bed rails, and bedside tables).

d. Hand hygiene options must be available even if domestic water supplies are not disrupted.

- **Alcohol based hand sanitizer** (ABHS) is an acceptable alternative with supplies readily available. ***To calculate volume needed*** - conservatively estimate four hand washes per employee per hour. Each hand wash will use about 1 ml of sanitizer, which is purchased in 1000 ml containers with 8 containers per case. With an average of 400 employees scheduled each day, adequate quantity for no less than 96 hours or 4 days will be stored on site. Environmental Services Department will inventory no less than 20 cases on site. *(547 employees x 4 ml x 24 hours x 4 days = 210,048 ml / 8000 ml per case = 26.3 cases).*

- A hand washing station may be improvised with a coffee urn at the edge of a table and a bucket underneath. The water must be clean and cannot be reused.

- Hand washing wipes or towelettes are acceptable.

e. Methods of hand hygiene that involve the use of standing water are ***not*** acceptable.

C. **Transporting Patients**

1. Limit patient movement and transport outside the isolation area to medically necessary purposes.

2. Use portable x-ray equipment when possible

3. Transport patients to diagnostic services according to hospital procedure.

   a. The patient must wear a mask if respiratory illness is suspected.

   b. If the patient cannot tolerate a mask, apply the most practical measures available to contain respiratory secretions, for instance, a face shield, etc.

   c. Instruct the patient to perform hand hygiene before leaving the room.

D. **Laboratory Specimens**

1. Transport specimens to the laboratory according to normal hospital procedures.

2. Laboratory personnel will adhere to chain of custody protocols developed by CDPH and/or the FBI, if applicable.

E. **Dietary Trays**

1. Wash reusable dishes and utensils according to normal hospital procedures.

2. Disposable dishes and utensils can be discarded as regular waste.

3. Personnel will wear gloves when handling patient trays, dishes, and utensils.

4. Trays, dishes and utensils can be transported to the kitchen in the usual manner.

5. The use of disposable dishes is not necessary unless water service is disrupted.

F. **Patient Care Equipment**

Follow standard practices and manufacturer's instructions for use for handling and reprocessing used patient care equipment, including medical devices.

1. Wear gloves when handling and transporting used patient care equipment.

2. Wipe external surfaces of portable equipment in the patient's room with an EPA-approved hospital disinfectant upon removal from the patient's room.

3. Equipment such as bedpans, urinals, and emesis basins should be cleaned in a manner that prevents splashing and spraying of blood and body fluids onto the healthcare worker's clothing.

4. Reusable equipment that requires cleaning and disinfection or sterilization should be sent to the Central Processing Department (CPD) in covered containers for reprocessing. Follow current policy for cleaning, disinfection and sterilization of re-usable patient care equipment.

5. Disposable equipment not intended for reuse should be discarded.

G. **Environmental Services (EVS)**

1. EVS personnel will wear appropriate PPE as required by the situation.

2. The area around the patient will be kept free of unnecessary supplies and equipment to facilitate cleaning.

3. Follow current policies for regular cleaning of patient occupied rooms:

a. Staff will give special attention to frequently touched surfaces, such as bedrails, bedside and over-bed tables, TV controls, call buttons, telephones, and lavatory surfaces.

b. Clean floors and other *horizontal* surfaces daily.

c. Clean and disinfect blood and body fluids as needed. After the patient is discharged from the room, clean room with an EPA registered disinfectant.

4. Follow current policies for cleaning and disinfection after patient discharge or transfer:

a. Clean and disinfect all surfaces that were in contact with the patient or might have become contaminated during patient care.

b. No special treatment is necessary for window curtains, ceilings, and walls unless there is evidence of visible soiling.

5. Do not spray or fog occupied or unoccupied rooms with disinfectant.

H. **Laundry and Linen**

1. Patient linen will be handled in accordance with Standard Precautions.

2. Place soiled linen directly into a leak-proof bag in the patient's room.

3. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area.

4. Wear gloves and gown when directly handling soiled linen and laundry such as bedding, towels, and personal clothing.

5. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.

6. Wear gloves for transporting bagged linen and laundry.

7. Perform hand hygiene after removing gloves that have been in contact with soiled laundry and linen.

8. Transport linen according to current policies.

I. **Patient's Clothing**

1. Bag patient's clothing if visibly soiled with blood or body fluids and send home with a family member with instructions to use warm water and a commercial laundry product.

2. NOTE: Before sending the patient's clothes home, determine whether law enforcement

J. Waste Disposal

Standard Precautions will be implemented for disposal of solid waste, both medical and non-medical, that might be contaminated with an infectious agent.

1. Contain and dispose of contaminated medical waste in accordance with current facility policies and local/state regulations.

2. Discard as routine waste any used patient care supplies that are not likely to be contaminated.

3. Wear disposable gloves when handling waste and perform hand hygiene after removal of gloves.

K. Deceased Patient

1. Use Standard Precautions for handling deceased patients.

2. Follow current hospital policy for transferring deceased patients to the mortuary.

L. Patient Placement

In small-scale events, routine facility patient placement and infection prevention and control practices will be followed. However, when the number of patients presenting to the facility is too large to allow routine triage and isolation strategies, other alternatives will be considered. These may include cohorting patients who present with similar syndromes. Designated cohorting groupings or sites will be determined by the IP Committee in consultation with facility engineering staff, based on patterns of airflow and ventilation, availability of adequate plumbing and waste disposal, and capacity to safely hold potentially large numbers of patients.

To the extent possible, limit contact between infectious and non-infectious persons.

1. Isolate infected persons.

2. Limit contact between nonessential personnel and other persons and patients who are ill.

3. If the infectious condition is respiratory in nature, promote spatial separation in common areas (at least 3 feet) to limit contact between symptomatic and non-symptomatic persons.

4. Limit admissions of infected patients to those with severe symptoms or complications and those who cannot be cared for outside the hospital setting.

5. Patients will be admitted to either a single patient room or to an area designated for cohorting.

6. Infection Prevention, Administrative and Maintenance staff will designate a unit or area of the facility that will be used for cohorting. Because of the high patient volumes anticipated during an influx, cohorting will be implemented early in the course of an outbreak.

   a. Clinical and non-clinical personnel assigned to cohorted patient care units will not float or otherwise be assigned to other patient care areas.

   b. The number of personnel entering the cohorting area will be limited to those necessary for patient care and support.

   c. Personnel assigned to cohorted patient care units must be made aware that patients may be concurrently infected or colonized with other pathogenic organisms and must adhere to standard precautions to prevent cross contamination.

K. Negative Pressure Surge Capacity

Negative pressure surge capacity is defined as a portion of a building or individual rooms where inpatient rooms can be used to temporarily isolate patients with airborne transmitted infections in an emergency situation.

1. The following rooms are permanent negative pressure isolation rooms:

   a. 260 – Telemetry

   b. 360 – Med/Surg

2. If no negative pressure room is available, the patient will be placed in a private room. The room will be equipped with a HEPA filtration unit if available. The windows and doors will remain closed and the patient will remain in the room.

3. As the need for airborne isolation increases, a wing of a nursing unit or an entire nursing unit will be designated the infectious disease unit. Infectious patients will be geographically isolated from non-infectious patients and the public.

4. Engineering controls and other methods may be used to establish temporary isolation rooms for patients with airborne transmitted infections.

5. Maintenance Department and Infection Control personnel will determine the best location within the facility to convert additional rooms to negative pressure through the use of engineering controls (shutting off the air supply and running the exhaust fans.)

L. Water

Both natural disasters and power disruptions may affect the supply and/or purity of water.; drinking water supplies will be stored and monitored on site by Dietary & Engineering Departments. An estimated 200 patients (163 licensed beds; 37 unlicensed beds – [ED, Flexcare & PACU] and 400 staff / physicians with a minimum of ½ gallon per person per day for drinking and one gallon per person per day for hand washing, bathing, sterilizing, dialysis, processing of scopes, flushing toilets, etc. for the duration of 96 hours or 4 days. A minimum of 2,600 gallons stored as bottled water in addition to a minimum of 1,030 gallons of water stored in domestic hot water tanks on site.

[600 (patients + staff) x 1.5 gallons x 4 days = 3,600 gallons].

If water quality is uncertain, it may be purified by:

1. Boiling for 5 – 10 minutes.

2. Adding 6 to 10 drops of unscented bleach (6% or 8.25% sodium hypochorite) per gallon (see EPA table below, https://www.epa.gov/ground-water-and-drinking-water/emergency-disinfection-drinking-water). Mix thoroughly and allow to stand for 30 minutes before using (Can be used for 24-hours).

Volume of Water	Amount of 6% Bleach to Add*	Amount of 8.25% Bleach to Add*
1 quart/liter	2 drops	2 drops
1 gallon	8 drops	6 drops
2 gallons	16 drops (1/4 tsp)	12 drops (1/8 teaspoon)
4 gallons	1/3 teaspoon	1/4 teaspoon
8 gallons	2/3 teaspoon	1/2 teaspoon

*Bleach may contain 6 or 8.25% sodium hypochlorite.

Assess all domestic water initially and periodically, as needed, to ensure it is safe to use. Communicate the findings of the assessment quickly to the Facilities and Safety Officer.

Following the event, determine the degree of water system purification necessary before using domestic water systems.

M. Food

Food must be provided for all individuals who will remain on the premises. Balanced meals are necessary for physical health. Monitor food services practices for basic sanitation. Monitor holding temperatures and the length of time food is held in the danger zone (41°F - 140°F). Food that has been in the danger zone for more than 4 hours must be discarded

N. **Toilet Facilities**

If sewer lines are disrupted or broken, toilets cannot be flushed. However, toilet facilities must be available. Temporary toilet facilities may include the following:

1. Place chemical toilets at various locations outside the facility.

2. Place three plastic bags in a bucket or toilet – Tie each bag separately, and store used bags in a leak-proof container, such as a garbage can, until the chemical toilet company can collect them.

3. One bag for one use only – Tie the bag off after use, and store in leak-proof container.

4. Use toilets without flushing until better arrangements can be made.

5. If sewer lines are intact, toilets may be flushed by pouring a bucket of water down them and the water need not be clean.

O. **Supplies**

Supplies may not be available in the usual quantities. The Infection Prevention Department will make decisions regarding curtailing of routine changes of tubing. The department will also determine when and/or if high level disinfection is an acceptable alternative to sterilization if reusable equipment is in short supply and sterilization is not an option.

Materials Management staff will be responsible for identifying facility resources for supplies and equipment.

P. **Surveillance**

Surveillance for infection control problems will be maintained to the extent feasible, even though infection prevention personnel will likely be assigned to disaster related duties. Problems existing before the event will continue to be monitored and problems specific to the event will be detected, assessed and acted upon in a timely manner. Heightened attention will be given to such things as waterborne illness, illness from improper food preparation/handling/storage, post-trauma wound infections, crush injuries, dehydration, heat stroke/exposure, and loss of HVAC in controlled environments.

Q. **Communicable Diseases**

The most realistic danger is the spread of locally endemic diseases as a result of crowding, compromised sanitary conditions, and increased susceptibility caused by stress.

Tuberculosis precautions for inpatients must be maintained. Outbreaks of communicable diseases must continue to be reported to local public health authorities.

R. **Dialysis Clinic**

The Dialysis Clinic provides episodic healthcare services. When a large-scale outbreak of infectious illness is present in the community, the Clinic will implement control measures similar to the Emergency Department. The Department Manager will consult with Infection Prevention staff to determine what interventions are appropriate for the circumstances.

Other infection prevention strategies that will be utilized include:

1. Screening patients by phone or before coming into the facility, if possible and rescheduling appoints for those individuals whose care can be postponed
2. Posting visual alerts in English and Spanish at the entrance to the facility instructing persons with symptoms of an infectious condition to inform reception and healthcare personnel when they register for care and to practice respiratory hygiene/cough etiquette.
3. Counseling patients calling for advice to avoid making unnecessary visits to the clinic or hospital and to implement measures to limit disease transmission in the home and when traveling to necessary medical appointments
4. Posting signs that promote respiratory hygiene/cough etiquette in common areas
5. Facilitating compliance with respiratory hygiene/cough etiquette by ensuring the availability of tissues, no-touch waste receptacles, masks and alcohol-based hand sanitizer in waiting areas

ATTACHMENTS:

- Attachment A: Surge Capacity Management Plan
- Attachment B: Pandemic Influenza Management
- Attachment C: Key Facts about Avian Influenza and Avian Influenza A Virus

REFERENCES:

- Emergency Disinfection of Drinking Water. United States Environmental Protection Agency. Accessed January 5, 2025.
- *Emergency Preparedness and Response: Preparedness and Planning.* Centers for Disease Control & Prevention. Last reviewed on Jan. 27, 2022. Available at: https://emergency.cdc.gov/planning/index.asp?CDC_AA_refVal=https%3A%2F%2Femergency.cdc.gov%2Fplanners-responders.asp Accessed January 5, 2025.
- *Preparation and Planning for Bioterrorism Emergencies*. Centers for Disease Control and Prevention. Last reviewed July 30, 2018. Available at: https://emergency.cdc.gov/bioterrorism/prep.asp. Accessed Jan. 2, 2025.
- *Preparedness for Influenza and Other Pathogens with Epidemic and Pandemic Potential*. U.S. Department of Health and Human Services. Last reviewed October 25, 2023. https://www.hhs.gov/about/agencies/oga/global-health-security/pandemic-influenza/index.html Accessed Jan. 5, 2024.
- *Resources for Emergency Health Professionals*. Centers for Disease Control & Prevention. Last. Available at: **https://emergency.cdc.gov/health-professionals.asp**. Accessed on January 5, 2025.
- Terri Rebmann. (2020, Mar. 4*Infectious Disease Disasters: Bioterrorism, Emerging Infections, and Pandemics*. In Boston K.M., et al, eds. APIC Text. https://text.apic.org/toc/community-based-infection-prevention-practices/infectious-disease-disasters-bioterrorism-emerging-infections-and-pandemics#book_section_17362 Accessed Jan. 2, 2025.
- Terri Rebmann. (2023, Nov. 4). *Emergency Management.* In Boston K.M., et al, eds. APIC Text. Available at: https://text.apic.org/toc/community-based-infection-prevention-practices/emergency-management Accessed Jan. 6, 2025.

ATTACHMENT A

SURGE CAPACITY MANAGMENT PLAN

PART I – CRITERIA

STATUS:	GREEN	YELLOW	ORANGE	(DISASTER PLAN)
Definition:	Staffing, resources and bed availability match patient needs and there is smooth collaboration between all departments.	Early triggers identify a need to initiate prompt interventions to avoid escalation and meet patient demand.	Escalating demand without available capacity and/or resources. Aggressive action is required to avoid declaring internal disaster.	Deployment of internal disaster plan is required. Will take many hours of intervention, perhaps days, to return to equilibrium.
	CRITERIA	**CRITERIA**	**CRITERIA**	**CRITERIA**
Census/Beds (census, number of available beds, number of scheduled procedures/visits, other volume indicators)	• Inpatient beds available = ≥6 • ≥ 2 ICU beds available • Discharges identified • Post-ops have tentative bed assignments • ED at Alert 1	• Empty inpatient beds = <6 • 1 ICU bed • Surgeries may be on hold • All post-ops do not have bed assigned • Homecare/SNF full/ unable to take patients	• 100% occupancy with temporary use of unlicensed space. • Few identified discharges • Surgeries rescheduled. • Diminished ED capacity due to holding of multiple admits.	• >100% occupancy with use of unlicensed space • Few or no discharges identified • ED ready to implement Internal Disaster Plan • Surgeries cancelled
Acuity (special patient needs, STATs, special circumstances)	• Manageable number of special needs patients (see "yellow"), allowing needs to be	• Multiple special needs patients such as: - mental/beha	• Multiple special needs patients in multiple units • Emergency surgeries • ICU admits held in ED	• Multiple ICU admits and/or special needs patients held in ED • Emergency surgeries

	met without stretching resources.	vioral health - isolation precautions - dialysis, chemo, trauma - several that require private room		
Resources (Equipment, Supplies, Information Technology systems)	• Equipment & supplies are available & in stock on units • IT services running and support is available • All utilities functioning (phones, elevator, power, water, gases, answering service, etc.)	• Equipment & supplies limited &/or not accessible on unit within acceptable time frames. • Prolonged unscheduled IT downtime affecting workload and/or communication. • Imaging/diagnostic equipment down • Failure of one or more utilities, although adequate back up in place	• Significant and prolonged equipment and/or supply shortages or prolonged delays • Severe pharmaceutical/blood shortage • Imaging/diagnostic/critical patient care equipment down/unavailable – back up system is stretched • One or more utilities failed • Prolonged unscheduled IT downtime affecting workload and interdepartmental communication	• Key equipment & supplies unavailable. • Full IT downtime >24 hrs impacting communication and workload without availability of adequate support • Multiple utility/power failures
Employees/Staffing (Number of personnel required vs. actual,	• Most departments meet staffing standards	• Acute units staffed per staffing plan/PCS/rat	• Multiple departments staffed below staffing	• Multiple departments staffed critically below staffing plan/PCS/ratios. • No additional staffing

department vs. float/temporary staff)	• All acute units have sufficient licensed staff per staffing plan • May be "short" in support staff positions. • Staff may be available for overtime, call in	ios • No staff available for overtime, call in • Multiple registry and/or float staff scheduled • Some ancillary departments not meeting staffing standards	plan/ratios • No additional staffing resources available (registry, other depts.) • Most managers on units; some not available	resources available (registry, other depts.) • Financial incentives not effective. • All management/non-direct care staff reassigned to patient care/ clinical areas with some not available.

PART II – INTERVENTIONS

For every criteria there must be an intervention. These are the required responses to achieve success in reducing the status to next lower level.

Status:	**GREEN**	**YELLOW**	**ORANGE**	**(DISASTER PLAN)**
Definition:	Staffing, resources and bed availability match patient needs and there is easy collaboration between all departments.	A state of early triggers identifying a need to initiate early interventions to avoid escalation and meet patient demand.	Escalating demand without readily available capacity and/or resources. Aggressive action is required to avoid system overload and gridlock.	Deployment of organization disaster plan required. Will take many hours of intervention, perhaps days, to return to equilibrium.
	INTERVENTIONS	**INTERVENTIONS**	**INTERVENTIONS**	**INTERVENTIONS**
Census/Beds (census, number of available beds, number of scheduled visits/procedures, other volume indicators)	• Beds cleaned within 30 minutes or less • Identify surgeries that may be placed "on hold" if status progresses • Cohort patients together in double rooms, to the extent possible	• Assign specific post-op beds just prior to/during procedure • Surgical and other appropriate female patients placed in OB beds • Identify inpatient and outpatient surgeries for	• Consider accommodating inpatients in unlicensed space (corridors, etc.) • Consider rescheduling non-emergent surgeries, procedures, and treatments • Consider using	• Consider use of non-hospital areas for acute care inpatients (off-site clinics and offices) • Cancel elective surgeries

		potential "hold" • Ensure that all outpatients are treated in outpatient treatment areas (and not occupying inpatient beds)	alternative area for discharge activities • Activate Corporate Communication staff for Service Recovery efforts	
Acuity (special patient needs, STATs, special circumstances)	• STATs ordered appropriately	• Surgical and other appropriate female patients placed in OB beds • Mobilize Social Workers to assist with potential for alternative placement of special needs patients	• Consider expanded use of safety attendants to free up clinical staff • Consider runners for labs, etc.	
Resources (Equipment, Supplies, Information Technology systems)	• Evaluate availability of IV pumps, ventilators and other patient care equipment in relationship to potentially climbing census • Evaluate linen, dietary supplies, etc. in relationship to potentially climbing census	• Gather spare equipment (IV Poles, pumps, etc.) and send to Central Processing • MM rents additional equipment • Additional PAR stock obtained by MM • Restock linen • Send spare gurneys to area of need • Increase number of trash runs • ED notifies Food & Nutrition services if patients need trays	• MM makes immediate purchase of needed supplies through established vendors, alternative vendors, or local shopping • Ensure presence of IT, Materials Management and Maintenance personnel throughout all shifts	• Implement Utilities Failure plan
Employees/Staffing (Number of personnel required vs.	• Intensive Units and ED are adequately staffed and additional staff is available if census	• Send float staff to areas of greatest need • Determine availability of staff	• Identify clinical staff who typically work in other roles for potential reassignment to	• Consider mandatory overtime. **Other interventions**

actual, department vs. temp/float staff)	increases	who are not currently on duty • Request staff from all sites/ departments to perform needed duties: o Couriers o Runners o Locate and send/deliver equipment/supplies o Trash emptying o Linen restocking o Calls to families to pick up patients o Answer patient call lights and provide information to patients and families o Answer phones, distribute faxes, obtain lab results, and perform other miscellaneous functions o Consider need for additional PBX operators	areas of need (PI, Risk Management, Education, etc.) • Managers called back from days off • Utilize "personnel pool" • IT and Maintenance available on-site • Bio-med available on-site • Communicate to patients that there will be delays	**as determined per disaster plan**

ATTACHMENT B

PANDEMIC INFLUENZA MANAGEMENT

Infection Prevention

PURPOSE:

- To provide guidelines for management of pandemic influenza.
- To provide planning and decision-making structures for responding to pandemic influenza.

POLICY:

A. Enhanced surveillance will be conducted when directed by the ***Tulare County Health and Human Services Agency*** (TCHHSA).

B. The following patients should be evaluated for possible infection with influenza A (H3N2, H1N1, H5N1) and/or Influenza B :

1. Hospitalized patients with:

   - Radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established, **AND**
   - History of travel within 10 days of symptoms onset to a country with documented high influenza rate in poultry and/or humans, **OR**

2. Hospitalized or ambulatory patients with:

   - Documented temperature of >38° C (>100.4°F), **AND**
   - One or more of the following: cough, sore throat, shortness of breath, **AND**
   - History of contact with poultry (e.g., visited a poultry farm, a household raising poultry, or a bird market) or a known or suspected human case of influenza A (H3N2, H1N1, H5N1.) in an affected country within 10 days of onset.

3. When both clinical and epidemiologic criteria for suspected influenza A infection have been met, the hospital will immediately proceed with the following actions:

   - Implement infection control precautions;

- Infection Prevention Office will report the case to the TCHHSA;
- Obtain clinical specimens for novel Influenza A infection and submit them to Tulare County Public Health laboratory, NOT to the State Health Department or hospital laboratory;
- Initiate antiviral treatment, if available;
- Triage to the appropriate level of care;
- Evaluate alternative diagnoses;
- Provide necessary clinical evaluation and management services, including monitoring the patient appropriately for complications; and
- Assist the TCHSSA with the identification of potentially exposed contacts including healthcare workers, as requested.

C. Prepare to activate Hospital Pandemic Influenza Plan as necessary.

D. Identify and isolate all potential patients with pandemic influenza.

E. All health care workers, volunteers, and Licensed Independent Providers will be offered vaccination against influenza annually as the vaccination becomes available in September. All appropriate patients will be given vaccination against influenza.

F. Antiviral drugs for influenza are an adjunct to influenza vaccine for controlling and preventing influenza and will be given as available.

G. In the event of pandemic influenza, the administrator will discuss with local health department whether how, and when an "Altered Standards of Care in Mass Casualty Events" will be invoked.

H. Hospital Emergency Incident Command System (HEICS) may be activated by volume of flu like symptoms, increase in in-patient census and/or staff shortages.

I. If necessary, cohort pandemic influenza patients.

J. Infection Prevention education will be provided on a regular basis.

K. Enhanced assessment of drugs, supplies and equipment inventory will be conducted.

DEFINITIONS

A. INFLUENZA: commonly called "The Flu," it is caused by the influenza virus, which infects the respiratory tract (nose, throat, lungs). Unlike many other viral respiratory infections, such as the common cold, the flu causes severe illness and life-threatening complications in many people. Symptoms of the flu include fever, headache, extreme tiredness, dry cough, sore throat, runny or stuffy nose, and muscle aches.

B. AVIAN INFLUENZA: is an infection caused by avian (bird) influenza viruses. These flu viruses occur naturally among birds. Wild birds worldwide carry the viruses in their intestines, but usually do not get sick from them. However, avian influenza is very contagious among birds and can make some domesticated birds, including chickens, ducks and turkeys very sick and kill them. Bird flu viruses do not usually infect humans, but more than 100 confirmed cases in human infection with bird flu viruses have occurred since 1997. Most cases of avian influenza infection in humans have resulted from direct or close contact with infected poultry or surfaces contaminated with secretions and excretions from infected birds. Last outbreak of H5N1 was in 2014-2015 season.

C. STAGES OF A PANDEMIC:

Inter Pandemic Period:

- Phase 1: No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.

- Phase 2: No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.

Pandemic Alert Period:

- Phase 3: Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.

- Phase 4: Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.

- Phase 5: Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans but may not yet be fully transmissible (substantial pandemic risk).

  NOTE: During the pandemic alert period, patients with confirmed infection with a novel influenza strain should be isolated from patients with seasonal influenza, in order to decrease the risk of co-infection and viral genetic re-assortment.

Pandemic Period:

- Phase 6: Pandemic; increased and sustained transmission in general population.

D. ALTERED STANDARDS OF CARE IN MASS CASUALTY EVENTS – when to consider:

1. Volume of flu-like symptoms to the Medical Center.
2. Increase in in-patient census.
3. Staff shortages.

PROCEDURE:

A. A multidisciplinary planning committee with responsibility for pandemic influenza preparedness and response will include the following individuals:

- Safety Officer
- Administrator(s)
- Infection Prevention
- Emergency Department
- Materials Management
- Clinical Education
- Marketing
- Facilities/Plant Operations
- Laboratory
- EHS
- Pharmacy
- Pharmacy Care Departments Representatives

B. If pandemic influenza is noted in local area:

- Infection Prevention will establish contact with TCHHSA.

- Conduct hospital surveillance for influenza.
- Monitor healthcare personnel who might be infected with a pandemic strain of influenza. Department director/manager will monitor all employee sick calls.
- Reinforce infection prevention procedures.
- Accelerate staff education
- Implement activities to increase capacity:
  - Consider revising admissions criteria and working with home care agencies.
  - Plan to shift some patients to other facilities or identify space that could be vacated for use as a supplemental hospital
  - Plan for isolation zones to prevent further spread of the disease.
  - Consider how to handle, treat, and isolate patients with no influenza illness.
  - Consider how decisions will be made about patient priorities for admission.
- Emergency department will segregate waiting areas for persons with symptoms of influenza.
- Limit number of visitors to those essential for patient support.
- Defer elective admissions and procedures until local epidemic wanes.
- Discharge patients as soon as possible.
- Cohort patients admitted with influenza.
- Monitor for hospital acquired infection transmission.
- Consider furlough or reassignment of pregnant staff and other staff at high risk for complications of influenza.
- Consider reassigning non-essential staff to support critical hospital services or placing them on administrative leave.
- Consider assigning staff recovering from influenza to care for influenza patients.
- Screen staff reporting for duty.

- Provide staff with antiviral prophylaxis. According to HHS recommendations.
- If widespread transmission in community and hospital:
  - Redirect personnel resources to support patient care.
  - Recruit community volunteers.
  - Consider placing on administrative leave all non-essential personnel who cannot be reassigned to support critical hospital services.
  - Consider cross-training programs.
  - Explore options for alternative healthcare workers (e.g., retirees, trainees, family members, or others) as supplemental staff.
  - Prepare for just-in-time training of non-clinical staff.
  - Consider that you might need to replace high-risk personnel, including pregnant women and immune-compromised workers, during an outbreak.

C. Infection Prevention General Guidelines

- Refer to SVMC's Policy Library for specific policies and details on infection prevention measures.
- Standard Precautions and Hand Hygiene policies are indicated.
- Soiled linen/laundry, environmental cleaning and solid waste disposal are performed in the usual manner as defined by policy.
- Special dietary trays and handling is not necessary.
- Respiratory hygiene/cough etiquette:
  - Signage will be posted in hallways, entrances, waiting rooms and other areas that patients visit to point out the urgency of good hygiene in preventing a pandemic.
  - Guidelines include the following:
    - Cover your cough.
    - Wear a mask.

- Perform thorough hand hygiene using soap and water if available, if not, use alcohol-based hand sanitizer. Keep patients with coughs at least 3 feet from others in waiting rooms.

- Droplet Precautions: place patients with influenza in a private room or cohort with other patients with influenza. Keep door closed. During the early stages of a pandemic, infection with influenza should be laboratory confirmed, if possible. Wear a surgical mask for entry into patient room.

- Patient Transport: limit patient movement outside of room to medically necessary purpose; have patient wear a surgical mask when outside the room.

- Aerosol-generating procedures: during procedures that may generate small particles of respiratory secretions, health care workers should wear gloves, gown, face/eye protection and a mask with attached shield, or a mask and goggles.

D. Post Emergency Event Actions:

- Recover normal facility, personnel and patient operations.

- Dissolve the Emergency Operations Center.

- Resume usual use of space and clinical areas.

- Resume normal practice for supplies, medications and equipment.

- Resume usual staffing patterns.

- Conduct post-evaluation and review of performance and operations.

- Debriefing.

E. Laboratory Procedures:

- Collect and handle all clinical specimens from suspect novel Influenza A patients while wearing gloves, face and eye protection and a laboratory coat.

- Collect a nasal and throat swab and place each swab into a separate vial of transport media.

- Label each specimen with the following information: PATIENT'S NAME; DATE COLLECTED, and TYPE OF SPECIMEN. PLEASE NOTE: "SUSPECT CASE OF INFLUENZA A " ON THE FORMS AND SPECIMENS.

- Complete the Specimen Submittal Form for Suspect Influenza A for each patient with the following information: patient's name, age, date of illness onset, type of specimen(s), date collected and clinical symptoms.

- Contact: Tulare County Public Health Lab for specimen transport instructions.

REFERENCES:

- *Pandemic Influenza: Domestic Preparedness Efforts.* Congressional Research Service. 2007: https://crsreports.congress.gov/product/pdf/RL/RL33145/7 Accessed on 6 January 2025.
- Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007. *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. Last reviewed on Jul. 11, 2023. Available at: https://www.cdc.gov/infection-control/hcp/isolation-precautions/index.html Accessed on 6 January 2025.
- Terri R. *Infectious Disease Disasters: Bioterrorism, Emerging Infections, and Pandemics*. In Boston K.M., et al, eds. APIC Text. Available at: https://text.apic.org/toc/community-based-infection-prevention-practices/infectious-disease-disasters-bioterrorism-emerging-infections-and-pandemics#book_section_17362 Accessed 6 January 2025

SUBJECT: **INITIATION OF HEMODIALYSIS USING DUAL LUMEN CATHETER**	SECTION: **Page 1 of 3**

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

PURPOSE:

To initiate the hemodialysis treatment with a dual lumen dialysis catheter.

POLICY:

- An informed consent must be signed prior to the first hemodialysis treatment.
- Current hepatitis B screening must be completed if this is not complete patient must be treated in isolation.

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

CAUTIONS:

- Do not put any tension on the catheter.
- If catheter suture is loose or not intact, notify the Nephrologist prior to initiation of dialysis.

EQUIPMENT:
Accessing:

- PPE
- alcohol prep pads
- Two (2) empty 10ml Syringes
- Two (2) 10ml Syringes with 10 ml of injectable normal saline in each
- One (1) 4 x 4 in. gauze pad
- Syringes and Blood Tubes for blood work, as necessary
- Tape

De-Accessing:

- PPE
- Clean Barrier e.g Blue Chux
- Alcohol prep
- 10 ml syringes with saline for flushing
- 3 ml syringes filled with anticoagulant dwell if ordered
- Sterile Catheter caps

ACCESSING PROCEDURE:

- Assess the site for signs and symptoms of infection, swelling, redness, excessive warmth, drainage or tenderness. If infection is a concern, stop and contact the nephrologist for further instruction

- Gather the supplies. Perform hand hygiene and put on clean gloves. Put on the gown, face mask and goggles/face shield. Provide the patient with a face mask and ensure that it is properly worn.
- If tolerated, apply mask to patient, if not turn patient head away from catheter
- Place a barrier and a sterile 4 x 4 in. gauze pad under the catheter. Remove the existing gauze dressing and assess for visible clots in ports. Remove the gloves, perform hand hygiene and put on clean gloves.
- Cleanse the catheter connection sites and Y connection with alcohol prep pads and allow to dry.
- Be sure both limbs of the catheter are clamped. Remove the cap from the arterial (red) limb.
- Remove the arterial port cap and cleanse the port with an alcohol prep pad and allow it to dry. Using a 10 ml syringe, aspirate approximately 5 - 10 ml of blood from the arterial limb to remove the heparin dwell and evaluate the blood flow. Re-clamp the catheter.
- Remove the 10mL blood-filled syringe and cleanse the port with an alcohol prep pad and allow it to dry. Attach vacutainer to obtain blood, as needed for lab work.
- Remove vacutainer and cleanse the port with an alcohol prep pad and allow it to dry. Irrigate the arterial limb with a 10 ml syringe of normal saline. Assess the blood flow. Re-clamp the catheter.

  Repeat the above steps, excluding any lab draws, for the venous port.
- Remove syringes, cleanse catheter connections, and attach lines.
- Initiate the hemodialysis treatment.
- Remove the gloves and perform hand hygiene.
- Document the initiation of the dialysis treatment in the patient's medical record.

DE-ACCESSING PROCEDURE:

- Perform hand hygiene and don PPE to complete rinse back of patient's blood as directed by manufacturer's recommendations.
- Assess for clinical stability, support if needed
- If tolerated, apply mask to patient, if not turn patient head away from catheter
- Remove gloves, perform hand hygiene and don fresh gloves
- Place barrier under catheter and perform catheter connection cleaning per disinfectant instructions.
- Close all clamps on patient access as well as the bloodlines of the extracorporeal system.

- Disconnect venous limb from bloodline, attach saline filled syringe and flush being sure to re-clamp when completed. Repeat with arterial limb of catheter.
- Instill anticoagulant dwell as per ordered, being sure to verify volume for each limb and close clamps when complete.
- Cap catheter limbs with approved caps
- Document procedure

REFERENCES:

Infections and patients on dialysis. (2024, March 26). Dialysis Safety. https://www.cdc.gov/dialysis-safety/about/index.html

Kallenbach, J.Z. (2016). *Review of Dialysis for Nurses and Dialysis Personnel* (9th ed). St. Louis, MO: Elsevier.

Nissenson, A.R., & Fine, R.A. (2017). *Handbook of Dialysis Therapy* (5th ed). Philadelphia, PA: Elsevier.

SUBJECT: **LARYNGEAL MASK AIRWAY; NEWBORN RESPIRATORY CARE SERVICES MEDICATIONS**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide guidelines for airway management using the laryngeal mask airway (LMA) for infants who require ventilator support when bag/mask ventilation is not advisable or sufficient.

POLICY:

Anatomical variations of the upper airway may render endotracheal intubation difficult. LMA may be used to facilitate oxygenation and ventilation during the time it takes to accomplish endotracheal intubation.

1. LMAs will only be placed by trained Healthcare Professionals.
2. Nurses and Respiratory Therapists who have completed NRP may assist or place the LMA per physician orders.
3. Infants who require ventilator support greater than 4 hours will be transferred to a Neonatal Intensive Care (NICU) with higher level of care services.

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

EQUIPMENT:

1. Appropriate size LMA based on weight.
    a. Size 0 for patients up to 2kg
    b. Size 0.5 for patients 2-4kg
    c. Size 1.0 for patients 4-7kg
2. Bag/mask with oxygen source
3. Suction apparatus, suction catheter, suction canister
4. Scissors
5. Pink/white tape for securing the LMA
6. Stethoscope

7. Water soluble lubricant
8. 10-12 ml syringe
9. Gloves
10. Pulse oximeter with heart monitor

PROCEDURE:

1. Consult with attending physician prior to insertion and verity physician order.
2. Use radiant warmer to ensure heated environment.
3. Throughout the LMA placement procedure, observation of the patient is mandatory:
    a. Cardio-respiratory monitors- with audible pulse rate.
    b. Pulse oximeter should be used (with the heart rate monitor).
    c. Request sedation to suppress pharyngeal relaxed and sensation, if applicable. *RN or physician will administer sedation if ordered.*
4. Prepare the appropriate LMA based on patient's weight.
5. Check cuff for patency.
6. Lubricate the external surface including the mask cavity ridges.
7. Place the front portion of the LMA mask between the base of the tongue and the soft palate at a slight forward angle.
8. Place the back of your index finger behind the mask, flexing finger forward to help guide the mask into the pharynx.
9. Continue to advance until fixed resistance to forward movement is felt. *Correct placement is determined by the resistance to further advancement.*
10. Carefully connect the bag/mask to ventilate.

a. Avoid airway pressures greater than 20cm H_2O.

11. Ensure adequate gas exchange by observation of chest wall movement, breath sounds, and improving clinical status.
12. Secure the LMA in the same fashion as an ETtube in the center of the lip.
13. Ensure the tube is pressed against the hard palate to maintain the seal at the larynx.

DOCUMENTATION

- Insertion time
- Name of person placing the tube
- Size of tube
- How infant tolerated the procedure noting difficulties if present
- Document vital signs pre and post insertion, Heart rate, Respiratory rate, SpO_2
- Quality of breath sounds

CROSS REFERENCES:

ENDOTRACHEAL INTUBATION_NEWBORN.

REFERENCES:

AIR-Q3 user guide. Retrieved from https://connect.myairlife.com/resources/UG-20000-C1_Air-Q3_UserGuide_rev1.pdf

SUBJECT:	SECTION:
LINEN AND LAUNDRY	***Multi – Specialty Clinic***

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

PURPOSE:

To ensure the use of sanitary gowns, drapes, and other linen and laundry.

POLICY:

Disposable patient gowns, drapes, pillowcases, and sheets will be utilized in the Multi-Specialty Clinic.

AFFECTED PERSONNEL/AREAS: *ALL MULTISPECIALTY CLINIC PERSONNEL, OB/GYN CLINIC, ACADEMIC HEALTH CENTER AND MEDICAL STAFF*

PROCEDURE:

A. Disposable patient gowns will be available in a variety of sizes, consistent with the patients served in the Clinic and physician preference.

B. Disposable patient drapes will be available in a variety of sizes, consistent with the procedures performed in the Clinic and physician preference.

C. Disposable exam/procedure table covers and pillow cases will be placed on all examination and procedure tables after those tables are sanitized between patients.

D. Disposable gowns, drapes, table covers, and pillowcases will be discarded in the regular waste bins unless those items are contaminated with biohazardous waste. Items contaminated with biohazardous waste will be disposed of in the biohazard waste bin(s).

CROSS REFERENCES:

- WASTE DISPOSAL

SUBJECT: **MAINTAINING PATENCY OF FEEDING TUBE**	SECTION:

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

PURPOSE:

To dissolve coagulated formula that may be occluding the feeding tube.

POLICY:

Occluded percutaneous endoscopic gastrostomy tube (PEG) feeding tubes will be reported to the physician, and an order obtained for a surgical consult for removal.

Note: Foley feeding tubes will be changed as needed by licensed nursing staff. Nursing staff are not to remove a PEG tube.

Agents:

- Warm Water

AFFECTED PERSONNEL/AREAS:

RN, LVN

EQUIPMENT:

- 60cc Syringe
- Warm Water
- Container

PROCEDURE:

1. Wash hands thoroughly.
2. Explain procedure to resident.
3. Draw up 20-50cc of warm water.
4. Attach syringe to tube, alternately push in and pull back on the plunger to avoid continued excessive pressure.
5. If unsuccessful, instill 10-20cc of H2O; clamp tube for about 20 minutes.
6. Check tube as per #4.
7. If unsuccessful, repeat 5 and 6.

8. If unable to unclog tube – replace per physicians orders. If the resident has a permanent tube which cannot be removed (PEG), notify the physician.

RECORDING:

1. Record procedure and results in resident's electronic medical record.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.30 United States of America, Med Pass Inc.

- WebMD, (Feb 8, 2023) Feeding Tubes: Types, Placement, What to Know, Medically reviewed by Poonam Sachdev. Retrieved from https://www.webmd.com

SUBJECT: **MATTRESS- AIR**	SECTION: **Page 1 of 1**

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

PURPOSE:

The purpose is to provide pressure reduction to residents at risk for skin breakdown and to distribute body weight, relieving areas of pressure.

POLICY:

It is the policy of this facility to utilize air mattress therapy under the direction of a physician's order or when the resident's clinical condition warrants pressure-reducing devices.

AFFECTED PERSONNEL/AREAS: *CNA, LICENSED STAFF*

EQUIPMENT:

- Air mattress

PROCEDURE:

1. Place mattress on bed.
2. Be sure that mattress is inflating properly.
3. Bed making
   a. Do not use pins
   b. Do not use chux, under-pads, or sheepskin pads on the bed. Use special air flow pads.
4. Check air mattress routinely to ensure that it is working properly.

REFERENCES:

- California Code of Regulations (2019). Title 22. §72315. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **MATTRESS- ALTERNATING AIR**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose is to provide stimulation and pressure relief to resident's at risk for skin breakdown and to distribute body weight relieving areas of pressure.

POLICY:

It is the policy of this facility to use pressure-relieving mattresses as indicated by the resident's physical condition.

AFFECTED PERSONNEL/AREAS: *RN, LVN, CNA*

PROCEDURE:

1. Explain the purpose of the mattress to the resident.
2. Wear gloves, then strip the linen from the bed. Then inspect the plug and electrical cord of the alternating pressure pad for evidence of frayed or broken wires.
3. Place the mattress on frame, with the appropriate side facing up.
4. Hang the motor on the bed if hooks are provided, near the mattress outlets. Connect the tubing securely to the motor and to the mattress outlets, and plug the cord into an electrical outlet. Turn the motor on.
5. After several minutes, observe the emptying and filling of the mattress chambers, and check the tubing for kinks that could interfere with the pad's function.
6. Place a bottom sheet over the mattress and tuck it in loosely. To avoid tube constriction, do not miter the corner where the tubing is attached. Use only an incontinent pad, if necessary, between resident and bottom sheet to maximize effect. Do not use pins.
7. Position the resident comfortably on the pad, cover him/her with the top linens, and tuck them loosely.
8. If the mattress becomes soiled, clean it with a damp cloth and mild soap, then dry well. To avoid damaging the mattress surface, do not use alcohol.
9. Record the use of the mattress and resident outcome in the resident Health Record.

REFERENCES:

- California Code of Regulations (2019). Title 22. §72315. Retrieved from **https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1**

- Wound Reference, Inc. (2019). Wound Reference. Retrieved from https://woundreference.com/.

SUBJECT: **MEASUREMENT OF BICARB AND DIALYSATE CONDUCTIVITY AND PH**	SECTION: 06-05 *Renal Services* **Page 1 of 3**

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

PURPOSE:

To monitor dialysate conductivity and potential hydrogen (pH).

POLICY:

In order to ensure patient safety the dialysis unit must test for conductivity and pH of dialysate before each patient treatment.
Note: Tablo machine for dialysis do not require pH and Conductivity testing.

AFFECTED AREAS/ PERSONNEL: *DIALYSIS PERSONNEL*

EQUIPMENT:

- pHoenix Meter
- 14.0 mS Conductivity Calibrator Solution (used for verification of calibration of meter when used to check conductivity of dialysate)
- 7.00 pH Calibrator Solution (used for verification of calibration of meter when used to check pH of dialysate)
- Tri•Station (used to rinse, disinfect and check the calibration of meter)

PROCEDURE:

Establishing Conductivity Range of Dialysate

1. Verify the calibration of the pHoenix meter using the 14 mS Conductivity Calibrator Solution.
2. Verify the calibration of the pHoenix meter using the 7.0 pH Calibrator Solution.
3. Press and release the [MODE] switch to turn the meter on.
4. Fill the sample collection cup approximately ¾ full with test solution from the distal port.
5. Draw liquid through the cell. Liquid should be flowing while measurement is taken. When no air bubbles are present and the readings stabilize, press and release the [MODE] switch to hold the readings on the display. A "HOLD" symbol will appear on the display. Press [MODE] again to deactivate the hold feature.

6. Discard the used solution in the appropriate disposal or waste container. The instrument will turn off automatically, three minutes after final use.

7. Thoroughly rinse the cell, syringe interior, and sampling cup/tube with RO water after use.

Disinfection Requirements

Frequency and Disinfectant:

1. The meter will be disinfected just prior to the first use on each day that it is used with a 1% bleach solution (one part bleach to 99 parts RO water), followed by a thorough rinsing with RO water.

2. Rinse 2-3 times with RO water to ensure that all residual disinfectant solution has been removed.

Calibration and Use of Meter after Disinfection

Each meter is to be checked for proper calibration prior to each day's use using 14 mS Conductivity standard solution and 7.0 pH standard solution.

1. Connect the cell to the 14 mS Conductivity standard solution bottle.

2. Hold the syringe with the plunger end elevated to eliminate any remaining air bubbles in the syringe.

3. Slowly draw solution through the cell. Observe the reading on the display while the solution is flowing. If the display reads the value of the conductivity standard solution being measured, calibration is not needed.

4. Rinse again with RO water before use or storage.

5. If calibration is needed, refer to the appropriate instrument calibration guide (02-04-01A).

6. Repeat steps 2- 5 with 7.0 pH buffer solution.

Overnight Cleaning and Storage Requirements

Frequency, Cleaning and Storage:

1. The meter will be rinsed with NEO-CARE Solution at the end of each day. To clean, rinse the meter thoroughly by filling the syringe and expelling NEO-CARE slowly, three times. After the third time, expel the NEO-CARE from the meter, draw the syringe back

halfway, and cap the sample port to prevent the residual NEO-CARE in the cell and syringe from drying out.

2. Never Store the meter with dialysate, bleach or RO water in the cell.

3. The facility will maintain a record of the date and time that the meter was disinfected, tested, calibrated and cleaned. If more than one meter is used by the facility, a separate record will be maintained for each meter. Each meter will be marked with a unique code to distinguish one meter from the other.

REQUIRED OBSERVATIONS and DOCUMENTATION

1. Confirm pH and conductivity are within normal ranges before putting the system in service for treatments.

2. Document levels of pH and conductivity. Findings should be documented on the following weekly log:

   a. Weekly Conductivity and pH Monitor Sheet for Total Chlorines & Testing.

REFERENCE:

- Mesa Labs (n.d.) Test Instrument User's Guide for the NEO-STAT+ Meter, phoenix Meter and HYDRA Water Quality Instrument. https://dialyguard.mesalabs.com/wp-content/uploads/sites/8/2014/01/Neo-Stat+Calibration-Guide.930004.RevD_.pdf
- Outset Medical. (2019). Tablo hemodialysis system user manual, PN-0004205 Rev. 08. San Jose, Ca: Outset Medical.

SUBJECT: **MEASUREMENT OF RECIRCULATION IN THE VASCULAR ACCESS**	SECTION: **Page 1 of 2**

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

PURPOSE:

Recirculation occurs when there is an obstruction or partial obstruction in the vascular access. The amount of recirculation during dialysis should be 10% or less.

POLICY:

- This procedure will be used when recirculation is suspected within a vein graft.
- The accuracy of this procedure is questionable when used on an AV fistula because of collateral circulation.

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

KEY POINTS:

1. Recirculation is an admix of arterial and venous blood during dialysis.
2. Signs of recirculation may include: saline returning through the arterial needle, increased venous resistance or blood becoming progressively darker as the dialysis proceeds.
3. The % of recirculation (R) is calculated as follows:

$$R = 100 \quad \frac{(Cs - Ca)}{Cs - Cv} \quad x\ 100$$

   a. Where Cs is the BUN in the systemic blood sample,

   b. Ca is the BUN in the arterial blood sample, and

   c. Cv is the BUN in the venous blood sample.

EQUIPMENT:

- Non-sterile gloves
- Gown, Goggles and Mask
- Three (3) Lab Tubes
- Four (4) 10 ml Syringes
- Three (3) 22 Gauge Needles
- Alcohol Wipes

SUBJECT: **MEASUREMENT OF RECIRCULATION IN THE VASCULAR ACCESS**	SECTION: **Page 2 of 2**

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

PROCEDURE:

- Put on gloves, gown, goggles and mask.
- Turn ultrafiltration pressure to zero (0) or as close as possible to minimize BUN clearance due to convective forces.
- Record the blood flow rate.
- Simultaneously draw blood samples from the arterial and venous sample ports.
- Turn the blood pump OFF. After clamping the arterial blood line and the arterial needle tubing, separate the line from the needle tubing.
- To clear the tubing, draw a 10 ml blood sample from the arterial needle tubing and discard.
- Draw a blood sample from the arterial needle tubing or dialysis catheter for the systemic blood sample.
- Fill three separate lab tubes with the blood samples. Label each tube with the appropriate sample site - venous, arterial or systemic.
- Send the samples to the lab for BUN.
- Use the formula to calculate the results.
- Document the procedure and results in patient EMR.

REFERENCE:

- Kallenback, J. (2021). Review of hemodialysis for nurses and dialysis personnel: Tenth ed. p. 153. St. Louis, Missouri: Elsevier.
- BerkoBen,M. and Blankestijn,P. (2022). Arteriovenous fistula recirculation in hemodialysis. Retrieved on 2/18/25 from https://www.uptodate.com/contents/arteriovenous-fistula-recirculation-in-hemodialysis

SUBJECT: **MEDICAL ADVICE VIA TELEPHONE**	SECTION: ***Multi – Specialty Clinic***

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

PURPOSE:

To ensure patient safety and staff compliance with legal scope of practice.

POLICY:

Medical advice will not be given over the telephone by the Multi-Specialty Clinic staff. Staff may provide patients with results of physician-ordered diagnostic testing only upon written direction from the provider.

AFFECTED PERSONNEL/AREAS: *ALL MULTISPECIALTY CLINIC PERSONNEL, OB/GYN CLINIC, ACADEMIC HEALTH CENTER AND MEDICAL STAFF*

PROCEDURE:

A. Patients seeking medical advice over the telephone will be courteously informed that it is the policy of the Clinic that medical advice is not given over the phone.

B. Staff will offer to take a message so that the physician may return the patient's call or offer to schedule an appointment for the patient with the physician.

C. Follow-up information or treatment due to physician-ordered diagnostic testing (lab, x-ray) may only be given by those personnel authorized to diagnose and prescribe (physicians, physician assistants, nurse practitioners).

D. Results of lab work are not to be given to patients by telephone unless approved in writing by the provider. A notation will be made in the medical record indicating the date, time, and name of person giving the information.

E. Confidential results (sexually transmitted diseases, pregnancy, etc.) will never to given over the telephone by Clinic personnel.

F. Under no circumstances will results of any kind (lab, x-ray, treatment) be left on answering machine or voice mail.

REFERENCES:

- "Is Your Medical Assistant Practicing Beyond His or Her Scope of Training?" Retrieved 3/11/15 from http://mbc.ca.gov.

SUBJECT: **MEDICAL ASSISTANT SCOPE OF PRACTICE**	SECTION: ***Multi-Specialty Clinics*** **Page 1 of 8**

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

PURPOSE:

To ensure that Medical Assistants (MAs) at the Sierra View Center are qualified and trained for their assigned responsibilities.

POLICY:

Medical Assistants (MA) are unlicensed health personnel who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a Licensed Practitioner. The Licensed Practitioner or the delegated Advanced Practice Provider must be physically present in the treatment facility during the performance of authorized procedures by the MA.

The Multi-Specialty Clinics areoperated and is fully integrated with the Sierra View Medical Center and follows applicable Policy and Procedures.

DEFINITIONS:

1. Under the law, "technical supportive services" are simple, routine medical tasks and procedures that may be safely performed by a Medical Assistant who has limited training and who functions under the supervision of a licensed physician, nurse practitioner, or nurse midwife.

2. "Supervision" is defined to require the licensed physician, nurse practitioner, or nurse midwife to be physically present in the treatment facility during the performance of those procedures.

3. "Specific authorization" means a specific documented order prepared by the supervising physician, nurse practitioner, or nurse midwife authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record.

AFFECTED PERSONNEL/AREAS:

All MULTI-SPECIALITY CLINICS STAFF, AND PROVIDERS

PROCEDURE:

A. MEDICAL ASSISTANTS

1. Medical Assistants will be trained and competent to perform basic administrative, clerical, and non-invasive routine technical supportive services in a secondary, post-secondary, or adult education program in a public school authorized by the Department of Education, in a community college program provided for in the Education Code, or a post-secondary institution accredited or approved by the Bureau for Private Postsecondary and Vocational Education in the Department of Consumer Affairs.

2. Prior to performing technical supportive services, a medical assistant shall receive training by an instructor in an approved school program to assure the medical assistant's competence in performing a service at the appropriate standard of care.

3. A medical assistant may prepare medication for intradermal, subcutaneous, or intramuscular injections, perform skin tests, or to perform venipuncture or skin puncture for the purposes of withdrawing blood and other technical supportive services upon the specific authorization and supervision of a licensed physician, nurse practitioner, or nurse midwife.

4. Training documentation and certification must be maintained on-site.

B. MEDICATIONS

1. A Medical Assistant may assist the Licensed Provider in preparing medications for subcutaneous or intramuscular injection; performing intradermal skin tests or venipunctures for withdrawing blood.

2. The Supervising licensed physician, nurse practitioner, or nurse midwife must specifically authorize all medications handled by a Medical Assistant by means of a specific documented order.

3. Medication preparation by a Medical Assistant means the direct preparation of pre- measured medication orally or topically.
4. After the Medical Assistant prepares the medication, the Licensed Practitioner or an Advanced Practice Provider will verify the pre-labeled medication container, correct medication and dosage.

5. Medical assistants ***may not*** prepare the following medications:
    a. Insulin (Humalog, Novalin, Novalog)
    b. Cardiac medications (Clonidine, Nitrostat, Epinephrine)
    c. Medication that requires mixing prior to administration, with the exception of vaccines that must be reconstituted per manufacturer' guidance;
    d. Psychotropic medications
    e. Anesthetic agents whether alone or as a component of any medication administration (Lidocaine, Zylocaine)

C. STANDARDIZED PROCEDURES

1. A Medical Assistant may perform technical supportive services as ordered by a Licensed Practitioner or an Advanced Practice Provider or by a standing order. The standing order will be prepared by the Licensed Practitioner, or Advanced Practice Provider authorizing the procedures to be performed, and the duration of which shall be consistent with accepted medical practice.

2. A notation of the standardized procedure will be placed in the patient's medical record. This will include the patient name, first initial and last name of the Medical Assistant, the date and time, a description of the service performed.

3. The Medical Director will approve Standardized Procedures.

4. Standardized Procedures will include:
   a. A specific symptom, condition or reason for visit (e.g. routine child check)
   b. Specified procedure(s) and/or technical services to be initiated.
   c. Timeframe for initiation of the procedure or technical service.

5. Examples of Standardized Procedures See Attachment A "Standardized Procedures for Medical Assistants".

D. OTHER SUPPORT SERVICES

1. The Medical Assistant may perform an electrocardiogram with an electronic order and under the supervision of a Licensed Practitioner or Advanced Practice Provider.

2. The Medical Assistant may apply and remove bandages and dressings; apply orthopedic appliances such as knee immobilizers, envelope slings, orthotics, and similar devices; remove splints and other external devices.

3. The Medical Assistant may remove sutures or staples from superficial incisions or lacerations.

4. The Medical Assistant may perform ear lavage to remove impacted cerumen.

5. The Medical Assistant may collect by non-invasive techniques, and preserve specimens for testing, including urine, sputum, semen and stool.

6. The Medical Assistant may assist patients in ambulation and transfers.

7. The Medical Assistant may prepare patients for and assist the Licensed Practitioner or Advanced Practice Provider in examinations or procedures including positioning, draping, and shaving, and disinfecting treatment sites; prepare a patient for gait analysis testing.

8. As authorized by the Licensed Practitioner or Advanced Practice Provider, the Medical Assistant may provide patient information and instructions.

9. The Medical Assistant may collect and record patient data including height, weight, temperature, pulse, respiration rate and blood pressure, and basic information about the presenting and previous conditions.

10. The Medical Assistant may perform CLIA waived screening tests customarily performed in a medical office with a documented order and under the supervision of a Licensed Practitioner or Advanced Practice Provider.

11. Medical Assistants ***may not*** place or remove an intravenous needle nor may they inject medication via intravenous needle.

12. Medical Assistants ***may not*** administer medications that are injected into the vein.

13. Medical Assistants ***may not*** insert urine catheters.

14. Medical Assistants ***may not*** perform telephone triage as they are not legally authorized to interpret date or diagnose symptoms.

15. Medical Assistants ***may not*** diagnose or treat a condition or illness.

16. Medical Assistants ***may not*** perform any invasive task (except skin tests as noted above).

17. Medical Assistants ***may not*** assess the patient's condition.

18. Medical Assistants ***may not*** interpret results of skin tests (but May measure and describe the test reaction and make a record in the patient chart.

19. Medical Assistants ***may not*** chart pupillary responses.

20. Medical Assistants ***may not*** inject collagen.

21. Medical Assistants ***may not*** use lasers to remove hair, wrinkles, scars, moles, or other blemishes.

22. Medical Assistants ***may not*** administer chemotherapy.

23. Medical Assistants ***may not*** enter a medication order into the EMR

24. Medical Assistants ***may not*** independently apply splints.

25. Medical Assistants ***may not*** perform outside of their scope of practice.

E. TRAINING

1. All Sierra View Medical Assistants upon hire will complete various training modules as well as a competency review.

2. All Sierra View Medical Assistants will be qualified for their responsibilities and adequately trained for their scope of work.

3. All Sierra View Medical Assistants will have a general understanding of the systems/processes in place, appropriate supervisions, and knowledge of the available sources of information on site.

4. All Sierra View Medical Assistants must be able to demonstrate operation of medical equipment used in their scope of work.

5. Refer to Human Resources Policy and Procedure; *Employee Orientation.*

6. Refer to Initial House Wide Orientation Checklist

7. Refer to Education Policy and Procedure*; Competency Assessment Process*

F. IDENTIFICATION

1. All staff shall disclose his or her name and title on a nametag with at least 18-point type.

   Note: It is unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a registered nurse or licensed vocational nurse.

REFERENCES:

Business and Professions Code, Division 2, Healing Arts, Chapter 5 Medicine, Article 3 Licenses Required and Exceptions. (2015) Retrieved February 20, 2025from: http://leginfo.legislature.ca.gov/faces/printCodeSectionWindow.xhtml?lawCode=BPC&sectionNum=2069.&op_statues=2014&op_chapter=333&op_section=1

Is Your Medical Assistant Practicing Beyond His or Her Scope of Training? (2025). Retrieved February 20, 2025 from http://www.mbc.ca.gov/Licensees/Physicians_and_Surgeons/Medical_Assistants/Beyond_Scope.aspx

Medical Assistants. (2025) Retrieved, February 20, 2025 from http://www.mbc.ca.gov/Licensees/Physicians_and_Surgeons/Medical_Assitants/

CROSS REFERENCES:

Education Policy and Procedure*; Competency Assessment Process*

Human Resources Policy and Procedure; *Employee Orientation.*

Initial House Wide Orientation Checklist

Attachment A

Standardized procedures for Medical Assistants

Adult Standardized Procedures

Symptom/Condition/Reason for Visit	Procedure/Technical Service	Approved to be Performed
Chest Pain R07.9	Electrocardiogram, tracing 93005	By MA at patient intake
Sore Throat J02.9 Pharyngitis unspecified	Rapid Strep 87430	By MA at patient intake
Dysuria R30.0 Dysuria	Routine UA - no Micro 81002	By MA at patient intake

Pediatric Standardized Procedures

Symptom/Condition/Reason for Visit	Procedure/Technical Service	Approved to be Performed
Screening visit for school/group home/other Z11 . l - Encounter for PPD	PPD 86580	By MA at patient intake
Sore throat *102.9* - Pharyngitis unspecified	Rapid Strep 87430	By MA at patient intake
Dysuria or frequent urination R30.0 - Dysuria	Routine UA - No Micro 81002	By MA at patient intake
Follow up visit for anemia Zl3 .0 - Encounter for screening for diseases of the blood and blood- forming organs and certain disorders involving the immune mechanism	Hemoglobin 85018	By MA at patient intake
Generalized abdominal pain Rl0.84- Generalized abdominal pain	Routine UA- No Micro 81002	By MA at patient intake

Generalized abdominal pain for female patient age 11+ (only if menses has started per patient report) RI0.84-Generalized abdominal pain	Pregnancy test 81025	By MA at patient intake
Routine infant or child health check 9- 11 months Z00.129 - Encounter for routine child health examination w/o abnormal findings	Hemoglobin 85018	By MA at patient intake
Routine child health check 12-15 months Z00.129 - Encounter for routine child health examination w/o abnormal findings	Hemoglobin 85018	By MA at patient intake
Routine child health check 16-23 months Z00.129 - Encounter for routine child health examination w/o abnormal findings	Hemoglobin 85018	By MA at patient intake
Routine child health check 2 years ZOO.129 - Encounter for routine child health examination w/o abnormal findings	Hemoglobin 85018	By MA at patient intake
Routine child health check 3 years Z00.129 - Encounter for routine child health examination w/o abnormal findings	Hemoglobin 85018	By MA at patient intake
	Routine Urinalysis - No Micro 81002	By MA at patient intake
Routine child health check 4-5 years Z00.129 - Encounter for routine child health examination w/o abnormal findings	Hemoglobin 85018	By MA at patient intake
	Routine Urinalysis - No Micro 81002	By MA at patient intake
Routine child health check 6-7-8 years Z00.129 - Encounter for routine child health examination w/o abnormal findings	Hemoglobin 85018	By MA at patient intake
	Routine Urinalysis - No Micro 81002	By MA at patient intake
Routine child health check 9-10-11-12 years Z00.129 - Encounter for routine child health examination w/o abnormal findings	Hemoglobin 85018	By MA at patient intake
	Routine Urinalysis - No Micro 81002	By MA at patient intake
Routine child health check 13-14-15-16 years Z00.129- Encounter for routine child health examination w/o abnormal findings	Hemoglobin **85018**	By MA at patient intake
	Routine Urinalysis - No Micro 81002	By MA at patient intake

Routine child health check 17-18-19-20 years Z00.129 - Encounter for routine child health examination w/o abnormal findings	Hemoglobin 85018	By MA at patient intake
	Routine Urinalysis - No Micro 81002	By MA at patient intake
Women's Care Standardized Procedures		
Symptom/Condition/Reason for Visit	**Procedure/Technical Service**	**Approved to be Performed**
Presenting with suspected pregnancy 232.00 - Encounter for Pregnancy test	Pregnancy test 81025	By MA at patient intake
Presenting with report of heavy menses N92.0 - Excessive and frequent menstruation with regular cycle	Hemoglobin 85018	By MA at patient intake

SUBJECT:	SECTION:
MEDICATION ADMINISTRATION: MEDICAL ASSISTANT	***Multi - Specialty Clinic***

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

PURPOSE:

To ensure patient safety in the Multi-Specialty Clinic during the administration of medications.

POLICY:

Medical Assistants may administer medications (excluding anesthetics and chemotherapy) either by intradermal, subcutaneous, intramuscular injection or oral, sublingual, topical, vaginal or rectal routes or by providing a single dose to a patient for immediate self-administration. In all cases, prior to administration, the supervising practitioner must verify both the medication and dose and be on-site during the administration.

AFFECTED PERSONNEL/AREAS: *ALL MULTI-SPECIALTY CLINIC PERSONNEL, OB/GYN CLINIC, ACADEMIC HEALTH CENTER AND MEDICAL STAFF*

PROCEDURE:

A. Medications will be maintained and dispensed via an automated dispensing cabinet system (Pyxis).

B. Physician orders will be placed electronically and interfaced with the Pyxis.

C. Medications will be dispensed only as per written, signed order of licensed, qualified practitioner.

D. Patient allergies will be verified prior to administration.

E. Medical assistants will verify all dispensed medications with ordering practitioner prior to administration and document said verification.

F. Two patient identifiers will be used prior to patient's receipt of ordered medications.

G. Unit dose packaging/single dose vials are used when available.

H. Multiuse vials are initialed by first user and dated as per Pharmaceutical Services Policy & Procedure, Multidose Vial Expiration.

I. When medication or solution is transferred/removed from original packaging to another container, the container will be labeled as soon as it is prepared with the following:

1. Medication name
2. Strength
3. Quantity
4. Diluent and volume of diluent
5. Initial of person preparing medication
6. Preparation date
7. After the medication is mixed, it must be administered within one (1) hour.

J. Those containers with above said labels will have the labels verified verbally and visually by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.

K. Enter date and time of administration of medication in patient's medical record, along with route of administration, and any reactions noted at the time the dose was given.

REFERENCES:

- California Business and Professions Code 2069-2071
- The Joint Commission (2019). Hospital National Patient Safety Goals (NPSG.03.04.01, page 3). Retrieved from https://www.jointcommission.org/assets/1/6/NPSG_Chapter_HAP_Jan2019.pdf.

CROSS REFERENCES:

- PROCESSING OF MEDICATION ORDERS AND DISPENSING OF MEDICATIONS
- MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL
- MEDICATION AND SOLUTIONS, MANAGEMENT IN THE OPERATING/PROCEDURE ROOM

SUBJECT: **MEDICATION ADMINISTRATION THROUGH A FEEDING TUBE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To administer medications via the nasogastric, gastrostomy, or jejunostomy tube in those residents who are unable to take medications orally.

POLICY:

Medications will be administered via the feeding tube by a Registered Nurse (RN) or Licensed Vocational Nurse (LVN).

AFFECTED PERSONNEL/AREAS: *RNs, LVNs*

EQUIPMENT:

- Medication
- 60 cc syringe with Luer tip
- Gloves
- Protective cap for feeding bag tubing
- Medicine cups
- Warm water

PROCEDURE:

1. Assemble supplies/equipment.
2. Wash hands. Wear gloves.
3. Explain the procedure to the resident.
4. Auscultate abdomen for gastrostomy tube placement.
5. Crush pills, tablets, or empty contents of capsules into small medicine cup and mix with water (one med per cup). Dilute liquid medications with warm water. Use a minimum of 15cc water for each medication. (Check with the pharmacist if there are questions as to whether to crush a particular pill or tablet.)
6. Put continuous tube feedings on hold. Check the residual and tube placement.
7. Close Lopez valve to the "off" position to feeding bag/bottle.

8. Put protective cap onto adapter of feeding bag tubing, if disconnected, to protect tubing and feeding from contamination.

9. Insert syringe to Lopez valve and check for gastric residuals and placement of the gastric tube.

10. Remove the plunger from the syringe and pour 30 ml H_2O into the syringe and let it flow by gravity, then pour each medication separately into the syringe and let it flow by gravity also (flush with a minimum of 15 ml H_20 as indicated in between meds given).

11. Flush tubes with 30ml water after all medications are given.

12. Turn the Lopez valve to "open" to feeding/bottle.

13. Resume feeding as ordered.

RECORDING:

Chart medications given on MAR in the EMR. Chart fluids administered with medication on EMR.

SPECIAL CONSIDERATIONS:

May gently use pressure to instill medications if gastric tube is sluggish and has some resistance.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.60, 483.25 (1) United States of America, Med Pass Inc.
- U.S. National Library of Medicine. National Institutes of Health (n.d.). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/.
- Pharmacy Management of Long Term Medical Conditions, March 2021, Ross Ferguson, Jonathan Burton, Pharmaceutical Press.

SUBJECT:	SECTION:
NEONATAL INTENSIVE CARE UNIT SCOPE OF PATIENT CARE/STAFFING GUIDELINES	10 **Page 1 of 8**

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

NEONATAL INTENSIVE CARE UNIT SCOPE OF SERVICE:

The Neonatal Intensive Care Level II Unit provides 24-hour specialized care to neonates. Sierra View Medical Center (SVMC) is equipped and staffed to provide Level II care to infants who need observation, stabilization, and management but who do not require Level III care. The unit is also equipped and staffed to provide ventilatory support until the transport team can arrive for transfer. Infants may be admitted in an unstable condition requiring stabilization and treatment or may be admitted for observation. Infants are admitted from Labor and Delivery, the mother-baby unit, transferred in from a higher level of intensive care unit not needing Level III care, or born out of asepsis.

The goals are to:

- Provide evidence-based practice and achieve optimal care for neonates admitted in the Neonatal Intensive Care Unit (NICU).
- Use collaboration and a multidisciplinary approach in providing treatment and care to neonates.
- Provide physical and emotional support, bonding, and rapport with childbearing families in an atmosphere conducive to supporting their birthing options, adaptation to parenting, and ability to cope with the health outcomes of mothers and infants.
- Provide stabilization and monitoring until the infant can be transferred to a facility that can provide the higher level of care required by the neonate.

Assessment of Patient Care Needs:

The registered nurse (RN) will complete and document, the initial infant assessment as soon as possible; ensuring to prioritize patient care. The infant's history and physical should be completed within 12 hours.

The need for reassessment depends on the patient's status and should be appropriate to the complexity of the presenting problem. Perform reassessments to determine the patient's response to treatment or when a significant change occurs in the patient's condition or diagnosis. Complete routine reassessments every 4 hours. Review patient care needs through ongoing assessment and evaluation.

Procedural Activities:

Licensed RNs primarily assigned to the NICU are expected to perform the following procedures independently after successful completion of educational and supervised experience requirements:

- Venipuncture for the purpose of establishing a peripheral line
- Assisting with changing of nasopharyngeal continuous positive airway pressure (CPAP) tubes
- Assisting with inserting umbilical arterial catheter (UAC), umbilical venous catheter (UVC)
- Care of the UAC and UVC lines, awaiting the transport team.

- Caring for intubated infants, including suctioning, awaiting transport team.
- Performing heel stick and venipuncture phlebotomy.
- Administering medications and blood products.
- Inserting orogastric and nasogastric indwelling feeding tubes.

When a nurse is deemed competent to serve as a second nurse in the NICU, they will operate under a modified competency level and work in a team-based approach. Every effort should be made to ensure that the NICU is staffed with two primary NICU nurses. If that is not possible, a team-style nursing model will be implemented. In this model, the primary ICU nurse will supervise the care provided by the second NICU RN. Both nurses will have full reports on their NICU patients and will work collaboratively as a care team. The primary nurse will delegate tasks to the second NICU nurse based on their competencies. This model may be utilized as long as patient acuity allows.

In addition, RNs assigned to the NICU must beNeonatal Resuscitation Program (NRP) certified and maintain cardiopulmonary resuscitation training to meet American Heart Association (AHA) standards.

- *Primary NICU RN's Only:* Sugar-Temperature-Airway-Blood pressure-Labwork-Emotional support (S.T.A.B.L.E.) Certification is to be obtained within six months of employment.

Standards of Practice for the NICU Level II:

- Nursing care in the NICU reflects a systematic approach to the nursing process.
- The NICU RN will perform procedures, treatment and care approved for Level 2 NICU with competencies.
- The NICU will admit and care for neonates identified level II, per the Admission, Discharge and Transfer policy and procedure of SVMC.

Standard I. Data Collection:

Data are obtained by parental interview, physical examination, review of records and reports, and consultation. Priority of data collection is determined by the immediate physical condition of the infant.

Data collection is systematic and continuous. Data is communicated to appropriate persons involved in the patient's care only, and they are recorded in the medical record.

1. **Process Factors; Data may include, but are not limited to, the following:**
   a. Current medical diagnosis and therapy
   b. Assessment of the function and status of the infant's major body systems
   c. Assessment of the infant's sleep, rest, activity, comfort, and state the patterns
   d. Information about the family's spiritual beliefs, family system, economic status, and environment factors
   e. Family's perception and expectations of the infant's hospitalization

f. Knowledge of patient and family rights.

2. Outcome factors:

a. The infant should have an initial health admission completed by an RN within 2 hours of admission.

b. The parents, as well as other family members, significant others, and health personnel, should participate in the data collection process.

c. The data should be synthesized and recorded in the medical record.

Standard II. Patient Focus:

The basis of nursing care is recognition and identification of actual or potential health problems that are within the scope of nursing practice.

1. Process Factors:

a. The patient focus of care should be based upon identifiable data and determined by continuous analysis and interpretation of the data.

b. Health deviations should be identified by ongoing comparison of the data with established norms or with the infant's previous condition.

c. Sufficient data should be collected to verify a diagnosis or patient problem.

d. The patient focus of care should be consistent with current knowledge and be subject to revision with subsequent data.

2. Outcome factors:

Patient care guidelines should be individualized. The Patient Care Plan should be initiated on admission. Patient care should be documented in the Electronic Medical Record (EMR).

Standard III Goal Setting and Outcomes:

A goal is an outcome toward which nursing actions are planned. Outcome achievement is dependent on variables such as known health status, age, sex, beliefs, time frame for individual achievement, availability of resources, and other significant variables.

1. Process factors:

a. Goals should be documented as expected outcomes on the patient care plan.

b. Goals should be stated in terms of observable outcomes.

c. Goals should be determined by the infant's parents, family, health personnel.

d. Goals should be congruent with the infant's present and potential physical and mental capabilities and behavioral patterns.

e. Goals should be attainable through available human, financial, and material resources.

f. Goals should be achievable in an identifiable time frame and should be appropriately prioritized.

2. Outcome factors:

a. Initial goals or outcomes should be recorded and reviewed every 24 hours and as needed.

b. New goals or outcomes should be added as additional data is gathered.

c. Goals or outcomes, achievements, changes, and updates should be reflected in the Patient Care Plan.

Standard IV Nursing Care Plan

A nursing plan prescribes nursing and infant-parent actions to achieve goals or outcomes. The Patient Care Plan should be used to guide intervention and effectively achieve the desired outcomes. The infant's actions should be appropriate to current and potential levels of functioning.

1. Process factors: The plan should:

a. Include priorities for nursing and infant actions

b. Contain a logical sequence of actions to attain the goals or outcomes

c. Be based on current, evidence-based practice using current hospital policies and procedures

d. Incorporate human and material resources

e. Reflect consideration of the infant's rights

f. Specify what is to be done, how to do it, where to do it, and who is to do it

g. Be developed with the parents or caregiver

2. Outcome factors: The plan's outcome factors should

a. Be documented in the EMR's Outcomes

b. Reflect continuous assessment of changes

c. Show evidence of revision and deletion of prescribed nursing actions as goals are achieved, changed, or updated.

Standard V Implementation of the Nursing Plan

The nurse should evaluate the infant's responses to nursing actions and revise the plan as necessary. Nursing care is a dynamic process that includes alterations in data, focus, or plans previously made.

1. Process factors

a. The nurse should delegate tasks and supervise the care the infant receives from others.

b. The nurse should coordinate the efforts of the health team members and refer to other support services when needed.

2. Outcome factors

a. Outcome factors should be consistent with plans for nursing care as outlined in the nursing care plan and in accordance with hospital policies and procedures.

b. The infant's progress should reflect achievement of the written goals or outcomes.

c. All documentation should be complete.

Standard VI Evaluation of the Nursing Plan

The nurse should evaluate the infant's responses to nursing actions and revise the plan as necessary. Nursing care is a dynamic process that includes alterations in data, focus or plans previously made.

1. Process factors

a. Current infant data should be used to measure progress toward goal achievement.

b. Parents should participate in the evaluation of goal achievement.

2. Outcome factors

Nursing Care Plans should show evidence of revision based upon ongoing evaluation and progress toward goals. Patient care guidelines should be initiated when outcome goals are not met within 48 hours. Any unmet goals should be the subject of a narrative notation.

Standard VII Teaching and Discharge Planning

The nurse should begin the teaching and discharge planning upon the infant's admission. Parental involvement in planning, performing, and evaluating care should begin when both the infant and the

parents are capable of interaction. Teaching should include orientation to the unit, routine care, infant communication principles, and follow-up information.

Staffing of the NICU:

Staffing guidelines are based on census, acuity, and job classification.

1. Standards of care are based on recognized American College of Gynecology (ACOG), Association of Women's Health, Obstetric and Neonatal (AWHONN), State, and American Academy of Pediatric guidelines.

2. When the level of care required by the patients exceeds the capabilities of this Hospital, neonatal transport to a tertiary neonatal unit shall be considered.

3. Appropriate support services, such as Radiology, Laboratory, Nutritional Care Services, Social Services, Pastoral Care, etc., shall be provided to the patient in a timely manner based on continual assessment of patient's needs. When the appropriate tests cannot be performed, neonatal transport to a tertiary neonatal unit will be considered.

4. Nursing care is delivered by registered nurses; a charge nurse will facilitate shift operations when required, due to acuity.

    a. Staff requirements

        - Basic requirements for Registered Nurse (RN) staff include:

            – Current state license;

            – Current BLS certification;

            – NRP

            – S.T.A.B.L.E. within 6 months of employment; applicable to *Primary* NICU RN's only.

5. Staffing Plan

    a. NICU

        - At least one registered nurse shall be assigned to the NICU area each shift, regardless of whether there are admitted infants in the NICU.. In addition, sufficiently trained personnel shall be assigned to assess patients, provide care for patients, assist family and provide appropriate family education. Examples of staffing patterns are as follows:

Nurse-to-Patient Ratio	NICU Staffing
1:3-4 Newborns requiring continuing care	2 RN's
1:2-3 Newborns requiring intermediate care	2+ RN's (Depends on the # and acuity of the other infants in the nursery)
1:1-2 Newborns requiring intensive care	2+ RN's (Depends on the # and acuity of the other infants in the nursery)
1:1 Newborns requiring multisystem support	2+ RN's (Depends on the # and acuity of the other infants in the nursery)
2:1 Critically ill, hemodynamically unstable newborn requiring complex care	2+ RN's (Depends on the # and acuity of the other infants in the nursery)

6. Assignment

   a. The charge nurse or designated registered nurse shall be responsible for making patient care assignments.

      - The charge nurse shall be familiar with policies, procedures and standards relative to patient assignments and shall review them as necessary to remain current.

   b. On a rotational basis, all NICU staff shall be responsible for and accountable for the ongoing Performance Improvement Program.

   c. Files shall be maintained for each employee, documenting their education and ongoing training programs. For the nursing staff, this shall include a yearly review of infection control practices and policies.

REFERENCE:

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

- Association of Women's Health, Obstetric and Neonatal Nurses. (2022). Standards for Professional Registered Nurse Staffing for Perinatal Units.

- California Code of Regulations Title 22 §70549. Accessed July 18, 2024. Available at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-19-37-Attachment3.pdf

- Gardner, S. L., Carter, B. S., Hines, M. E., & Hernandez, J. A. (2016). Merenstein & Gardners handbook of neonatal intensive care (8th ed.). St Louis, MO: Elsevier

- Simpson, K. R., & Creehan, P. A., O'brien-Abel, N., Roth, C.K., & Rohan, A.J. (2021). Perinatal nursing (5th ed.). Philadelphia: Lippincott Williams & Wilkins Health.

- Verklan, M. T., Walden, M., & Forest S. (2021). Core curriculum for neonatal intensive care nursing (6th ed.). St. Louis, MO: Elsevier Saunders.

CROSS-REFERENCES:

- NICU-Documentation
- Neonatal Intensive Care Unit (NICU) Admission, Transfer, and Discharge
- NICU Nursing Responsibilities and General Routines

SUBJECT: **NOURISHMENTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To meet the nutritional needs of identified residents.

POLICY:

It is the policy of this facility that residents may be given nourishments without obtaining a physician's order, following appropriate diet as recommended by the registered dietitian or licensed nurse.

AFFECTED PERSONNEL/AREAS: *RN, LVN, CNA, NUTRITION SERVICES, DIETITIAN*

SCOPE:

Provision of nourishments is the responsibility of the Nutrition Services Department. The Dietitian will initiate nourishment service whenever it has been determined that a resident requires additional nutritional support. Nourishments are not a replacement for routine meals.

PROCEDURE:

1. ORDERING AND DISCONTINUING – The Dietitian will coordinate with nursing regarding residents who require nourishments. If initiated by nursing, the Charge Nurse will order and/or discontinue via Meditech.

2. IMPLEMENTATION – The food service staff and Dietitian will maintain a current "Nourishment List- Dietary Special Needs."

3. MONITORING – The Dietitian will review the need for the nourishment with Charge Nurse monthly for continuance. The Registered Dietitian will review the list of residents routinely.

4. NOURISHMENT COST – Nourishments will be included in the food cost and will not be charged to residents.

5. NOURISHMENT TIME AND DISTRIBUTION

    a. Routine Nourishments (Snacks)

    - Routine nourishments will be offered at bedtime (H.S.) unless contraindicated by diet or condition. Items available for H.S. nourishments will be recommended by the Registered Dietitian.

      Schedule is as follows:

      a. 0800 – 1000 (coordinated with activities)
      b. 1400
      c. 1900

///

- Bedtime (H.S.) nourishments will be provided by Nutrition Services and will be delivered by the staff to each nursing station before closing the kitchen each night.

b. Recommended Nourishments

- Recommended nourishments will be served at the designated times and frequency. They will be labeled with the resident's name and room number and delivered by dietary to the nursing station.

- The Nursing Staff will be responsible for nourishment distribution each time and will document intake in the appropriate notes.

REFERENCE:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72335 (2), 72351, San Francisco, California, Title 22.

SUBJECT: **NURSING CARE, RESTORATIVE AND SUPPORTIVE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide residents with restorative and supportive nursing care to enhance the resident's physical, mental and social well-being and independence.

POLICY:

It is the policy of this facility that each resident will be provided with an individualized restorative and supportive plan of care to allow the resident the highest degree of independence possible within their physical and mental capabilities and to provide early detection and intervention when independence declines in order to prevent complications and maintain the resident at their highest level of functioning.

AFFECTED PERSONNEL/AREAS: *RN, LVN, RNA, CNA*

PROCEDURE:

1. Each resident shall be assessed upon admission for levels of functional abilities utilizing the Nursing Assessment and the interdisciplinary Minimum Data Set.

2. An interdisciplinary plan of care will be established identifying short-term and long-term resident goals.

3. The resident and family will be involved in establishing the plan of care whenever possible.

4. Restorative and supportive care shall include:

    a. Maintaining good body alignment and proper positioning of bedfast and dependent residents.

    b. Encouraging and assisting residents at least every two hours.

    c. Making every effort to keep residents active and out of bed for reasonable periods of time, except when contraindicated by physician order.

    d. Encouraging resident to achieve the highest degree of independence in activities of daily living by teaching self-care, transfer and ambulation techniques and providing assisting devices.

    e. Assessing bowel and bladder function, providing toileting assistance and retraining programs based on the individual resident need and abilities.

f. Providing range of motion to maintain joint mobility, prevent contractures or prevent further deterioration and complications of limited range of motion.

g. Assessing self-feeding skills and providing adaptive devices and retraining programs based on resident needs and capabilities, including weaning from feeding tubes.

h. Assessing skin integrity and nutritional status to ensure prevention or early detection of pressure ulcers.

i. Assessing social activity preferences/needs and implementing social service and activity plans of care to enhance the residents' emotional and social well-being.

j. Referring therapy programs (PT, OT, and ST) as indicated by resident assessment and need.

5. Restorative and Supportive Nursing Care Services when provided to the resident will be documented on the CNA / RNA in the EMR as indicated.

REFERENCE:

- California Code of Regulations (2019). Title 22. §70557. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Med Pass, Inc.,(updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25 (e)(1), 483.25 (e)(2) United States of America, Med Pass Inc.

SUBJECT: **NURSING WEEKLY SUMMARY**	SECTION: **Page 1 of 2**

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

PURPOSE:

- To address the resident's progress toward resolution of care plan problems.
- To evaluate the outcomes expected from care plan approaches and interventions.

POLICY:

- Weekly Nursing Summaries will be written on each DP/SNF resident in the unit in accordance with State and Federal regulations.
- The Weekly Summary will address all care plan problems, resident tolerance of care and procedures, resident progress and goals.
- The Weekly Summary will be done in the EMR or in accordance with facility documentation policies.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RNs)*

PROCEDURE:

1. Review the resident personalized care plans, nurses' notes, ancillary progress notes, intake and output record, physician's orders, MAR, TAR, lab and radiology reports for the last seven days.
2. Assess the resident.
3. Complete the weekly summary, addressing all personalized care plan problems.
4. Be sure to include resident status and progress in the following basic areas of focus:

    a. Skin Integrity

    b. Intake and Output

    c. Elimination

    d. Mobility

    e. Skin Risk

    f. Neurological Evaluation

    g. Psych/Social Evaluation

    h. HEENT Evaluation

i. Cardiovascular Evaluation

j. Gastrointestinal Evaluation

k. Genitourinary Evaluation

l. Integumentary Evaluation

m. Musculoskeletal Evaluation

n. Male/Female Reproductive Evaluation

o. Airway (if diagnosis warrants, or if tracheotomy patient)

p. Restraints, if present

q. Infection, if present

Update the care plans at the time the Weekly Summary is completed in the electronic medical record (EMR).

REFERENCE:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72071, §72315 (3) San Francisco, California, Title 22.

SUBJECT: **ORAL NUTRITION SUPPLEMENT**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish protocol for oral nutrition supplement (ONS).

DEFINITIONS:

ONS includes high calorie protein drinks and protein powders/liquids that are considered by the manufacturer to be medical foods.

POLICY:

ONS and oral modular supplements are available to patients as ordered by the physician and/or registered dietitian (RD).

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

PROCEDURE:

A. The RD may order or discontinue any ONS for patients on a modified diet using the ONS and Diet Type chart. The RD may modify the frequency, delivery time, and flavor of the existing ONS orders entered by the physician. RDs may only discontinue ONS ordered by other RDs. *See attached addendum.*

B. The RD may add protein modular (amino acid powders/protein powders/liquids).

C. The RD may adjust the diet downwards for calories, protein and textures.

REFERENCES:

- California Code, Business and Professions Code - BPC § 2585. (n.d.). Retrieved from https://codes.findlaw.com/ca/business-and-professions-code/bpc-sect-2585.html.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2024). 482.2 8(b) Tag-0629 482.28(b)(1). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2024). Hospital accreditation standards. PC.02.02.03, EP 7

SUBJECT: **ORAL NUTRITION SUPPLEMENT**	SECTION: **Page 2 of 3**

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

ADDENDUM

Food and Nutrition Services Dept. Diet Manual
Diet Types & Oral Nutrition Supplements (ONS)

Oral Nutrition Supplements by Diet

A crosswalk illustrating the ONS that fits the macronutrient composition and pattern of the diets listed. These may be selected by the Clinical Dietitian or Nurse, to be offered to patients based on assessed need. Only a physician may order alternate supplements.

Diet in Electronic Medical Record	Allowed Oral Nutrition Supplements
• **High Iron** • **Regular** • **Vegetarian** • **Kosher** • **High Calorie/High Protein Pregnancy/Lactation** • **Low Microbial/Neutropenic** • **Full Liquid** • **Low Fiber, Low Residue** • **Dysphagia I,II, III** • **Blenderized Puree** • **Cardiac** • **Low Sodium2 gm** • **No Added Salt (4 gm)** • **Low Fat** • **Gluten Free** • **PUD/GERD** • **6 Small Meals** • **Hyperemesis Gravidarum**	• Boost Plus • Ensure Clear • Ensure Plus • Ensure Plant Based Protein • Ensure Max Protein • Glucerna Therapeutic Nutrition Shake • TwoCal HN • Nepro • SF Mighty Shake, Regular Mighty Shake • Suplena • Pediasure • Propass Powder • SF Prostat • Banatrol Plus • Juven
• **Thickened Liquids**	All ONS thickened to appropriate consistency
• **Clear Liquid w/Supplement** • **Clear Liquid** • **Diabetic Full Liquid** • **Diabetic Clear Liquid**	• Ensure Clear (Not on Diabetic Clear/Diabetic Full Liquid) • Juven • SF ProStat • Diabetic FL: Glucerna, SF Mighty Shake, Ensure Max Protein, Banatrol Plus, Ensure Plant Based
• **Consistent Carbohydrate** • **Consistent Carbohydrate Low** • **Gestational DM**	• Glucerna Therapeutic Nutrition Shake • Ensure Plant Based • Ensure Max Protein

	• Banatrol Plus • Nepro • Suplena • Propass powder • SF ProStat • SF Mighty Shake
• **Renal** • **Renal – High Protein**	• Nepro, Glucerna (dialysis) • Suplena (Low Protein Diet, no dialysis) • Ensure Clear • Propass Powder, SF ProStat • Juven
• **Calorie Restriction: 1200, 1500, 1800, 2000, 2400**	• All ONS • Propass • SF Prostat • Consult RD if needed
• **Hepatic 2gm Na+, 50gm protein** • **Low protein (50gm)** • **Renal Low Protein (60g)**	• Suplena, consult RD if needed
Combination Diets • **Consistent Carb/Renal** • **Consistent Carb Cardiac** • **Cardiac Low Potassium**	• Glucerna, no chocolate • Nepro • Suplena • Propass Powder • SF Prostat
• **Toddler 1-2** • **Pediatric 2-12**	• Pediasure • Ensure Plus High Protein
• **Gastro Pediatric** • **BRAT**	No supplement
• **NPO Except Supplements**	Any liquid oral supplement (No Meal Tray)

SUBJECT: **ORDERS- PHYSICIAN NOTING**	SECTION:

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

PURPOSE:

To ensure accuracy and clarity in the noting of physician orders.

POLICY:

It is the policy of this facility that each physician order will be noted and verified by the licensed nurse.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN)*

PROCEDURE:

1. The nurse shall verify each order for completeness, clarity, and appropriateness of dose and allergies.
2. Monitoring criteria for the medications (vital signs, behavior, laboratory tests, etc.) are part of the Medication Administration Record (MAR) in the EMR.
3. Orders are entered into Meditech in the residents' EMR by the RN.
4. Appropriate doses and administration times are established for each medication. (See MEDICATION ADMINISTRATION TIMES)
5. All new orders are phoned or faxed to the contracted drug company.
6. If applicable, signal labels are affixed to current containers of medication (Order Change, Discontinued, and Hold).
7. The order is "noted" when the above steps, and any other appropriate actions, are taken. To note an order the nurse shall acknowledge the order in the EMR.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, § 74701 United States of America, Med Pass Inc. Thomson Reuters: (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, San Francisco, California.
- Cal. Code Regulations, Title 22 ,§74701, Current through Register 2025 Notice Reg. No 2, January 10, 2025. Retrieved from: https://casetext.com

CROSS REFERENCES:

- MEDICATION ADMINISTRATION TIMES

SUBJECT: **ORDERS- PHYSICIAN RECAPPING**	SECTION: **Page 1 of 1**

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

PURPOSE:

To ensure accuracy and clarity of physician orders and accurate administration of medications, treatments and resident care per physician order.

POLICY:

It is the policy of this facility to review all physician orders for accuracy on a daily basis.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN)*

PROCEDURE:

1. The Registered Nurse will review the physician orders that turn red in the EMR each shift at 1500 and 0300. Accuracy is essential and all orders will then go to the Medical Director for signature.

2. All new orders will be added during each shift when received by the MD, and discontinued orders will be removed after discontinued date. The Charge Nurse and licensed nurse needs to make sure all medications have an administration time.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20. United States of America, Med Pass Inc.

SUBJECT:	SECTION:
OUTPATIENT - FALL RISK IDENTIFICATION AND MITIGATION	***PATIENT CARE***

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

PURPOSE:

To identify patients who may be at risk of falling and to ensure a safe environment for all patients.

DEFINITIONS:

1. **Fall**: a sudden, uncontrolled, unintended, assisted or unassisted event resulting in a person coming to rest on the ground/floor.

2. **Unwitnessed Fall**: a report of a person who has landed or been found on the floor that is un-witnessed.

POLICY:

A. Sierra View Medical Center (SVMC) Multi-Specialty clinic patients will be asked if they have a fear of falling when registering the patient.

AFFECTED PERSONNEL/AREAS: *ALL MULTI-SPECIALTY CLINIC PERSONNEL, OB/GYN CLINIC, ACADEMIC HEALTH CENTER AND MEDICAL STAFF*

EQUIPMENT:

- YELLOW ARM BAND

PROCEDURE:

A. If the patient is determined to be a fall risk, the front office personnel will place a yellow arm band on the patient and offer a wheelchair.

B. The Medical Assistant will educate the patient to allow either staff or family member to accompany them when ambulating in the clinic.

C. Staff will indicate that the patient has been informed of fall risk education by documenting such in the medical record.

D. Any patient who experiences a fall within the clinic will receive the appropriate medical intervention and the fall (occurrence) will be reported via the house-wide incident reporting system.

REFERENCES:

- "Important Facts about Falls" (February 2017). Retrieved 01/03/2020 from https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html.

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Patient Care Services Policy & Procedure Manual; FALL PREVENTION (ADULT AND PEDIATRIC)
- Housewide Policy & Procedure Manual; SERIOUS CLINICAL ADVERSE EVENT

SUBJECT: **Overlapping Operations/Flipping Rooms**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1**

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

PURPOSE:

The primary attending surgeon is personally responsible for the patient's welfare throughout the operation. In general, the patient's primary attending surgeon should be in the operating suite or should be immediately available for the entire surgical procedure.

POLICY: CMS guidelines and the American College of Surgeons (ACS) statement of principles of Overlapping Operations will be followed to ensure patient safety in the OR. Flipping rooms/overlapping operations are allowed. Concurrent operations are not permitted

AFFECTED AREAS/PERSONNEL: Physicians, RNs

PROCEDURE:

1. Informed Consent/Consent: Patients whose elective procedures are scheduled or expected to overlap with that of another patient must be informed by the primary attending surgeon prior to the planned procedure.
2. Key and Critical Element(s):
   a. Surgeon needs to be present for key and critical element(s);
   b. The attending surgeon needs to document that they were present for the key elements and specify these elements in the operative note.
   c. The surgeon may delegate non-critical elements of the operation to qualified practitioners including but not limited to PA, RNFA, or physician.
3. RN Circulators will accurately document In/Out of Room Time, procedure start and stop times, and

DEFINITIONS:

Overlapping operations or flipping rooms for surgeons: The practice of the primary surgeon initiating and participating in another operation when he or she has completed the critical portions of the first procedure.

Concurrent operations: Surgical procedures when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time.

"Critical" or "key" portions of an operation: The "critical" or "key" portions of an operation are those stages when essential technical expertise and surgical judgment are necessary to achieve an optimal patient outcome. The critical or key portions of an operation are determined by the primary attending surgeon.

REFERENCES:

- https://www.facs.org/about-acs/statements/statements-on-principles/#anchor172771
- https://www.finance.senate.gov/imo/media/doc/Concurrent%20Surgeries%20Report%20Final.pdf

SUBJECT: **PANDEMIC COVID-19 MANAGEMENT PLAN**	SECTION: **Page 1 of 16**

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

INTRODUCTION:

In early 2020, a Public Health Emergency (PHE) was declared by the U.S. Government due to the SARS-CoV-2/COVID-19 Pandemic. Since that time, the PHE was renewed more than 10 times. Throughout the world, a public health emergency was declared "to catalyze timely evidence-based action to limit public health and societal impacts of emerging and re-emerging disease risks while preventing unwarranted travel and trade restrictions." Governor Newsome ended California's COVID-19 PHE in early 2023 based in part on CDC recommendations (update at https://www.cdc.gov/covid/prevention/index.html). As a result, the updated policy reflects these changes *but still includes items that may be re-implemented* should another COVID-19 PHE were to be enacted. As of the writing of this policy, most of the items within the policy are not in use.

PURPOSE:

- California's State of Emergency has been terminated. The majority of the items found within this document have been kept to have a record on how to proceed should another COVID-19 Public Health Emergency be declared within California or the United States.
- To describe processes that would ensure the safety of patients, visitors, volunteers, and healthcare personnel in the event of another COVID-19 pandemic.
- To review the CDC's mitigations strategies then to select the best options within a continuum of options to address shortages, including staffing shortages
- Due to concerns of increased transmissibility of the SARS-CoV-2 variants, to update protection for healthcare personnel (HCP), patients and visitors that align with current CDC recommended guidelines (According to the current CDC website, "…updates will be refined as additional information becomes available to inform recommended actions.")

POLICY:

A. This plan is an essential extension of the hospital's existing Emergency Management Plan and it is a living document that will be updated based on changes from Centers for Disease Control and Prevention (CDC, https://www.cdc.gov/covid/prevention/index.html), the California Department of Public Health (CDPH) and/or directives from Tulare County Public Health.

B. Enhanced surveillance and reporting will be conducted *when directed* by the Tulare County Health and Human Services Agency (TCHHSA).

C. Patients that fall within the following categories are considered high risk for severe illness from COVID-19:

1. People 65 years and older.
2. People who live in a congregate arrangement, such as a nursing home, group home and/or long-term care facility.
3. People with underlying medical conditions such as:

- Chronic lung disease or moderate to severe asthma
- Serious heart conditions
- Immunocompromised (people receiving cancer treatment, smoking, or taking immune weakening medications)
- Severe obesity (body mass index of 40 or higher)
- Diabetes
- Chronic kidney disease undergoing dialysis
- Liver disease
- Hypertension

D. Should another COVID-19 PHE be declared, the following patients, regardless of vaccination status, should be evaluated for possible COVID-19 infection:

1. Fever and signs or symptoms of lower respiratory illness (e.g., cough, difficulty breathing), repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell, persistent pain or pressure in chest, new confusion or inability to arouse, bluish lips or face.

2. Close contact with any person, including health care workers, who had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset.

E. In the event of another COVID-19 PHE, and both clinical and epidemiologic criteria for suspected COVID-19 have been met, SVMC will immediately proceed with the following actions:

- Implement transmission based precautions.
- Obtain clinical specimens for COVID-19 testing.
- Results, if required, will be reported to TCHHSA by the lab via CalRedie, the Command Center, and/or the Infection Prevention Department.
- Triage patients to the appropriate level of care.
- Provide necessary clinical evaluation and management services, including monitoring the patient appropriately for complications.
- Assist the TCHSSA with the identification of potentially exposed contacts including healthcare workers, as requested.

F. Prepare to activate the COVID-19 Hospital Pandemic Plan as necessary.

G. Identify and isolate all potential patients with COVID-19.

H. In the event of another COVID-19 pandemic, the Sierra View Medical Center (SVMC) administrator will discuss with the local health department how and when an "Altered Standards of Care in Mass Casualty Events" (influx of cases or deaths) will be invoked.

I. Hospital Emergency Incident Command System (HEICS) may be activated when the volume of patients with flu-like symptoms (COVID-19) increases, there is an increase in the inpatient census along with staff shortages.

J. If necessary, cohort COVID-19 patients.

K. Infection prevention education will be provided to staff via new hire orientation, annual competency exams, training sessions, staff meetings, on the spot training during daily rounds, use of posters, messages uploaded to the intranet, and/or email correspondence.

L. Re-establish the enhanced assessment of supplies and equipment inventory in an effort to avoid shortage of materials.

AFFECTED PERSONNEL/AREAS: *ALL HEALTH CARE WORKERS, HOSPITAL STAFF, PATIENTS, VISITORS AND ANY OTHERS ENTERING SVMC*

PREPARATION & IDENTIFICATION

Triggers that identify a potential COVID-19 influx:

- A local, state or national health department alert of a potential increase in admissions of infectious patients requiring isolation.
- A rapidly increasing COVID-19 incidence within hours or days in a normally healthy population.
- Emergency Department (ED) report of an increase in patients with potential COVID-19 symptoms/conditions.
- Infection Control, Nursing Supervisors, Emergency Department, or Urgent Care personnel note an unusual increase in the number of people seeking care, especially with fever, shortness of breath, chills, muscle pain, sore throat, new loss of taste and smell complaints.

COMMUNICATION

If the potential for a new COVID-19 influx is identified, then:

- The Vice President of Patient Care Services, the Chief of Staff, the Safety Officer, Infection Prevention Manager/Nurse, the Hospital Supervisor and other appropriate individuals will review the available information and determine whether additional action is needed.
- Current resource availability will be assessed using the Surge Capacity Management Plan.
- The Vice President of Patient Care Services, Chief of Staff, or other designee, will determine if the facility's HEICS Plan needs to be activated, and if so, will notify the Safety Officer and other appropriate individuals.

Ongoing communication considerations will include the needs for:

- Frequent updates for managers, physicians, and other hospital personnel.
- Infection Prevention Nurse visits to units to assess situations and offer assistance regarding infection prevention and control issues.
- Initial notification and continued communication with local Public Health Services.
- Requests for assistance from the local or state health departments and/or other support agencies.

EVALUATION

The Vice President of Patient Care Services, Chief of Staff, Safety Officer, Infection Prevention Nurse, Chair of Infection Prevention/Control Committee and other appropriate individuals will evaluate the situation on an ongoing basis to determine:

- If other patient admissions need to be suspended.
- If elective procedures, including surgery, need to be cancelled.
- If the facility's visiting policy needs to be temporarily revised or suspended depending on the CDC COVID-19 Community Transmission rates within California
- Appropriate patient placement, including alternative sites for patient holding, triage, treatment and morgue facilities, as needed.
- When the COVID-19 influx Contingency Plan is no longer needed.

VISITATION

SVMC will follow current visitation guidance provided through Public Health Orders or CDPH AFLs. Due to the variability in COVID-19 surges and the multiple variants, visitation policies are subject to change in order to protect staff and patients and ***may, at times***, be more stringent than current guidance based on CDC COVID-19 community transmission rates.

PATIENT MANAGEMENT

A. Initial Management of Persons with COVID-19 Conditions

To aid in the detection of persons entering the facility who may have COVID-19, the following interventions will be implemented:

1. Visual alerts, in appropriate languages, will be posted at all appropriate entrances to the facility instructing all persons with signs/symptom of infectious disease, especially respiratory, to:

a. Inform reception and healthcare personnel when they first register for care that they may be infectious.
b. Practice respiratory hygiene/cough etiquette
c. Wear a mask (or face shield if diagnosed with a severe respiratory disease.)

2. Patients calling SVMC for advice will be instructed to avoid making unnecessary visits to the hospital.

3. As the number of infectious patients increases, measures will be implemented to reduce the spread of infection within the facility:

a. A triage officer will be assigned responsibility for managing patient flow, including deferral of patients who do not need emergency care.
b. A separate waiting area will be designated for patients with respiratory symptoms to sit at least 6 feet away from other patients and visitors.

4. Signs that promote respiratory hygiene/cough etiquette will be placed in waiting areas, cafeterias, etc., where they serve as reminders to all persons in the facility. The signs will instruct persons to:

a. Cover the nose/mouth when coughing or sneezing.
b. Use tissues to contain respiratory secretions.
c. Dispose of tissues in the nearest waste receptacle after single use.
d. Patients will be given masks upon entry to the facility with instructions to wear them until they have been evaluated and admitted or discharged, if the symptoms/syndrome suggests that airborne and/or droplet transmission is a possibility.
e. Perform hand hygiene after contact with respiratory secretions.
f. Practice physical distancing:

- Avoid "congregate settings" as much as possible
- Avoid mass gatherings
- Maintain distance of 6 feet form others when possible

5. SVMC will facilitate adherence to respiratory hygiene/cough etiquette by ensuring the availability, if in supply, of appropriate materials mentioned above in waiting areas for patient and visitors.

6. Visitors will be screened for signs/symptoms of infectious disease before entry into the facility:

a. Symptomatic visitors will be excluded from the facility.
b. Family members who accompany patients with infectious illness to the hospital will be assumed to have been exposed to the infectious condition and will be asked to don masks

c. Visitors will be limited to 1 person for the patient's emotional well-being and care.
d. Visitors will be required to wear appropriate Personal Protective Equipment (PPE) while visiting an infected patient.
e. Visitors will be instructed on hand hygiene practices.

B. Isolation Precautions and PPE

In the early stages of a new influx of patients, it may not be clear that patients have been exposed to COVID-19. Therefore, precautions consistent with all possible etiologies must be implemented for suspect or confirmed cases. Standard precautions, combined with contact, and airborne precautions will be implemented until a diagnosis is established. Staff will be instructed to don PPE before patient contact to avoid the need to make PPE adjustments and the risk of self-contamination during use. Careful removal of PPE will also be stressed. An Assessment Tool will be used during training for each staff member to insure PPE donning and doffing competency.

1. GLOVES

a. Disposable gloves are to be worn when contact with visible blood and body fluids is anticipated. Gloves should also be worn when touching environmental surfaces and patient care articles visibly soiled with blood or body fluids.

b. Gloves should be donned immediately prior to performing patient care and removed immediately, without touching uncontaminated surfaces, when the task is complete.

c. When performing multiple procedures on the same patient, gloves should be changed after contact with blood and body fluids that contain high concentrations of microorganisms (e.g., feces, wound drainage or oropharyngeal secretions) and before contact with a clean body site such as non-intact skin and vascular access sites.

d. Remove and dispose of gloves after use on a patient..

e. Staff will be reminded to avoid touching their eyes, nose or mouth with contaminated hands, gloved or ungloved.

2. FACIAL PROTECTION

FACE MASK:

a. Universal Source of Control Measures: Use medical/surgical facemask (FDA cleared medical/surgical masks) to cover person's mouth and nose to prevent spread of respiratory secretions when breathing, talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommend for everyone in the healthcare facility:

- Patients and visitors will be given an approved mask upon arrival to use throughout their stay in the facility. If they do not have a face covering, they will be offered a facemask

  - Patients may remove their facemask when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or when leaving their room.
  - Facemasks should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
  - Visitors who are not able to wear or tolerate a mask should be encouraged to use alternatives to on-site visits with patients (e.g., telephone or internet communication), particularly if the patient is at increased risk for severe illness from SARS-CoV-2 infection.

b. All staff and HCP should wear a medical/surgical facemask at all times while they are in the healthcare facility including and especially patient care areas.

c. Staff will be required to wear an N-95 respirator when entering a PUI or COVID-19 confirmed patient's room.

  - N-95 respirators will be worn once and then discarded
  - N-95 respirators will be removed or discarded if soiled, damaged, or hard to breathe through.

Contingency Capacity Strategies:

- Consider removing all facemasks from public area.
- Facemask can be provide to asymptomatic and symptomatic patients upon check in at screening points.
- Consider placing mask in a secure and monitored site.
- Implement extended use of face mask (Wearing the same facemask for repeated close contact encounters with several different patients, diagnosed with COVID-19 without removing the facemask between patient encounters).
- Facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- On the spot teaching and training healthcare providers regarding not touching or adjusting their facemask when providing patient care.
- Have patients with symptoms of respiratory infection use tissues or other barriers to cover their mouth and nose.

Crisis Capacity Strategies:

- Cancel all elective and non-urgent procedures and appointments for which a facemask is used by healthcare provider.
- Use facemask beyond the manufacturer-designated shelf life during patient care activities.

- The user should visually inspect the facemask prior to use and discard if the mask is visibly soiled, damaged, or hard to breathe.
- Implement limited re-use of facemask (using the same facemask by one healthcare provider for multiple encounters with different COVID-19 patients but removing when COVID-19 patient encounters are completed.
- Review proper donning and doffing of masks, ensuring that healthcare providers do not touch outer surfaces of the mask during care, and removal and replacement of mask.
- Healthcare providers will leave patient care area if they need to remove the facemask.
- Facemask will be carefully stored between uses in a clean paper bag or breathable container.
- Hand hygiene will be performed upon touching or discarding a used mask.

Prioritize facemasks for selected activities such as:

- For provision of essential surgeries and procedures.
- During care activities where aerosol-generation, splashes and sprays are anticipated.
- During activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable.
- For performing aerosol-generating procedures, if respirators are no longer available.

When No Facemasks Are Available, Options Include:

- Exclude healthcare providers who may be at higher risk for severe illness (e.g., older in age, those with chronic medical conditions, or those who may be pregnant) from caring for patients with confirmed or suspected COVID-19 patients.
- Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face.
- Consider use of expedient patient isolation rooms for risk reduction.
- Consider the use of HEPA filtration to reduce the risk to individuals entering the room without respiratory protection.

3. FACE SHIELD/GOGGLES (EYE PROTECTION)

Eye protection provides a barrier to infectious materials entering the eye and is often used in conjunction with other personal protective equipment (PPE) such as gloves, gowns, masks or respirators.

a. All staff and HCP should wear eye protection (goggles or face shields)
- Screening areas
  - When no glass/Plexiglas barrier is in place
  - When physical distance is not feasible
- When providing care to patients in COVID-19 areas
  - Any staff (including auxiliary staff e.g. Environmental Services (EVS), Respiratory Therapist (RT), Lab Technician) entering patients' room.

b. Conventional capacity strategies:

- Use eye protection according to product labeling and local, state, and federal requirements.

c. Contingency capacity strategies:

- Selectively cancel elective and non-urgent procedures and appointments for which eye protection is typically used by healthcare providers.
- Shift eye protection supplies from disposable to re-usable devices (i.e., goggles and reusable face shields). Staff will clean and disinfect goggles and face shields between uses.
- Consider the use of powered air purifying respirators (PAPRs).
- Implement extended use or eye protection (wearing the same eye protection for repeated close contact encounters with several different patients without removing eye protection between patient encounters).
- Extended use of eye goggles/face shields can be applied to disposable and reusable devices.
- Eye protection should be removed, cleaned, and disinfected if it becomes visibly soiled or difficult to see through.
- If a disposable face shield is reprocessed, it should be dedicated to one HCP and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on.
- Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- Healthcare providers should take care not to touch their eye protection. If they touch or adjust their eye protection they must immediately perform hand hygiene.
- Healthcare providers should leave patient care area if they need to remove their eye protection. See protocol for removing and reprocessing eye protection below.

d. Crisis capacity:

- Cancel all elective and non-urgent procedures and appointments for which eye protection is typically used by healthcare providers.
- Use eye protection devices beyond the manufacturer-designated shelf life during patient care activities.
- Visually inspect the goggles/face shield, if there are concerns (such as degraded materials), discard googles/face shield.
- Consider using safety glasses (e.g., trauma glasses) that have extensions to cover the side of eyes.
- Exclude healthcare providers at higher risk for severe illness (older age, those with chronic medical conditions, or those who may be pregnant) from COVID-19 from contact with known or suspected COVID-19 patients.

4. GOWNS

a. Conventional Capacity Strategies:

- Use isolation gown alternative that offers equivalent or higher protection.
- In time of gown shortages, surgical gowns should be prioritized for surgical and other sterile procedures.

b. Contingency capacity strategies:

- Selectively cancel elective and non-urgent procedures and appointments for which a gown is typically used by healthcare providers.
- Consider reusable (e.g., washable) gowns.
- Ensure that healthcare providers do not touch outer surfaces of the gown during care.
- Train healthcare providers in donning and doffing of reusable gowns.
- Inspect and replace reusable gowns when needed (e.g., when they are thin or ripped).
- Consider the use of coveralls.
  - Train and practice in their use, prior to using during patient care

c. Crisis Capacity Strategies:

- Consider extended use of isolation gowns (gowns worn by same healthcare worker when interacting with more than one patient known to be infected with COVID-19).
- Re-use of cloth isolation gowns among healthcare worker for multiple patients.
- Any gown that becomes visibly soiled during patient care should be disposed of or cleaned.
- Surgical gowns should be prioritized for surgical and other sterile procedures.
- Consider suspending use of gowns for endemic multidrug resistant organisms (e.g., MRSA, VREM ESBLE-producing organisms)

d. Prioritize Gowns:

- During care activities where splashes and sprays are anticipated, which typically includes aerosol-generating procedures.
- During the following high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers, such as:

  ➢ Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care.

e. When No Gowns Are Available:

- Consider using gown alternatives that have not been evaluated as effective.
- Disposable laboratory coats.

- Reusable (washable) patient gowns.
- Routinely inspect and replace reusable gowns when needed (e.g., when they are thin or ripped).

Discontinuation of Transmission-Based Precautions and isolation for patients with confirmed COVID-19 infection will be made using a symptom-based strategy as described below. The time period used depends on the patient's severity of illness and their immune status (patient is immunocompromised).

Note: Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge from a healthcare facility.

A. Patients with mild to moderate illness who are not severely immunocompromised:
   - At least 24 hours have passed since last fever without the use of fever-reducing medications and
   - Symptoms (e.g., cough, shortness of breath) have improved
   - Or at least 10 days have passed since symptoms first appeared

Note: For patients who are ***not*** **severely immunocompromised** and who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test

B. Patients with severe to critical illness or who are severely immunocompromised:
   - At least 10 days and up to 20 days have passed since symptoms first appeared and
   - At least 24 hours have passed since last fever without the use of fever-reducing medications and
   - Symptoms (e.g., cough, shortness of breath) have improved
   - Consider consultation with infection control experts

Note: For **severely immunocompromised** patients who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

Discontinuation of Empiric Transmission-Based Precautions for Patients Suspected of Having COVID-19 Infection

The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current COVID-19 infection for a patient with suspected COVID-19 infection can be made based upon having negative results from at least one respiratory specimen tested.

A. If a higher level of clinical suspicion for COVID-19 infection exists, consider *maintaining* Transmission-Based Precautions and *performing a second test for SARS-CoV-2 RNA.*

Disposition of Patients with COVID-19 Infection

Patients can be discharged from the healthcare facility whenever clinically indicated:

A. If discharged to home:

- The decision to send the patient home include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations.

B. If discharged to a nursing home or other long-term care facility (e.g., assisted living facility), **AND**

- If Transmission-Based Precautions *are still required*, the patient will go to a facility with an ability to adhere to infection prevention and control recommendations for the care of residents with COVID-19 infection.
- If Transmission-Based Precautions *have been discontinued*, the patient does not require further restrictions based upon their history of COVID-19 infection.

DEFINITIONS AND OTHER IMPORTANT INFORMATION

COVID-19: (2019 Novel Coronavirus (2019-nCov) and Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)

- An infectious disease caused by a recently discovered coronavirus, which infects the respiratory tract. COVID-19 spreads from person to person through droplets of saliva or discharge form the nose when an infected person coughs or sneezes. Most people infected with COVID-19 will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people and those with underlying medical conditions like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are at higher risk for developing serious complications. People with COVID-19 may have a wide range of symptoms reported, ranging from no symptoms, to mild symptoms or severe illness. Symptoms may appear 2-14 days after exposure to the virus.

Common symptoms:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea
- The list of symptoms may change according to the SARS-CoV-2 variant

Emergency warning signs:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion
- Inability to wake or stay awake
- Bluish lips or face

Prevention:

- *Wash hands regularly* with soap and water, or clean them with alcohol-based hand rub.
- Maintain social distancing (at least 6 feet distance) from others especially in enclosed spaces.
- Avoid touching face (eyes, nose, and mouth).
- Cover your mouth and nose when coughing or sneezing.
- Stay home if you feel sick.
- Refrain from smoking and other activities that weaken the lungs.
- Practice physical distancing by avoiding unnecessary travel and staying away from large groups of people.

ALTERED STANDARDS OF CARE IN MASS CAUALTY EVENTS:

- Volume of COVID-19 symptoms
- Increase in inpatient census
- Staff shortage

PROCEDURE:

A. A multidisciplinary planning committee with responsibility for pandemic COVID-19 preparedness and response will include the following SVMC HCW and Staff:

- Emergency Department
- Marketing
- Chair of Environment of Care (EOC)
- Safety Officer
- Materials Management
- Clinical Leaders
- Human Resources (HR)/Employee Health
- Engineering
- Education
- Respiratory
- Laboratory
- Administration
- Environmental Services
- Information Technology

- Ambulatory Clinics
- Radiology
- Infection Prevention
- Security
- Infectious Disease Physician
- Community Physician Task Force

B. If a COVID-19 Pandemic is noted in local area any or all of the following may be implemented:

- Command Center will establish contact with Tulare County Health and Human Services Agency (TCHHSA).
- Conduct hospital surveillance of COVID-19.
- Monitor healthcare personnel who might be infected with COVID-19. Department director/manager will monitor all employee sick calls in accordance with current updated Centers for Disease Control & Prevention (CDC) guidelines & the local Health Officer.
- Reinforce infection prevention procedures in accordance with CDC guidelines & local Health Officer.
- Accelerate staff education.
- Implement activities to increase capacity in accordance with CDC guidelines & local Health Officer:
  - Plan for isolation zones to prevent further spread of the disease.
  - Consider how to handle, treat, and isolate patients with no COVID-19 illness.
- Emergency Department will triage in the designated area and place patients in the isolation area for persons with symptoms of COVID-19.
- Limit the number of visitors to those essential for patient support in accordance with CDC guidelines and the local Health Officer.
- Defer elective admissions and procedures until the local epidemic declines in accordance to guidelines of the CDC and the local Health Officer.
- Cohort patients admitted with COVID-19.
- Consider furlough or reassignment of high risk staff.
- Consider reassigning non-essential staff to support critical hospital services or placing them on administrative leave.
- Consider assigning staff recovering from COVID-19 to care for COVID-19 patients.
- Screen staff prior to the start of each shift.
- Provide staff access to appropriate PPE.
- If widespread transmission is seen within the community and hospital:
  - Redirect personnel resources to support patient care.
  - Recruit community volunteers.
  - Consider placing on administrative leave all non-essential personnel who cannot be reassigned to support critical hospital services.
  - Consider cross-training programs.
  - Explore options for alternative healthcare workers (e.g., retirees, trainees, family members, or others) as supplemental staff.
  - Prepare for just-in-time training of non-clinical staff, if possible.

- Consider the need to replace high-risk personnel (e.g., immunocompromised workers) during an outbreak.

C. Infection Prevention General Guidelines

- Refer to SVMC's Policy Library for specific policies and details on infection prevention measures.
- Use of standard, droplet and airborne precautions and hand hygiene policies is indicated.
- Implement Dietary Plan.
- Soiled linen/laundry, environmental cleaning, and solid waste disposal are performed as defined by policy/procedure.
- Respiratory hygiene/cough etiquette:
  - Signage will be posted at entrances, waiting rooms and other areas that patients visit.
  - Guidelines include:
    - Cover your cough.
    - Wear a mask and or face covering.
    - Perform thorough hand hygiene using soap and water if available. If not, use alcohol-based hand sanitizer. Keep patients with coughs at least 6 feet from other individuals in waiting rooms.

- Contact/Droplet/Airborne Precautions: Place patients with COVID-19 in a private room or cohort with other COVID-19 patients. Keep the door closed.
- COVID-19 shall be laboratory confirmed if the patient exhibits respiratory symptoms and the rapid antigen test is negative
- Wear an N-95 mask, gown, goggles/face shield, and gloves for entry into patient rooms that are suspected or confirmed COVID-19 positive.
- Patient transport: See Standard Operating Procedure on ***Transport or Transfer a Patient Under Investigation or Confirmed with COVID-19.***
  - Limit patient movement outside of room to medically necessary purpose.
- When aerosol-generating procedures are necessary:
  - Place patient in negative pressure room, when possible.
    - If negative pressure room is not available, use a private room with the door closed and a portable HEPA filter (when available)
  - Healthcare workers need to wear gloves, gown, face/eye protection, and an N-95 mask/PAPR.

D. Laboratory Procedures:

<u>Outpatient:</u>

- Collect and handle all clinical specimens from suspect COVID-19 patients while wearing a gown, gloves, N-95 mask, face and eye protection.
- Collect nasal swab and place swab into vial of transport media.
- Label each specimen with the following information:

- Patient identifier information.
- Date/time specimen collected.

Inpatient:

- Label each specimen with the following information:
  - Patient identifier information.
  - Date/time specimen collected.
  - Staff initials.

E. Post Emergency Event Actions:

- Reinstate normal facility, personnel and patient operations according to local, state and federal guidelines.
- Dissolve the Command Center.
- Resume usual use of space and clinical areas.
- Resume normal practice for supplies, medications and equipment.
- Resume usual staffing patterns.
- Conduct post-evaluation and review of performance and operations.
- Debriefing.

REFERENCES:

- Wilder-Smith A, Osman S. Public health emergencies of international concern: a historic overview. J Travel Med. 2020 Dec 23;27(8):taaa227. Accessed 2025 Jan 27. doi: 10.1093/jtm/taaa227. PMID: 33284964; PMCID: PMC7798963. From https://pmc.ncbi.nlm.nih.gov/articles/PMC7798963/pdf/taaa227.pdf

- CALHHS information on the end of California's COVID-19 state of emergency and the Federal Public Health Emergency for covid-19. (2023, March 02). Accessed 2025 Jan 27, from https://www.chhs.ca.gov/end-of-covid-emergency/

CROSS REFERENCES:

- INFLUX OF INFECTIOUS PATIENTS CONTINGENCY PLAN
- INFLUENZA A+B (BD VERITOR SYSTEM) WAVED POINT OF CARE TESTING
- EMERGENCY OPERATIONS PLAN

SUBJECT:	SECTION:
PATIENT ASSESSMENT AND REASSESSMENT-ACUTE RENAL SERVICES	***Provision of Care, Treatment & Services (PC)***
	Page 1 of 3

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

PURPOSE:

To provide safe and effective dialysis by assessing the patient and monitoring equipment.

POLICY:

- Patient assessment and reassessment is a series of repeated or continuous observations of the patient's appearance and physiologic state before, during and after the dialysis procedure. These observations are recorded and made part of the patient's record. The objective is to provide a comfortable and safe procedure for the patient and to identify and respond to any complication that may result from the patient's disorder or from some untoward event as a part of the procedure.

- Patients will be assessed PRE and POST treatment.
  -PRE treatment assessment will be completed prior to treatment initiation.
  -POST treatment assessment will be completed after safe blood return and disconnect from dialysis access.
  -All data must be documented.

- The patient's general condition, changes and responses to treatment will be assessed and monitored while on dialysis on a continual basis with vital signs and machine parameters being monitored and documented at least every thirty (30) minutes if stable, and every fifteen (15) minutes if unstable (BP drop > 20 mm Hg from previous reading).

AFFECTED AREAS/ PERSONNEL: *DIALYSIS PERSONNEL*

PROCEDURE:

1. Patient:

   a. Observe patient for changes in sensorium and unusual physical responses. Patient may not verbalize or be aware of signs representing complications.

      - Hemodynamic Complications
      - Hypotension
      - Angina
      - Arrhythmias
      - Congestive Failure
      - Pulmonary Complications

- Hypoxia
- Shortness of Breath
- Muscle Cramping
- Generalized Weakness/Lethargy
- Hypoglycemia/Hyperglycemia
- Headache
- Nausea/Vomiting
- Dialysis Disequilibrium

b. Evaluate patient complaints and refer to primary nurse or physician if necessary. Patient may need medication, specific treatment or reassurance.

c. Check temperature, pulse, blood pressure and respirations every thirty (30) minutes or more often as needed. Changes in vital signs can occur rapidly and can indicate possible complications.

d. Observe lines every thirty (30) minutes to verify that they are well secured. Safety devices should be used during treatment to prevent line disconnection. Tape may become loose during treatment.

EQUIPMENT:

- Monitor lines and chambers for leaks and/or air to prevent blood loss and air-foam emboli.
- Monitor dialysate temperature and conductivity to prevent hemolysis and to maintain dialysate prescribed by physician.
- Monitor blood flow rate to provide an effective hemodialysis.
- Monitor arterial pressure and venous resistance pressure to prevent air from entering system. Prevent pressure build up in system.
- Monitor Transmembrane Pressure (TMP) to provide appropriate fluid loss.
- Monitor dialysate flow to provide an effective hemodialysis.

- Monitor heparin infusion to maintain correct anticoagulation, if used.
- Monitor air-foam detector to prevent air-foam emboli.

REFERENCES:

- Counts, C. (2020). Core Curriculum for Nephrology Nursing, 7th edition. Pitman, New Jersey. American Nephrology Nurses Association.

SUBJECT: **PRECAUTIONS FOR ANTIBIOTIC-RESISTANT MICROORGANISMS**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 1 of 6**

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

PURPOSE:

To provide isolation guidelines for the management of patients with active or a history of recent infection with Multi Drug-Resistant Organisms (MDROs). Some examples of MDROs include Methicillin-resistant *Staphylococcus aureus* (MRSA), Vancomycin-resistant *Enterococcus* (VRE), Carbapenem-resistant *Enterobacteriaceae* (CRE), *Streptococcus pneumoniae* and other MDROs (see Table 1 for other common examples, from North Carolina Department of Health and Human Services, NC SHARPPS Program).

The CDC recommends the implementation of a "multifaceted, evidence-based approach with four parallel strategies: infection prevention; accurate and prompt diagnosis and treatment; prudent use of antimicrobials; and prevention of transmission." Thus, prevention of hospital-acquired infections (HAIs), especially from MDROs is achievable through consistent implementation of the appropriate isolation precautions which are presented within this SMVC policy.

POLICY:

Patients with an active MDRO infection shall be placed in isolation under the appropriate precautions as soon as possible. Patients with a history of an MDRO shall be placed in isolation under the appropriate precautions until determined to be free of the MDRO utilizing the guidelines provided. A patient who has a "colonized/non-infectious" MDRO such as MRSA in the nares does not need to be in Contact Precautions because the patient is not considered infectious.

AFFECTED AREAS/PERSONNEL:

A. It is the responsibility of the physician and the nursing staff to place any patient positive for an MDRO culture in isolation under Contact Precautions until it is determined that the patient is no longer infectious.

B. It is the responsibility of the Infection Prevention Department staff to monitor any patient positive for an MDRO infection through surveillance and to serve as a resource for the nursing and medical staff when determining patient room placement. The Infection Prevention Department will provide education regarding MDRO upon request or as needed when determined through surveillance. Electronic Medical Record (EMR) documentation of MDRO education by Registered Nurse or Physician is mandatory and must be placed in the appropriate area within the EMR.

PROCEDURE:

A. Patients with a positive MDRO culture (other than "nasal" MRSA, etc.) shall be placed in isolation under Contact Precautions.

B. Implement Contact Precautions as stated in Infection Prevention policy, including:

   a. A private room

The use of gown and gloves whenever the staff enter the patient's room

c. Strict adherence to hand hygiene – especially the use of hand washing with soap and water when working with a *C. difficile* patient

d. The use of any additional personal protective equipment (PPE) described under each specific type of precaution, such as contact precautions, airborne precautions, droplet precautions, etc.

e. The use of dedicated non-critical equipment or devices such as stethoscopes, etc. is recommended.

Type of MDRO	Laboratory Evidence	Isolation Precaution *in addition* to Standard Precautions	Removal of Isolation Precaution
Carbapenem-resistant Enterobactericeae (CRE)	Positive laboratory test of the bacterial family Enterobacteriaceae with susceptibility results that indicate resistance to Ertapenem, Doripenem, Imipenem and/or Meropenem (e.g. Escherichia coli, Klebsiella pneumoniae Enerobacter species)	**Contact**	Discontinuation will be determined by Infection Prevention on a case by case basis
Clostridium Difficile (C. diff)	Positive laboratory result for Clostridium difficile	**Contact**	After 48 hours with no diarrhea
Extended Spectrum Beta-Lactamase Producers (ESBL)	Positive laboratory test with susceptibility results that indicated ESBL producers	**Contact**	Discontinuation will be determined by Infection Prevention on a case by case basis
Methicillin-resistant Staphylococcus aureus (MRSA)	Positive results for laboratory test, *excluding nasal swab*, for MRSA with susceptibility results that indicate resistance to oxacillin	**Contact**	Discontinuation will be determined by Infection Prevention on a case by case basis
Vancomycin-resistant Enterococci (VRE)	Positive result for laboratory test for Enterococcus faecalis, Enterococcus faecium or Enterococcus species unspecified with susceptibility results that indicate resistance to vancomycin	**Contact**	Discontinuation will be determined by Infection Prevention on a case by case basis

C. Recommendation Readmission Diagnosis

a. If a readmission diagnosis is related to the MDRO infection, follow contact precautions until treatment has been completed

b. If a subsequent readmission diagnosis is unrelated to the MDRO infection, isolation is unnecessary if all of the following conditions are met:

i. A culture from the previously infected MDRO site is negative

ii. The patient has no symptoms related to the previous admission

D. Cohort

a. If the resistance pattern of the MDRO for two patients is the same and neither patient has any other potentially transmissible infection, then the patients may cohort

b. If a private room is not available and cohorting with a patient with the same resistance pattern is not possible, then it is important to consider the site of infection and mode of transmission of the infecting pathogen and select roommates carefully. Consultation with Infection Prevention is advised before patient placement. Items for consideration during the decision process should include:

i. The source patient's hygienic habits,

ii. Contamination of the environment or

iii. Cognitive impairment.

iv. The roommate's condition, including non-intact skin, renal failure, immunocompromised condition or cognitive impairment.

E. Patient Transport

a. Limit the movement and transport of the patient from the isolation room to essential purposes only.

b. If transport or movement is necessary, ensure that the appropriate precautions are maintained to minimize the risk of transmission of microorganisms to other patients, the environment or equipment. Insure that this information is included in the hand-off report given to staff *prior* to transporting the patient.

c. The patient should be transported directly to the procedure room and immediately returned to the patient's room. The patient should not be in a holding room/area prior to or after the procedure.

d. Exceptions include but are not limited to:

i. Patients that need to be kept in the Post Anesthesia Care Unit (PACU) for recovery

ii. A lack of available beds

iii. A backlog in the procedure schedule

e. For planning assistance, call the Infection Prevention Department at ext. 3781 or ext. 4722

F. Duration of Contact Isolation Precautions

a. The patient is considered infectious and should be placed in isolation under the appropriate precautions for the duration of the MDRO-associated illness.

b. If the original MDRO culture site is no longer accessible (such as a closed wound, peritoneal or pleural fluid, catheter site, etc.) and the patient is asymptomatic for that site, then isolation is no longer necessary

G. Discharge from Hospital

a. If the patient is being transferred to an extended care facility, then the removal of isolation precautions is per the receiving facility's admission criteria.

b. If the patient is discharged to home, then the removal of isolation precautions is at the discretion of the M.D. Patient education must be provided on MDROs and home care by the nurse who is discharging the patient. Education of MDRO/home care must be documented in the EMR.

c. If the patient is still in isolation and decides to leave the hospital against medical advice (AMA) *and* the patient poses a health risk to the community due to a communicable MDRO, a representative of the Infection Prevention Department or the House Supervisor (during afterhours or the weekend) shall notify the Tulare County Public Health Department, Communicable Diseases at (559) 685-5720.

H. Cleaning of the Patient's Room

a. EVS staff must don appropriate protective equipment (gown, gloves, etc.) prior to entering the patient's room

b. The Occupied Room:

i. High-touch environmental surfaces should undergo thorough cleaning at least daily using a hospital-approved detergent disinfectant. Surfaces are left wet for a certain amount of time (contact time) depending on the disinfectant's instruction for use.

ii. Materials, such as the bucket of disinfectant, mop heads and rags, are changed after cleaning the room for the following (but not limited to) MDROs such as MRSA, VRE CRE or *C. difficile.*

c. Terminal Cleaning upon patient discharge. Clean the patient room with the appropriate disinfectant, making sure follow the proper kill time.

i. The materials used during the cleaning/disinfecting process, such as the bucket of disinfectant, mop heads and rags, *etc.,* are changed after cleaning a room that housed a patient with an MDRO Curtains are to be removed, placed in a plastic bag and laundered.. Replace with clean curtains after the room has been terminally cleaned.

c. Prior to exiting cleaned area, remove PPE, discard and perform hand hygiene

REFERENCES:

Centers for Disease Control (CDC) and Prevention (2022). *COVID-19 & Antimicrobial Resistance*. Last reviewed: 16 July 2024. Accessed 12 November 2024 from: https://www.cdc.gov/antimicrobial-resistance/data-research/threats/covid-19.html?CDC_AAref_Val=https://www.cdc.gov/drugresistance/covid19.html

Centers for Disease Control (CDC) and Prevention. *COVID-19: U.S. Impact on Antimicrobial Resistance*. Special Report 2022. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2022. https://www.cdc.gov/antimicrobial-resistance/media/pdfs/covid19-impact-report-508.pdf DOI:https://dx.doi.org/10.15620/cdc:117915

North Carolina Department of Health and Human Services, NC SHARPPS Program. *Multidrug-Resistant Organisms (MDROs) Toolkit for Long-Term Care Facilities 2024.* Accessed 12 November 2024 from: https://epi.dph.ncdhhs.gov/cd/docs/MDROToolkit.pdf

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee 2007. Updated September 2024. *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. Accessed 12 November 2024. Available at: https://www.cdc.gov/infection-control/media/pdfs/Guideline-Isolation-H.pdf

Cross Reference:

Standard Precautions

Contact Precautions DP/SNF

Isolation and Standard Precautions

SUBJECT: **PREVENTATIVE MAINTENANCE FOR FRESENIUS DIALYSIS MACHINES**	SECTION: Page 1 of ~~2~~ 1

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

PURPOSE:

To ensure equipment safety and reliability

POLICY:

1. Preventative maintenance shall be done on all dialysis equipment. The Dialysis Technician shall perform the following:

   a. Preventative Maintenance is performed annually, or after 4000 hours of use, perform semi-annually:

      - Check O-Rings
      - Lube O-Rings
      - Check conductivity against conductivity meter
      - Check temperature for high and low
      - Check light panel for bulb replacement
      - Check blood leak for sensitivity of blood detection
      - Check blood pump for pump speed and occlusion
      - Check arterial and venous pressure gauge for resistance
      - Check dialysate pressure gauge for dialysate flow

2. The **Renal Services Bio-Med Technician** will attempt to correct any problems with the equipment. If unable to correct malfunctions, contact the Fresenius service representative to make the necessary repairs. All necessary repairs and maintenance will be recorded in a maintenance logbook and each machine will have its own maintenance log record. All entries are made by the Dialysis technician or the Fresenius Technician.

AFFECTED AREAS/ PERSONNEL: *DIALYSIS PERSONNEL*

REFERENCE:

- FRESENIUS Medical care. (2023). *Preventative maintenance procedures*. Retrieved on February 18, 2025 from https://freseniusmedicalcare.com/content/dam/fmcna/live/support/documents/technical-documentation/2008t-hemodialysis-systems/508033-Rev-R.pdf

SUBJECT	SECTION:
QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT-DP/SNF	**Page 1 of 4**

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

PURPOSE:

The purpose of the Quality Assurance/ Performance Improvement Program is to facilitate an organized approach to improving quality patient care, maintaining patient safety and services at Sierra View Medical Center, Distinct Part Skilled Nursing Facility.

POLICY:

The Director of Nursing is responsible for maintaining the department's Quality Assurance/Performance Improvement (QA/PI) program. This includes prioritizing quality improvement activities in response to unusual or urgent events with continuous focus on patient safety and patient outcomes. The Quality Assurance/ Performance Improvement program is guided by the needs of the patient and data gathered by the MDS coordinator. QA/PI is to ensure a systematic, comprehensive, data-driven approach to care. QA/PI creates a self-sustaining approach to improving safety and quality while involving all caregivers in practical problem solving.

The program provides a comprehensive and objective assessment of aspects of care with respect to cultural sensitivity and diversity and ensures that the delivery of care is supported by evidence-based medical and healthcare research. QA /PI is a proactive and continuous study of processes with the intent to prevent or decrease problems. This is done by identifying the problem and finding new approaches to fix the underlying causes. The information is collected on an ongoing basis, is recorded, benchmarked against third party organizations empowered by regulatory agencies to gather and report on healthcare performance measures. This information is analyzed and shared with the Medical Director of the unit and employees, to foster continuous improvements.

DPSNF policies and procedures will be developed, reviewed and/or revised yearly by to include, but not limited to one physician, the Director of Nursing Services, Clinical Manager, MDS Coordinator, Pharmacist, the Activity Director, and representatives of each required services as needed. Policies ready for approval will be forwarded through Power DMS to the Vice President of Patient Care Services for review and approval then presented at the Medical Executive Committee and Board of Directors meeting for review and approval. The new versions of revised policies will be published in the electronic policy management software and the old version will automatically be archived.

OBJECTIVES

To implement a planned, systematic and ongoing process of monitoring and evaluating the delivery of care in order to prioritize opportunities for improvement that support patient safety and appropriateness of care.

To support the use of best practices and form a comprehensive approach to ensuring high quality and cost effective health care.

To promote a collegial and multidisciplinary approach to all performance improvement activities, allowing for the exchange of relevant information that results in improved patient care.

MODEL

The facility utilizes PDSA (Plan, Do, Study, Act), as the model for quality. This cycle of improvement model is used for problem solving and for the design and implementation of new services. This model supports and encourages small test of change, cycles for improvement and allows for an organized process to make change that affects patient care. This process supports closing the loop and ensuring for adequate monitoring and evaluation of the actions taken.

P – Plan — The planning stage evaluates and researches the identified problem.

D –Do — This stage is implementing the change that will improve a process.

S – Study — This stage studies the results of the change by viewing data for process variation and evidence of process improvement.

A – Act — This stage is taking action needed to maintain improvements or to determine the next steps for further improvement or to maintain the gain.

REPORTING OF QUALITY DATA

QA/PI data is collected monthly and reported to the department's Quality Improvement Committee at least quarterly, or more often as necessary. Quality improvement tools are used to track and trend progress and also serve to help identify deficiencies that will need correction, address gaps in systems or processes, develop and implement a corrective plan and continuously monitor effectiveness of interventions. An example of this tool is the "Dashboard" which provides a "snap shot" view of the department's performance.

QUALITY IMPROVEMENT COMMITTEE

The Quality Improvement Committee consists of the Director of Nursing, the Medical Director, Infection Control and Prevention Officer, three other staff (one of which must be the administrator, owner, board member or other individual leadership role), the Clinical Manager, Activities Coordinator, MDS (Minimum Data Set) Coordinator, Dietitian, RNPC (Restorative Nursing Program Coordinator), Social Services Designee, Physical Therapist, Compliance RN, Respiratory Therapist, Environmental Services and any necessary discipline that participates in the care of the patients. The purpose of this committee is to prioritize performance improvement activities that maintain patient safety and provide quality patient care, and develop and improve appropriate plans and action to correct identified deficiencies. Performance Improvement activities are determined by the review of quarterly data/reports that reflect quality of patient care. The data collected is analyzed by the committee and when deficiencies are identified, actions are determined to correct the problem. Monitoring of the plan of corrections will continue until the problem has been resolved as evidenced by two quarters of meeting set benchmarks. In addition, spot checking will take place during the year to check for sustained improvements.

QA/PI ASSESSMENT AND ASSURANCE

a) Create systems to provide care and achieve compliance of regulations

b) Track, investigate and prevent recurrence of adverse events

c) Receive and investigate complaints

d) Seek feedback from residents and caregivers

e) Set targets for quality

f) Strive to achieve improvements in specific goals related to pressure ulcers, falls, restraints, or other areas.

g) Commit to balancing a safe environment with resident choices

h) Strive for deficiency-free surveys

i) Assess residents' strengths and needs, to design and implement measurable and interdisciplinary care plans.

j) Perform a Root Cause Analysis to get to the heart of the reason for problems.

k) Undertake systemic changes to eliminate problems at the source.

FIVE ELEMENTS OF QA/PI

1. Design and Scope: Address all systems of care and management practices, to include, clinical care, quality of life and resident choice.

2. Governance and Leadership: Leadership should seek input from facility staff, residents, families and/or representatives. The governing body ensures staff accountability, and an atmosphere where staff are comfortable identifying and reporting quality problems as well as opportunities for improvement.

3. FEEDBACK, DATA SYSTEMS AND MONITORING: Have systems in place that monitor care, services and get data from multiple sources. Use Performance Indicators to monitor care processes and outcomes and review findings against benchmarks and/or targets. Monitor Adverse Events that must be investigated and action plans implemented to prevent recurrences.

4. PERFORMANCE IMPROVEMENT PROJECTS (PIP): This involves a team composed of interdisciplinary team members to gather information systemically to clarify problems and intervene for improvement.

5. SYSTEMIC ANALYSIS AND SYSTEMIC ACTION: Use a systemic approach to determine analysis that is needed to understand the problem, its causes and implications for change. These problems may be caused by the deliverance of the care or services. This will also serve to address the following: a) the need to develop Policies and Procedures and demonstrate proficiency in the

use of Root Cause Analysis, b) the need to focus primarily on systems and processes, and c) develop and review Systemic Actions that will focus on continual learning and continuous improvement.

COMMUNICATION:

a) Make sure all residents and families/caregivers know that their views are sought, valued and considered and discussed in QAPI and Resident Council

b) Identify opportunities for improvement and let the residents and families/caregivers know how it is proactively being addressed.

AFFECTED PERSONNEL/AREAS: *ALL DP/SNF STAFF*

REFERENCES:

- Thomson Reuters (2019) Barclay's California Code of Regulations, 72082, 72319, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.75 (0) United States of America, Med Pass Inc.

U.S. Centers for MEDICARE & Medicaid Services, December 1, 2021, Quality Measurement and Quality Improvement-CMS, retrieved from https://www.cms.gov

SUBJECT: **RAZOR CLEANING- ELECTRIC**	SECTION: **Page 1 of 2**

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

PURPOSE:

To clean and maintain electric razors.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that razors will be cleaned between each use and will be maintained as per procedure.

AFFECTED PERSONNEL/AREAS:

REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA)

PROCEDURE:

AFTER RESIDENT HAS SHAVED:

1. Switch razor off and unplug razor.
2. Using brush, clean head slots to remove any hair.
3. Wipe head slot thoroughly with alcohol swab.
4. Lift razor head off using thumb and index finger.
5. Clean razor head assembly inside and out with brush (over trash can).
6. Wipe thoroughly inside and out with brush (over trash can).
7. Press razor head assembly back on razor housing.
8. Wipe entire razor housing with alcohol swab and allow to dry.

NOTE:

- DO NOT operate electric razor if oxygen is being administered via nasal cannula.
- DO NOT reach for a razor that has fallen into water. Unplug immediately.
- DO NOT use while bathing or in shower.
- NEVER operate razor if it has a damaged cord or plug.

- ALWAYS unplug the razor from the electrical outlet immediately after using, except when razor is charging.

REFERENCES:

- How to Clean an Electric Shaver to Ensure It Has a Long Life. Retrieved September 2019 from https://groomandstyle.com/clean-electric-shaver/.

- Manufacturer's guide for each razor

SUBJECT: **RECIRCULATION OF BLOOD IN EXTRACORPOREAL CIRCUIT- ACUTE RENAL SERVICES**	SECTION: 04-04 *3022 Renal Services* **Page 1 of 2**

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

PURPOSE:

To recirculate through the dialyzer, for no more than 30 minutes with a Blood Flow Rate of 100 ml/minute, the blood in the extracorporeal circuit without damage or contamination. This procedure is used when a fistula/access must be replaced or modified as a result of infiltration, clotting, inadequate blood flow, increased resistance to flow, a dislodged needle or to remove air/foam from blood lines or dialyzer.

POLICY:

Recirculation of blood in Extracorporeal Circuit

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

EQUIPMENT:

- Recirculation Tube
- Tubing with Clamps
- Two (2) 10 ml Syringes with Saline Solution
- Gloves

PROCEDURE:

1. Pause the treatment.
2. Turn off the blood pump.
3. Clamp both the arterial and venous blood lines and both the needle tubing/catheter lines.
4. Disconnect the blood lines from the access and ensure that all ends are sterile. Attach both blood lines together via the recirculation tube. Decrease the negative pressure to -20 mm/Hg. Set the blood pump on 100 ml/minute.
5. Remove the clamps. Start the blood pump at 100 ml/minute. Open the saline line as needed to replace fluid lost due to minimal ultrafiltration. Push heparin, as needed, to prevent clotting.
6. Flush the access that is functioning properly with saline to prevent clotting.
7. Attempt to reposition the malfunctioning needle. If this is not successful, leave this needle in place, if possible, until treatment is finished.

8. Insert a new needle/de-clot cannula.

   Note: Never recirculate more than 30 minutes.

9. To restart dialysis:

   a. Check the entire circuit for air.

   b. Turn off the blood pump.

   c. Clamp the arterial and venous blood lines.

   d. Reconnect the arterial blood line to arterial access.

   e. Reconnect the venous blood line to venous access.

   f. Remove the clamps.

   g. Turn the blood pump on and gradually increase the blood flow rate. Clamp the saline line.

   h. Reset negative pressure, monitors and limits. Check the remaining heparin (may be insufficient amount to finish treatment).

   i. Perform all routine monitoring checks

REFERENCE:

UpToDate. (n.d.). UpToDate. Retrieved on 2/18/25 from

https://www.uptodate.com/contents/arteriovenous-fistula-recirculation-in-hemodialysis

SUBJECT: **RESIDENTS' PERSONAL CLOTHING**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish guidelines for the care of each resident's articles of personal clothing.

POLICY:

It is the policy of the Distinct Part/Skilled Nursing Facility (DP/SNF) that residents are allowed to maintain and utilize their own personal articles of clothing, separate from any provided by the facility.

AFFECTED PERSONNEL/AREAS:

NURSING STAFF; SOCIAL SERVICES; UNIT DIRECTOR

PROCEDURE:

1. All articles of personal clothing are to be noted on the resident's list of possessions which is kept in the residents chart.

2. Each article of clothing is to be labeled with the resident's name and is for the exclusive use by the resident.

3. Arrangements will be made for the laundering of the clothing articles either by the family or by the facility laundry service. If the family chooses to launder the resident's clothing themselves, they will provide a hamper that is plastic, wipe able and has a lid for dirty clothing.

4. No alterations will be made to any personal article of clothing without the express noted permission of the resident or their representative. Any alterations made for the ease of use of the clothing article will be done in a manner that maintains the look and integrity of the piece of clothing.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72613, San Francisco, California, Title 22.

SUBJECT: **RESIDENTS' PERSONAL REFRIGERATOR**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish guidelines for monitoring residents' personal refrigerator temperatures and the storage of food items.

POLICY:

It is the policy of the Distinct Part/Skilled Nursing Facility (DP/SNF) unit to monitor the temperature of the residents' personal refrigerators and storage of food items on a daily basis.

AFFECTED PERSONNEL/AREAS:

NURSING STAFF, SOCIAL SERVICES, UNIT DIRECTOR

PROCEDURE:

1. The DP/SNF personnel will record the residents' personal refrigerator temperature daily. Any temperatures not within the appropriate temperature range will be reported to engineering immediately.
   a. Refrigeration Safe Zone will be below 45 degrees F.
   b. Freezer Safe Zone will be below 0 degrees F.
2. Temperature records will be maintained for one year.
3. All patient items in their personal refrigerator will be properly covered and dated.
4. All partially used items will be discarded after 72 hours. Pickled items will be discarded after 30 days.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §70273, San Francisco, California, Title 22.

SUBJECT: **RESTRAINTS, CHEMICAL**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 6**

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

PURPOSE:

To establish set guidelines for the proper use of chemical restraints in the DP/SNF

POLICY:

When psychoactive medications are ordered, the assessment process will be utilized to ensure:

1. Environmental causes of resident's distress or behavior have been ruled out.

2. Alternative behavioral management programs have been attempted prior to the use of psychoactive medication.

3. Early identification and reporting of drug side effects are documented.

4. Physician is provided with summaries of resident's behavioral manifestation, frequency, response to behavioral programs and medications, as well as recommendations for changes in medication.

5. Psychoactive medications are used in the lowest possible dose, and are discontinued when no longer required to treat a mood or behavior problem, unless the medication is used to maintain a resident with a psychotic diagnosis, or organic mental disorder.

6. Psychoactive medications are given only after the physician has obtained informed consent from the resident/surrogate decision maker.

7. Facility staff have verified that informed consent has been obtained.

8. Residents with dementia on antipsychotic/psychotropic medications will be reviewed by Pharmacy for any issues of adverse medication effects that may cause cognitive impairments and may be mistaken as worsening dementia.

POLICY:

1. Residents will be enabled to achieve the highest level of functioning, and will receive psychoactive medications only when they are necessary to treat medical, mood, behavioral, or psychiatric symptoms. These medications will not be used for the convenience of staff. Informed consent will be obtained by the physician from the resident, unless the resident lacks decisional capacity, in which case, consent will be obtained from the surrogate. In the absence of surrogate, the Interdisciplinary Team will make the recommendation regarding the use of the medication. Consent will also be obtained for any change of dosage.

2. Antipsychotic Medications

a. Anti-psychotic medications will not be initiated for residents who have not used them previously, unless the clinical record documents the medication is necessary to treat a "specific condition".

b. Non-pharmacological interventions will be initiated and documented prior to the use of antipsychotic medications.

c. Psychologist consults as per MD order.

d. In the event that non-pharmacological interventions are ineffective, and a pharmacological intervention has been initiated secondary to consult, licensed nursing staff will document the frequency of incidents of the targeted behavior each shift, in order to demonstrate the necessity for treatment with anti-psychotic medications.

e. Continued aggravation or deterioration in status will be reported to the physician.

f. Anti-psychotics will be given in the lowest effective dose to start, and increased as needed by physician order.

g. Use of a one-time only dose of anti-psychotics more than two times in seven days will be assessed by the Interdisciplinary Team for side effects and continued use.

h. Gradual dose reductions will be attempted twice in a year unless the physician documents that it is clinically contraindicated.

i. The medication's effectiveness will be reevaluated by the physician on a weekly basis during the Interdisciplinary Team Meeting.

3. Anti-anxiety Medications

a. Nursing will document the frequency of incidents of the targeted behavior each shift, in order to demonstrate the necessity for treatment with anxiolytics.

b. Antianxiety medications are to be administered for 14 days only, then reevaluation for continued use every 14 days x3 then may be extended to 30 days thereafter with a reevaluation done every 30 days.

c. Anti-anxiety medications will be administered only when the appropriate indications/diagnoses are present:

- Generalized anxiety disorder
- Organic mental syndrome associated with agitated states
- Panic disorder

- Symptomatic anxiety that occurs in residents with another diagnosed psychiatric disorder (e.g., depression, adjustment disorder).

d. Long acting benzodiazepines will not be used unless the short acting benzodiazepines have failed.

4. Antidepressant Medications

a. Residents with symptoms of depression (e.g., withdrawn behavior, refusal to speak, poor appetite, and/or loss of interest) will be provided appropriate non-pharmacological interventions such as altered lighting, distractions with activities, relaxation techniques, calming music, repositioning, sit and conversing with resident, etc. These non-pharmacological interventions will be attempted prior to the initiation of any drug therapy.

b. Any use of an antidepressant medication outside the Diagnostic and Statistical Manual of Mental Disorders (DSM V) guidelines will be justified by a physician's note explaining why the medication is clinically appropriate, and this should be supported by a psychiatrist/psychologist consultation.

c. Behavioral monitoring charts via EMR will be used for residents receiving antidepressant medications.

5. Sedative/Hypnotic Medications

a. All environmental factors for insomnia will be ruled out before pharmacological interventions will be initiated to assist a resident to sleep.

b. Daily use of drugs for sleep induction will be less than ten consecutive days or as the physician deems necessary, unless an attempt at a gradual dose reduction has been unsuccessful.

c. Barbiturates will not be used except as a single dose for dental or medical procedures, and phenobarbital will be used only for seizure disorder.

d. When resident is admitted with barbiturates, or miscellaneous hypnotic, sedative, or anxiolytic drugs, there will be a gradual dose reduction at least two times in one year before dose reduction is determined to be "clinically contraindicated".

e. Neither barbiturates, nor miscellaneous sedative, hypnotic, anxiolytic drugs will be initiated in the facility as part of an initial therapeutic treatment program.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICES, INTERDISCIPLINARY TEAM*

PROCEDURE:

1. Residents who are admitted with a psychoactive medication will have an assessment of the continued need, dosage, and indications for the medication.

   a. The physician's admitting order for psychoactive medication will state the behavior or mood problem being treated.

   b. The physician is to obtain the informed consent.

   c. The behavior or mood problem will be entered on the care plan with the side effects of the drug and non-drug interventions.

   d. The Interdisciplinary Team will complete the "Psychoactive Medication Assessment" at the first Team Conference Meeting following admission, review the treatment progress in the monthly Team Conference Meeting, and reevaluate in a quarterly assessment the appropriateness of continued treatment with psychoactive medications.

   e. Nursing and Social Service Designee will document in their progress notes the interventions provided, and resident's response to treatment.

   f. Nursing will stop the medication and notify the physician if medication side effects are suspected.

2. When psychoactive medications are initiated on the unit, the resident's medical record will contain completed assessments, documented interventions, and appropriate consents, before the drug is administered.

   a. The physician's order for psychoactive medication will identify the mood or behavior problem being treated and order behavioral monitoring when behaviors are targeted.

   b. The physician will then complete the appropriate consent form for the medication with the resident.

   c. If the resident is not capable of giving informed consent, consent will be obtained from the resident's surrogate.

   d. Nursing will have documentation in regards to the non-drug interventions that have been unsuccessfully implemented.

   e. A care plan will be completed noting the behavior or mood problem being treated, non-drug interventions, and drug side effects.

3. Informed consent, assessment, and response to psychoactive medications will be documented in the medical record.

a. Prior to the administration of any psychoactive medications initiated on the unit, the consent for the specific medication will be documented in the medical record.

b. When a resident, or the resident's surrogate refuses a psychoactive medication that has been ordered, the Refusal of Medication will be documented in the medical record. Documentation will state that the resident was informed, inclusive of details, regarding the risk and benefits of the medications ordered.

c. The Interdisciplinary Team will review the use of psychoactive medications in the Interdisciplinary Team Conference meeting, and will document in the Team Conference notes a re-evaluation of the medication's effectiveness, with recommendations for the continued usage, dose reduction, or discontinuance of the medication.

d. When resident is receiving a psychoactive medication and dosage reduction is "clinically contraindicated," the physician will document the reason as to why the medication is necessary on a Risk vs. Benefits form.

e. When medications are ordered outside the "Unnecessary Drug Guidelines," the physician will document the reason for the medication and the psychiatric condition necessitating the medication. The physician's documentation should be supported by a psychiatric/ psychologist consultation.

f. Nursing will document frequency of incidents of the behavior on each shift, when a resident is receiving any psychotropic medication for a disorder, which is manifested by inappropriate behaviors.

g. Nursing will document responses to dosage reduction attempts.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) *Barclays California Code of Regulations,* 72319 (j) San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- American Psychiatric Nurse Association, (2022) R3 Report: New and Revised Restraint and Seclusion, The Joint Commission. Retrieved From; *https://omsapaprod,wpenginepowered.com/wp-content/uploads/2023/03/APNA-Standards-of-Practice-Seclusion-and-Restraint-2.2022.pdf*

- Medicare State Operations Manual for Long Term Care Facilities, Department of Health and Human Services, September 2000 , Tag F221, F222, Appendix PP.

CROSS REFERENCES:

- DP/SNF Policy and Procedure: CARE OF RESIDENTS WITH DEMENTIA ON THE DP/SNF UNIT .

SUBJECT: **SCOPE OF SERVICE- RENAL SERVICES**	SECTION: **Page 1 of 1**

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

PURPOSE:

The purpose of this policy is to establish guidelines for the scope of renal services.

POLICY:

Renal Services is an acute service that provides dialysis and hemoperfusion treatment on an "as needed" basis to acute areas. All equipment, disposable supplies, staff and services are provided for the following conditions:

- Acute renal failure
- Exogenous intoxication
- End-stage renal failure patient requiring hospitalization
- Other conditions deemed eligible by the nephrologist
- All patients 18 years and older regardless of ability to pay.

This service will be ordered by an attending nephrologist. A physician orders and consent for hemodialysis must be on the chart prior to treatment. The nephrologist is responsible for all hemodialysis treatments performed at Sierra-View Medical Center. . If multiple patients need dialysis, they will be prioritized by the Nephrologist.

Dialysis is performed by and is the responsibility of the Dialysis Services nurse. Primary patient care is the responsibility of the hospital nursing staff. A Dialysis Flowsheet will be maintained by the dialysis nurse for the patient medical record.

After hours there is only one (1) nurse on-call and patients will be dialyzed on a first call basis. In the event that there is more than one emergent need the on-call nurse will make every effort to recruit another qualified nurse.

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

REFERENCES:

- Centers for Medicare and Medicaid Services. (2022). Dialysis. Retrieved on 2/18/25 from. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Dialysis

SUBJECT: **SHARED BATHROOMS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To outline the process for maintain each resident's right to privacy with regards to shared bathroom assignments.

POLICY:

It is the policy of this facility to ensure access to bathroom facilities for all ambulatory residents while respecting their right to privacy.

AFFECTED PERSONNEL/AREAS:

NURSING STAFF; DIRECTOR; CLINICAL MANAGER; SOCIAL SERVICE DESIGNEE

PROCEDURE:

1. Ambulatory residents are to share bathroom facilities with residents of the same sex only.

2. Residents of the opposite sex who have no possibility for personal use of the bathroom facilities may be given room assignments with a designated shared bathroom.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 United States of America, Med Pass Inc.

SUBJECT: **SIDERAILS**	SECTION: **Page 1 of 1**

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

PURPOSE:

The purpose of this policy is to provide a device to assist residents in independent bed mobility, to provide a safety device for preventing residents from falling from bed, or as a restraint to prevent injuries for those residents who have been screened for the use of restraints and for whom the use of side rails has been determined to be the appropriate, least restrictive type of restraint. An Informed Consent from the family/responsible party and a physician's order has also been obtained for their use and must be obtained before they are used.

POLICY:

It is the policy of this facility to assess all residents for the appropriate use of side rails.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA)*

PROCEDURE:

1. Upon admission, all residents will be assessed for functional and cognitive levels.
2. The appropriate use of side rails will be determined by the resident DPSNF Bed/Side rail Assessment in the EMR.
3. Residents for whom side rails are determined appropriate for assistive or safety reasons will have care plan entries identifying the reason for use.
4. Residents for whom side rails are determined appropriate will have an appropriate personalized care plan completed and informed consent signed by the resident, family, significant other or guardian.

REFERENCES:

- Thomson Reuters (2019). Barclay's California Code of Regulations, 72319, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25(n), (2) (3) (4) United States of America, Med Pass Inc.

SUBJECT: **SKIN INTEGRITY TEAM GUIDELINES**	SECTION:

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

PURPOSE:

The purpose of this policy is to provide a systematic interdisciplinary approach to wound care.

The primary purpose(s) of developing a specialized team is to evaluate each pressure area and skin problem and assist the physician to provide the most effective coordination of treatment as well as a baseline of information for the nursing staff and other team management members.

POLICY:

- The wound care team will consist of facility personnel.
- The team will improve overall skin/wound care management and continuity of treatment throughout the facility.
- A comprehensive and ongoing education program will be provided for nursing personnel and all other team members.

AFFECTED PERSONNEL/AREAS:

REGISTERED NURSE (RN); PHYSICIAN; RESPIRATORY THERAPIST (RT); REGISTERED DIETITIAN (RD); CERTIFIED NURSING ASSISTANT (CNA); RN WOUND NURSE

PROCEDURE:

A. SKIN INTEGRITY TEAM RESPONSIBILITIES

1. The Clinical Director/Designee will coordinate skin integrity team activities.
2. The team may include the following: Treatment Nurse, Charge Nurse, Clinical Director, RT, RD or Food Service Supervisor, Nursing Assistant, M.D., and RN Wound Nurse.
3. Pressure and dermal ulcers, skin tears and excoriations will be reviewed every week.
4. The RN Wound Nurse and nursing will assess and document the status of skin problems in the electronic medical record (EMR).
5. Nursing will assess for skin risk status on admission and as needed thereafter. This interdisciplinary assessment will include information on nutritional state, incontinency and mental status, mobility and activity.

B. SKIN INTEGRITY TEAM MEMBERS RESPONSIBILITIES

1. Clinical Director/ Designee
   a. Will see that there is a functioning Skin Integrity Team in the facility.

b. Will monitor new admission skin integrity assessments.

c. Will monitor ongoing skin integrity assessments and effectiveness of prevention and treatment procedures.

d. Will play a key role in staff education by the Director of Staff Development (DSD) / Education Department of the hospital on an ongoing basis.

e. Will coordinate and periodically review all aspects of skin integrity management in the facility.

f. Review ongoing skin issues weekly during Interdisciplinary Team Meetings.

2. Treatment Nurse/Charge Nurse, RN Wound Nurse

a. Will make recommendations to physicians consistent with current policies and procedures and carry out treatments as indicated.

b. Will provide documentation as indicated.

c. Will supervise nursing assistants to insure an ongoing high quality of direct resident care.

3. Nursing Assistants

a. Will carry out direct resident care with special emphasis on prevention and skin integrity management.

b. Will attend in-service programs related to skin integrity by the DSD.

c. Will communicate to charge nurse any change in skin integrity, verbally notifying licensed nurse.

REFERENCES:

- Thomson Reuters (2021) Barclay's California Code of Regulations, §72315 (7) , San Francisco, California, Title 22, Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **STANDARD MAINTENANCE OF WATER TREATMENT SYSTEM**	SECTION:

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

PURPOSE:

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

POLICY:

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

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

DAILY:

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

MONTHLY:

1. A monthly bacteria culture of the hemodialysis water system.
2. A monthly bacteria culture of the hemodialysis dialysate.
3. A monthly endotoxin culture of the hemodialysis water system.
4. A monthly disinfection of the Reverse Osmosis (RO) Unit system following operation and maintenance manual guidelines.
5. A monthly Preventative Maintenance Inspection performed by dialysis biomedical personnel.

6. A routine Preventative Maintenance Inspection of Domestic Water Booster Pump performed by facilities engineering.

7. A monthly sanitization of the hemodialysis water system.

   a. Additional sanitization of the water system is necessary if any of the following apply:

      - Promptly any time the levels of bacteria or endotoxin exceed action levels.
      - Promptly any time the water system has been shut down for more than 8 hours.

   b. The disinfection process will be performed only by trained personnel.

   c. A bacteria and Limulus Amoebocide Lysate (LAL) culture will be obtained promptly after disinfect.

NEW EQUIPMENT:

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

MONITORING AND DOCUMENTATION:

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

REFERENCES:

- Water Quality Standard for Hemodialysis American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI) 13959:2014.
- Quality of Dialysis Fluid for Hemodialysis and Related therapies, ANSI/AAMI/ISO 11663:2009.
- Guidance for the Preparation and Quality Management of Fluids for Hemodialysis and Related Therapies ANSI/AAMI/ISO 23500:2011.
- Mar Cor Purification. (2016). Millennium reverse osmosis unit. Operations and maintenance manual.
- Outset Medical. (2019). Tablo hemodialysis system user manual, PN-0004205 Rev. 08. San Jose, Ca: Outset Medical.

SUBJECT: **STERILE PRODUCTS:EDUCATION AND COMPETENCY**	SECTION: **Page 1 of 7**

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

PURPOSE:

To provide the necessary training and education of pharmacy personnel to promote preparation of pharmacy-prepared sterile products.

DEFINITIONS:

Validation: Documented evidence providing a high degree of assurance that a specific process will consistently produce a product meeting its predetermined specifications and quality attributes.

USP 797- United States Pharmacopeia (USP) is a quality organization that publishes acceptable standards for sterile preparations and "797" refers to the chapter that deals with sterile product quality benchmarking.

Category 1 CSP- A compounded sterile preparation (CSP) assigned a beyond use date (BUD) of 12 hours or less at controlled room temperature or 24 hours or less refrigerated. All sterile products compounded in the hospital pharmacy will not exceed a BUD of 12 hours as they are prepared in a segregated compounding area.

Category 2 CSP- A CSP assigned a BUD of greater than 12 hours at controlled room temperature or greater than 24 hours refrigerated that is compounded in accordance with all applicable standards found in USP 797.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that the Pharmacist in Charge shall ensure that all personnel engaging in preparation and handling of sterile products will have training and demonstrated competence in the safe handling and compounding of sterile drug preparations. All sterile products will be prepared according to USP 797 standards by appropriately trained pharmacy personnel.

AFFECTED PERSONNEL/AREAS: *PHARMACY*

PROCEDURE:

A. Initial and annual education shall include at the minimum:

1. USP 797 and 800: Pharmacy personnel preparing or dispensing sterile products will receive didactic and experiential training. Personnel shall read core competencies assigned by the PIC and take a test based on the contents. A passing score will be 90%.
    a. One who fails this competency cannot engage in sterile compounding until he or she passes. The test may be retaken multiple times.

2. Calculations and terminology: A test on calculations and terminology will be required annually and maintained in personnel files. A passing score is 90%.
    a. One who fails this competency cannot engage in sterile compounding until he or she passes. The test may be retaken multiple times.

3. Education of core skills shall include a review of:

   a. Contamination of critical area/ environmental monitoring

   b. Proper use or movement of PEC, equipment, and supplies

   c. Compounding and documentation

   d. Quality assurance procedures as outlined in COMPOUNDED STERILE PREPARATION:QUALITY ASSURANCE PROGRAM and STERILE PRODUCTS: STERILE PRODUCT QUALITY ASSURANCE.

   e. Non-pharmacy and pharmacy personnel cleaning

   f. Process validation

   g. Aseptic technique

   h. Proper hand hygiene, gowning, gloving and garbing technique

   i. General conduct

   j. Decontamination (where applicable), cleaning, disinfecting, and maintaining of the PEC, equipment, and controlled area.

   k. Principles of High Efficiency Particulate Air (HEPA) filtered air

B. Initial and bi-annual (every 6 months) competencies shall include at the minimum:

1. Garbing and Hand Hygiene

   i. Initial evaluation will be done immediately following initial hand hygiene and garbing procedure, each individual shall complete a gloved fingertip and thumb (GFT) sampling procedure (zero CFUs both hands) at least three times before being initially allowed to compound sterile drugs.

   ii. Sampling must occur after garbing but before applying sterile 70% IPA to gloves.

2. Aseptic manipulation confirming sterile technique shall also be performed every 6 months. This process evaluates practical skills of personnel's sterile technique by

analyzing a culture from multiple aseptic procedures upon a sterile broth medium, i.e., media fill test.

i. Surface sampling immediately after aseptic manipulation

C. Recertification of competencies including GFT sampling, media fill, garbing and hand hygiene, aseptic technique shall be done every 6 months after initial competency.

- Subsequent GFT sampling will be done once, not thrice like during the initial evaluation. Failure is indicated if the samples exceed 3 CFUs total.
- A visual observation will be conducted and documented.
- All records will be maintained on file in the pharmacy for at least three years.

D. Personnel who fail the didactic tests regarding hand hygiene, garbing, and aseptic technique; gloved fingertip sampling; or media-fill test;

1. Must undergo immediate requalification and pass with 90% before they can resume compounding or supervising, if applicable.
2. Any IV technician that has failed routine requalification must swap duties with one who passed to continue Pharmacy sterile compounding services.
3. In the event a staff member with direct supervision and control fails, such privileges, except compounding, may continue for no longer than 30 days after failure while results are pending.

E. Personnel who fail any visual observation of hand hygiene, garbing, and aseptic technique; gloved fingertip sampling; or media-fill test;

1. Must repeat and pass the evaluation in the deficient area(s) before they can resume compounding.
2. One who fails may not engage in sterile compounding until all results are passed.
3. Any IV technician that has failed routine requalification must swap duties with one who passed to continue Pharmacy sterile compounding services.
4. In the event a staff member with direct supervision and control fails, such privileges, except compounding, may continue for no longer than 30 days after failure while results are pending.

F. After a pause in compounding-related activities (including but not limited to compounding & quality assurance monitoring)- Personnel who have not compounded in 6 months must be requalified. If the pause exceeds 6 months, that person will be treated as a new employee.

G. Competencies can be completed in approximately 8 weeks before the due date.

a. Competency for Core skills must be at least every 12 months and include the following: Hand hygiene, garbing, cleaning & disinfection, calculations, measuring & mixing, aseptic technique, sterility, use of equipment,

documentation of the compounding process, principles of unidirectional airflow within the ISO Class 5 area, proper use of PEC's & principles of movement of materials & personnel within the compounding area.

b. Competency in Garbing/Hand Hygiene (including GFT) & aseptic manipulation (media fill with post GFT and Surface sampling) must be completed by compounding personnel at least once every 6 months.

H. Routine performance checks shall occur to ensure adherence to aseptic policies and procedures.

I. All policies and procedures pertaining to sterile compounding shall be reviewed by all staff annually or when there are changes to any of the policies. All staff shall sign off on education of these policies and acknowledge that any material failure to follow the policies and procedures shall constitute a basis for disciplinary action by SVMC and/or the Board of Pharmacy.

J. Personnel Cleansing and Garbing

1. Personnel experiencing rashes, sunburns, weeping sores, oozing tattoos, conjunctivitis, or active respiratory infections or other communicable diseases shall not compound sterile products until their conditions have resolved.

2. Compounding personnel shall not wear cosmetics, hand, wrist, or other visible jewelry, artificial nails, or extenders. Cover any jewelry that cannot be removed. Natural nails shall be kept neat and trimmed. Remove head phones, ear buds, cell phones, bandanas, coats, hats, jackets, scarves, sweaters, and vests while compounding.

3. In preparation for entering the ante room, personnel shall first don shoe covers, hair covers, and facial covers.

4. Hand Hygiene

   a. Remove debris from under fingernails, if present. Use a nail cleaner (pick) under warm water.
   b. Hands and forearms shall be washed vigorously with soap and water for at least 30 seconds.
   c. Dry hands and forearms up to the elbows with low-lint disposable towels.
   d. Immediately before donning sterile gloves, apply a suitable alcohol-based hand rub, Sterillium©. Allow a sufficient time and amount of product to keep hands wet for manufacturer specified application time, at least 3 minutes.
   e. Allow hands to dry thoroughly before donning sterile gloves.
   f. After donning sterile gloves, apply sterile alcohol 70% to outside of gloves and allow alcohol to dry.

5. Gowns

   a. For a Category 1 & 2: Low-lint garment (non-shedding) with sleeves that fit snugly around the wrists and an enclosed neck (e.g., gown or coverall)

b. Visibly soiled gowns must be changed immediately. Gowns and garbing items must be segregated and stored before use in an enclosure to prevent contamination (away from sinks to avoid splashing).

c. If compounding Category 1 and Category 2 CSPs, gowns may be reused within the same shift by the same person if the gown is maintained in a classified area or adjacent to, or within, the SCA in a manner that prevents contamination. This privilege does not apply to hazardous drugs.

6. Garbing and de-garbing shall not occur in the ante-area at the same time.

7. After gowning, sterile gloves shall be donned. If sterile sleeves are used, then they are donned after sterile gloves.

8. Once inside the compounding area, hands will be disinfected with an alcohol-based hand scrub.

9. Gloves will be disinfected with 70% IPA prior to entering the glovebox and anytime hands are removed and placed back into the glovebox.

10. Gloves that are in contact with non-sterile surfaces will be disinfected with 70% isopropyl alcohol.

K. Doffing Procedure when Exiting Hazardous Drug Compounding Area

i. Remove outer pair of HD gloves and place in HD waste container.
ii. Remove outer pair of booties and place in yellow HD waste container.
iii. Remove the HD gown and place in yellow HD waste container.
iv. Remove inner pair of HD gloves and place in HD waste container.
v. Exit HD buffer room, enter clean side of anteroom, and go to the sink.
vi. Remove bouffant/mask and discard in yellow HD waste container under the sink.
vii. Wash hands as stated above.
viii. Remove booties and step across LOD.
ix. Use Sterillium© gel.

L. Conduct

1. Food, drinks, and cardboard will not be permitted in the SCA or cleanroom suites.

2. Actions such as talking and coughing should be directed OUT of the SEC.

3. Unnecessary motion in the SEC should be avoided to minimize turbulence of air flow.

4. Activities in the SEC should only be related to procedures for parenteral preparations.

M. On cleaning the SCA, pharmacy personnel will be trained on:

1. Using the appropriately-labeled cleaner and disinfectant for the types of surface to be cleaned (floor, wall, etc.)

2. Following garbing procedures when cleaning in the SCA.

3. Mopping floors with a pharmacy-specific mop used ONLY for floors. The mopping should start at the wall opposite the entry room door. Mop the floor with even strokes toward the operator. The applied agent (Ecolab- hospital grade germicidal) shall remain visibly wet for 10 minutes, i.e., dwell time.

4. Cleaning the sink and all contact surfaces.

5. Cleaning of walls top to bottom, ceilings left to right toward the operator.

6. Cleaning of shelves, bins, buffer area chair, exterior of trash bins.

7. Documenting all cleaning.

N. On cleaning the CAI/hood, pharmacy personnel will be trained as follows:

1. When properly garbed, the pharmacy technician will, at a minimum twice a day, when there is a spill, or prior to preparing a new sterile product:

a. Wipe down the entire CAI/Hood chamber with sterile water.

- Using long strokes left to right on the bottom and top surfaces and long strokes top to bottom progressing towards the operator on the vertical sides of the CAI/Hood.

- This process will be repeated with 70% sterile alcohol and sporicidal agent approved by designated person, such as Peridox© or Decon-Spore.

b. This procedure will be used for the application of germicidal and sporicidal agents (sporicidal agent approved by designated person, such as Peridox© or Decon-Spore) with a dwell time of at least 3 minutes) as well. The daily, weekly and monthly cleanings shall NOT overlap and will be performed separately.

O. Cleaning competencies will be assessed with a test and a visual observation annually. Records will be kept for three years.

P. Record Keeping

Records of training and demonstrated competency shall be maintained for each individual for at least three years.

Q. Whenever a change in a policy or procedure occurs, the pharmacist-in-charge will notify the staff via a meeting or an email. Staff shall sign off to acknowledge the change(s) with the 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.

R. Failure to comply with the elements covered in this policy prompts additional training and re-education. These concerns should be addressed during Pharmacy huddles or one-on-one sessions with the PIC in reference to the USP Chapters <797> and <800>.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Pharmacy Law: California Edition. (2024) San Clemente, California: Law Tech Publishing Group.
- USP 797. (n.d.). Retrieved July 9, 2024, from http://www.usp.org/compounding/general-chapter-797.
- USP 800. (n.d.). Retrieved July 9, 2024, from http://www.usp.org/compounding/general-chapter-hazardous-drugs-handling-healthcare.

CROSS REFERENCES:

COMPOUNDED STERILE PREPARATION: QUALITY ASSURANCE PROGRAM

SUBJECT:	SECTION:
STERILE PRODUCTS: STERILE PRODUCT QUALITY ASSURANCE	**Page 1 of 15**

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

PURPOSE:

To provide procedures to ensure that compounded sterile preparations (CSPs) prepared at Sierra View Medical Center (SVMC) are of high quality and sterility.

DEFINITIONS:

Biological Safety Cabinet (BSC), Class II – A ventilated cabinet with an open front and inward and downward unidirectional HEPA-filtered airflow and HEPA-filtered exhaust. A BSC used to prepare a CSP must be capable of providing an ISO Class 5 or better environment for preparation of the CSPs.

Beyond-use date (BUD) – The date, or hour and the date, after which a CSP must not be used, stored, or transported. The date is determined from the date and time the preparation is compounded.

Category 1 CSP – A CSP that is assigned a BUD of 12 hours or less at controlled room temperature or 24 hours or less refrigerated

Category 2 CSP – A CSP that may be assigned a BUD of greater than 12 hours at controlled room temperature or greater than 24 hours refrigerated

Compounded sterile preparation (CSP) – A preparation intended to be sterile that is created by combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug product or bulk drug substance.

Compounding aseptic isolator (CAI) – A type of RABS that uses HEPA filtration to provide an ISO Class 5 unidirectional air environment designed for compounding of sterile non-HDs.

Compounding aseptic containment isolator (CACI) – a type of RABS that uses HEPA filtration to provide an ISO Class 5 unidirectional air environment designed for the compounding of sterile HDs.

ISO Class 5 - An airborne-particulate standard that states there are no more than 3,520 particles of at least 0.5-microns in size per cubic meter.

Media-fill test: A simulation used to qualify processes and personnel engaged in sterile compounding to ensure that the processes and personnel are able to prepare CSPs without contamination.

Primary engineering control (PEC) - A device or zone that provides an ISO Class 5 or better environment through the use on non-turbulent air, unidirectional HEPA-filtered first air for compounding sterile preparations.

Restricted-access barrier system (RABS) – An enclosure that provides HEPA-filtered ISO Class 5 unidirectional air that allows for the ingress and/ or egress of materials through defined openings that have been designed and validated to preclude the transfer of contamination, and that generally are not to be opened during operations. Examples include CAIs and CACIs.

Secondary Engineering Control (SEC) – The area where the PEC is placed (e.g., a cleanroom suite or an SCA).

Segregated Compounding Area (SCA) - Space designated for sterile-to-sterile compounding where a PEC is located within a demarcated area (of at least 3 foot perimeter). This area will be void of activities and materials extraneous to sterile compounding. This area shall not be in a location that has unsealed windows or doors that connect to outdoors, location with high traffic flow, or adjacent to food preparation areas or construction. The SCA must contain a PEC and is suitable for preparation of Category 1 CSPs only.

USP 797 - United States Pharmacopeia (USP) is a national quality agency that creates the sterile product quality standards. The "797" designation is the chapter that relates specifically to the sterile product environment.

POLICY STATEMENT:

It is the policy of SVMC that all compounded sterile preparations (CSPs) will adhere to USP 797 standards of practice. No CSP shall be compounded if it is known, or reasonably known, that the environment fails to meet criteria specified in the pharmacy's written policies and procedures for the safe compounding of CSPs.

PROCEDURE:

I. SVMC will administer aseptic manipulation competency evaluations to ensure a quality product.

A. The evaluation consists of the following:
   a. Visual observation
   b. Media-fill testing
   c. Gloved fingertip and thumb (GFT) sampling on both hands
   d. Surface sampling of the direct compounding area

B. Process validation is assured by using simulated production of the aseptic processes in use at SVMC, substituting growth media for medications to check sterility.

C. All staff responsible for CSPs must be trained in aseptic technique and demonstrate competency by direct observation and successful passing of a media-fill test.

D. Aseptic technique will be monitored and critiqued. Retraining will be considered if major technique violations are seen. Major violations may include:

1. Violations of gowning, gloving and hand-washing policy

2. Touching of critical sites

3. Failure to wipe stoppers

4. Failure to work within proper hood area

5. Blockage of "first air" to critical sites

6. Failure to clean hood properly and keep clean during compounding

E. Gloved fingertip sampling

Initial Competencies	Subsequent Competencies
Visual observation of hand hygiene and garbing (3 times)	Visual observation of hand hygiene and garbing (1 time)
GFS after visual observation of hand hygiene and garbing (3 times)	GFS after visual observation of hand hygiene and garbing (1 time)
Media-fill test	Media-fill test
GFS after the media-fill test	GFS after the media-fill test
Surface sample in the DCA after the media-fill test	Surface sample in the DCA after the media-fill test

Note: GFT sampling shall occur after production of CSPs but before sterilization with alcohol.

F. An actionable level is a CFU count (from both hands) greater than zero after garbing and greater than 3 CFUs after media-fill testing.

1. Employee will be retrained in hand-hygiene, garbing, glove and surface disinfection and conduct in compounding area. Sampling will be repeated and didactic testing repeated.

2. Actionable levels will result in removal from compounding duties and require retraining.

3. Repeated actionable levels will require complete retraining and removal from compounding until sampling meets minimum standards. Root cause for repeat positive sampling will be sought out by the pharmacist-in-charge.

II. The sterile-compounding areas will be cleaned as per USP 797 established standards. All cleaning materials must be non-shedding and dedicated to use in compounding areas and shall not be removed except for disposal.

A. Cleaning of the compounding areas must be documented on a cleaning log.

B. Minimum cleaning frequency

Site	Cleaning	Disinfecting	Sporicidal
PEC(s) and equipment inside the PEC(s)	Daily and when surface contamination is known or suspected	Daily and when surface contamination is known or suspected	Monthly for entities compounding Category 1 or 2 CSPs
Removable work tray of the PEC	Daily on days when compounding occurs Monthly on all surfaces and the area underneath the work tray	Daily on days when compounding occurs Monthly on all surfaces and the area underneath the work tray	Monthly on all surfaces and the area underneath the work tray
Pass-through chambers	Daily on days when compounding occurs	Daily on days when compounding occurs	Monthly for entities compounding Category 1 or 2 CSPs
Work surface(s) outside the PEC	Daily on days when compounding occurs	Daily on days when compounding occurs	
Floor(s)	Daily on days when compounding occurs	Daily on days when compounding occurs	
Wall(s), plastic curtain(s), door(s), and door frame(s)	Monthly	Monthly	Monthly
Ceiling(s)			
Storage shelving and bin(s)			
Equipment outside the PEC(s)			

C. Disinfection of a PEC will be executed with sterile water, sterile 70% isopropyl alcohol (cleaning and disinfecting), and sporicidal agent approved by designated person, such as Peridox© or Decon-Spore (agent must be applied and be visibly wet for 3 minutes)

D. Sterile 70% isopropyl alcohol must also be applied in the follow scenarios:
   a. At the beginning of each shift and at the end of each shift
   b. After a spill
   c. At least every 30 minutes if the compounding process takes 30 minutes or less
   d. Immediately after when compounding activities exceed 30 minutes, or
   e. When surface contamination is known or suspected

E. Daily mopping of the floor using a clean/low-shedding mop. Mop must be kept in the SCA or buffer area and only be used for cleaning the buffer area floor. Mopping will be done by trained personnel using approved cleaning agents and will mop in a direction from clean area to dirty area. To ensure proper contact time, the mopped floor must remain visibly wet for 10 minutes.

F. Competency records of housekeeping staff will be kept in pharmacy for a minimum of three years after employment.

G. Weekly cleaning

   1. Hoods must be disinfected using an approved disinfecting agent, sporicidal agent approved by designated person, such as Peridox© or Decon-Spore, will be used (agent must be applied and be visibly wet for 3 minutes). Use of this agent will occur after the use of sterile water and sterile 70% alcohol.

H. Monthly cleaning

   A. In addition to above cleaning, all surfaces in ISO classified areas or segregated compounding area will be wiped with sterile water and then sterile 70% alcohol including the inside of storage bins, carts, wheels, outside of hood, and wire racks, shelves, walls and ceilings, stools, and all other items in segregated compounding area

   B. A sporicidal will be used on the entire room and outside AND inside the RABS or BSC. SVMC will use sporicidal agent approved by designated person, such as Peridox© or Decon-Spore (agent must be applied and be visibly wet for 3 minutes).

I. Fixed glove assembly will be changed at least every 6 months or:

   1. When there is a visible tear;

   2. When a positive culture is obtained from sampling;

3. When there is suspected contamination of product

IV. Certification or recertification

A. **Classified areas and PEC(s) will be recertified every six months by an outside agency**. During certification, the agency will evaluate the following:

1. Airflow testing
2. HEPA filter integrity testing
3. Total particle count testing
    a. Failure to meet ISO standards will be immediately addressed PRIOR to the vendor leaving SVMC.
    2. Corrective actions may include the following:
        - Replacing HEPA filters
        - Re-measuring the airborne particle count
        - Searching for mechanical causes
4. Dynamic airflow smoke pattern test

B. In addition, classified areas will be recertified in the following circumstances:

1. Classified area was redesigned
2. Classified area was constructed
3. Any PEC was replaced or relocated
4. Configuration of the room was altered that could affect airflow or air quality

C. A corrective action plan will be implemented in response to any out-of-range results.
1. LSE 100625
    a. PEC - failure to meet ISO Class 5 specifications
        a. Collaborate with vendor and troubleshoot section A. This may require assistance from the Engineering Department (e.g. replacing the HEPA filter or adjusting the air pressures).
        b. Vendor to re-test the PEC.
        c. If the PEC continues to fail, pharmacy personnel is unable to compound Category 1 CSPs. Pharmacy to conduct sterile compounding in a secondary certified PEC, if available.

d. In the absence of any other PEC, Pharmacy to contact contracted pharmacy to temporarily make compounded sterile preparations.
e. Exercise immediate-use compounding when appropriate until the PEC passes recertification.

2. SCE 101591
   a. PEC - failure to meet ISO Class 5 specifications
      a. Collaborate with vendor and troubleshoot section A. This may require assistance from the Engineering Department (e.g. replacing the HEPA filter or adjusting the air pressures).
      b. Vendor to re-test the PEC.
      c. If the PEC continues to fail, pharmacy personnel is unable to compound Category 1 or 2 CSPs. Pharmacy to conduct sterile compounding in a secondary certified PEC, if available.
      d. Exercise immediate-use compounding when appropriate.
      e. Hazardous sterile compounding is strictly prohibited unless an assessment of risk is completed.

   b. SEC or buffer room - failure to meet ISO Class 7 specifications
      a. Collaborate with vendor and troubleshoot section A. This may require assistance from the Engineering Department (e.g. replacing the HEPA filter or adjusting the air pressures).
      b. Vendor to re-test the SEC.
      c. If the SEC continues to fail, pharmacy personnel is unable to compound Category 2 CSPs. As long as the SEC satisfies the conditions of a SCA (non-hazardous) or C-SCA (hazardous), staff may exercise Category 1 sterile compounding per USP 797 and 800.
      d. In the event that the conditions of neither the SCA nor C-SCA are met for non-hazardous or hazardous compounding respectively, exercise immediate-use compounding when appropriate.
      e. Immediate-use compounding is strictly prohibited for hazardous drugs unless an assessment of risk is completed.

   c. Anteroom – failure to meet ISO Class 7 specifications
      a. If the anteroom is at least ISO Class 8, may continue normal operations in the non-hazardous buffer room. Meanwhile, the hazardous buffer room is limited to Category 1 sterile compounding as long as it satisfies the conditions of a C-SCA.
      b. Collaborate with vendor and troubleshoot section A. This may require assistance from the Engineering Department (e.g. replacing the HEPA filter or adjusting the air pressures).
      c. Vendor re-test the anteroom.

D. Decontamination and terminal cleaning of PEC and SEC will occur immediately AFTER recertification.

V. Viable Sampling

A. The Department of Pharmacy or an outside agency will conduct viable surface and air sampling at least every one and six months, respectively.

1. In addition, sampling must be performed in the following circumstances:

a. In conjunction with the certification of new facilities and equipment

b. After any servicing of facilities or equipment

c. In response to identified problems (e.g. positive growth in sterility tests of CSPs)

d. In response to identified trends (e.g. repeated positive GFT sampling results, failed media fill testing, or repeated observations of air or surface contamination

2. Surfaces include one surface in each PEC, surfaces of all classified areas, and pass-through chambers connecting to classified areas.

B. An actionable level of colony-forming units (CFUs) upon viable surface sampling is:

1. Action Levels for Surface Sampling

ISO Class	Surface Sampling Action Levels (CFU/Plate)
5	>3
7	>5
8	>50

C. An actionable level of CFUs upon viable air sampling shall be:

1. Action Levels for Air Sampling

ISO Class	Air Sampling Action Levels (CFU/m^3)
5	>1
7	>10
8	>100

D. Any actionable level in the PEC will result in the following action(s):

1. Immediate cessation of activity in the PEC.
2. Immediate cleaning and disinfecting of PEC and SEC.
3. Resampling of affected area after cleaning and disinfecting is completed.
4. Evaluation of engineering controls.
5. Communication with Infection Control and expert infectious disease consultation.
6. Communication with Risk Department and investigation for any product potentially-contaminated.
7. Review of cleaning and compounding operations and facility management.
    a. If levels measured exceed above action levels, an investigation and corrective action must be taken to prevent future deviations.
    b. Corrective action plans may include a change in procedure, facility, or equipment.

E. Any actionable level outside the PEC will result in the following action(s):

1. Investigate the cause.
2. Implement corrective action.
3. Evaluate the trend if data is available.
4. Resample the failed area to confirm corrective action was successful.
5. Attempt to identify microorganisms recovered to the genus level.

F. When evaluating the results, the designated person will examine the counts in relation to previous data to identify adverse results or trends.

G. If needed, Pharmacy will adopt current SOPs when collecting viable surface samples to monitor environmental sterility.

H. If needed, Pharmacy will adopt current SOPs when collecting viable air samples to monitor environmental sterility.

VI. Quality Assurance/ Quality Control Testing

A. Sterility testing of a Category 1 CSP will occur at least quarterly.

a. In the event of a positive culture

i. Technician who compounded IV will be retrained in hand hygiene, garbing, gloving, and surface disinfection. Fingertip and sterility testing

will be repeated under observation for technique. Technician will stop compounding until a negative test is obtained.

ii. If repeat testing results in a positive response, the technician will be removed from compounding duties and completely retrained.

iii. In addition to the above, if the product is a batched product where more than one dose of a preparation has been made:

- The lot number of the product will be identified
- Potential patients exposed to contaminated product will be identified using dispensing and administration records
- The physicians involved in that patient's care and infection control officer will be notified of possible exposure as well as organism(s) involved in order to evaluate the patient.

iv. Risk, Infection Control, and Chief Nursing Officer will be immediately informed.

B. Quantification testing shall be performed at a minimum of twice a year to ensure product integrity and to validate labeled strength.

A. A random CSP will be sent out to a qualified laboratory to test for potency, endotoxin, and particulate matter. Pharmacy will follow the process outlined by the contracted laboratory.

B. If the drug sample is identified as not within the standards for potency, endotoxin, or particulate matter:

a. The technician and pharmacist making/checking the product will be removed from sterile product processing and retrained.

b. A complete analysis of the compounding process will occur.

c. An additional product will be sent out for validation.

C. All of the above steps will be performed and BUD dating will be confirmed by using standard reference materials and research.

VII. Compounding Room Temperature and Lighting

A. The sterile compounding area shall have a well-lit working environment.

B. A room temperature of 68 degrees Fahrenheit and humidity below 60% is ideal for sterile compounding. The temperature and humidity will be recorded daily.
   i. In the event of a temperature excursion:
      1. Engineering will be contacted for temperature or humidity correction.
   ii. Pharmacist-in-Charge will be notified.
   iii. If temperature > 40 degrees Celsius for at least 4 hours, any CSP exposed to these conditions will be discarded.

VIII. Pressure Differential

A. A minimum of 0.02-inch water column is required for positive pressure to separate each ISO classified area, except in segregated compounding areas.
B. Negative pressure will be negative 0.01 to negative 0.03 inches of water.
C. A pressure gauge or velocity meter will be used to monitor airflow between the following paired areas:
   1. Ante-area and buffer areas
   2. Ante area and outside the cleanroom suite
   3. RABS and the SCA.
D. The pressures will be documented and reviewed daily or by a continuous monitor.

IX. In the event of a product recall, SVMC will follow the established policy of DRUG RECALL PROCEDURE

X. All records will be retained for a minimum of three years.

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

EDUCATION:

SVMC Pharmacy Staff: All pharmacists and pharmacy technicians will receive education regarding the preparation of pharmacy-prepared IV admixtures.

REFERENCES:

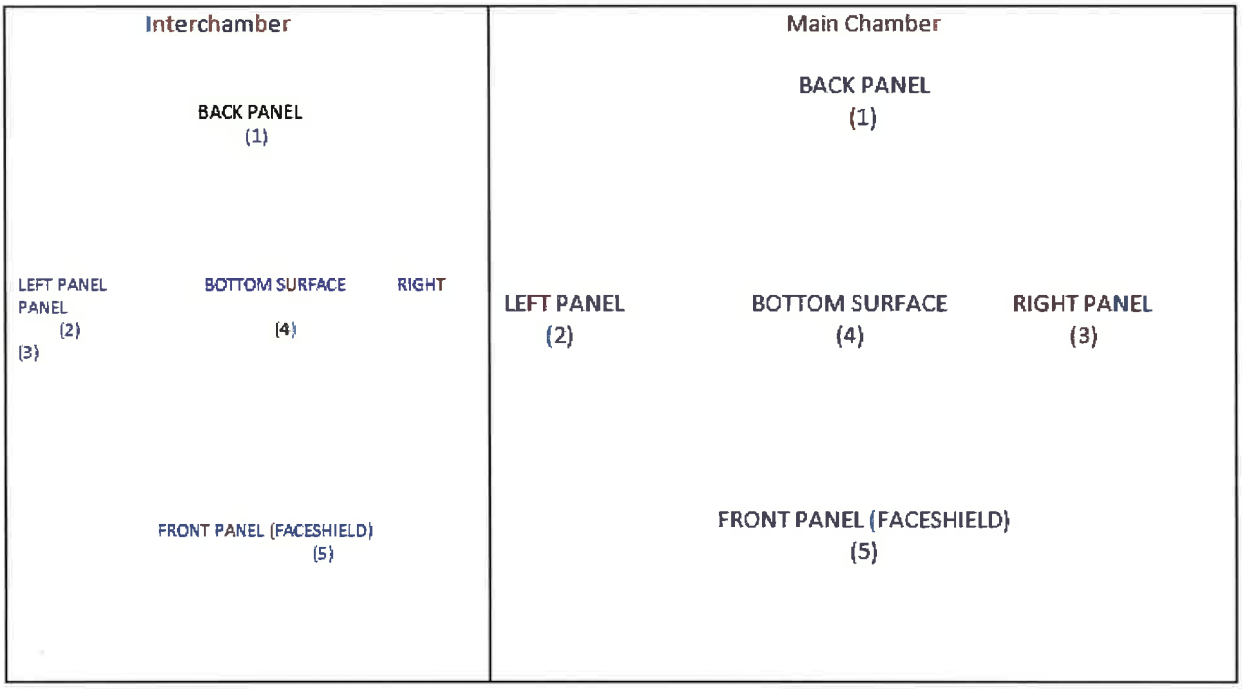
- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Pharmacy Law: California Edition. (2024) San Clemente, California: Law Tech Publishing Group.
- USP 797.(n.d.). from http://www.usp.org/compounding/general-chapter-797.

- CCR 1751.4 Facility and Equipment Standards for Sterile Compounding. Retrieved November 24, 2021, from https://www.law.cornell.edu/regulations/california/16-CCR-Sec-1751-4.

CROSS REFERENCES:

- DRUG RECALL PROCEDURE

Map of NuAire COMPOUNDING ASEPTIC ISOLATOR – Main Pharmacy



SUITE "B" POSITIVE & NEGATIVE PRESSURE HOODS ENVIRONMENTAL SAMPLING MAP

NUAIRE HOOD

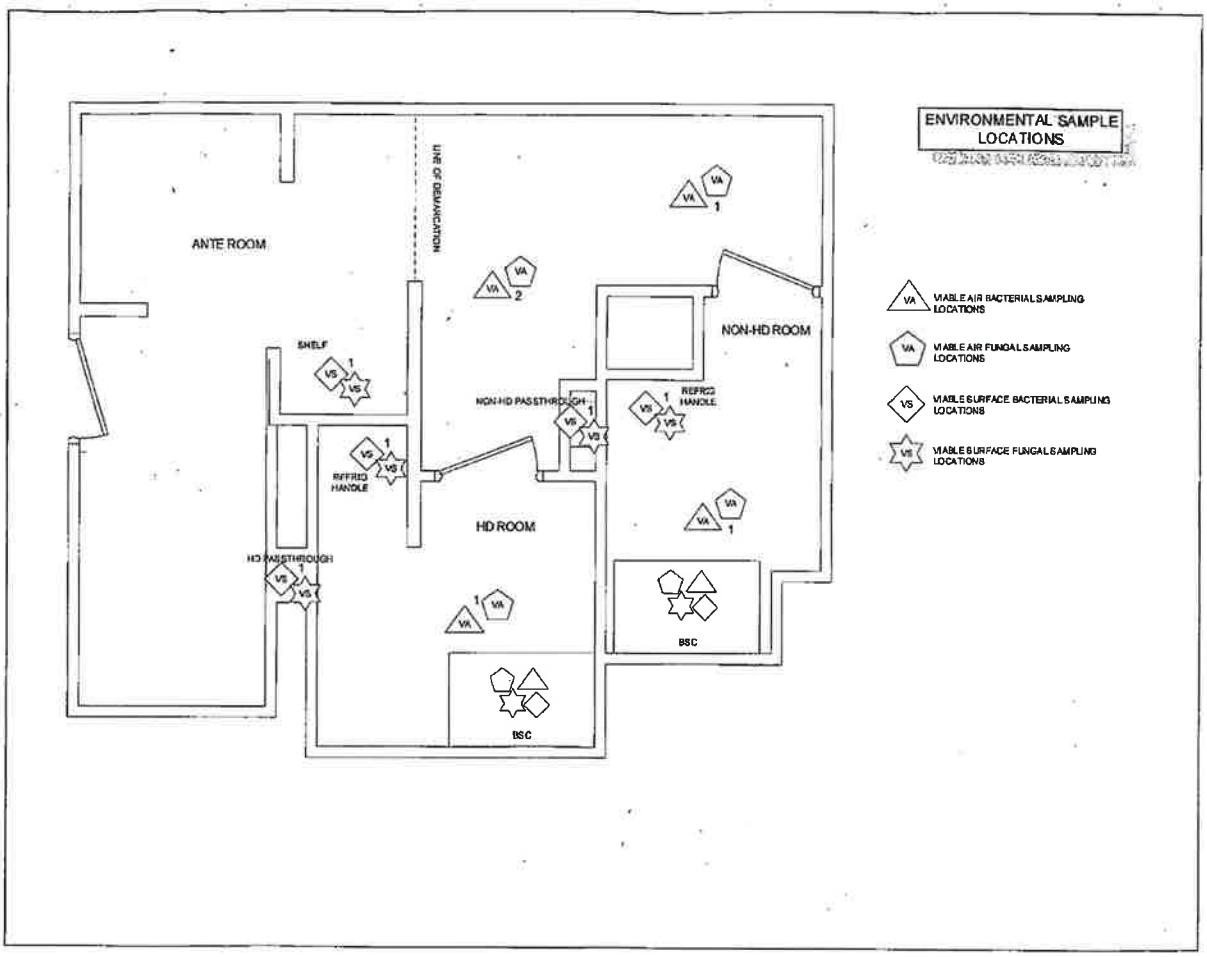
BACK PANEL
2

LEFT PANEL
1

BOTTOM PANEL
3

RIGHT PANEL
4

FRONT PANEL
5


ENVIRONMENTAL SAMPLE LOCATIONS
ANTE ROOM
LINE OF DEMARCATION
NON-HD ROOM
SHELF
NON-HD PASSTHROUGH
REFRIG HANDLE
HD ROOM
HD PASSTHROUGH
BSC
BSC
VIABLE AIR BACTERIAL SAMPLING LOCATIONS
VIABLE AIR FUNGAL SAMPLING LOCATIONS
VIABLE SURFACE BACTERIAL SAMPLING LOCATIONS
VIABLE SURFACE FUNGAL SAMPLING LOCATIONS

SUBJECT: **SUCTIONING –NASO-ORPHARYNGEAL**	SECTION: **Page 1 of 3**

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

PURPOSE:

To set guidelines in the use of suction catheter used to maintain clear nasal and oral passage and removal of any secretions.

POLICY:

To keep airways patent and free of secretions by gently suctioning nasopharynx with a suction catheter.

EQUIPMENT:

1. Gloves
2. Suction catheter/suction catheter kit
3. Sterile normal saline, preservative free
4. Stethoscope
5. Suction equipment and tubing
6. Oxygen, if indicated
7. Catheter Size Guidelines:

Age	Catheter Size
Neonate to 18 months	5-8 french
18 months to 7 years	8-10 french
7 years to 10 years	10-14 french
11 years and up	12-16 french

- Catheter should be one half the diameter of the child's airway
- Suction machine shall be set at lowest possible pressure level of clear secretions

PROCEDURE:

1. Indications for Suctioning:
   a. May hear gurgling of mucous or emesis in infant's mouth or throat.
   b. May see mucous or emesis in nose, mouth or throat.
   c. Infant may be struggling for air:
      - Head thrown back

- Eyes open and staring
- Stiff body motions

d. May be cyanotic.

2. Wash hands.

3. Explain procedure to parent/guardian, and child if applicable.

4. Place the infant's head lower than its chest and hyperextend the neck slightly.

5. To suction the pharynx:

   a. Measure from the child's nose to ear lobe (approximately distance)

6. Put on gloves.

7. Lubricate suction catheter with normal saline.

8. For patients using oxygen, give oxygen before and during suctioning.

9. Infants with thick secretions: instill 1-2 saline drops into infant's nares.

10. Insert suction catheter into the child's nose or mouth.

11. DO NOT apply suction when inserting the catheter.

    Note: Applying suction while inserting the catheter may cause a vagal response in the infant, leading to bradycardia and/or hypoxia and/or trauma to the infant's airway mucosa.

12. Listen to the patient's heart for possible bradycardia.

13. Apply suction and gently rotate catheter between your thumb and forefinger while slowly removing the catheter.

14. DO NOT suction for longer than five (5) seconds.

15. Rinse catheter between passes with saline.

16. Discard gloves and suction catheter in hazardous waste.

17. Flush suction tubing with sterile normal saline until clear.

18. Use suction trap when obtaining secretions for culture.

DOCUMENTATION:

- Patient's tolerance to the procedure
- Patient's respirations, breath sounds, color, respiratory effort before and after suctioning
- Secretions: amount, color, consistency and odor

REFERENCES:

- Bowden, V. and Greenberg, C. (2016). Lippincott, Pediatric Nursing Procedures forth Ed. P.506-510 Philadelphia, PA. Lippincott Williams & Wilkins

SUBJECT: **SWALLOWING ASSESSMENT AND RESIDENTS' RIGHTS – DP/SNF**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish collaborative guidelines between resident, physician and other healthcare professionals in order to deliver safe and effective healthcare.

To define the rights and responsibility of the residents receiving care and the safety issues involved in those decisions made by the resident.

POLICY:

The Physician and Speech Therapist will define the safety issues to the resident who is willing to exercise their rights and responsibility to take oral meals when the swallowing evaluation establishes the potential for aspiration.

AFFECTED PERSONNEL/AREAS:

PHYSICIAN, SPEECH THERAPIST, REGISTERED NURSE (RN), REGISTERED DIETITIAN

PROCEDURE:

1. All residents will receive an evaluation conducted by the speech therapist on admission to the DP/SNF Unit.

2. The physician and nursing staff will be notified of the results of the evaluation.

3. If the resident does not meet criteria for a swallow evaluation at the time of admission, a re-evaluation will be written when the nursing staff and physician see the resident has shown improvement to warrant such evaluation.

4. If the resident does receive a swallow evaluation and does not pass, the resident will be re-evaluated when the speech therapist and physician see the resident has shown improvement or the resident themselves requests it and is ordered by the physician.

5. If the resident does not pass their swallow evaluation and insists, per their patient rights, to have oral meals, then the following must be met.

    a. The physician will speak to the resident and fully disclose to him/her the risks entailed with eating meals and the possibility of aspiration.

    b. The resident will be placed at a 35-90 degree angle in bed during meals.

    c. The resident will be monitored during meals by licensed nursing staff as per the order of 100% supervision by the speech therapist and physician.

    d. A comprehensive care plan will be maintained in the residents' EMR, on the potential for aspiration, and the residents' right to eat meals against the medical advice of the

physician. Per SVMC Policy & Procedure: Patient Rights and Responsibilities, "The resident is responsible for his/her actions if she/he refuses treatment or does not follow the practitioner's instructions."

e. The resident must have an adequate decision making capacity, and the level of his/her decision-making capacity must be evaluated by the physician.

Per CMS and the New Dining Practice Standards, "It is ethically and legally permissible for patients with decision making capacity to refuse unwanted medical interventions and to ignore recommendations of the clinician. If the patient is sufficiently informed about the risks and benefits of acceptance (informed consent) or refusal (informed refusal) of a proposed intervention or treatment and refuses, the clinician should respect the patient's decision".

REFERENCES:

- California Department of Public Health, updated Oct 6, 2017, Nursing Home Residents Rights, retrieved from: https:www.cdph.ca.gov
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72527, San Francisco, California, Title 22.
- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.10. United States of America, Med Pass Inc.

CROSS REFERENCES:

- SVMC House Wide Policy & Procedure: "PATIENT RIGHTS AND RESPONSIBILITIES "

SUBJECT: **TABLO PRO+ IN THE ACUTE CARE SETTING**	SECTION: **1 of 2**

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

PURPOSE:

- To provide safe and effective treatment management for using Tablo PRO+ software
- To provide extra-corporeal blood purification therapy to patients with impaired renal function for an extended period per MD order.

POLICY:

1. All staff must be trained on hemodialysis using the Tablo System.
2. PRO+ treatments will be performed in the Intensive Care Unit setting.

DEFINITIONS:

UF: Ultrafiltration

AFFECTED PERSONNEL/AREAS: *Intensive Care Unit, Dialysis*

EQUIPMENT:

- Tablo System
- PPE EQUIPMENT
- TREATMENT RELATED MEDICAL SUPPLIES

PROCEDURE:

STAFF TRAINING

- The initial training will include:
  a. Pretreatment procedures
  b. Water and dialysate testing
  c. Initiation and termination of treatment
  d. Post treatment management and disinfect
  e. Managing of complications
  f. Emergency procedures

- Validation of staff learning will be verified by a written and/or oral competency assessment
- Continue staff performance evaluation is ongoing, and further education may be provided as needed to reinforce skills and knowledge

PRO+ IN THE ACUTE SETTING

- Verify physician's order, and monitor the Tablo system and Acid/Bicarb, and changing as needed

- Chlorine testing per policy
- Document and record intake and output ultrafiltration as prescribed
- Monitor and record: arterial pressures, venous pressures, TMP, UF rate, UF removal, dialysate rate, and heparin.
- Monitor and change the dialyzer for clotting
- Monitor Tablo for alarms and troubleshoot following the on screen prompts
- Adjust treatment settings as necessary, and per the physicians orders

CROSS REFERENCE:

- Tablo set up, treatment, and post device care
  Standard maintenance of water treatment system

REFERENCES:

- Johnson, K.L. (2024). AACN procedure manual for progressive and critical care. (8th edition). Elsevier.
- Outset Medical. (2019). Tablo hemodialysis system user manual, PN-0004205 Rev. 08. San Jose, Ca: Outset Medical.

SUBJECT: THEFT AND LOSS	SECTION:

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

PURPOSE:

The purpose of this policy is to ensure reasonable efforts are made by Sierra View Medical Center (SVMC) to safeguard resident property and to reimburse a resident for or replace stolen or lost property at its then current value.

POLICY:

SVMC will prevent theft or loss of resident valuables and possessions in consideration for providing a safe and secure environment for addressing the resident's medical and social needs. The facility will comply with all applicable regulations and laws, including California Health and Safety Code Section 1289, 1289.3, 1289.4, 1289.5.

The administrator is responsible for the overall monitoring and implementation of the Theft and Loss Policy and Procedures.

AFFECTED PERSONNEL/AREAS:

SOCIAL SERVICES, LICENSED NURSING STAFF, CLINICAL DIRECTOR, CLINICAL MANAGER

PROCEDURE:

1. The Social Service Designee will provide information regarding the facility's policies and procedures relating to theft and loss prevention program to residents and responsible parties upon admission.

2. Staff shall receive this information during annual orientation, and updated annually during in-services/staff meetings.

3. For recording and tracking, the facility shall utilize a Theft and Loss Monitoring Report and a Theft and Loss Log. The Social Service Designee shall be responsible for the maintenance of the reports and the log. Theft and loss reports should be completed by any staff when a report is received from a resident/family. Staff shall ensure the reports are provided to the Director for follow up and timely resolution.

4. Lost or stolen property shall be documented and reported to the administrator and/or designee and also reported to the California Department of Public Health, Law Enforcement, and the Long Term Care Ombudsman, Risk Management, and Hospital Security.

5. Any theft or loss determined to be $100.00 or greater will be documented and reported to the California Department of Public Health, and to the Office of the State long-term care Ombudsman in response to a specific complaint. Theft and loss records need only be provided upon request, for the prior twelve months.

6. The Theft and Loss Monitoring Report will include the following information and the Social Worker Designee / Nursing Staff will attempt to have the form filled out as completely as possible to facilitate review and possible recovery of losses.

   a. A description of the article;

   b. The article's estimated value;

   c. The date and time the theft or loss was discovered;

   d. If determinable, and the date and time the loss or theft occurred;

   e. The action taken.

7. When items are reported lost or stolen by a resident/family, the Social Worker Designee will do the following:

   a. Determine whether items were removed from the facility;

   b. Search the immediate area, facility laundry, and areas on the unit to determine whether items may have been misplaced;

   c. Determine value of items (obtain receipts as possible);

   d. Submit report of theft and loss to the Director.

8. Resident's personal property inventory. (Cross reference: Policy re: Inventory/Personal Effects)

   Upon Admission:

   a. Upon admission to the facility, the Social Service Designee initiates the completion of the Resident's Personal Belongings form # 014897, Attachment M –Theft and Loss Prevention Program Requirements Health and Safety Code Sections 1289.3-5.The Social Service Designee then completes the resident's personal property inventory form #013048.

   b. This inventory form is retained by the facility and a copy provided to the resident and/or resident's representative upon admission if requested.

   During the resident's stay:

   a. Additions to and deletions from the resident's personal inventory form will be completed by Social Services Designee on the inventory form, which accompanies the original form in the resident's medical record. Upon request from the resident or resident's family,

items brought in or taken out shall be recorded on the inventory form to properly maintain an accurate record of items retained in the facility.

b. The facility shall not be liable for items which have not been requested to be included in writing on the inventory form or for items which have been deleted from the inventory form.

c. A copy of the current inventory shall be made available upon request to the resident, responsible party, or other authorized representative.

d. The resident's family or a responsible party is responsible for items which are subject to frequent removal from the facility and not signed in or out, such as personal clothing or laundry.

e. If an item is on the inventory list and after investigation, the facility was determined to be at fault for the loss, the item will be replaced by the facility.

Upon Discharge:

a. Nursing Staff shall inventory and surrender the resident's personal effects and valuables upon discharge to the resident or authorized representative in exchange for a signed inventory form.

b. Upon the death of a resident without a representative or known next of kin as specified by Section 7600.5 of the California Probate Code, the facility will provide immediate written notice to the public administrator of the county.

9. The facility shall establish a method of marking, to the extent feasible, personal items for identification purposes upon admission or as items are added to the property list, including engraving or marking of Dentures, Eyeglasses, Hearing aids, and other prosthetics. This will be carried out by Nursing and Social Services Staff.

10. The facility shall report to the local law enforcement agency within thirty-six (36) hours when the Administrator of the facility has reason to believe resident property with a then current value of one hundred dollars ($100) or more has been stolen. The administrator or designee will oversee the reporting process to a Law Enforcement Agency.

11. The facility will make a referral within 3 calendar days and if not possible, document why Dentures are missing or broken. The facility will get a dietary consult to maintain adequate hydration and nutrition. Hearing, glasses or other prosthesis referrals will be made within 3 working days.

12. The facility shall make available and maintain a secured area for the safekeeping of resident property upon the request of the resident or resident's responsible party.

a. A locked area will be kept in the facility to provide security for items that can be accommodated. All items provided for the safe keeping shall be properly receipted when accepted by facility staff and when returned.

13. The facility will accept residents' funds for safe keeping, upon residents' request. Such residents' funds will be maintained in a resident trust account pursuant to Title 22 Section 72529 or 73557.

14. A copy of Sections 1289.3, 1289.4, 1289.5 of Health and Safety code will be provided by the Social Worker Designee to all residents and their responsible parties, during the admission process, and available upon request, to prospective residents and their responsible parties.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 1289.3, 1289.4, 1289.5. United States of America, Med Pass Inc.

- Thomson Reuters (2019) Barclay's California Code of Regulations, 72529, 73557, San Francisco, California. Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCES:

- RESIDENTS' FUND POLICY

SUBJECT: **TRANSFER OF RESIDENT TO-FROM BED**	SECTION: **Page 1 of 3**

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

PURPOSE:

The purpose of this policy is to set forth a procedure to assess the resident's capabilities and provide the form of transfer best suited to his/her needs and to maintain resident safety during the procedure.

POLICY:

It is the policy of this facility to assess and provide appropriate and safe transfer techniques for each resident based on individual need.

AFFECTED PERSONNEL/AREAS: *RNs, LVNs, CNAs, PTs*

EQUIPMENT:

- Wheelchair
- Geri chair
- Hoyer Lift
- Gait Belt
- Maxi Lift
- Steady

PROCEDURE:

ASSISTING TO CHAIR:

a) One Person Pivot Transfer (resident must be able to bear weight):

a. Place the chair on the convenient side of the bed with the back of the chair parallel to the foot of the bed and facing the head of the bed.

b. If using wheelchair, make sure footrests are not in the way and wheels are locked.

c. Place appropriate pressure reducing devices into chair.

d. Adjust bed to appropriate level for resident. Raise the head of the bed.

e. Turn resident on his side and pivot him to a sitting position, with legs dangling over side of bed.

f. Assist resident into daily attire.

g. Apply gait belt (unless contraindicated) around resident's waist securely enough to prevent sliding up over ribs.

h. Make sure resident's feet are flat on the floor.

i. Facing resident, establish a broad base with feet spread and one foot slightly in front of the other and grasp the gait belt with thumbs down on either side of the resident and slightly to the back. Pull the resident to a standing position, bracing the resident's knees with yours, if necessary, to prevent buckling.

j. Turn or pivot resident around with his back to the chair. Flex your knees and lower resident into chair. Remove gait belt.

k. Cover lap and knees with lap robe and make sure he/she is comfortable. Utilize postural support and/or positioning devices per physician order and resident need. Make sure call bell is within resident's reach before leaving.

b) Two-Person Assisted Transfer (heavy resident who must be able to bear weight):
(Use Sara 3000 or Steady where indicated)

a. Place the chair parallel to the bed, and facing the head of the bed with wheels locked.

b. Adjust bed to convenient level for resident. Raise the head of the bed.

c. With resident properly attired, assist to a sitting position, legs extended over side of bed and feet resting firmly on the floor. Apply gait belt around resident's waist unless contraindicated.

d. Each person will stand facing the resident with one on either side of the resident.

e. Provide a broad base of support by spreading feet and placing foot farthest from the resident slightly in front of the other.

f. Each person will extend the arm closest to the resident forward between the resident's side and elbow. With fingers pointing downward, grasp the gait belt firmly. Have resident place his hand between your body, the arm grasping the gait belt and holding onto the back of your upper arm.

g. On a verbal command, draw the resident gently but firmly forward and upward to a standing position. Brace his knee with yours to prevent buckling.

h. Pivot or turn resident so that their back is towards the chair. Gently lower resident into chair. Remove gait belt.

i. Cover lap and knees with lap robe and make sure resident is comfortable. Utilize postural supports and/or positioning devices per physician order and resident need. Make sure call bell is within resident's reach before leaving.

c) Two-Person Total Lift (resident unable to bear weight):
No lift facility; always use Hoyer Lift/ Maxi Lift for these types of residents.

SUBJECT: **TRANSFER OF RESIDENT TO-FROM BED**	SECTION: **Page 3 of 3**

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

TRANSFER TO BED:

1. Select appropriate level of transfer utilized for resident transfer to chair:

   a) Physical therapist assist
   b) Mechanical Devices

2. Utilizing proper body mechanics, reverse the procedure steps to return resident to bed.

3. Make sure resident is comfortable and adjust bed linens. Raise side rails when appropriate for resident safety. Make sure call bell is within resident's reach before leaving resident.

4. Return bed to lowest level after transfers before staff departure.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 483.25(a)(1)(ii), San Francisco, California, Title 22.
- Occupational Safety and Health Administration. *Safe Patient Handling Programs: Effectiveness and Cost Savings* (n.d.). https://www.osha.gov/dsg/hospitals/documents/3.5_SPH_effectiveness_508.pdf.
- R. Bergman, (2022) Patient Care Transfer Techniques, National Institutes of Health, retrieved from: https://www.ncbi.nlm.nih.gov

SUBJECT: **TRAPEZE- OVERBED**	SECTION: **Page 1 of 1**

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

PURPOSE:

The purpose of this policy is to ensure residents are enabled to improve independence in bed mobility.

POLICY:

It is the policy of this facility to provide an over bed trapeze for all residents who are assessed as being able to utilize and are in need of a device to increase bed mobility.

AFFECTED PERSONNEL/AREAS: *NURSING (RNs, LVNs)*

PROCEDURE:

1. Nursing will assess each resident upon admission for level of mobility and mental status.
2. Those residents assessed as alert and able to utilize an over bed trapeze as well as in need of improved bed mobility will be provided with an over bed trapeze.
3. Nursing will request the Engineering Department to attach the trapeze to the bed.
4. Nursing will instruct the resident on the use of the trapeze.
5. Once a resident becomes independent in bed mobility or no longer has a need for the trapeze, nursing will notify the Engineering Department of the need to remove the trapeze and to clean and store it.
6. The use of an over bed trapeze to improve bed mobility will be included as an approach on the resident's personalized care plan in the EMR.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, §72315, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **UROLOGY CLINIC- URINE SPECIMEN COLLECTION AND TESTING (STANDARDIZED PROCEDURE)**	SECTION: **Multi-Specialty Clinic Page 1 of 2**

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

PURPOSE:

To define and clarify procedures and tests that may be performed by a qualified medical assistant or nurse presenting to the Multi-Specialty Clinic

POLICY:

To proactively direct clinic staff in the timely collection and accurate processing of patient urine specimens during the operation of the Multi-Specialty Clinic.

AFFECTED PERSONNEL/AREAS: *OB-GYN CLINIC STAFF, ACEDEMIC HEALTH CLINIC STAFF, MEDICAL STAFF*

EQUIPMENT:

- Urine Analyzer

PROCEDURE:

A. Clinic Medical Assistants, will complete training and documentation of demonstrated competency to perform Clinical Laboratory Improvement Amendments (CLIA) Urinalysis Tests (Dipstick Method).

B. The Medical Staff authorizes trained and competent Medical Assistants to instruct all patients presenting for care to provide a clean catch urine specimen for testing in the Clinics prior to the patient being placed in the examination room and examined/treated by the physician and/or physician assistant.

C. The following patient specimens will be tested upon collection as a standardized procedure:

   a. Patient history of hematuria

   b. Patient history of chronic UTI

   c. Patient with any of the following symptoms:

      i. pain on urination,

      ii. cloudy/odorous urine,

      iii. difficulty in urination,

      iv. frequent urination,

v. pain in back located near kidney region

d. Or as directed by physician/provider.

D. All urine specimens collected will be processed using the designated point-of-care testing equipment, with results being recorded in the Electronic Health Record.

E. Unless directed to send the specimen to the laboratory for further testing, all specimens collected in the clinic will be disposed of at the end of the clinic day.

F. Urinalysis testing is a useful assessment and is required to identify primary and secondary health issues and to monitor some health conditions.

REFERENCES:

- California Hospital Association. CHA Guidelines for Standing Orders, Standardized Procedures and Other Delegation Tools. Retrieved on July 23, 2015 from calhospital.org.

CROSS REFERENCES:

- Waived and Point of Care Testing- Competency and Quality

SIERRA VIEW MEDICAL CENTER **RESPIRATORY PFT REQUISITION**

Call (559) 788-6017 to schedule a test

Fax# (559) 791-3813

Patient Name:_____ DOB:_____

Patient Phone:_____

Patient pulmonary history _____

_____

Smoking history _____

Reason for PFT _____

Diagnosis/ICD-10 Code _____

- ☐ **COMPLETE PULMONARY FUNCTION TEST**
- ☐ Diffusion Lung Capacity
- ☐ Spirometry with bronchodilator
- ☐ Spirometry without bronchodilator
- ☐ Total Lung Compliance
- ☐ Room air rest ABG
- ☐ 6 minute walk test
- ☐ Out-patient trach change

Special instrucons:

1) No caffeine at least 6 hours prior to test
2) No breathing medications at least 6 hours prior to test, unless otherwise instructed by your physician

REFERRING PHYSICIAN/PRACTITIONER INFORMATION

Name _____ Fax(Mandatory) _____

_____ _____ _____

Physician's Signature Date Time

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

RESPIRATORY PFT REQUISITION

Form # 026785 REV 03/25

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

PATIENT'S LABEL

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MEETING MINUTES

BOARD OF DIRECTORS REGULAR MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly **March 25, 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 5:00 p.m.

Directors Present: **LOMELI, REDDY, PANDYA, MARTINEZ**
Directors Absent: KASHYAP

Others Present: Donna Hefner, President/Chief Executive Officer, Craig McDonald, Chief Financial Officer, Ron Wheaton, VP of Professional Service, Melissa Crippen, VP of Regulatory Affairs, Tracy Canales, VP of Human Resources and Marketing, Terry Villareal, Executive Assistant and Clerk to the Board, Kim Pryor DeShazo, Director of Marketing and Community Services, Gary Wilbur, Administrative Director of General Services Alex Reed-Krase, Legal Counsel, Ahmad Hakimi, Vice Chief of Staff, Diane Johnson, Dr. Timothy Suorsa, Julieta Munoz and Magdalenda Echeveste

I. Approval of Agenda:

Chairman LOMELI motioned to approve the Agenda. The motion was moved by Director MARTINEZ, seconded by, Vice Chair REDDY and carried to approve the agenda. The vote of the Board is as follows:

MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:04 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

At 5:11 p.m., Director Pandya briefly answered a cell phone call in the Board Room; the call was immediately ended.

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning. Estimated date of Disclosure: January 1, 2027

Closed Session Items D, E and F were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session's scheduled start time.

III. Open Session: Chairman LOMELI adjourned Closed Session at 5:35 p.m., reconvening in Open Session at 5:36 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report presented by Vice Chief of Staff Hakimi.
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 Vice Chair REDDY, seconded by Director PANDYA and carried to approve the Evaluation – Quality of Care/Peer Review/Credentials as presented. The vote of the Board is as follows:

MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

2. Quality Division Report

Following review and discussion, it was moved by Vice Chair REDDY, seconded by Director MARTINEZ, and carried to approve the Quality Division Update – Quality Report as presented. The vote of the Board is as follows:

MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

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

IV. Public Comments

None

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). It was moved by Vice Chair REDDY, seconded by Director PANDYA, and carried to approve the Consent Agenda. The vote of the Board is as follows:

MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

VI. Minutes Deferred:

Following review and discussion, it was moved by Vice Chair REDDY and seconded by Director MARTINEZ to defer the February 25, 2025 Board Meeting Minutes to the next regularly scheduled meeting scheduled for April 22, 2025. The motion carried and the vote of the Board is as follows:

MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

VII. Business Items

A. Porterville Health Academy

Dianne Johnson, PAHS Scholarship Committee Chairperson presented to the Board on the benefits of the Health Academy pathway to students and how donated dollars are able to impact the educational journey for many students who are at the beginning of their healthcare career.

Following review and discussion, it was moved by Director MARTINEZ, seconded by Director PANDYA and carried to donate $15,000 to the Porterville Academy of Health Sciences. The vote of the Board is as follows:

MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

B. February 2025 Financials

Craig McDonald, CFO presented the Financials for February 2025.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chair REDDY and carried to approve the February 2025 Financials as presented. The vote of the Board is as follows:

MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

C. Conflict of Interest Code

The amended Conflict of Interest Code was approved by the Board on September 24, 2024, and subsequently submitted to Tulare County as part of the Biennial Review process. The Tulare County Board of Supervisors approved the amended Code for Sierra View Local Health Care District on December 3, 2024, through Resolution No. 2024-1091. Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chair REDDY and carried to approve the finalized Conflict of Interest Code as presented. The vote of the Board is as follows:

MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

Business item D will be deferred until after the Board reconvenes from Closed Session.

VIII. CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View.

IX. Announcements:

A. Regular Board of Directors Meeting – March 25, 2025 at 5:00 p.m.

X. Closed Session: Chairman LOMELI adjourned Open Session at 6:30 p.m., reconvening in Closed Session at 6:40 p.m.

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Hospital Facilities. Estimated date of disclosure January 1, 2026.

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2027

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

XI. Open Session: Chairman LOMELI adjourned Closed Session at 7:16 p.m., reconvening in Open Session at 7:16 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Discussion Regarding Trade Secrets Pertaining to Hospital Facilities.
Recommended Action: Information Only; No Action Taken

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

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

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The Board resumed consideration of deferred Business Item.

D. Request to Increase OR Air Handler Unit Capital Project

Following review and discussion, a motion was made by Vice Chair REDDY, seconded by Director MARTINEZ and carried to approve to increase the capital budget for the OR Air Handler Unit by $300,591. The vote of the Board is as follows:

MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

XII. Adjournment

The meeting was adjourned at 7:17 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

MEETING MINUTES
BOARD OF DIRECTORS REGULAR MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly **February 25, 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 5:00 p.m.

Directors Present: **LOMELI, MARTINEZ, KASHYAP**

Others Present: Donna Hefner, President/Chief Executive Officer, Craig McDonald, Chief Financial Officer, Jeffery Hudson, VPPCS/CNO/DIO, Ron Wheaton, VP of Professional Service, Tracy Canales, VP of Human Resources and Marketing, Terry Villareal, Executive Assistant and Clerk to the Board, Kim Pryor DeShazo, Director of Marketing and Community Services, Cindy Gomez, Compliance Privacy Officer, Alex Reed-Krase, Legal Counsel and Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

Chairman LOMELI motioned to approve the Agenda. The motion was moved by Director MARTINEZ, seconded by, Director KASHYAP and carried to approve the agenda. The vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:01 p.m. to discuss the following items:

A. Pursuant to Evidence Code 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

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2027

Closed Session Items C and E were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session's scheduled start time.

III. Open Session: Chairman LOMELI adjourned Closed Session at 5:36 p.m., reconvening in Open Session at 5:36 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report provided by Chief of Staff Sandhu.
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 KASHYAP, 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 Yes
MARTINEZ Yes
LOMELI Yes

2. Compliance Report – Quarter 2

Following review and discussion, it was moved by Director MARTINEZ, seconded by Director KASHYAP, and carried to approve the Quality Division Update – Quality Report as presented. The vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

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

IV. Public Comments

None

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda

attached to the file copy of these Minutes). It was moved by Director KASHYAP, seconded by Director MARTINEZ, and carried to approve the Consent Agenda. The vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Director MARTINEZ and seconded by Director KASHYAP to approve the January 28, 2025 Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

VII. Business Items

A. January 2025 Financials

Craig McDonald, CFO presented the Financials for January 2025. A copy of this presentation is attached to the file copy of these minutes.

Following review and discussion, it was moved by Director KASHYAP, seconded by Director MARTINEZ and carried to approve the January 2025 Financials as presented. The vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

B. Board Self Evaluation and Goals
Recommended Action: Information Only: No Action Taken

C. President/CEO Contract

Following review and discussion, it was moved by Director KASHYAP and seconded by Director MARTINEZ to defer this item to the following meeting. The motion carried and the vote of the Board is as follows:

KASHYAP Yes
MARTINEZ Yes
LOMELI Yes

VIII. CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View.

IX. Announcements:

A. Regular Board of Directors Meeting – March 25, 2025 at 5:00 p.m.

X. Closed Session: Chairman LOMELI adjourned Open Session at 6:23 p.m., reconvening in Closed Session at 6:28 p.m.

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (2 Items). Estimated date of Disclosure: January 1, 2027

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

XI. Open Session: Chairman LOMELI adjourned Closed Session at 7:10 p.m., reconvening in Open Session at 7:11 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

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C. Discussion Regarding Trade Secrets Pertaining to Service 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 7:11 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

MINUTES OF A SPECIAL MEETING OF THE BOARD OF DIRECTORS OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The special meeting of the Board of Directors of Sierra View Local Health Care District was held **April 10, 2025 at 12:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California.

Directors Present: REDDY, MARTINEZ, KASHYAP
Directors Present Via Conference Phone and Zoom: LOMELI
Director Absent: PANDYA

Others Present: Donna Hefner, President/Chief Executive Officer, Terry Villareal, Executive Assistant and Clerk to the Board, BETA Team (three individuals)

I. Call to Order: Vice Chair Reddy called the meeting to order at 12:03 p.m.

Technical difficulties logging into Zoom account, therefore Clerk could not move Chairman Lomeli into the meeting from the Zoom waiting room. Chairman Lomeli joined by Board Room conference phone.

II. Approval of Agendas: Vice Chair REDDY asked for approval of the agenda. It was moved by Director MARTINEZ and seconded by Director KASHYAP and carried to approve the agenda as presented. The vote of the Board is as follows:

KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

III. Closed Session: Board adjourned Open Session and went into Closed Session at 12:03 p.m. to discuss the following items:

A. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service Regarding BETA HEART (1 Item). Estimated date of Disclosure: January 1, 2026

Chairman Lomeli was no longer connected to the meeting as of 12:25pm

Chairman Lomeli rejoined the meeting via Zoom with audio only at 12:54pm

IV. Open Session: Board adjourned Closed Session at 1:10 p.m. and went into Open Session at 1:00 p.m. to discuss the following items:

A. Pursuant to Gov. Code Section 54962: Discussion Regarding Trade Secrets Pertaining to Service Regarding BETA HEART
Information Only: No Action

V. Public Comments
None.

XIII. Announcements:

A. Regular Board of Directors Meeting – April 22, 2025

Adjournment: There being no further business, the meeting was adjourned at 1:01 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors
AM: trv

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FINANCIAL PACKAGE
March 2025

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
March 2025

Statistic	Mar-25 Actual	Mar-25 Budget	Mar-25 Over/ (Under)	Mar-25 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 24 YTD	Increase/ (Decrease) Mar-24	% Change
Utilization											
SNF Patient Days											
Total	-	56	(56)	-100.0%	127	506	(379)	-74.9%	450	(323)	-71.8%
Medi-Cal	-	56	(56)	-100.0%	127	504	(377)	-74.8%	450	(323)	-71.8%
Sub-Acute Patient Days											
Total	939	970	(31)	-3.2%	8,830	8,727	103	1.2%	8,731	99	1.1%
Medi-Cal	458	883	(425)	-48.1%	4,406	7,513	(3,107)	-41.4%	7,523	(3,117)	-41.4%
Acute Patient Days	1,725	1,648	77	4.7%	14,963	14,828	135	0.9%	14,989	(26)	-0.2%
Acute Discharges	418	427	(9)	-2.1%	3,956	3,842	115	3.0%	3,875	81	2.1%
Medicare	200	165	35	21.3%	1,602	1,493	109	7.3%	1,505	97	6.4%
Medi-Cal	174	204	(30)	-14.5%	1,853	1,891	(38)	-2.0%	1,907	(54)	-2.8%
Contract	41	56	(15)	-27.2%	476	432	44	10.1%	437	39	8.9%
Other	3	2	1	43.7%	25	26	(1)	-2.0%	26	(1)	-3.8%
Average Length of Stay	4.13	3.86	0.27	6.9%	3.78	3.86	(0.08)	-2.0%	3.87	(0.09)	-2.2%
Newborn Patient Days											
Medi-Cal	140	161	(21)	-13.1%	1,369	1,441	(72)	-5.0%	1,494	(125)	-8.4%
Other	18	31	(13)	-42.2%	309	288	21	7.1%	258	51	19.8%
Total	158	192	(34)	-17.8%	1,678	1,729	(51)	-3.0%	1,752	(74)	-4.2%
Total Deliveries	84	99	(15)	-15.2%	877	891	(14)	-1.6%	904	(27)	-3.0%
Medi-Cal %	85.71%	83.43%	2.28%	2.7%	82.23%	83.43%	-1.20%	-1.4%	84.78%	-2.55%	-3.0%
Case Mix Index											
Medicare	1.4888	1.6368	(0.1480)	-9.0%	1.6095	1.6368	(0.0273)	-1.7%	1.6235	(0.0140)	-0.9%
Medi-Cal	1.1204	1.1975	(0.0771)	-6.4%	1.1913	1.1975	(0.0062)	-0.5%	1.2115	(0.0202)	-1.7%
Overall	1.3363	1.3724	(0.0361)	-2.6%	1.3677	1.3724	(0.0047)	-0.3%	1.3782	(0.0105)	-0.8%
Ancillary Services											
Inpatient											
Surgery Minutes	6,908	8,224	(1,316)	-16.0%	67,685	74,015	(6,330)	-8.6%	74,518	(6,833)	-9.2%
Surgery Cases	76	94	(18)	-18.9%	803	844	(41)	-4.8%	843	(40)	-4.7%
Imaging Procedures	1,541	1,404	137	9.7%	13,605	12,638	967	7.6%	12,670	935	7.4%
Outpatient											
Surgery Minutes	13,409	12,775	634	5.0%	122,599	114,976	7,623	6.6%	110,617	11,982	10.8%
Surgery Cases	175	204	(29)	-14.1%	1,675	1,834	(159)	-8.7%	1,803	(128)	-7.1%
Endoscopy Procedures	161	192	(31)	-15.9%	1,622	1,724	(102)	-5.9%	1,629	(7)	-0.4%
Imaging Procedures	4,257	3,886	371	9.6%	36,866	34,972	1,894	5.4%	35,328	1,538	4.4%
MRI Procedures	310	302	8	2.8%	2,716	2,715	1	0.0%	2,732	(16)	-0.6%
CT Procedures	1,255	1,237	18	1.5%	11,047	11,132	(85)	-0.8%	11,075	(28)	-0.3%
Ultrasound Procedures	1,347	1,244	103	8.3%	11,755	11,193	562	5.0%	11,274	481	4.3%
Lab Tests	34,792	32,140	2,652	8.3%	285,941	289,262	(3,320)	-1.1%	285,693	248	0.1%
Dialysis	5	6	(1)	-21.1%	32	57	(25)	-43.9%	34	(2)	-5.9%

Sierra View Medical Center
Financial Statistics Summary Report
March 2025

Statistic	Mar-25 Actual	Mar-25 Budget	Mar-25 Over/ (Under)	Mar-25 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 24 YTD	Increase/ (Decrease) Mar-24	% Change
Cancer Treatment Center											
Chemo Treatments	2,148	1,924	224	11.7%	17,347	17,314	33	0.2%	14,652	2,695	18.4%
Radiation Treatments	1,762	1,836	(74)	-4.0%	16,466	16,522	(56)	-0.3%	16,434	32	0.2%
Cardiac Cath Lab											
Cath Lab IP Procedures	15	11	4	33.3%	115	101	14	13.6%	115	-	0.0%
Cath Lab OP Procedures	34	30	4	13.6%	297	269	28	10.3%	265	32	12.1%
Total Cardiac Cath Lab	49	41	8	19.0%	412	371	42	11.2%	380	32	8.4%
Outpatient Visits											
Emergency	3,511	3,415	96	2.8%	31,108	30,731	377	1.2%	30,866	242	0.8%
Total Outpatient	14,763	13,994	769	5.5%	126,181	125,948	233	0.2%	120,682	5,499	4.6%
Staffing											
Paid FTE's	936.84	855.00	81.84	9.6%	875.37	855.00	20.37	2.4%	860.96	14.41	1.7%
Productive FTE's	770.68	734.21	36.47	5.0%	748.70	734.21	14.49	2.0%	736.37	12.33	1.7%
Paid FTE's/AOB	5.50	4.98	0.52	10.4%	5.17	4.89	0.28	5.7%	5.05	0.12	2.3%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,327	10,552	775	7.3%	11,251	10,552	699	6.6%	10,669.23	582	5.5%
Cost/Adj.Patient Day	2,877	2,600	277	10.6%	2,813	2,621	192	7.3%	2,685.67	127	4.7%
Revenue/Adj. Discharge	59,113	53,065	6,048	11.4%	55,015	53,065	1,949	3.7%	53,503	1,512	2.8%
Cost/Adj. Discharge	15,016	13,077	1,939	14.8%	13,754	13,179	575	4.4%	13,468	286	2.1%
Adj. Discharge	1,011	1,057	(46)	-4.3%	9,484	9,517	(33)	-0.3%	9,308	176	1.9%
Net Op. Gain/(Loss) %	-2.99%	-3.58%	0.59%	-16.6%	-2.37%	-3.58%	1.21%	-33.9%	-5.98%	3.61%	-60.4%
Net Op. Gain/(Loss) $	(440,685)	(478,192)	37,507	-7.8%	(3,017,602)	(5,268,560)	2,250,958	-42.7%	(7,075,588)	4,057,986	-57.4%
Gross Days in Accts Rec.	84.10	95.03	(10.93)	-11.5%	84.10	95.03	(10.93)	-11.5%	94.06	(9.96)	-10.6%
Net Days in Accts. Rec.	40.23	57.75	(17.51)	-30.3%	40.23	57.75	(17.51)	-30.3%	54.69	(14.45)	-26.4%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	MAR 2025	FEB 2025
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 11,949,566	$ 15,830,636
SHORT-TERM INVESTMENTS	314,737	93,740
ASSETS LIMITED AS TO USE	4,035,431	3,561,044
PATIENT ACCOUNTS RECEIVABLE	161,930,035	167,095,206
LESS UNCOLLECTIBLES	(13,651,827)	(20,639,684)
CONTRACTUAL ALLOWANCES	(129,409,393)	(126,354,247)
OTHER RECEIVABLES	29,516,065	27,244,148
INVENTORIES	4,489,599	4,579,619
PREPAID EXPENSES AND DEPOSITS	3,322,053	2,990,827
LEASE RECEIVABLE - CURRENT	303,872	303,872
TOTAL CURRENT ASSETS	72,800,139	74,705,161
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	32,005,619	31,917,314
LONG-TERM INVESTMENTS	137,035,318	136,655,661
PROPERTY, PLANT AND EQUIPMENT, NET	72,592,483	73,059,199
INTANGIBLE RIGHT OF USE ASSETS	315,261	327,287
SBITA RIGHT OF USE ASSETS	3,946,961	4,097,994
LEASE RECEIVABLE - LT	841,271	867,533
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,321,716	1,342,695
TOTAL ASSETS	$ 321,108,767	$ 323,222,845

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	MAR 2025	FEB 2025
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 346,763	$ 231,175
CURRENT MATURITIES OF BONDS PAYABLE	4,235,000	4,235,000
CURRENT MATURITIES OF LONG TERM DEBT	1,382,212	1,466,865
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	4,110,667	5,966,400
ACCRUED PAYROLL AND RELATED COSTS	6,917,816	6,838,755
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	5,609,731	6,118,761
LEASE LIABILITY - CURRENT	135,181	136,899
SBITA LIABILITY - CURRENT	1,702,294	1,706,184
TOTAL CURRENT LIABILITIES	24,439,663	26,700,039
SELF-INSURANCE RESERVES	2,116,478	2,123,530
BONDS PAYABLE, LESS CURR REQT	33,275,000	33,275,000
BOND PREMIUM LIABILITY - LT	2,234,448	2,286,405
LEASE LIABILITY - LT	203,582	213,822
SBITA LIABILITY - LT	2,506,168	2,621,303
DEFERRED INFLOW - LEASES	1,078,139	1,104,657
TOTAL LIABILITIES	65,853,477	68,324,754
UNRESTRICTED FUND	248,385,511	248,385,511
PROFIT OR (LOSS)	6,869,779	6,512,580
TOTAL LIABILITIES AND FUND BALANCE	$ 321,108,767	$ 323,222,845

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

MAR 2025 ACTUAL	MAR 2025 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,417,118	5,253,784	(163,334)	3%	INPATIENT - NURSING	48,331,273	47,284,056	(1,047,217)	2%
19,439,923	17,396,289	(2,043,634)	12%	INPATIENT - ANCILLARY	170,049,846	156,566,607	(13,483,239)	9%
24,857,041	22,650,073	(2,206,968)	10%	TOTAL INPATIENT REVENUE	218,381,119	203,850,663	(14,530,456)	7%
34,933,106	33,463,072	(1,470,034)	4%	OUTPATIENT - ANCILLARY	303,387,734	301,167,645	(2,220,089)	1%
59,790,147	56,113,145	(3,677,002)	7%	TOTAL PATIENT REVENUE	521,768,852	505,018,308	(16,750,544)	3%
				DEDUCTIONS FROM REVENUE				
(22,464,599)	(18,243,309)	4,221,290	23%	MEDICARE	(157,196,593)	(164,189,781)	(6,993,188)	(4)%
(17,429,080)	(18,032,202)	(603,122)	(3)%	MEDI-CAL	(159,281,921)	(162,289,818)	(3,007,897)	(2)%
(12,608,803)	(6,660,852)	5,947,951	89%	OTHER/CHARITY	(68,450,347)	(59,947,668)	8,502,679	14%
(129,629)	(9,556)	120,073	1,257%	DISCOUNTS & ALLOWANCES	(13,945,535)	(86,004)	13,859,531	16,115%
6,977,272	(499,610)	(7,476,882)	(1,497)%	BAD DEBTS	(736,396)	(4,496,490)	(3,760,094)	(84)%
(45,654,839)	(43,445,529)	2,209,310	5%	TOTAL DEDUCTIONS	(399,610,793)	(391,009,761)	8,601,032	2%
14,135,308	12,667,616	(1,467,692)	12%	NET SERVICE REVENUE	122,158,060	114,008,547	(8,149,513)	7%
612,007	682,481	70,474	(10)%	OTHER OPERATING REVENUE	5,270,319	6,142,335	872,016	(14)%
14,747,315	13,350,097	(1,397,218)	11%	TOTAL OPERATING REVENUE	127,428,378	120,150,882	(7,277,496)	6%
				***** OPERATING EXPENSE *****				
5,899,572	5,539,411	360,161	7%	SALARIES	50,949,271	49,743,557	1,205,714	2%
619,623	674,211	(54,588)	(8)%	S&W PTO	5,642,316	6,059,453	(417,137)	(7)%
1,475,230	1,472,325	2,905	0%	EMPLOYEE BENEFITS	12,663,446	13,159,693	(496,248)	(4)%
2,133,069	1,400,468	732,601	52%	PROFESSIONAL FEES	16,442,478	12,719,300	3,723,178	29%
788,609	851,535	(62,926)	(7)%	PURCHASED SERVICES	7,628,495	7,524,498	103,997	1%
2,368,236	2,028,102	340,134	17%	SUPPLIES & EXPENSES	19,067,255	18,270,003	797,252	4%
300,749	265,797	34,952	13%	MAINTENANCE & REPAIRS	2,339,449	2,462,141	(122,692)	(5)%
231,874	277,064	(45,190)	(16)%	UTILITIES	2,425,718	2,493,576	(67,858)	(3)%
80,542	19,605	60,937	311%	RENT/LEASE	365,307	176,437	188,870	107%
130,811	121,228	9,583	8%	INSURANCE	1,116,180	1,091,052	25,128	2%
858,982	853,764	5,218	1%	DEPRECIATION/AMORTIZATION	8,434,419	8,823,918	(389,499)	(4)%
300,704	324,779	(24,075)	(7)%	OTHER EXPENSE	3,160,366	2,895,814	264,552	9%
0	0	0	0%	IMPAIRED COSTS	211,281	0	211,281	
15,188,000	13,828,289	1,359,711	10%	TOTAL OPERATING EXPENSE	130,445,980	125,419,442	5,026,538	4%
(440,685)	(478,192)	(37,507)	(8)%	NET GAIN/(LOSS) FROM OPERATIONS	(3,017,601)	(5,268,560)	(2,250,959)	(43)%
138,253	138,253	0	0%	DISTRICT TAXES	1,244,277	1,244,277	0	0%
387,566	343,455	(44,111)	13%	INVESTMENTS INCOME	3,446,329	3,091,090	(355,239)	12%
31,013	54,010	22,997	(43)%	OTHER NON OPERATING INCOME	2,699,781	486,094	(2,213,687)	455%
(83,184)	(80,574)	2,610	3%	INTEREST EXPENSE	(712,637)	(725,159)	(12,522)	(2)%
(21,094)	(36,954)	(15,860)	(43)%	NON-OPERATING EXPENSE	(334,645)	(332,577)	2,068	1%
452,553	418,190	(34,363)	8%	TOTAL NON-OPERATING INCOME	6,343,106	3,763,725	(2,579,381)	69%
11,868	(60,002)	(71,870)	(120)%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	3,325,505	(1,504,835)	(4,830,340)	(321)%
345,331	100,000	(245,331)	245%	NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	3,544,275	900,000	(2,644,275)	294%
357,200	39,998	(317,202)	793%	NET GAIN/(LOSS)	6,869,779	(604,835)	(7,474,614)	(1,236)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
03/31/25

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(440,685)	(3,017,601)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	858,982	8,434,419
Provision for bad debts	(6,987,857)	(9,894,448)
Change in assets and liabilities:		
Patient accounts receivable, net	8,220,318	14,840,627
Other receivables	(2,271,917)	(11,265,882)
Inventories	90,020	(198,947)
Prepaid expenses and deposits	(331,226)	(1,000,649)
Advance refunding of bonds payable, net	20,979	188,816
Accounts payable and accrued expenses	(1,855,733)	(2,212,926)
Deferred inflows - leases	(26,518)	(145,777)
Accrued payroll and related costs	79,061	(1,642,003)
Estimated third-party payor settlements	(509,030)	1,952,786
Self-insurance reserves	(7,052)	(72,522)
Total adjustments	(2,719,973)	(1,016,506)
Net cash provided by (used in) operating activities	(3,160,658)	(4,034,107)
Cash flows from noncapital financing activities:		
District tax revenues	138,253	1,244,277
Noncapital grants and contributions, net of other expenses	(8,324)	(46,214)
Net cash provided by (used in) noncapital financing activities	129,929	1,198,063
Cash flows from capital and related financing activities:		
Purchase of capital assets	(380,240)	(4,073,598)
Proceeds from sale of assets	-	3,255,420
Proceeds from lease receivable, net	26,262	147,748
Principal payments on debt borrowings	-	(4,055,000)
Interest payments	(1,311)	(1,491,955)
Net change in notes payable and lease liability	(64,603)	(812,646)
Net changes in assets limited as to use	(562,692)	393,093
Net cash provided by (used in) capital and related financing activities	(982,584)	(6,636,938)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(34,326)	(4,755,682)
Investment income	387,566	3,446,329
Net cash provided by (used in) investing activities	353,240	(1,309,353)
Net increase (decrease) in cash and cash equivalents:	(3,660,073)	(10,782,335)
Cash and cash equivalents at beginning of month/year	15,924,376	23,046,638
Cash and cash equivalents at end of month	12,264,303	12,264,303

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
March 2025

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Apr-24	13,314,378	6,920,700	20,235,078
May-24	11,564,879	10,488,610	22,053,489
Jun-24	10,598,225	7,664,994	18,263,219
Jul-24	13,499,837	278,849	13,778,686
Aug-24	10,684,807	298,095	10,982,902
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**

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

March 2025 Summary of Other Activity:

253,428	M-Care interim payments
197,831	Miscellaneous
451,259	03/25 Total Other Activity