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

AGENDA
May 28, 2024

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

3. Compliance Report – Quarter 3

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service to Fill the Chief Financial Officer Position– One (1) Item. Estimated Date of Disclosure September 1, 2024 for materials that are not part of an individual's private personnel file.

D. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter Chief Financial Officer Agreement Mutual Termination – One (1) Item. Estimated Date of Disclosure May 28, 2024 for materials that are not part of an individual's private personnel file.

E. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter Chief Executive Officer Performance Evaluation 2023 – One (1) Item. Estimated Date of Disclosure May 28, 2024 for materials that are not part of an individual's private personnel file.

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning

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

3. Compliance Report – Quarter 3
Recommended Action: Approve/Disapprove Report as Given

C. Discussion Regarding Filling Position of Chief Financial Officer
Recommended Action: Information Only: No Action Taken

D. Discussion Regarding Chief Financial Officer Agreement Mutual Termination
Recommended Action: Information Only: No Action Taken

E. Discussion Regarding Chief Executive Officer Performance Evaluation 2023
Recommended Action: Information Only: No Action Taken

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

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. **April 23, 2024 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove April 23, 2024 Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

A. **Moss Adams Entrance Presentation FY '23 Audit (Virtual)**
Recommended Action: Information Only: No Action Taken

B. **April 2024 Financials**
Recommended Action: Approve/Disapprove April 2024 Financials

C. **Capital Budget Report Quarter 3**
Recommended Action: Approve/Disapprove Capital Budget Report Q3

D. **Investment Policy**
Recommended Action: Approve/Disapprove Investment Policy

E. **Investment Report Quarter 3**
Recommended Action: Approve/Disapprove Investment Report Q3

F. **Incoming Chief Financial Officer Employment Contract and Negotiation of Salary**
Recommended Action: Approve/Disapprove Incoming CFO Agreement

G. **Current Chief Financial Officer Agreement Mutual Termination**
Recommended Action: Approve/Disapprove Current CFO Agreement Mutual Termination

H. **CEO 2024 Salary Negotiations**
Recommended Action: Approve/Disapprove CEO 2024 Salary Increase

X. CEO Report

XI. Announcements:

A. Special Board of Directors Meeting – June 3, 2024 at 5:00 p.m.
B. Regular Board of Directors Meeting – June 25, 2024 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 Mitchell, 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.

MEDICAL EXECUTIVE COMMITTEE	05/01/2024
BOARD OF DIRECTORS APPROVAL	
	05/28/2024
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
May 28, 2024 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**
• Attire in the Operating Room, Endoscopy, Central Processing, Obstetrics, Interventional Radiology, Cardiac Cath Lab	1-5	↓
• Clinical Dietitian Scope of Practice	6-8	
• Diagnosis of Death by Neurologic Criteria	9-15	
• Diet Orders	16-17	
• Do Not Resuscitate (DNR) in the Operating Room	18-25	
• Maternal Sepsis	26-34	
• Menu Planning	35-38	
• Patient Education for Modified Diet	39-40	
• Physician Ordered Consultation	41	
• Scope of Service – Cardiac Cath Lab	42-44	
• Storage and Transportation of Supplies	45-46	

SUBJECT:	SECTION:
ATTIRE IN THE OPERATING ROOM, ENDOSCOPY, CENTRAL PROCESSING, OBSTETRICS, INTERVENTIONAL RADIOLOGY, CARDIAC CATH LAB	**Page 1 of 5**

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

PURPOSE:

To define guidelines for clean surgical attire to be worn by all persons moving within the surgical environment.

Our Goal:

- Minimize numbers of microorganisms in the perioperative environment.
- Present a professional appearance, minimize lint & bacterial shedding, and provide comfort to the wearer.
- Provide a barrier to contamination and protect patients and persons from exposure to infectious microorganisms or hazardous materials within the surgical environment.

POLICY:

All staff and persons entering the semi-restricted and restricted areas of Surgical Services, Endoscopy, Maternal Child Health (MCH) operating room (OR), Interventional Radiology (IR), Cardiac Catheterization Laboratory (CCL) and Central Processing Department (CPD) are required to wear clean surgical attire provided by and donned at the facility. Reusable items will be laundered to hospital standards. Healthcare personnel shall cover their heads, hair and facial hair to minimize bacterial contamination in the restricted perioperative areas.

This policy is not intended to address sterile attire worn at the surgical field.

AFFECTED AREAS/ PERSONNEL: *MAIN OR, ASD, MCH-OR, ENDOSCOPY, CPD, IR, CARDIAC CATH LAB*

PROCEDURE:

1. All persons who enter the semi-restricted and restricted areas change into clean, processed scrub attire after arriving at the facility; this reduces the number of microbes introduced into the department from outside the facility. Dressing areas and secure lockers are provided by the facility for the donning of surgical attire and storage of personal belongings.
2. All scrubs and scrub dresses, including Cover Coats, will be laundered at a healthcare accredited laundry facility, exceptions being undergarments and stockings. Uniforms are not to be worn home. In the event an employee needs to step outside the facility, scrubs must be changed upon re-entry to a restricted area. Scrub dresses must be worn with undergarments and stockings.
3. Change surgical attire daily or whenever becoming visibly soiled, contaminated or wet.

4. Reusable woven cloth attire (scrubs) in sizes as indicated by director/manager will be provided to each Department. Hospital approved attire may be worn in all restricted/semi-restricted areas as indicated by hospital.

5. Single use disposable scrubs are provided in the event that reusable cloth scrubs are unavailable for staff and visitors. These suits are to be discarded into the trash after use, and may not be re-used. These disposable scrubs must completely cover the wearer's clothing, and is intended for short-term use.

6. Limited use, non-woven fabric cover-all or "bunny suit" is provided to persons entering the semi-restricted or restricted areas for limited purpose. This disposable coverall must completely cover the wearer's clothing, and is intended for short-term use.

7. Providers are to change into clean scrubs when returning to a restricted area from outside the facility.

8. Staff not scrubbed in the sterile field may or may not wear long sleeved jackets during all OR cases. Long sleeve jackets should fit closely to the arms and torso and be snapped or buttoned closed.
    a. Central processing staff will wear long sleeved jackets at all times while preparing and packaging items in the clean assembly section of sterile processing.

9. Shoes worn within the perioperative environment must have closed toes and backs, low heels, and nonskid soles. Shoes made of cloth or containing any holes or perforations on top of shoe or sides will not be used in the OR. It is preferred that staff keep shoes dedicated for use within the perioperative area. Shoe covers or boots must be used in the operating rooms when there is potential for a large amount of fluid, gross contamination, or blood. Single use shoe covers should be removed immediately, discarded, and hand hygiene should be performed. Shoe covers may not be worn outside the department.

10. ID badges should be worn secured on the scrub top or jacket, and should be visible. Badges should be cleaned daily and when soiled.. Lanyards should not be worn.

11. Jewelry that cannot be confined within the scrub apparel should not be worn within the semi-restricted or restricted areas.

12. Place used surgical attire in appropriate container for laundering vendor. Do not hang or place worn attire in locker for future use.

Scrubbed and non-scrubbed team members should limit jewelry to the following:

1. Earrings, limited to a small stud type contained in the head covering
2. Necklaces should be limited to a small single chain contained under the scrub top.

Non-Scrubbed team members may also wear:

1. Watch
2. Rings, one per hand. No elevated settings which might cause harm to a patient are to be worn.

13. A clean surgical head cover or hood that confines all hair and completely covers the ears, scalp skin, and nape of the neck should be worn. All head and facial hair including sideburns, moustaches and beards shall be covered when in the semi-restricted and restricted areas. Hair covering should be the first article donned when wearing surgical attire.

    a. Hair covering shall be clean low lint surgical hat or hood which confines all head and facial hair and is designed to reduce microbial dispersal.

    b. Hair covering will be changed only when contaminated with blood or bodily fluids and discarded at the end of the day.

    c. Reusable cloth hats are to be changed daily, laundered appropriately and covered by a disposable bouffant.

14. All persons entering the restricted areas of the surgical suite or Core area shall wear a mask when there are opened sterile items present, or a case is in progress. Surgical masks in combination with eye protection devices such as goggles, glasses with solid side shields, or face shields, must be worn whenever splashes, spray, splatter or droplets of blood, bodily fluids or other potentially infectious materials may be generated and eye, nose or mouth contamination can be reasonably anticipated.

    a. Reusable eye protection, such as goggles, should be cleaned according to the manufacturer's instructions before and after each use.

b. Single use surgical masks must be worn in the surgical environment where open sterile supplies or scrubbed persons are located. The mask must cover both mouth and nose, and be flush with the sides of the face in such a manner that prevents venting at any point around the mask.

c. Masks are to be carefully removed and discarded after use by handling only the ties or loops. Masks are not to be tucked in a pocket or saved by hanging around theneck.

d. Wet masks do not provide a protective barrier and are capable of transmitting blood borne pathogens. A mask contaminated by blood or bodily fluids must be changed as soon as possible.

e. In the event that a mask tie becomes loose and dangles below the shoulder level of a gown, the surgical gown must be considered contaminated.

15. Nails must be clean, short, and no more than ¼ inch in length. If nail polish is worn, it must be unchipped and cannot be worn for more than 4 days. All artificial nails are prohibited in the operating room, including gel and shellac polish.

DECONTAMINATION AREA: *SURGERY MAIN, ASD, MCH-OR, ENDOSCOPY, CENTRAL PROCESSING DEPARTMENT*

Additional personal protective attire is required in the Decontamination area as delineated below:

- The Occupational Safety and Health Administration (OSHA) exposure control plan outlines potential hazards personnel might encounter on the job. To maintain the Health and Safety of personnel working in a decontamination area, they are required to wear Personal Protective Equipment (PPE). Protective attire must be appropriate for the task being performed. In situations that require the highest level of protection, a Level 4 gown (as defined by ANSI/AAMI) should be used.
- In addition to attire recommendations for semi-restricted and restricted areas, personnel working in the decontamination areas should wear general purpose utility gloves and a liquid resistant covering with sleeves (for example a backless gown, jumpsuit or surgical gown). Liquid resistant shoe covers should be worn if there is a potential for shoes becoming contaminated and/or soaked with blood or other bodily fluids.
- If there is any risk of splash or splatter, PPE should include a fluid-resistant face mask and eye protection which protects from exposure to splash from all angles.

Hand washing with soap and water is to be performed after removal of protective attire.

All other items:

- **Personal bags, briefcases, backpacks, etc are not allowed in the operating rooms unless they can be wiped down prior to entering.**
- **Clean cellphones, tablets, and other electronic devices prior to entry to the operating room according to the manufacturer's instructions.**
- **Clean stethoscopes before each patient use according to manufactures instructions.**

- **REFERENCES:**

- AORN Guideline for Surgical Attire, AORN Standards and Recommended Practices, 2023.. Retrieved from https://aornguidelines.org/guidelines/content?sectionid=173717946&view=book#173717946.
- Association of Surgical Technologist. AST Guidelines Surgical Attire. AST Standards of Practice for Surgical Attire, Surgical Scrub, Hand Hygiene and Hand Washing. 2024. Retrieved from https://www.ast.org/uploadedfiles/main_site/content/about_us/standard_surgical_attire_surgical_scrub.pdf.

SUBJECT: **CLINICAL DIETITIAN SCOPE OF PRACTICE**	SECTION: *Leadership (LD)* **Page 1 of 3**

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

PURPOSE:

The Registered Dietitian(s) (RD) will provide optimal medical nutrition therapy to patients of the organization to improve patient outcomes and reduce length of hospital stay.

POLICY:

The RD will be qualified through education, training, and experience in educational and clinical skills.

AFFECTED AREAS/PERSONNEL: *FOOD AND NUTRITION SERVICE S (FNS), PATIENT CARE AREAS*

Staffing: Full time RDs are available Monday- Saturday 0730-1700, and on call on Sunday for physician referrals from 0800-1630.

Qualifications: RDs are food and nutrition experts who have met the Commission on Dietetic Registration's (CDR) criteria to earn their RD credential.

- Maintains current registration, or eligible for registration, with the Academy of Nutrition and Dietetics (AND) and the Commission on Dietetic Registration (CDR).
- Complete continuing education requirements, and remain in good standing with CDR.
- Shall work within the "Revised 2024 Scope and Standards of Practice for the RDN"

PROCEDURE:

The Clinical Nutrition Manager and Clinical RDs are responsible for the following:

1. Evaluate the nutritional needs of residents/patients, provides nutrition education and documents in the medical record.
2. Interprets, evaluates and utilizes current research relating to nutritional care.
3. May assist in implementing continuing education programs for FNS employees.
4. Develops interdisciplinary care planning and nutrition care plans.
5. May assist in evaluating and monitoring the meal delivery system.
6. May assist in monitoring FNS for sanitation, safety and infection control.
7. Visits residents/patients to monitor food acceptance.
8. Reviews, revises and makes recommendations as needed for the FNS policy and procedures.
9. Reviews, revises and makes recommendations as needed for the FNS clinical diet manual.
10. Meets ongoing continuing education requirements as established by facility with evidence of current registration and current contract for services.
11. Reports concerns regarding the nutritional care of patients/residents to the FNS Director.

Communication/Collaboration:

The Physician:

1. Has direct control of patient care in all cases and at all times.

2. Will enter/write the initial diet order

3. If physician desires, he/she may enter/write order for "Registered Dietitian to recommend oral diet consistency, calorie or protein level and supplements, tube feeding or macronutrient regimen for parenteral nutrition," in the physician order section of the medical record. The physician may discontinue any RD recommendation at his/ her discretion.

4. All orders, including telephone orders, must be authenticated within 48 hours by the Licensed Independent Practitioner (LIP).

The Registered Dietitian:

RDs may receive a consult/referral from a physician. The RD will recommend Medical Nutrition Therapy (MNT) by calling the physician or notifying the Registered Nurse (RN) who communicates with the physician. Telephone order read back (TORB) is acceptable. The type of nutrition regimens may include:

1. Nutritional counseling and/or assessment: Estimated caloric and protein regimen. Refer to speech therapy for diet texture.

2. Lab test: RDs may order medical laboratory tests related to medical nutrition therapy when approved by the referring physician. A Registered Nurse is notified and will order the laboratory test (State dietetic practice law). Examples are:
    a. Pre-Albumin
    b. Albumin
    c. Glucose, Hemoglobin A1C
    d. Cholesterol, Triglycerides, HDL, LDL
    e. Serum Iron, Folate, vitamin B12
    f. Magnesium and Phosphorus
    g. Liver, pancreatic, and kidney related test

3. Oral Nutritional Supplements: See Oral Nutrition Supplement policy for further discussion.

4. Diets: The RD may individualize the patient's nutritional or dietary treatment when necessary by modifying the distribution, type or quantity of food and nutrients within the parameters of the diet order to provide medical nutrition therapy. Without a physician's explicit order, the RD may not adjust a calorie or protein level (i.e. 2000 calorie to 1500 calorie) or upgrade diet texture (i.e. Dysphagia to Regular).

5. Snacks: The RD may recommend adding or discontinuing snacks if on a therapeutic diet. If a patient is on a regular non-therapeutic diet, the RD can order the snacks. The Physician may order bedtime (HS) snacks, if desired, for the diabetic patient. Routine snacks are not sent. The gestational diabetic diet does include six (6) small meals and does not require Dietary Special Needs (DSN) snack order.

6. Wound Care Nutrients: The RD may receive a consult/referral by the physician or nursing staff. The RD may recommend vitamin and mineral supplements such as vitamin C, zinc, fortify diets with calories and protein, add therapeutic nutrition drink mixes (amino acids) or protein powders/liquids.

7. Tube Feedings (TF), Parenteral Nutrition (PN), Central Parenteral Nutrition (CPN) and Peripheral Parenteral Nutrition (PPN):

    a. The RD may receive a consult/referral by a physician to initiate or change the regimen. The RD may recommend the rate for a tube feeding.

    b. The RD may enter/write the initial TF/PN order when the physician defers the order to the RD to meet the metabolic needs of the patient or specifies in the physician order that RD and Pharmacy are to collaborate on appropriate macronutrients.

    c. The RN, RD or Pharmacist may discuss with the physician prior to nutrition regimen initiation.

REFERENCES:

- Revised 2024 Scope and Standards of Practice for the Registered Dietitian Nutritionist
  Retrieved from:
  https://www.cdrnet.org/vault/2459/web//Scope%20Standards%20of%20Practice%202024%20RDN_FINAL.pdf

- California Code, Business and Professions Code - BPC § 2585. (n.d.). Retrieved from:
  https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=BPC&division=2.&title=&part=&chapter=5.65.&article=

- Centers for Medicare and Medicaid Services, Conditions of Participation (2024). Retrieved from
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/CE-Associations-List/The-Commission-on-Dietetic-Registration

- Academy of Nutrition and Dietetics, EatrightPro.org

- CIHQ Acute care Accreditation Standards:
  file:///C:/Users/josec/Downloads/CIHQ%20Acute%20Care%20Accreditation%20Standards%20-%20Participating%20in%20Medicare%20Rev.%201.21.pdf

  https://www.cdrnet.org/certifications/registered-dietitian-rd-certification

- The Joint Commission. (2024). Accreditation Participation Requirements (APR) Manual.

CROSS REFERENCES:

- Oral Nutrition Supplement Policy
- Physician Ordered Consultation Policy

SUBJECT: **DIAGNOSIS OF DEATH BY NEUROLOGIC CRITERIA**	SECTION: ***Provisions of Care, Treatment and Services (PC)*** **Page 1 of 7**

PURPOSE:

To give guidance to physicians and hospitals in California as they care for patients with brain injury or disease that leads to death.

Suggest working with Intensivist and Neuro to ensure necessary aspects of care represent our practice.

POLICY:

Sierra View Medical Center (SVMC) supports a comprehensive management strategy when death has been diagnosed using neurologic criteria. The following elements should be considered:

- Criteria for the Determination of Death
- Neurologic Criteria for Determination of Death
- Procedure for Determination of Death
- Documentation of the Determination of Death
- Procedure following Determination of Death
- Procedure following Determination of Death in a pregnant patient

DEFINITIONS:

Death by neurologic criteria, commonly referred to as brain death, occurs in individuals who have sustained catastrophic brain injury, with no evidence of function of the brain as a whole, a state that must be permanent.

Death diagnosed by *neurologic criteria* should be declared when a patient with a known cause of catastrophic brain injury has permanent loss of function of the entire brain, including the brainstem, resulting in (1) coma, (2) brainstem areflexia, and (3) apnea in the setting of an adequate stimulus.

Permanent Vegetative State is a condition of apparent wakefulness without awareness, where breathing may be unassisted.

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

PROCEDURE:

CRITERIA FOR THE DETERMINATION OF DEATH

1. Death is the permanent cessation of the critical functions of an organism as a whole. A determination of death is made in accordance with one of two accepted medical standards:
   a. Cardiopulmonary criteria – in the absence of cardiopulmonary support, death is determined by the prolonged absence of spontaneous circulatory and respiratory function.
   b. Neurologic criteria – in the presence of cardiopulmonary support, death is determined using neurologic criteria in accordance with accepted professional guidelines.

2. When cardiopulmonary criteria are used, a single physician may determine that death has occurred.

3. When neurologic criteria are used, any licensed physician may make an initial determination of death subject to the following:

   a. Confirmation by a second licensed physician is required. Preferably, one of the physicians making the determination should be a neurologist or neurosurgeon.

   b. When the patient in question is an infant or child, at least one of the examinations shall be done by an appropriate specialist knowledgeable about the special criteria appropriate for the determination of death by neurologic criteria in infants and children.

4. Neither the physician making the determination of death nor the physician making the independent confirmation shall participate in procedures for procuring or transplanting organs or tissues from the deceased.

DETERMINATION OF DEATH USING NEUROLOGIC CRITERIA

1. Prerequisites for determination of death using neurologic criteria:

   a. The proximate cause of death must be known and must be demonstrably irreversible. There must be:

      - Clinical or neuroimaging evidence of an acute central nervous system (CNS) catastrophe that is compatible with the clinical diagnosis of death using neurologic criteria.

      - Exclusion of medical conditions that may confound clinical assessment, e.g. severe electrolyte imbalance, acid-base imbalance, endocrine-metabolic disturbance, or hypothermia, and

      - No confounding drug intoxication or poisoning that might cause coma.

   b. Neurologic Criteria for Determination of Death

      - Determination of death using neurologic criteria shall be in conformity with California Statutes (California Health & Safety Code § 7180, 7181, and 7182).

      - The physicians making the determination of death using neurologic criteria will determine: (a) the presence of coma or unresponsiveness, (b) the absence of brain stem reflexes, and (c) the presence of apnea.

      - Determination of death using neurologic criteria is a clinical determination. The following conditions may interfere with the determination of death on clinical grounds alone so that confirmatory testing may be needed:

        – severe facial trauma

        – pre-existing pupillary abnormalities

- drug intoxication
- sleep apnea
- pulmonary disease with chronic CO_2 retention or impaired oxygenation
- hypothermia (occurs as your body temperature falls below 95 F (35 C).

- Clinical examination for determining neurological death should include
  - coma with unresponsiveness to visual, auditory, and tactile stimulation
  - absent motor responses, other than spinally mediated reflexes, of the head/face, neck, and extremities after application of noxious stimuli to the head/face, trunk, and limbs
  - absent pupillary responses to bright light bilaterally
  - absent oculocephalic reflex (unless there is concern for cervical spine or skull base integrity)
  - absent oculovestibular reflexes bilaterally
  - absent of corneal reflexes bilaterally
  - absent gag reflex
  - absent cough reflex
  - absence of sucking and rooting reflexes (patients <6-months only)

- The following clinical observations are not incompatible with a determination of death by neurologic criteria:
  - spontaneous "spinal" limb movements
  - shoulder elevation, back arching, intercostal expansion without significant tidal volume
  - sweating, blushing, tachycardia
  - normal blood pressure without pressors
  - normal osmolar balance
  - deep tendon reflexes
  - Babinski response.

SUBJECT: **DIAGNOSIS OF DEATH BY NEUROLOGIC CRITERIA**	SECTION: ***Provisions of Care, Treatment and Services (PC)*** **Page 1 of 7**

PROCEDURE FOR DECLARATION OF DEATH AND INTERACTION WITH FAMILY MEMBERS

After a determination of death has been made using neurologic criteria, artificial cardiopulmonary support may be continued temporarily, pending notification of the appropriate organ procurement agency and final disposition decisions.

1. When the organ procurement agency has determined that the deceased is a potential donor of transplantable organs or tissue, support measures should be continued until a representative from the organ procurement agency has completed discussion regarding retrieval of organs or tissue.

2. When the organ procurement agency has determined that the deceased is not a potential donor of organs or tissue, or when the family is unwilling to give consent for retrieval of organs or tissue, artificial support shall be discontinued. Family consent for this withdrawal of support is not required and should not be sought, but if the family objects, reasonable accommodation should be attempted.

3. At the request of the family of the deceased, and with physician agreement, artificial support occasionally may be continued for compelling social reasons for a reasonably brief period of time after declaration of death.

    a. During this time of family accommodation, the deceased and the family shall be treated with respect. If the family has voiced disbelief in the diagnosis, the involved clinicians shall further explain both the rationale of determination of death using neurologic criteria and the fact that it is consistent with California law. The family should be given spiritual and emotional support by hospital staff and, if they desire, by their own clergy or spiritual advisor. If they have voiced religious and/or cultural objections to a declaration of death using neurologic criteria, appropriate support and counsel shall be offered.

    b. During this time of family accommodation, no attempt at cardiopulmonary resuscitation shall be made in the event of cardiac arrest, and no increase in the level of organ support shall be instituted. The decedent's family shall be so notified and appropriate orders shall be written.

    c. During this time of family accommodation, it may be appropriate to offer ethics consultation and/or other clinical opinion by a qualified physician of the family's choice if the family is experiencing difficulty with understanding or accepting the diagnosis.

4. The concept of death diagnosed by neurologic criteria may be accepted best by a family prepared for this idea. Prior to the declaration of death, physicians may indicate to the family that the patient is ill enough to merit such an evaluation. Issues can be discussed before the second physician is called to ascertain death, or at any convenient time before the confirmed diagnosis is made. Although such a conversation may not always be practical, this advance discussion is always desirable. At that time, if a family has problems understanding or accepting the concept of death diagnosed by neurologic criteria, additional education, appropriate emotional support, psychological, and spiritual counseling can be offered.

5. If there is no medical dispute about the diagnosis of death and one or more members of the family insist that support be continued beyond this brief period of accommodation, they should be informed that support will be discontinued at a specified time. If the family files a court challenge, support shall be continued (within the limits set in 3.b. above) until the court has issued a ruling.

SUBJECT: **DIAGNOSIS OF DEATH BY NEUROLOGIC CRITERIA**	SECTION: ***Provisions of Care, Treatment and Services (PC)*** **Page 1 of 7**

DOCUMENTATION AND CONFIRMATION OF THE DETERMINATION OF DEATH

1. The physicians making the initial and the confirmatory determinations of death shall document this in the medical record of the deceased.

2. A licensed physician shall complete a death certificate unless the case is subject to coroner's inquiry (California Government Code § 27491), in which case the coroner shall complete the death certificate.

3. For legal and certification purposes, the time of death to be recorded is the time of the confirming (second physician's) examination.

PROCEDURE FOLLOWING DETERMINATION OF DEATH

1. Following determination of death by neurologic criteria, a formal pronouncement of death shall be made.

2. In organ donors, once death has been declared, further testing and management become the responsibility of the transplant team or organ procurement agency. The deceased's family shall be notified that death has occurred and informed of the necessity of continued ventilatory and circulatory support to preserve vital organs.

3. In non-organ donors, all lines, tubes, machines and monitors shall be removed. The deceased, the bed and the room shall be cleaned as needed. Removal of medical instruments and devices avoids the perception of continuing to "treat" the dead body. The family shall then be notified that death has occurred.

4. In notifying family members that death has occurred, the confusing and ill-advised term "brain dead" should be avoided.

5. In cases where a conflict with family members has occurred in prior discussions, notification of death should be made by enough members of the professional team (physicians, nurses, social workers, clergy, and administrators) to ensure that the family understands there is no professional doubt that death has occurred.

6. Family members shall be given an opportunity to remain with the body of the deceased for a reasonable period of time if visitation is safe for family and staff.

PROCEDURE FOLLOWING DETERMINATION OF DEATH USING NEUROLOGIC CRITERIA IN A WOMAN KNOWN TO BE PREGNANT:

1. The pregnant woman who has been declared dead using neurologic criteria poses a unique situation in that her fetus may or may not have been affected by the condition that has caused the woman's brain injury and death. It is occasionally possible to maintain cardiopulmonary function in the deceased mother for an extended period of time and thereby allow the fetus to become more mature and possibly to survive.

2. When a pregnant woman has been declared dead using neurologic criteria, fetal viability should be assessed by appropriate obstetrical and/or neonatal consultation prior to removal of cardiopulmonary support.

3. A request for maintenance of organ function in the dead mother in order to provide support to the fetus until viability may be made by the father or another appropriate surrogate decision-maker for the mother.

4. In assessing a request for maintenance of function in the dead mother, consideration should be given to the wishes and values of the mother as known through an advance directive or previous oral expressions, when available. In addition, the wishes and values of the father and other appropriate surrogate decision-maker should be considered.

5. If a decision is made to maintain cardiopulmonary support of the mother in an attempt to bring the fetus to viability or to term, the following measures and procedures shall be taken:

   a. An appropriate advocate for the fetus shall be identified. This individual shall be involved in discussions and decisions about care of the fetus.

   b. Nursing staff involved in the care of the dead mother shall be involved in management discussions.

   c. Goals for support will be established, including the ideal delivery date for the fetus as well as the earliest date that attempts will be made to deliver the fetus in the event of cardiopulmonary deterioration.

   d. If, despite attempted support, cardiovascular collapse of the mother occurs prior to the earliest set delivery date, cardiopulmonary support of the deceased mother will be stopped and no effort will be made to deliver the fetus.

   e. If fetal death occurs at any time, cardiopulmonary support shall be stopped.

   f. Once the fetus is delivered, the procedures for termination cardiopulmonary support following determination of death using neurologic criteria are in order.

6. If there is no request for maintenance of maternal organ function, or if it is determined to be unlikely that fetal viability can be achieved, the procedures for terminating cardiopulmonary support following determination of death using neurologic criteria are in order.

REFERENCES:

- Aboubakr M, Alameda G. Brain Death Criteria. [Updated 2020 May 30]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK545144/.

- California Health & Safety Code, Section 7180, 7181, 7182 (1982). Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=7180.

- Greer DM, Kirschen MP, Lewis A, et al. Pediatric and Adult Brain Death/Death by Neurologic Criteria Consensus Guideline: Report of the AAN Guidelines Subcommittee, AAP, CNS, and SCCM. *Neurology*. Published online October 11, 2023. doi:https://doi.org/10.1212/WNL.0000000000207740

- Mayo Clinic Staff. Hypothermia - Symptoms and Causes. Mayo Clinic. Published March 5, 2022. https://www.mayoclinic.org/diseases-conditions/hypothermia/symptoms-causes/syc-20352682#:~:text=Hypothermia%20is%20a%20medical%20emergency

CROSS REFERENCE:

- ORGAN AND TISSUE PROCUREMENT AND DONATION

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

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

PURPOSE:

To establish the procedure for processing diet orders.

POLICY:

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

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

PROCEDURE:

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

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

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

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

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

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

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

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

9. Diet orders will include the desired texture consistency.

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

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

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

REFERENCES:

- California Code of Regulations (2024). Title 22. § 70273.(a),
  Retrieved from
  https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Centers for Medicare and Medicaid Services, Conditions of Participation (2024). § 70273(a), § 70273(d), § 70273(e).
  Retrieved from https://www.cms.gov/Regulations-and-Guidance.

- The Joint Commission (2024). Hospital accreditation standards. PC.02.01.03.

SUBJECT: **DO NOT RESUSCITATE (DNR) IN THE OPERATING ROOM**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 8**

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

PURPOSE:

Patients designated DNR ("Do Not Resuscitate" or "No Code Blue") in the physician's orders for the purpose of floor care and ICU care, who subsequently present for care in the operating room:

- Patients have the right to self-determination; that is, to accept or refuse medical treatments. This is fundamental, particularly when faced with a terminal illness. The aim of this policy statement is to preserve and make known this right as it pertains to the patient in the operating room.

- The administration of anesthesia necessarily involves some practices and procedures that might be viewed as "resuscitation" in other settings. Prior to procedures requiring anesthetic care, any existing directives to limit the use of resuscitation procedures (that is, do-not-resuscitate orders and/or advance directives) should, when possible, be reviewed with the patient or designated surrogate. As a result of this review, the status of these directives should be clarified or modified based on the preferences of the patient. One of the three following alternatives may provide for a satisfactory outcome in many cases:

    1. Full Attempt at Resuscitation: The patient or designated surrogate may request the full suspension of existing directives during the anesthetic and immediate postoperative period, thereby consenting to the use of any resuscitation procedures that may be appropriate to treat clinical events that occur during this time.

    2. Limited Attempt at Resuscitation Defined with Regard to Specific Procedures: The patient or designated surrogate may elect to continue to refuse certain specific resuscitation procedures (for example, chest compressions, defibrillation or tracheal intubation). The anesthesiologist should inform the patient or designated surrogate about which procedures are 1) essential to the success of the anesthesia and the proposed procedure, and 2) which procedures are not essential and may be refused.

    3. Limited Attempt at Resuscitation Defined with Regard to the Patient's Goals and Values: The patient or designated surrogate may allow the anesthesiologist and surgical/procedural team to use clinical judgment in determining which resuscitation procedures are appropriate in the context of the situation and the patient's stated goals and values. For example, some patients may want full resuscitation procedures to be used to manage adverse clinical events that are believed to be quickly and easily reversible, but to refrain from treatment for conditions that are likely to result in permanent sequelae, such as neurologic impairment or unwanted dependence upon life-sustaining technology.

- Any clarifications or modifications made to the patient's directive should be documented in the medical record. In cases where the patient or designated surrogate requests that the anesthesiologist use clinical judgment in determining which resuscitation procedures are appropriate, the anesthesiologist should document the discussion with particular attention to the stated goals and values of the patient.

- Plans for postoperative/post-procedural care should indicate if or when the original, pre-existent directive to limit the use of resuscitation procedures will be reinstated. This occurs when the patient leaves the post-anesthesia care unit or when the patient has recovered from the acute effects of anesthesia and surgery/procedure. Consideration should be given to whether continuing to provide the patient with a time-limited or event-limited postoperative/post-procedure trial of therapy would help the patient or surrogate better evaluate whether continued therapy would be consistent with the patient's goals.

- It is important to discuss and document whether there are to be any exceptions to the injunction(s) against intervention should there occur a specific recognized complication of the surgery/procedure or anesthesia.

- Concurrence on these issues by the primary physician (if not the surgeon/proceduralist of record), the surgeon/proceduralist and the anesthesiologist is desirable. If possible, these physicians should meet together with the patient (or the patient's legal representative) when these issues are discussed. This duty of the patient's physicians is deemed to be of such importance that it should not be delegated. Other members of the health care team who are (or will be) directly involved with the patient's care during the planned procedure should, if feasible, be included in this process.

- Should conflicts arise, the following resolution processes are recommended:

    1. When an anesthesiologist finds the patient's or surgeon's/proceduralist's limitations of intervention decisions to be irreconcilable with one's own moral views, then the anesthesiologist should withdraw in a nonjudgmental fashion, providing an alternative for care in a timely fashion.
    2. When an anesthesiologist finds the patient's or surgeon's/proceduralist's limitation of intervention decisions to be in conflict with generally accepted standards of care, ethical practice or institutional policies, then the anesthesiologist should voice such concerns and present the situation to the appropriate institutional body.
    3. If these alternatives are not feasible within the period necessary to prevent further morbidity or suffering, then in accordance with the American Medical Association's Principles of Medical Ethics, care should proceed with reasonable adherence to the patient's directives, being mindful of the patient's goals and values.

- Modification of these guidelines may be appropriate when they conflict with local standards or policies, and in those emergency situations involving patients lacking decision-making capacity whose intentions have not been previously expressed.

- Resuscitation efforts in the operating room may help patients to achieve their original treatment objectives. Many patients when presented with these facts may elect to suspend DNR orders during the perioperative period. This policy makes allowances for those patients who wish to continue their DNR status into the operating room.

POLICY:

1. It is recognized that most cardiac arrests in the operating room occur as a consequence of surgical or anesthetic interventions. Resuscitative efforts may in fact facilitate the achievement of the objectives for which the patient has elected surgery. It is therefore the policy of this operating room that all patients are to be granted the benefit of resuscitative efforts in the event of a cardiac arrest regardless of the underlying disease and circumstances, unless they specify differently.

2. The Department of Anesthesia fully realized that in the case of terminally ill patients, it is easier to withhold the initiation long-term therapies than to discontinue such therapies once initiated. The nature of surgery and anesthesia that events occur very rapidly and an individual patient's condition, being a constant state of flux, does not always permit a practitioner the luxury of assessing whether a particular treatment initiated in the operating room will be a short-term intervention or evolve into a long-term therapy. Such assessments of particular modes of therapy can only be made over the course of the ensuing postoperative days, after a particular patient's response to those interventions can be evaluated. The general policy of the Department of Anesthesia in all cases, other than the exceptions provided for herein, to institute resuscitative measures in those requiring them under the assumption that these therapies are short-term by the nature of operating room arrests.

3. The Department of Anesthesia recognizes that, despite careful explanation of the facts and principles outlines above, some patients may insist on the continuation of their DNR status into the operative setting. In the spirit of emphasizing patient rights in structuring the medical treatment plan, it is therefore also recognized that exceptions to the above-stated policy may occur.

4. One of the four following DNR alternatives may provide for a satisfactory outcome to the patient's wishes:

    a. Full suspension of DNR orders during the anesthetic and immediate postoperative period.

    b. Limited attempt at resuscitation as defined by refusal of specific measures; i.e., chest compressions, defibrillation or intubation. The anesthesiologist should inform the patient or designated surrogate about what is essential and what is not essential for the provision of anesthesia.

    c. Limited attempt at resuscitation to be decided by the anesthesiologist and surgeon to respect the patient's own personal goals and values. The physicians would use their

clinical judgment as to the outcome of the resuscitation; i.e., neurological impairment or unwanted dependency on life-sustaining support.

d. Continue all DNR orders through the entire perioperative period.

5. Clear documentation of discussion should be done by the anesthesiologist as well as the surgeon, of the definitions, explanations and agreements with the patient and/or designated surrogate.

6. Plans for postoperative care should indicate if and when the original pre-surgery DNR order will be reinstated; that is, when the patient leaves the PACU or when the patient has recovered from the acute effects of anesthesia and surgery. Consideration should be given to the effects of continued life-support measures as being consistent with the patient's goals.

7. These guidelines apply to competent patients and also to incompetent patients who have previously expressed their preferences.

AFFECTED PERSONNEL/AREAS: *MAIN OR/PACU STAFF; ANESTHESIA PROVIDERS; SURGEONS*

Definition of Perioperative Period:

For the purpose of this policy, discussion of the term "perioperative period" will refer to the time when an anesthesiologist accepts responsibility for the patient's care until responsibility is relinquished back to another service or practitioner. This period is usually pre-op holding, the OR, the PACU and the immediate post-op ICU period.

Definition of Cardiac Arrest:

1. For the purpose of this policy statement, cardiac arrest shall be defined by the occurrence of one or more of the following:

a. Asystole;

b. Ventricular fibrillation;

c. Sustained ventricular tachycardia without perfusion;

d. Pulseless Electrical Activity (PEA).

e. The defining point of cardiac arrest is the need to use closed cardiac compression to maintain circulation or the need to employ DC countershock.

2. Maintenance of physiologic function under anesthesia is to be clearly distinguished from resuscitation measures. Interventions to support anesthesia may include the following:

   a. Drugs to maintain a stable blood pressure;

   b. Drugs to maintain a stable cardiac rhythm;

   c. Drugs used in the support of airway maintenance;

   d. Drugs used to support spontaneous ventilation;

   e. Drug used to maintain an adequate cardiac output;

   f. Drugs used to treat adverse effects of anesthetic agents or other agents used in the support of anesthesia;

   g. Assisted or controlled positive pressure ventilation, whether by mask or by endotracheal tube;

   h. Endotracheal intubation.

MANAGEMENT OF CARDIAC ARREST:

1. When the patient who is designated DNR in the perioperative setting develops cardiac arrest, closed cardiac compression and DC countershock may not be employed, except to treat arrests which occur as a direct result of the anesthesia or the surgical intervention.

   a. Endotracheal Intubation:

   - While it is realized that there may be the unusual situation of all parties involved agreeing on resuscitative measures short of endotracheal intubation, it is the policy that endotracheal intubation be considered a modality of support under anesthesia and that an anesthesiologist should be loath to relinquish the option to use this adjunct should the circumstances warrant. Patients reluctant to agree to the possibility of endotracheal intubation in the operating room for fear of prolonged ventilatory support postoperatively (at the end of surgery or in PACU) should address the issue of "time limited therapeutic interventions: and extubation with the with the involved practitioners, especially their primary care physician.

   - To reiterate, endotracheal intubation is a routine supportive measure included in the rendering of anesthesia and does not, in the operating room, constitute a resuscitative measure.

b. Multidisciplinary approach to patient discussion – shared responsibility:

- Patients who agree to the suspension of their DNR status during the operative period do not necessarily require further extensive explanations from their anesthesiologist, as this will be the usual policy, unless otherwise stated.

- Patients requested explanations or the institution of a protocol involving anything but the total suspension of DNR status shall have a preoperative discussion with the involved surgeon, the primary care physician and the anesthesiologist who will administer care in the operating room. This discussion, which must be documented, shall cover the following:

  - The patient's ultimate therapeutic objectives;

  - A clear description of specific potential arrest situations in the operating room; i.e., respiratory or cardiac;

  - A clear explanation of the distinction between anesthesia supportive measures and resuscitation measures;

  - A clear discussion of those measures which the patient does and does not agree to and under what circumstances; i.e., compressions, defibrillation and intubation;

  - The specifics of this discussion shall be documented in the medical record progress notes section by the anesthesiologist with supporting documentation notes from the surgeon, primary care physician and other relevant practitioners.

  - It is the responsibility of the patient's primary care physician to initiate a discussion of this subject.

  - It is the responsibility of the anesthesiologist to further explain in detail the operating room DNR policy; i.e., intubation is not resuscitation.

  - It is the responsibility of all involved practitioners (i.e., internist, surgeon and anesthesiologist) to clearly communicate with each other the proposed treatment plan, as concerns DNR status in the operative setting, and to document in the progress notes that this multidisciplinary discussion has transpired.

c. Individualized Patient Plan

- In the case of any patient, who has been designated DNR at any time preoperatively, it musts be clearly stated at the end of the anesthesiologist's preoperative note that the patient falls into one of two categories:
  - Patient has agreed to suspension of DNR status (all resuscitative measure will be employed in the operating room and PACU).
  - Patient wished DNR status continued into the perioperative setting and into the operating room. In this case there must be a clear discussion of the intervention to be withheld in the operating room and under what circumstances specifically they are to be withheld.
- A member of the multidisciplinary team (i.e., anesthesiologist, surgeon and internist) must designate in the physician's orders, preoperative, that the patient is either "Suspend DNR for Anesthesia" or "Continue DNR for Anesthesia".
- The OR nurses preoperative checklist should note the presence or absence of"OR-DNR Discussion in Progress Notes" and "OR-DNR Orders Written".

d. An anesthesiologist may withdraw from a DNR case any time prior to the induction of anesthesia, if the shared plan is ethically, morally or emotionally unacceptable to that individual practitioner.

- An anesthesiologist who elects to withdraw from a DNR case must assist the patient and surgeon in their search for another anesthesiologist, from within the department who is amenable to the DNR plan.
- If the second anesthesiologist finds the proposed DNR plan objectionable, the case must then be referred to the Department of Anesthesia Chairperson.
- Cases of DNR status disputes, which remain unresolved by the Department of Anesthesia Chairperson, must then be referred to the Chairperson of Surgery, then the Chief of Staff.

REFERENCES:

- American Society of Anesthesiologist (2020). Guidelines, Statements, Clinical Resources. Ethical Guidelines for the Anesthesia Care of Patients with Do-Not-Resuscitate Orders or Other Directives that Limit Treatment. Committee on Ethics. Reaffirmed October 17, 2018.

https://www.asahq.org/standards-and-guidelines/ethical-guidelines-for-the-anesthesia-care-of-patients-with-do-not-resuscitate-orders-or-other-directives-that-limit-treatment.

CROSS REFERENCE:

- Policy & Procedure Manual: ADVANCE DIRECTIVE

SUBJECT:	SECTION:
MATERNAL SEPSIS	*[Enter manual section here]*
	Page 1 of 9

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

PURPOSE:

To guide and support Obstetrical care providers implement methods for timely recognition of sepsis and for an organized evidence based-response to this life-threatening condition. The implementation of this Sepsis policy is to improve maternal safety related to sepsis at Sierra View Medical Center. This is an accordance with California Maternal Quality Care Collaborative.

DEFINITIONS:

1. **Maternal Sepsis:** A life threatening condition with organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion, or the postpartum period (up to 42 days).

2. **Maternal Sepsis Alert:** An overhead page or electronic notification announcing the presence and location of a maternal sepsis alert. This is an internal alert can be activated anytime, via a defined process, for any obstetrical patient that displays the sepsis alert criteria as defined per policy.

3. **Maternal Sepsis Team:**

   a. **OB Attending Provider** §
   b. **Primary Bedside RN** **
   c. **Unit Charge RN** **
   d. **Phlebotomist** **
   e. **Pharmacist** §
   f. **Clinical Unit Leaders** Ω
   g. **Stroke and Sepsis Coordinator** Ω
   h. **MCH Charge RN** Ω
   i. **Radiology**§

** denotes presence required upon maternal sepsis alert

± denotes presence is required upon sepsis alert in-house

Ω denotes presence is required, when available, for maternal sepsis alert

§ denotes required to be available in person or by phone, but not immediately present

4. **Initial Hypotension**: Two hypotensive (SBP < 90, or MAP < 65) blood pressure readings within 3 hours of each other.

5. **Persistent Hypotension**: Two consecutive blood pressure readings with a MAP less than or equal to 65 or SBP less than or equal to 90, in the hour following the IVF bolus.

POLICY:

Implementation of the maternal sepsis program at SVMC will increase maternal patient safety, appropriate sepsis response, quality of care, and compliance with the evidence-based standards within the California Maternal Quality Care Collaborative.

AFFECTED PERSONNEL/AREAS:

Maternal Child Health, Emergency Department, Medical/ Surgical Unit, Telemetry, Intensive Care Unit, Surgical Services, Laboratory, Pharmacy, Radiology

EQUIPMENT:

- Vital Signs Machine
- Fetal Heart Tone Doppler
- External Fetal Monitor
- Code Cart
- Cardiac Monitor

PROCEDURE:

A. Maternal Sepsis Alert will be initiated by providers or nursing staff when a patient demonstrates a **suspected infection** and with 2 or more of the following criteria are present:

Step 1: Initial Sepsis Screen

- Oral temperature <36°C (96.8°F) or ≥ 38°C (100.4°F)
- Heart rate > 110 beats per minute and sustained for 15 minutes
- Respiratory rate >24 breaths per minute and sustained for 15 minutes
- White Blood Cell Count > 15,000/mm^3 or <4,000/mm^3 or > 10% immature neutrophils (bands

***IN THE SETTING OF SUSPECTED INFECTION, A MEAN ARTERIAL PRESSURE (MAP) OF <65 mmHg is SUFFICIENT TO activate the maternal sepsis alert process

*** Sepsis screening criteria parameters should be continued through all stages of labor and continued until the patient is discharged from the hospital. Avoid taking vital signs during uterine contractions to avoid aberrant values.

1. Unit Charge RN will call the attending provider to inform he/her of the patient meeting criteria for maternal sepsis alert
2. Maternal Sepsis alert to be activated per below:

a. The Emergency Department (ED) and Intensive Care Unit (ICU) will call the alert directly by dialing #55.
b. All other inpatient areas will initiate the process by dialing #55 for the Rapid Response Team (RRT). The RRT will assess the patient and call the maternal sepsis alert.

B. A maternal sepsis alert is a nurse driven process that will be called for any obstetrical patient, as defined in this policy, where sepsis is suspected, based on the initial sepsis screen

C. An obstetrical patient with suspected sepsis that meets criteria during the initial sepsis screen will have an electronic screening tool completed.

D. If the initial Sepsis Screen is positive, evaluation for end organ injury via laboratory studies and prompt bedside evaluation by a physician shall be performed. The Charge RN will order initial diagnostics tests as STAT priority for confirmation of sepsis.

Step 2: Confirmation of Sepsis/Organ Dysfunction

- Labs:
  - Complete Blood count (including % immature neutrophils [bands], platelets)
  - Coagulation status (prothrombin time/international normalized ratio/ partial thrombin time)
  - Comprehensive metabolic panel (specifically include bilirubin, creatinine)
  - Venous lactic acid
  - Blood Culture
    - Should be drawn within 3 hours following diagnosis of sepsis with organ dysfunction. It is acceptable to draw blood cultures if antibiotics were commenced in the previous 24 hours.
    - If able, obtain blood cultures prior to antibiotics. Do not delay antibiotics to obtain the blood cultures.
  - UA with Culture
  - Chest X-Ray, per order
    - Only for suspected pulmonary source. Should be performed after initial IV antibiotics dose.
- Bedside assessment
  - Urine output (place Foley catheter with urometer)
  - Pulse oximetry
  - Mental status assessment

E. Ensure the patient has IV access, preferably two large bore

F. Intravenous fluid bolus (1-2 liters IV crystalloid fluid –Lactated Ringer's at least 30 ml/kg) and source-directed antibiotic therapy shall be initiated promptly (ideally within one hour), per orders, while awaiting for laboratory results. Start broad spectrum antibiotics if source of infection is unclear, as per physician order.*** Use non-invasive cardiac output monitor to assess additional IV fluids administration and hemodynamic status if needed for higher level of care

*** If hypotension persists, consider vasopressor use in higher level of care

*** Involve Stroke and Sepsis Coordinator or RRT for escalation of care coordination. Consider ICU admission as needed.

G. Assessment and monitoring following positive step 1 sepsis screen

Monitoring	**Time frame**	**Additional Considerations**
Fetal Monitoring	Continuous	Antepartum/ Intrapartum
Pulse oximetry	Continuous	Until Vital Signs are normalized
Blood Pressure (MAP)	Q 30 minutes from Time Zero	Until Lactate < than 2.0 mmol/L, then q 2 hours for non-laboring patients
Temperature	Q 30 minutes from Time Zero	Until Lactate < than 2.0 mmol/L, then q 2 hours for non-laboring patients
Urine Output	Q 1 hour from Time Zero	Foley catheter with urometer
Mental Status	Continuous	Note agitation, confusion, or unresponsiveness

Verify all diagnostic testing is obtained, completed, and resulted to quickly identify a potential source of infection.

I. Notify the attending provider of all results

J. Criteria for End Organ Injury for Diagnosis of Maternal Sepsis (only one criterion is sufficient for diagnosis)

Measure of End Organ Injury	Criteria (one criterion is sufficient for diagnosis)
Respiratory Function	• Acute respiratory failure as evidence by acute need for invasive or non-invasive mechanical ventilation, or • PaO_2/FiO_2 <300
Coagulation Status	• Platelets <100 x 10^9/L, or • International Normalized Ration (INR) >1.5, or • Partial Thromboplastin Time (PTT) > 60 seconds

Liver Function	• Bilirubin > 2mg/dL
Cardiovascular Function	• Persistent hypotension after fluid administration o SBP <85 mmHg, or o MAP <65 mmHg, or o > 40 mmHG decrease in SBP
Renal Function	• Creatinine > 1.2 mg/dL, or • Doubling of creatinine, or • Urine output <0.5mL/kg/hour (for 2 hours)
Mental Status Assessment	• Agitation, confusion, or unresponsiveness
Lactic Acid	• 2mmol/L in the absence of labor (Lactic acid is not used for diagnosis in labor, but remains important for treatment)

K. Follow the Standard Operating Procedure: Maternal Sepsis Pink Form, whether paper or electronic (see addendum A for Paper Copy). This form is not part of the medical record

L. If a patient continues to meet sepsis alert criteria, despite initial treatment; even if the patient was previously a sepsis alert within current admission, notify the attending provider and activate RRT

M. Treat fevers as ordered

N. Additional considerations

1.

Consideration	**Comment**
Vasopressors	Norepinephrine if MAP < 65 mmHg, if unresponsive to IV fluids
Inotrope	Dobutamine if myocardial dysfunction or hypoperfusion despite IV fluids and Vasopressors
Glucose Control	Avoid hyperglycemia, > 180 mg/dl
Maternal Temperature Control	Acetaminophen, cooling blankets
Fetal Lung Maturity	Consider betamethasone for fetal lung maturity if gestational age is 23-36 weeks
DVT prophylaxis	Lower leg (below knee) sequential compression devices while on bed

2. Consider transfer to a higher level of care facility if appropriate.
   - Criteria considerations:
     a. Hypotension (MAP < 65 mmHg) despite fluid resuscitation or need for administration of vasopressors

b. Persistent hypoxia (SpO2 <92% on room air)
c. Altered mental status (combativeness, confusion, disorientation)

3. Assessment and treatment of Maternal Sepsis: Antibiotics and Source Control
   a. Administer antibiotics within one hour of diagnosis of maternal sepsis
   b. Initiate empiric broad-spectrum antibiotics. Within 48-72 hours, narrow antibiotics spectrum as blood cultures results become available.
   c. Coordination between Pharmacy and RRT for rapid delivery of antibiotics ordered.

4. Suggested empiric antibiotic coverage for patients with sepsis of unknown cause

Antibiotics choice	Duration of therapy
Gram-negative plus anaerobic coverage Piperacillin/ tazobactam 3.375 g IV q8h (extended infusion) or 4.5 g IV q6h **Or** Meropenem 1 g IV q8h **Or** Cefepime 1-2 g IV q8h plus metronidazole 500 mg IV q8h **Or** Aztreonam 2 g IV q8h (for penicillin allergy) plus Metronidazole 500 mg IV q8h **Or** Aztreonam 2 g IV q8h plus clindamycin 900 mg IV q8h **PLUS** **Gram-positive coverage** Vancomycin 15-20 mg/kg q 8-12h **Or** Linezolid 600 mg IV q 12h (for vancomycin allergy)	7-10 days 7-10 days

1. Suggested antibiotics for sepsis and specific infectious conditions

Condition	Antibiotic choices
Chorioamnionitis	Ampicillin 2 g IV q6h **PLUS** Gentamicin 2 mg/kg IV load, then 5 mg/kg every 24h **Alternate regimens:** Ampicillin-sulbactam 3 g IV q6h **OR**

	Piperacillin-tazobactam 3.375 g IV q6h **OR** Cefoxitin 2 g IV q8h **OR** Ertapenem 1 g IV q24h **For severe penicillin allergy** Clindamycin 900 mg IV q8h **OR** Vancomycin 15-20 mg/kg q 8-12h, goal trough 15-20 **PLUS** Gentamicin 5 mg/kg every 24h
Endomyometritis	Clindamycin 900 mg IV q8h (or metronidazole 500 mg IV q8h) **PLUS** Gentamicin 5 mg/kg IV q24h **PLUS** Ampicillin 2 g IV q6h **OR** Ampicillin-sulbactam 3 g IV q6h **PLUS** Gentamicin 5 mg/kg IV q24h
Septic abortion Retained products of conception	Cefoxitin 2 g IV q6h **OR** Cefotetan 2 g IV q12h **PLUS** Doxycycline 100 mg PO (or IV) q12h **OR** Clindamycin 900 mg IV q8h **PLUS** Gentamicin 3 to 5 mg/kg IV q 24h
Pyelonephritis	Ceftriaxone 2 g IV q24h **OR** Cefepime 2 g IV q12h **OR** **For severe penicillin allergy** Aztreonam 1 g IV q8h
Hospital-acquired complicated intra-abdominal infection- after a surgical procedure or a bowel perforation in a hospitalized patient	Piperacillin/tazobactam 3.375 g IV q8h (extended infusion) or 4.5 g IV q6h if not extended infusion **OR**

	Ertapenem 1 g IV q24h **OR** Meropenem 1 g IV q8h
Pelvic abscess- can be an infectious complication of surgery (e.g., hysterectomy, cesarean delivery, induced abortion) or the result of infectious processes (e.g., pelvic inflammatory disease)	Piperacillin/tazobactam 3.375 g IV q8h (extended infusion) or 4.5 g IV q6h if not extended infusion **OR** Ertapenem 1 g IV q24h **OR** Meropenem 1 g IV q8h
Community-acquired pneumonia	Ceftriaxone 2 g IV daily **OR** Ampicillin-sulbactam 3 g IV q6h **PLUS** Azithromycin 500 mg IV/PO daily **PLUS** Oseltamivir 75 mg PO BID (during influenza season)

5. Control of source of infection
   a. For patients without improvement with initial antibiotics regime or refractory fevers, consider Infectious Disease consultation.
   b. For patients with identified source of infection that are amenable to percutaneous drainage, consider Interventional Radiology consultation
   c. For patients with identified source of infection requiring surgery (abdominal abscess, appendectomy, cholecystectomy, or debridement for necrotizing fasciitis.), consider General surgery consultation

O. Timing of delivery

1. Timing of delivery should be individualized based on gestational age and maternal-fetal status.
2. In cases of Chorioamnionitis, delivery is indicated regardless of gestational age.
3. Betamethasone for fetal lung maturity should be considered between 23-36 weeks of gestational age.
4. Mode of delivery will be determined by obstetric considerations and maternal-fetal status.
5. Anesthesia consultation should be obtained by the attending physician when delivery is indicated.
6. Type of anesthesia to be used will be determined by anesthesia
7. Consider transfer to a higher level of care facility with NICU if gestational age is less than 34 weeks

P. Discharge instructions and education

1. All patients should be screened for depression, anxiety, and post-traumatic stress disorder before discharge.

    a. In addition to the standard discharge instructions, include educating the patient and support person on the danger signs associated with infection
    b. Contact a healthcare provider if you have the following danger signs:
    c. A temperature of 38°C (100.4°F) or higher
    d. An incision that is not healing (episiotomy, perineal laceration, or cesarean birth)
    e. Increasing pain at any incision site
    f. Increased redness, drainage, or pus of any incision or laceration
    g. Foul smelling bleeding or discharge from vagina or incision
    h. Pain unrelieved by discharge medication

2. Patients should be promptly referred for rehabilitation for weakness and cognitive impairment.
3. Patients with sepsis during their delivery hospitalization should have contact with their primary healthcare provider within 3-4 days of discharge.
4. Consider completing Maternal Sepsis debriefing form. Sepsis Coordinator to complete form, if identified.

REFERENCES:

Gibbs, R., Bauer, M., Olvera, L., Sakowski, C., Cape, V., Main, E. (2022). Improving diagnosis and treatment of maternal sepsis. California Maternal Quality Care Collaborative. Retrieved from https://www.cmqcc.org/sites/default/files/Sepsis%20Toolkit_FINAL.2_Errata_7.1.22.pdf

CROSS REFERENCES:

Treatment of Adult with Suspected Sepsis - Standard Operating Procedure
CMQCC Maternal Sepsis Evaluation Flow Chart

SUBJECT: **MENU PLANNING**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide nutritionally-balanced meals for patients/residents, hospital staff, and visitors.

POLICY:

1. The Food and Nutrition Service (FNS) Director will plan all menus for patient/resident food service, cafe, and special food service functions with assistance from the dietitian. CBORD software is used as a guide for menu planning, recipe modification, nutrition analysis, and food ordering. Principles of good menu planning are considered to include taste, texture, color, flavor, seasonal variations, and cultural, religious, and regional preferences. The Clinical Nutrition Manager (CNM) will approve all patient/resident menus.

2. Menus written for patient/resident food service, unless prevented by therapeutic modification, shall meet the nutritional standards of the Recommended Dietary Allowances as set by the Food and Nutritional Board of the National Research Council and National Academy of Sciences. Those that do not will be noted in the Diet Manual. Determination of nutritional adequacy is based on a weekly average of each nutrient.

AFFECTED PERSONNEL/AREAS:

FOOD AND NUTRITION SERVICE, PATIENT CARE AREAS, HOSPITAL STAFF, VISITORS

PROCEDURE:

1. Menus for both the regular and therapeutic diets shall be planned to comply with the Diet Manual, which has been approved by the Medical Staff and the CNM.

2. A minimum of a three-week cycle menu shall be for Distinct Part Skilled Nursing Facility (DP/SNF). A minimum of a seven-day cycle menu shall be for the acute care facility. Patient/resident food preferences shall be respected as much as possible and substitutes shall be offered through use of a selective menu or substitutes from appropriate food groups.

3. The cycle menu is available in an electronic version. A copy of the three-week cycle is posted on the DP/SNF unit and is available upon request. If any meal served varies from the planned menu, the change shall be noted in writing on the posted menu in the kitchen.

4. Diets shall be in accordance with the approved diet manual.

5. The regular diet house menu is written with the goal of at least 1800 calories per day. The following menu pattern is used as a guide for menu development.

    - Bread group: 6 oz- equivalents per day, ½ being whole grain

- Vegetable group: 2 ½ cup equivalents (raw) per day. (1 cup raw = ½ cup cooked)
- Fruit group: 1 ½ cup equivalents per day
- Dairy group: 3 cup equivalents per day
- Protein group: 5 ounce equivalents per day

Servings are defined as:

a. Breads:

- 1 oz slice bread
- ½ cup cooked rice or pasta
- ½ cup cooked cereal
- 1 ounce of ready cooked cereal
- 2 x 2 inch piece of cake or ¾ to 1 ounce of cookie

b. Vegetables:

- ½ cup chopped raw or cooked
- 1 cup leafy raw vegetables

c. Fruit:

- 1 piece of fruit or ½ cup canned; usually juice packed
- 1 cup 100% fruit juice
- ½ cup dried fruits

d. Milk:

- 8 ounces of milk, fortified soy milk
- 8 ounces of yogurt
- 1 ½ ounces of natural cheese

- 2 ounces of processed cheese

e. Protein:

- 1 oz cooked lean meat, fish, or poultry
- 1 egg
- ¼ cup cooked legumes, 1 tbsp. peanut butter, ½ oz nuts/seeds

6. Nutritional considerations in meal planning:

a. A good source of Vitamin C is included in the daily menu.

b. A good source of Vitamin A is included at least 3 to 4 times during the seven-day cycle to ensure the daily average meets the Recommended Daily Allowance of the vitamin. (5000 IU or 4000 RE).

c. Vitamin D fortified milk or milk substitute is used to ensure Vitamin D adequacy.

d. Enriched breads are routinely included at once or more a day on the modified diet when permitted.

e. Raw fruit or vegetables are routinely included once or more a day and on modified diets when permitted.

Sample Menu pattern:

BREAKFAST
Fruit/juice
Cereal
Egg or substitute as ordered
Breakfast meat as ordered
Toast
Milk
Margarine
Jelly

LUNCH & DINNER
Meat or substitute
Starch or starchy vegetable
Salad
Dessert or fruit
Bread/margarine

Milk

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. PC.02.02.03, EP 6
- Code of Federal Regulations Title 42: Chapter 4 §483.60 Food and nutrition services.
- Dietary Guidelines for Americans 2020-2025 pg 96.

SUBJECT: **PATIENT EDUCATION FOR MODIFIED DIET**	SECTION:

PURPOSE:

To establish a protocol for patient diet education.

POLICY:

Sierra View Medical Center (SVMC) provides diet education with discharge instructions to the patient/resident, family or individuals who are responsible for their care.

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

PROCEDURE:

1. Diet instruction is provided when ordered by nursing or the physician, or when it is determined that it is needed during patient nutritional screening or assessment.

2. The dietitian is responsible for patient/resident nutrition/diet instruction including, but not limited to, therapeutic diets, drug-food interaction and complex clinical nutrition.

3. Nursing may provide written and/or verbal diet instruction upon discharge for those patients/residents being discharged on a mechanically altered or therapeutic diet.

4. Approved reference materials, instructional tools, etc., are kept in the dietitian's office, and on the computer using the Nutrition Care Manual and Krames on Demand. Verbal and written instructions are provided to facilitate the patient's/resident's understanding and ability to follow through with the diet at home. Written instructions for diet after discharge are also given to the representative responsible for the patient's/resident's health care needs.

5. Instructions may include the following:

    a. Brief explanation of the need for the diet with their present condition.

    b. Review of the foods allowed, portion size, and foods to be discouraged/avoided.

    c. Discussion of appropriate food items that can be bought to replace regularly used items (i.e., low sodium versions).

    d. Suggestions for food preparation, recipes, etc.

    e. Hospital telephone number with the dietitian's phone number to call with questions as needed after discharge.

6. Patients/residents may be encouraged to watch AllenTek videos on their hospital TV on varying health conditions

7. Documentation of the diet instruction provided, information covered, patient/resident understanding and expected compliance will be included in the dietitian assessment and in Interdisciplinary Education Record section.

REFERENCES:

- California Department of Public Health (2024). Retrieved from https://www.cdph.ca.gov
- Centers for Medicare and Medicaid Services, Conditions of Participation (2024). Retrieved from https://www.cms.gov/regulations-and-guidance/regulations-and-guidance.html
- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PHYSICIAN ORDERED CONSULTATION**	SECTION:

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

PURPOSE:

To establish protocol for a physician-requested nutritional consult.

POLICY:

Nutrition consultations ordered by the physician will be completed by a Registered Dietitian (RD).

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

PROCEDURE:

1. A physician may order a nutritional consultation utilizing the electronic medical record (EMR). The RD will be notified of the nutritional consultation through the EMR.

2. A thorough nutrition assessment will be completed for all patients with a physician-ordered nutritional consultation. The RD will complete the nutrition assessment with recommendations within 24 hours of notification.

3. A nutritional assessment and recommendations will be communicated to the physician in the EMR and may include diet order changes, enteral or parenteral nutrition changes, dietary supplements, and/or vitamin and mineral supplementation.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. LD.04.01.05 EP 3

SUBJECT: **SCOPE OF SERVICE – CARDIAC CATH LAB**	SECTION: **Cardiac Cath Lab** **Page 1 of 2**

PURPOSE:

To provide elective, scheduled, diagnostic and interventional outpatient cardiac catheterization services for adult and geriatric patients.

AFFECTED PERSONNEL/AREAS: *ALL CATH LAB STAFF*

POLICY:

The Cardiac Catheterization Laboratory (CCL) provides services for diagnostic and angiography studies. These services consist of:

- Right and left heart catheterization
- Angiography of the coronary arteries, left ventricle, and aorta
- Coronary and peripheral intervention, including balloon angioplasty and stenting
- Pacemaker/device placement and extraction
- Myocardial biopsy
- Electrophysiological studies
- Intra vascular ultrasound (IVUS)
- Fractional flow reserve (FFR)

The CCL is comprised of physicians who specialize in interventional cardiology, and/or maintain the appropriate credentials to exercise specific procedural privileges. These physicians are ultimately responsible for care of the patients pre-procedurally, intra-procedurally, and post-procedurally.

Hours/Days of Operation: 0700-1600 Monday - Friday

CCL Admit/Recovery Areas: Provides care for CCL patients during the pre- and post-procedure periods under RN oversight.

Scope of Patient Care Needs: The CCL department provides a safe and comfortable environment for both patients and personnel in order to provide optimum assistance to the physicians in meeting the health needs of the patients. The CCL staff provides quality-conscious, competent, and cost-effective care with respect for life and dignity. Patients' physical, psychological, and social needs are assessed, evaluated, and documented prior to admission, upon admission, prior to discharge, and as needed throughout their stay in the CCL department.

Staffing Patterns: CCL procedures will only be performed if the necessary staff and equipment are available.

A. The CCL team consists of Registered Nurses (RNs) and Radiological Technologists (RTs).

B. Admit/Recovery is staffed by two RNs.

C. CCL procedure suite staffing includes one sedation Registered Nurse, one Radiological Tech, and one transcriber/monitor RN and/or RT.

D. During procedures where moderate sedation is administered, the policy titled "Procedural Sedation" will be adhered to.

E. Staff Accountability/Responsibility:

1. Medical Director: Directly accountable and responsible to the Department of Radiology/Pathology and the Governing Board.

2. Department Director: Directly accountable and responsible to the Administrative Director of Radiology and the Vice President of Physician Recruitment & Professional Services for all aspects of CCL operations.

3. RN: Accountable to the Department Director and is responsible for direct patient care and other duties as per job description.

4. RT: Accountable to the Department Director and is responsible for duties as per job description.

F. CCL equipment and supplies shall include the following, or include alternate equipment which meet the intent of the prescribed equipment:

- X-ray machine
- Image intensifier
- Pulse generator
- Camera
- Spot film device
- Videotape viewing equipment of fluoroscopic procedures
- Magnetic tape recording and playback equipment
- Motor-driven cardiac table
- Cinefluorography and radiography equipment
- Monitoring and recording equipment
- Pressure transducers
- Equipment for determining cardiac output
- Appropriate cardiac catheters and accessory equipment
- Resuscitation equipment
- GE Innova flat panel C-Arm
- Hemodynamic monitoring equipment
- Power injector

REFERENCES:

- California Code of Regulations (2019). Title 22. §70433-70439. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I

D7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCES:

- Procedural Sedation

SUBJECT: **STORAGE AND TRANSPORTATION OF SUPPLIES**	SECTION: ***Management of the Environment of Care (EC)*** **Page 1 of 2**

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

PURPOSE:

To provide guidelines for optimal storage and transportation of supplies from Materials Management to the Operating Room (OR), and measures for preventing surgical wound infection to include provision of instruments, supplies, and equipment free of contamination at the time of use.

POLICY:

Surgical Services Staff will follow guidelines for storage and transportation of supplies.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR), MATERNAL CHILD HEALTH (MCH)-MATERIALS MANAGEMENT/ALL EMPLOYEES*

PROCEDURE:

- Sterile materials will be stored 12 inches from the floor, at least 18 inches from the ceiling and at least 2 inches from outside walls. Sterile supplies will be stored and transported separate from non-sterile supplies.
- Supplies will be stored and handled carefully to avoid crushing, bending, compressing, puncturing, or otherwise compromising the sterility of the contents. Medical and surgical supplies are not to be stored next to or under sinks, under exposed water or sewer pipes, or in any location where they can become wet. Storage of supplies on floors, windowsills, and areas other than designated shelving counters or carts should be avoided.
- Sterile processed supplies will be transported on case carts to the clean core in the Operating Room via the "clean dumbwaiter." For in-depth information, refer to the Surgical Services Structure Standard: Case Cart System.
- Sterile supplies not sent on the case carts will be transported to the Operating Room directly from Materials Management on a cart with a solid bottom shelf. Sterile supplies out of their shipping boxes will be placed in enclosed bins on the top shelf and covered with a clean sheet for transport.
- Boxed supplies will be placed on the bottom shelf.
- Supplies will be checked against the pick list and off-loaded onto an OR department cart by OR staff. Supplies will be wiped with a damp moist cloth as designated and PRN. Plastic bottles will be wiped routinely.

REFERENCE:

- The Joint Commission. (2020). Comprehensive Accreditation Manual. (IC.02.02.01). Ambulatory; Infection Prevention and Control IC. https://www.jointcommission.org/standards/standard-faqs/ambulatory/infection-prevention-and-control-ic/000002145/. Oakbrook Terrace, IL.
- ANSI/AAMI ST79: 2023. Comprehensive Guide to Steam Sterilization and Sterility Assurance In Health Care Facilities.

CROSS REFERENCE:

- CASE CART, PROCEDURE CARDS, PROCEDURE PACKS

This Page Intentionally Left Blank

Senior Leadership Team	5/28/2024
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	5/28/2024

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
May 28, 2024
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	Action
		Approve ↓
Policies:		
Activation of the Command Center	1-8	
Disaster Communications	9-11	
Disaster Response Security	12-13	
Equipment and Supplies	14-16	
Key Control	17-18	
Lost and Found	19-20	
Meal Discount	21-22	
Medical Records During a Mass Casualty Event	23-24	
On-Call/Call Back	25-26	
Paid Sick Leave	27-30	
Per Diem Protocol (Non-Exempt Employees)	31-34	
Request to Operate Under a CMS 1135 Waiver Procedure	35-38	
Response to Wildfires	39	
Use of Electrical Extension Cords	40-41	
Utility System Operational Plans and Failure Procedures	42-73	
Forms:		
014726 ED Consent to Treatment	74	

SUBJECT:	SECTION:
ACTIVATION OF THE COMMAND CENTER	***Initiation of Disaster Plan*** **Page 1 of 8**

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

POLICY:

Each incident will be directed from a Command Center. The Command Center brings together those responsible for the sections or parts of the disaster response and provides an efficient mechanism for communication, decision making, coordination of efforts, and resource utilization.

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

PROCEDURE:

1. In the event that the disaster incident necessitates the full implementation of the Emergency Operations Plan, the Incident Command Center will be activated.

2. The responsibility for the hospital function in a disaster rests with the Chief Executive Officer (CEO) or designee.

3. The Command Center will be active throughout the duration of a disaster response and until recovery is underway. Closure of the Command Center and resumption of normal activity will be the decision of the Incident Commander.

4. All incoming calls from County Emergency Services, Fire, Police, or other official(s) with disaster responsibilities will be routed to the Command Center.

5. "Runners" will be assigned to deliver written messages between sections and treatment areas and to supplement and support the communication process.

6. As Incident Commander, the CEO or designee will appoint Section Chiefs as indicated by the nature of the disaster incident.

7. The Disaster Organizational Chart will be followed. It delineates the chain of command, communication pathways, and scope of responsibility.

8. Each Section Chief will follow the appropriate Job Action Sheet, which outlines duties to be focused upon in a disaster.

9. Each Section Chief will appoint other personnel to fill the additional job roles within their section.

10. Only Incident Commander, Section Chiefs, and support runners/clerks will be authorized to remain in the Command Center.

11. The Command Center will be located in the Board Room with alternate sites identified on the "*Location of Disaster Workstations*" grid.

12. Communication from the Command Center Section Chiefs and functional areas throughout the facility will be by hand held radio and by written message communication. (Refer to Communications).

13. All communication with the news media will proceed from the Public Information Officer (PIO) in the Command Center.

14. Guidelines for assignments to Command Center and Section Chief responsibilities: (these recommendations list the **primary choice** for the assignment and optional choices depending on availability and need)

    a. Incident Commander-
    CEO
    Administrator on-call
    VP of Patient Care Services/Chief Nursing Officer

    b. Public Information Officer –
    Director of Marketing
    Public Relations Coordinator

    Executive Assistant

    c. Liaison Officer –
    VP of Quality & Regulatory Affairs
    VP of Professional Services
    Chairperson of Safety Committee

    d. Logistics Chief –
    Administrative Director of General Services

    Environment of Care/Safety & Security Manager

    On-Site Security Staff member

    e. Planning Chief –
    Director of Information Technology
    or Designee

    Situation-Status Unit Leader
    Director of Information Technology
    or Designee

    Labor Pool Unit Leader
    Human Resources Manager
    Staffing Coordinator

Recruiter

Medical Staff Unit Leader
Medical Staff Office

Nursing Unit Leader
Director of Critical Care Services
Director of Emergency Services

f. Finance Chief –
V.P. of Finance or designee

g. Operations Chief –
VP of Patient Care Services/Chief Nursing Officer
VP of Professional Services

Medical Staff Director –
Chief of the Medical Staff
Director of Medical Staff

Medical Care Director –
House Supervisor
Designated Inpatient Unit Director

Inpatient Areas Supervisor-
Designated Inpatient Unit Director
Designated Clinical Manager

Treatment Areas Supervisor-
Director of Emergency Services
ED Nursing Staff

Ancillary/Human Services –
VP of Professional Services

Designated Ancillary staff

15. The Situation Status Leader from the Planning Section will assign a Command Center Recorder to keep the *Situation Status/Condition Board* current and to track messages to the Command Center.

REFERENCES:

- California Code of Regulations (2020). Title 22. § 70741, 70743, 70745, 70746. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I

D7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- The Joint Commission (2024). Hospital accreditation standards. EM.09.01.01 Joint Commission Resources. Oak Brook, IL.

APPENDIX A: Disaster Workstations Grid

MEDICAL	LOCATION	INITIAL STAFFING NEEDS	COMMUNICATION	EQUIPMENT NEEDS
Triage	Emergency Dept ambulance entrance	1 MICN 3 escorts 1 clerk	Hand held radio	Gurneys, wheelchairs
Immediate Level I (RED TAGS)	Emergency Dept treatment area	1-2 physicians 2 RN's 2 LVN's 1 RT 2 clerks	Phone Hand held radio if no phone service	Disaster Supply Cart
Delayed Level II (YELLOW TAG)	Emergency Dept Core Employee Health Serv.	1 physician 1 RN 1 LVN 1 clerk	Phone	Disaster Supply Cart
Minimal Level III (GREEN TAG)	Rural Health Clinic SNF	1 physician 1 RN 1 LVN 1 clerk	Phone	Disaster Supply Cart

MEDICAL	LOCATION	INITIAL STAFFING NEEDS	COMMUNICATION	EQUIPMENT NEEDS
Dead – Morgue (BLACK TAG)	Hall outside Pharmacy/Central Supply	Security		May need body bags
Surgical Area	OR	1 surgeon 1 anesth. 1 RN 1 ORT 1 RNFA	Phone Hand held radio if no phone service	
Burn Care	Transfer to UMC Fresno after stabilization			
Decontamination Area	Emergency Dept Decontamination Room			Decon Cart from Engineering
Discharge Area for In-Patients	Flex Care 2nd and 3rd floor waiting rooms	1 RN 1 clerk	Phone	
Discharge Area for Disaster Victims	Mt. Whitney Room	1 LVN 1 clerk	Phone	

Ambulance Off load for Triage	Emergency Dept Ambulance Entrance		Phone Hand held radio if no phone service	
Ambulance Loading for In-Patient Transfers	Front Lobby		Phone	

NON-MEDICAL	LOCATION	INITIAL STAFFING NEEDS	COMMUNICATION	EQUIPMENT NEEDS
Command Center	1. Board Room 2. Administration Offices 3. MOB Upstairs Offices	See plan	Hand Held Radio Phones	Org Chart board Disaster Boxes Status Boards
Radio Location	Emergency Dept	1 MICN		

NON-MEDICAL	LOCATION	INITIAL STAFFING NEEDS	COMMUNICATION	EQUIPMENT NEEDS

SUBJECT: **ACTIVATION OF THE COMMAND CENTER**	SECTION: ***Initiation of Disaster Plan*** **Page 8 of 8**

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

Labor Pool staff	Command Center	Staffing Coordinator 2 clerks	Hand held radio Phone	
Personnel Staging Area	Command Center			
Medical Staff Pool	Medical Staff Office	Med Staff Secretary or designee	Phone	
Visitors/Family	Mt. Whitney Room	1 Volunteer		
Press Area	Front Entrance			
Supply Area	Materials Management	2 MM personnel	Phone	
Security Locations	• Emergency Dept entrances and exits • Front Lobby • Hallway in front of Volunteer desk	1 person at each location (4)	Hand held radios	

SUBJECT: **DISASTER COMMUNICATIONS**	SECTION: ***Resource Management and Preparation*** **Page 1 of 3**

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

POLICY:

Communication shall be maintained between the Hospital and Disaster Scene and between the Hospital Command Center, Section Chiefs, disaster response functional areas, and alternate care sites.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

1. Communication between Hospital and Disaster Scene for External Events:

    a. The Pre-hospital radio system (Status Net) will be the main communications link to communication between the hospital Emergency Department (ED) and the Medical Commander in the field.

    b. The Medical Commander will provide the ED with the information necessary to prepare the initial "Emergency Situation Report", communication regarding victims and patients or residents, to include, but not limited to, the census of the facility that day and all updates.

    c. If a Disaster Scene is at many locations, as in a flood or earthquake, the Status Net communication may come from multiple scenes.

2. Communication between Hospitals:

    a. The Status Net Radio is equipped with a channel for inter-hospital communication in the event of a disaster (Privacy Plus). The Privacy Plus system connects the three Base Station Hospitals in Tulare County (Sierra View Medical Center, Adventist Health Tulare, and Kaweah Health). The Coordinating Hospital will use Privacy Plus to communicate to the other Base Stations of the disaster and to give and receive bed and treatment capabilities. Each Base Station is responsible for contacting the Receiving Facility in its area by use of the HEAR Radio Channel or by land line to determine their bed capacity for report to the Coordinating Hospital. This is recorded on the "Hospital Cumulative Inventory Status" and communicated to the Hospital Command Center and to the Medical Commander in the field to provide information for field distribution of casualties. The facility will also notify assisting hospitals and agencies of its ability to function, including its needs and its capability to provide assistance.

    b. Upon activation of Privacy Plus, the assigned MICN in the Emergency Department will announce the following information and then monitor for a response:

        - Hospital name and the fact that this is an "all channel disaster call."
        - Explain nature of incident, location, possible number of casualties.

- Ask all hospitals to stand by for Roll Call.
- Wait five minutes, then call the roll of hospitals using the "*Hospital Cumulative Inventory Status.*"

c. Continue to monitor Privacy Plus for duration of disaster response. When the response is terminated, announce an "all clear" and resume normal operations.

d. If an "all channel disaster" call goes out from another hospital:

- Respond to the roll call with information needed on the Inventory form (number of beds available, etc.). Information will need to be obtained from House Manager/Staffing Coordinator.
- Continue to monitor the channel until the "all clear" is called by the Coordinating Hospital.

3. Communication In-House:

a. All non-emergency use of all telephones should cease upon initiation of the disaster response. Communication will be limited to messages essential to the disaster response.

b. Runners will be assigned to deliver and receive messages both internally and externally to supplement communications.

c. All messages will be written on the "message form" with date and time sent or received and the names of the sender and recipient.

d. A message log will be maintained by the Command Center Secretary.

e. Internal phones of the hospital are supported by an emergency power system. Should telephone service be interrupted, all communications shall be done by portable radio, cell phone or runner. Portable radios are available for distribution to Command Center, Sections Chiefs, and Section Officers as determined by the Command Center.

4. External Communications:

a. All communication with outside agencies such as County Emergency Operations Center, City Command Center, Police, Fire, or other officials with disaster responsibilities will be handled through the Command Center. All community partners will be notified of the facilities ability to function, the occupancy of the Hospital and the needs of the facility at that time.

b. Hospital to Hospital communications will be handled by the Privacy Plus channel on the ED radio as described above. Information for transmission will be received from the

Command Center. Information received from outside facilities will be forwarded to the Command Center.

c. Cellular telephone, two-way radios and runners will be used to communicate with alternate care sites and community partners such as the local Authority Having Jurisdiction and Tulare County Health and Human Services.

REFERENCES:

- The Joint Commission (2024) Hospital accreditation standards. EM.12.02.01 Joint Commission Resources. Oak Brook, IL.

SUBJECT:	SECTION:
DISASTER RESPONSE SECURITY	***Disaster Security***

POLICY:

The security of patients, employees, and physical plant will be provided for during the disaster response.

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

PROCEDURE:

1. Internal security will be provided by the Engineering Department and by the contracted On Site Security service.

2. Security personnel will be stationed at the following minimal locations to provide security presence and to direct vehicles and persons seeking entrance:

   a. Emergency Department Lobby entrance

   b. Emergency Department Ambulance entrance

   c. Main Hospital Lobby entrance

3. Security personnel will be responsible for securing all outside exits and entrances to the facility.

4. Security personnel will work closely with the City of Porterville Police Department in providing traffic control and securing accesses to the hospital.

5. All employees of the hospital are required to wear assigned nametags identifying them as employees. Security personnel will require proper identification from persons entering the facility.

6. Personnel responding to the hospital will park in the front of the hospital and avoid use of ED parking and ambulance areas.

7. All relatives, visitors and news media will be directed to the main lobby.

8. No visitors for inpatients will be allowed unless the patient is critical and permission is received from the nursing unit.

9. During Disaster Exercises, routing visiting privileges will be followed.

10. The Emergency Department entrance will be secured and off limits to all but victims and staff.

11. Security personnel will be alert to possible walk-in victims or other ill persons seeking treatment and assist them in routing to a triage location.

REFERENCES:

- California Code of Regulations (2020). Title 22. §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 (2024). Hospital accreditation standards. EM.12.02.07 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **EQUIPMENT AND SUPPLIES**	SECTION: ***Resource Management and Preparation*** **Page 1 of 3**

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

POLICY:

Procedures shall be established to assure that adequate hospital supplies and equipment are available as needed to permit the expanded provision of services in a disaster situation.

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

PROCEDURE:

MEDICAL SUPPLIES:

1. Materials Management Department maintains a "Disaster Supply" cart containing basic fluid resuscitation and wound management supplies. This Cart is delivered to the Emergency Department upon initiation of the Disaster Response for use in treatment of "Immediate" patients. Supplies subject to deterioration or outdating should be rotated.

2. Materials Management Department collects and forwards basic first aid supplies and Emergency Department Records to the Delayed Treatment area for use in treatment of "Delayed" patients upon initiation of the Disaster Response. Supplies subject to deterioration or outdating should be rotated.

3. Materials Management Department maintains a current inventory list of essential equipment and supplies for distribution to treatment areas as required during the Disaster Response.

4. Materials Management Department shall maintain current lists of supply resources in the community for procurement of needed supply replacements as needed during the Disaster Response.

5. During the Disaster Response, the "Medical Supply Unit Leader" will collect information on equipment and supply needs, coordinate distribution of needed items, identify additional needs, and coordinate procurement efforts.

6. The "Medical Supply Unit Leader" shall log all procurements from outside vendors during the Disaster Response on the form *HICS Procurement Summary Report.* A copy will be forwarded to the Finance Section Chief.

7. The "Medical Supply Unit Leader" shall log the flow of resources obtained and dispensed on the form. A copy will be forwarded to the Finance Section Chief.

MEDICAL EQUIPMENT:

PHARMACY:

1. The Pharmacy will maintain routine levels of drug supplies in the Pharmacy.

2. During the Disaster Response, the Pharmacy will monitor, replace, and coordinate procurement of floor stock used and requests for medications from the Treatment locations.

3. The Pharmacy will maintain a list of medication supplier sources in the community to assist in procurement of needed medications supplies.

FOOD SUPPLIES:

1. The Dietary Department shall maintain a two day supply of perishable food in the Main Kitchen and kitchen freezers.

2. A three day supply of non-perishable food shall be rotated to maintain current dates for use.

3. The Dietary Department will maintain a list of food supplier sources in the community to assist in the procurement of needed food supplies.

LABORATORY SUPPLIES:

1. The Clinical Laboratory shall maintain an inventory of supplies and reagents to maintain laboratory services for 10 days.

2. The Clinical Laboratory shall maintain a list of sources for back-up or additional needed supplies or reagents in the community to assist in the procurement of needed supplies. Resource list is on file in the Lab.

3. The Clinical Laboratory shall maintain an inventory of blood and blood products. They shall communicate with the Central California Blood Bank for blood inventories, communicate needs to them, and provide inventory information to them upon request regarding Sierra View Medical Center (SVMC) stock as part of mutual aid information in the event of large scale multi-facility impact.

LINEN SUPPLIES:

1. Environmental Services shall maintain an inventory of linen supplies to maintain services for 3 days.

2. Environmental Services shall maintain an inventory of linen supplies stored on the units.

3. Environmental Services shall monitor, distribute and evaluate linen needs during the Disaster Response and communicate needs to the Logistics Chief.

4. Environmental Services shall maintain a list of possible sources for linen supplies and contingencies for linen procurement or substitution when demands for supplies exceed stock. Resource lists are on file in EVS.

REFERENCES:

- California Code of Regulations (2020). Title 22. § 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 (2024). Hospital accreditation standards. EM.12.02.09 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **KEY CONTROL**	SECTION: *Security Management* **Page 1 of 2**

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

POLICY:

All keys are to be closely managed to prevent unauthorized access to facilities and security sensitive areas. The term "key" shall include traditional keys as well as electronic key cards that function with the organization's electronic access system or "DSX". A security sensitive area is one that has special security needs beyond the general hospital areas due to vulnerable patients, financial issues, drug issues, access to protected health information, and critical equipment.

The Engineering Department is responsible for traditional lock and key control. The Information Technology (I.T.) Department controls the electronic key card access system (DSX) with assistance and coordination from the Engineering Department.

Pharmacy and medication room access approval and key distribution to the pharmacy and medication rooms are controlled by the Director of Pharmacy. Engineering shall not have access to any medication storage area keys. The Director of Pharmacy will coordinate any medication related room re-keying and key copying directly with a bonded locksmith.

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

PROCEDURE:

- The Administrative Director of General Services is responsible for the master key system and key cabinet located in General Services.
- All traditional key requests are initiated by the affected department head and forwarded to the Administrative Director of General Services or Engineering Department for review, approval and disposition.
- Electronic key card requests will be submitted through an I.T. request.
- The department head requests the necessary keys or electronic access for their staff member. All keys to facility are documented on the Facilities Key Control Log by the Environment of Care/Safety & Security Manager. The Facilities Key Control Log is kept in the Environment of Care/Safety & Security Manager's office.
- Department Directors, Engineering and the Security Department are responsible, in conjunction with Human Resources, for collecting and accounting for all keys and key cards from terminated personnel. Records of dispersed DSX key cards are maintained by the I.T. department.
- Requests presented for replacement or duplication of lost or misplaced keys or electronic access cards are processed only after an investigation by the Safety Officer and Security Department establishes that the lost or misplaced keys cannot be recovered and that the key system was not compromised. Upon completion of the investigation, a new electronic request will be submitted by the Safety Officer using the I.T. request system.

- Broken or damaged keys that cannot be used are turned in to the Engineering Department for proper disposal.
- Duplicate keys will be provided by the Engineering Department only at the approval of the Administrative Director of General Services, Facilities Manager or the Environment of Care/Safety & Security Manager.
- All newly cut keys will be stamped "Do Not Duplicate."
- Grand Master keys will open all doors in the facility with the exception of medication storage rooms and are accounted for in the Key Log.
- Keys and/or electronic key cards may be issued to Employees, Foundation Members, Board Members, Physicians, Allied Healthcare Professionals and Contracted Vendors as determined to be appropriate by the Administrative Director of General Services. Keys and/or electronic key cards shall not be issued to patients, visitors and/or the general public without written permission of the Chief Executive Officer (CEO) and Administrative Director of General Services.
- Personnel shall not loan their hospital keys or key cards to any other individual.
- Personnel are required to return all hospital keys upon termination of employment. Human Resources is responsible for collecting all keys and key cards from personnel upon termination. Human Resources shall forward all returned keys to the Administrative Director of General Services.
- Human Resources shall return all returned key cards to the I.T. Department to prevent any unauthorized access.
- All Grand Master keys are issued only with the permission of the Chief Executive Officer.
- The following list of personnel have been approved by the Chief Executive Officer to be issued a Grand Master key:
  - Chief Executive Officer
  - Senior Management
  - Administrative Director of General Services
  - Facilities Manager
  - Nursing House Supervisor

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. EC.02.01.01 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Security Management Plan

SUBJECT: **LOST AND FOUND**	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 establish guidelines when lost items are found or turned in to the Security Department.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

- All persons finding personal property on hospital property should contact the Security Department at the earliest opportunity and make arrangements to turn over found property to the Security Department.
- Every reasonable effort will be made by the Security Department to locate the owner and return lost items to the owner.
- Items found will be recorded in a *Lost and Found Log* with the following information:
  - Name of Finder
  - Time and location of find
  - Name of Security Officer receiving items
  - Description of item(s)
- Items will be kept in plastic bags and stored by the Security Department in a security storage area or the security safe.
- The *Lost and Found Log* will be kept in the Security Office.

DISPOSAL:

- Clothing or other items that have not been claimed may be disposed of in the following manner:

  a. Property without apparent substantial value will be given to a charitable organization not affiliated with the hospital, if unclaimed within 90 days.

  b. Property with apparent substantial value, i.e. money, jewelry, certified checks, fur coats, money orders, cashier's checks, and any endorsed checks, shall be disposed of in accordance with California Civil Code Section 1862.5 as follows:

  "Whenever any personal property has been found, deposited, and has remained unclaimed with any licensed hospital for a period of 180 days following the departure of the owner from

the hospital, the hospital may proceed to sell the items at public auction." *[Civil Code Section 1862.5]*

- Persons attempting to claim lost items must describe property to the satisfaction of the Security Officer, provide proper identification to the satisfaction of the Security Officer, and sign the Lost and Found Log book.

REFERENCES:

- California Code, Civil Code - CIV § 1862.5 (1988). https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV&sectionNum=1862.5.

SUBJECT: **MEAL DISCOUNT**	SECTION:

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

PURPOSE:

To establish meal discount guidelines for personnel working.

POLICY:

Personnel who are working and wearing their Sierra View Medical Center (SVMC) badge will receive a meal discount when eating food from the café. The Food and Nutrition Service (FNS) Director is responsible to monitor department costs and present meal cost analysis to the Senior Leadership Team.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS, PHYSICIANS, VOLUNTEERS, ON SITE SECURITY GUARDS & STUDENTS*

PROCEDURE:

1. Personnel must be wearing their SVMC badge and be on duty to receive discounted meal prices. Regular pricing will apply to employees without a SVMC badge and/or who are off-duty.

2. Items eligible for discount are established by the FNS Department, and pre-set and maintained in the Point of Sale (POS) computer software system.

3. Personnel (including, but not limited to, hospital staff, physicians, volunteers, security guards and students with SVMC badges) are eligible for meal discounts.

4. Complimentary coffee and brewed tea made in the Café is provided for all personnel on duty at no charge.

5. Complimentary (free) meals:
   a. The following personnel are eligible:
      i. Emergency Department Physicians
      ii. Hospitalists
      iii. Intensivists
      iv. Anesthesiologists & CRNA's
      v. Surgeons
      vi. Food Service Staff

   b. Convenient food items such as chips, pre-packaged items, bottled beverages, etc. are excluded and must be purchased.

   c. One meal per four (4) hour shift is permitted. Complementary meals may not be given or shared with non-eligible personnel.

6. The café will charge for all to-go containers.

7. The café offers fountain soda refills for a reduced cost, with proof of receipt for the same day.

8. An appropriate charge for condiments and disposable products will be charged for customers utilizing these products for foods purchased off-site.

9. Bulk food purchases have the potential to deplete prepared food supplies for staff, visitors and physicians working and will not be permitted.

10. Discounted pricing applies to personnel as specified above, and may not be extended to friends or family of qualifying personnel.

11. With the assistance of the FNS Director, the Senior Leadership Team will review meal cost analysis a minimum of annually and adjust prices as necessary.

SUBJECT:	SECTION:
MEDICAL RECORDS DURING A MASS CASUALTY EVENT	***Patient Management***

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

POLICY:

Each victim presenting for treatment, including those Dead on Arrival (DOA), will have a medical record initiated upon arrival.

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

PROCEDURE:

1. METTAG – Disaster Tag identification

    a. Each victim shall have a METTAG disaster tag affixed to their person on arrival. If one is not in place, it should be placed by the Triage staff on an accessible limb and a triage category assigned by tearing off the colored strips until the proper category color is the last remaining strip.

    b. The METTAG is a pre-numbered tag that contains patient identifying information. It also serves as the pre-hospital patient care record by providing space for the documentation of injuries and field treatments. It serves as the patient identifier in the event no name has been determined.

    c. The METTAG number shall be written on all registration, treatment and diagnostic requisition forms used during the course of treatment to assure consistent patient identification.

    d. The METTAG is not to be removed from the patient until discharge, at which time it becomes part of the permanent medical record.

2. Disaster Patient Chart:

    a. The pre-hospital patient care record in multi-casualty situations will be the *"Base Station Multiple Victim Patient Care Record."*

    b. Downtime Emergency Department (ED) chart procedure shall be followed. Downtime forms shall be sent to the locations for Delayed and Minimal Treatment.

    c. Patients may not be registered into the computer until after the disaster situation has been stabilized and resources may be allocated to this function. In the early stages of the disaster, resources will concentrate on patient identification and collection of information on the downtime registration record using downtime numbers or "STAT Admit Kits" and patient tracking. Triage Victim Lists shall be used to verify that all victims are registered.

    d. Upon completion of procedures for patients admitted to the hospital, the Admitting Clerk shall take the appropriate forms to the unit and attach identification bands to the patient. At this time, the METTAG may be removed from the patient and attached to the chart.

e. Records generated during initial disaster care shall be routed as per usual procedures for admissions, transfers, or discharges. Patients transferred to other facilities during a disaster will have inter-facility transfer forms completed before leaving. These forms become part of the permanent medical record following normal policy.

3. Clerical assistants in the Triage Area shall log all victims to include METTAG number, triage category, and disposition onto the *Disaster Victim List* (see Victim Tracking policy).

REFERENCES:

- Title 22: Section 70741, 70743, 70745, 70746
- The Joint Commission (2024). Hospital accreditation standards. EM12.02.05 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Victim Tracking
- Meditech Downtime- Clinical Documentation

SUBJECT: **ON-CALL/CALL BACK**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide definitions for "On-Call" and "Call Back" status and provide the compensation calculation of each for payroll purposes.

POLICY:

In order for the Hospital to provide 24 hour/7 day/week coverage in specified areas, employees who are designated to be "on-call" will be compensated as stated below.

DEFINITIONS:

On-Call: An employee is considered to be on uncontrolled "On-Call" when placed on a pre-determined schedule and assigned by their Department Director/designee to be available for return to work. On-Call employees must be available and expected to return to work within 30 minutes of notification. However, while an employee is On-Call, s/he is free to use the time for his/her own benefit. The employee will be notified in advance by the Department Director to respond to the needs of the department.

Call Back: "Call Back" applies when an employee who is On-Call is called in to work.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL NON-EXEMPT EMPLOYEES*

PROCEDURE:

1. Compensation will be calculated on the employee's actual base hourly rate of pay. The On-Call pay is included in calculating the regular rate of pay for purposes of determining overtime rates; however, hours paid for being scheduled On-Call, but for which no work is performed, is not included in calculating the regular rate of pay for purposes of overtime. Pay for hours worked for Call Back will be used in calculating premium overtime rates.

2. An employee who is placed On-Call will be paid a percentage of her/his base hourly rate of pay for all time spent On-Call. When they receive a call to report to work, On-Call status and pay will stop when the employee clocks in at the work site, and at that time, they will be paid at the rate of 1 ½ times their base rate of pay for the first four (4) hours of "Call Back" and double-time (two times their base rate of pay) for any "Call Back" hours worked thereafter, up to and until the beginning of the next business day unless Fair Labor Standards Act (FLSA) overtime rates apply. In addition, they will be paid for a minimum of one (1) hour each time they are called in.

3. On-Call status begins upon the completion of the regularly scheduled working hours.* If placed on call during your regular shift and your called back in, the callback rule will apply.,

4. While On-Call, for all issues resolved remotely, the employee will be paid a minimum of 0.25 hours. If the resolution requires the employee to come onsite, they will be paid a minimum of one (1) hour.

5. All other specific department procedures must be followed in accordance with each department's On-Call policy

6. On-Call time must be documented for appropriate compensation.

7. Time On-Call and the time returned to work must be documented on the employee's timecard.

REFERENCES:

- Fair Labor Standards Act of 1938 (Revised May 2011). Retrieved from https://www.dol.gov/whd/regs/statutes/fairlaborstandact.pdf.

CROSS REFERENCES:

- OVERTIME
- VACATION/HOLIDAY LEAVE

SUBJECT: **PAID SICK LEAVE**	SECTION: *Human Resources* **Page 1 of 4**

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

PURPOSE:

To define the purpose and scope of Sick Leave benefits provided at Sierra View Medical Center (SVMC).

POLICY:

PAID SICK LEAVE ELIGIBILITY AND ACCRUALS

All Full Time and Part Time Employees: The Hospital will provide a lump sum of 40 hours or five (5) days (whichever is greater) of paid sick leave (PSL) at the beginning of each 12-month period (employee's date of hire). An employee is not eligible to begin using any PSL until the 91st day of employment with the Hospital.

All Per Diem Employees: Per diem Employees are eligible to accrue PSL beginning with their first day of employment. Employees will accrue PSL at the rate of one hour for every 30 hours of work. Employees may begin to utilize their hours on their 91st day of employment. Unused accrued PSL will carry over from one year to the next. However, an employee's accrued PSL may not exceed 80 hours or 10 days, whichever is greater If the cap is met, no further PSL will accrue until the employee falls below the cap. Employees are limited to 5 days of PSL usage per year from their date of hire.

PERMITTED USE OF SICK LEAVE

An employee will not be discriminated against or retaliated against for requesting or using PSL for qualifying reasons protected by the Healthy Workplaces Healthy Families Act (HWHFA).

An employee may submit a verbal or written request to use PSL for the following reasons:

A. Diagnosis, care, or treatment of an existing health condition for an employee or covered family member, as defined below:
B. Preventive care for an employee or covered family member. Preventive care may include annual physicals or vaccinations.
C. For an employee who is a victim of domestic violence, sexual assault, or stalking, to take time off (i) to obtain or attempt to obtain any relief to help ensure the health, safety, or welfare of the employee or the employee's child, such as a temporary restraining order, restraining order or other injunctive relief, (ii) to seek medical attention, obtain services from a shelter, program or rape crisis center, (iii) to obtain psychological counseling, (iv) to participate in safety planning, or (v) to take other actions to increase safety from future incidents.

For purposes of PSL, a covered "family member" includes:

- A "child" defined as a biological, foster or adopted child, or a legal ward, regardless of the age or dependency status of the child. A "child" also may be someone for whom you have accepted the duties and responsibilities of raising, even if they are not your legal child.
- A "parent" is defined as a biological, foster or adoptive parent; a stepparent; or a legal guardian of an employee or the employee's spouse or registered domestic partner. A parent may also be someone who accepted the duties and responsibilities of raising you when you were a minor child, even if they are not your legal parent.
- A spouse
- A registered domestic partner
- A grandparent
- A grandchild
- A sibling
- A "designated person". A designated person is any individual you identify at the time you request paid sick leave. You are limited to one designated person per 12-month period for purposes of paid sick leave.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

TERMS AND CONDITIONS

- An employee shall provide reasonable advance notice of their need to use available accrued PSL to their supervisor if the need for such PSL use is foreseeable (e.g., doctor's appointment scheduled in advance). If the need is unforeseeable (*e.g.*, employee is ill at time of shift), the employee shall provide notice of the need for the leave to their supervisor as soon as practicable.
    - If the absence is foreseeable, the employee's time sheet must be completed in advance of the absence. If the absence is unforeseen, the employee must complete their time sheet upon return from the absence. If the absence extends beyond the close of the payroll period, it is the employee's responsibility to request PSL be added to the time sheet at the time the absence is reported. If PSL is not noted on the time sheet, the absence is considered an unexcused absence. The employee is required to approve/attest the PSL entry on the time sheet upon return.
- Departments may require an employee who uses available PSL hours from their leave bank to do so with a minimum increment of two hours.
- PSL use will not be counted as an absence occurrence or used as a basis for disciplining an

employee for absenteeism. However, if an employee does not have any PSL hours to use for an absence, the absence will be counted as a full occurrence under the Attendance and Punctuality policy. In a declared emergency/disaster related to a medical situation like a pandemic, a physician's note will be required after the third day of work missed not protected under PSL.

- Full Time employees will receive compensation for their unused PSL each year on their anniversary date. Employee must still be employed on their anniversary date to qualify for the payout.Employees will not receive compensation upon termination, resignation, retirement or other separation reasons. If an employee is rehired within one year from date of separation, the employee shall receive upon new hire date, 40 hours or 5 days (whichever is greater) of PSL to be used on or after the 91st day of re-employment.
- Per Diem employees who have not used all accrued PSL prior to the last day of employment will not be paid out at the time of termination, resignation, retirement or other separation reasons. If an employee is rehired within one year of the date of separation, any accrued and unused PSL will be reinstated and available for the employee to use.

- PSL will not be considered hours worked for purposes of overtime calculation.
- PSL will be compensated at the same wage as the employee normally earns during regular work hours. The rate of pay will be based on the employee's regular hourly wage.
- Any available PSL must be used simultaneously with an employee's FMLA/CFRA leave and may be used on Pregnancy Disability Leave (PDL) leave.
- Transfers from Per Diem to Full Time: A partial frontload of the difference between what was already used and the full amount of the front load (e.g., per diem used 2 days' worth of PSL since their date of hire prior to transferring to Full Time status, will be frontloaded an additional of 3 PSL days at time of transfer. If the Per Diem used 5 days' worth of PSL since their date of hire, no additional PSL hours will be added.).
  - o If an employee has more than 5 days at time of transfer, they would forfeit the difference.
- Transfers from Full Time to Per Diem: Employee will maintain their PSL balance at time of transfer and then switch to the accrual method.

REQUIRED RECORD KEEPING:

As part of a department's routine process of receiving information from employees who call in sick, procedures need to be in place to inquire about the following:

- Whether the sick day is due to a covered reason under this policy.

- If the sick day is used to care for a covered person as listed above, what is that person's relationship to the employee? (Mother, child, etc.)

- Whether the illness is a serious health condition also may be covered under FMLA/CFRA/PDL. Employees do not need to disclose a diagnosis. If the illness qualifies as a serious health condition, employees should be directed to contact Human Resources. Directors/Managers must notify Human Resources once they learn an employee/employee's family member may have a qualifying illness/serious health condition, so the employee may be informed of leaves available to them.

CAUTION: The scope of the questions must be limited, to protect the confidentiality of medical information of an employee or family member's health condition. For example, the department cannot ask the employee to reveal what the specific health condition is.

A Leave of Absence does not need to be requested unless the employee will be absent for more than three (3) continuous workdays and the absence qualifies as an FMLA/CFRA, PDL or other medical leaves.

An employee taking PSL is not required to submit a doctor's note.

REFERENCES:

- **AB 1522- The Healthy Workplaces, Healthy Families act of 2014**

CROSS REFERENCES:

- Reasonable Accommodation policy
- Attendance & Punctuality policy
- Leave of Absence – FMLA/CFRA policy

SUBJECT: **PER DIEM PROTOCOL (NON-EXEMPT EMPLOYEES)**	SECTION: *Human Resources* **Page 1 of 4**

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

PURPOSE:

To establish the requirements, protocol and work expectations for non-exempt per diem employees working at Sierra View Medical Center (SVMC).

POLICY:

ALL Per Diem Staff:

All non-exempt, per diem employees must provide a minimum of four (4) full shifts in a four (4) week schedule that they would be available to work. Once the Department leadership receives the per diem employee's availability, they will then assess the staffing needs and schedule the per diem employees for full shift(s) based on their availability in conjunction with the needs of the department. The per diem employee's scheduled shifts could be less than their actual availability provided as it will be based on the needs of the department/hospital.

1. It is the responsibility of all per diem employees to provide their schedule of available shifts to their Department Director/Manager or their designee based on the above minimum requirements.

2. At the discretion of the Department Director/Manager, per diem employees may be scheduled on the dayshift(s) they are needed most by the department for a full complement of staff.

3. Per diem staff who work in departments who are regularly scheduled for on-call shifts may be required to take rotation of the on-call schedule based on the business need.

4. Two (2) of the four (4) full shifts scheduled should be one (1) complete weekend or its equivalent as defined below.

5. A complete weekend consists of the following:

   - Saturday **and** Sunday—**OR--** all two (2) Saturdays—**OR--** all two (2) Sundays for the day and/or evening shifts.

   - Friday **and** Saturday—**OR--** Saturday **and** Sunday—**OR**—all two (2) Fridays, Saturdays, or Sundays for the night shift.

   An employee may work two (2) Saturdays **OR** one (1) Saturday and one (1) Sunday during the four (4)-week schedule, as long as the equivalent of a complete weekend has been scheduled. *(Exception: Surgery and PACU Departments)*

6. All per diem employees are required to work a minimum of one (1) Sierra View Medical Center holiday each calendar year. SVMC recognizes the following holidays:

New Year's Day	Labor Day
President's Day	Veteran's Day
Memorial Day	Thanksgiving Day
Independence Day	Christmas Day

7. For the purposes of scheduling, the holiday is considered to be:

   - 0645 AM – 1515 PM; 0645 AM – 1915 PM; and 1445 PM – 2315 PM for the day of the holiday.

   1845 PM – 715 AM; and 2245 PM – 0715 AM for the eve of the holiday.

AFFECTED AREAS/PERSONNEL: *ALL PER DIEM & SEASONAL STAFF*

PROCEDURE:

1. All per diem employees will be scheduled based upon department needs after all full-time and part-time employees have completed their schedules.

2. Once the schedule is posted, per diem employees are expected to work their scheduled full shifts(s). If assigned to a ***nursing*** unit, trading is allowed according to General Nursing Personnel Policies. All others must receive approval in advance from their Department Director/Manager.

3. Per Diem employees who have been placed on the schedule but are called-off by the hospital for their scheduled shifts will be considered to have met their minimum requirements.

4. Per Diem employees who fail to work their schedule and have no protected leave will be subject to SVMC's Attendance and Punctuality Policy and will be considered to not have met their minimum requirements.

5. Per diem staff who fail to work or provide SVMC with any scheduled shifts over a four (4) week consecutive period or who do not provide availability that fulfils the needs of the department consistently for more than four (4) months in a 12-month period will be provided a letter from the Human Resources Department requesting them to provide availability to their department leadership. If the per diem employee does not contact SVMC within the time designated on the letter and continues to not offer or provide availability of shifts for SVMC, they will be separated from employment based on lack of availability to provide hours to SVMC.

6. All per diem staff will receive a copy of the "Per Diem Protocol" policy, and an "Acknowledgment of Receipt" form will be signed by the employee. The original will be placed in the employee's Personnel File, and a copy will be given to the employee.

7. If after receiving two (2) letters in a rolling 12-month period, the employee will be recommended for separation from employment with the district.

EXCEPTIONS TO THIS POLICY

- Per Diem employees who are full time students and currently enrolled in a hospital approved program, must provide a school schedule to their leaders. If unable to fulfil the 4 shifts per month due to school scheduling, they must commit to working full time during school breaks.

8.

ALL Per Diem Staff:

SEASONAL PER DIEM STAFF

SVMC will designate and recruit for seasonal per diem staff when the business need in a specific department/service line has critical staffing shortages. The seasonal per diem program will be approved by the senior leadership team. Once approved, the seasonal per diem program will include the following guidelines:

- Seasonal per diem staffing will be scheduled for a designated period of time utilizing either an 8 week or 13 week assignment.
- The number of per diem positions available within each assignment will be determined by the respective VP in coordination with the VP of HR.
- A flat rate of pay for seasonal per diem will be assigned by senior leadership team based on the competitive market, availability of the position, and critical staffing levels impacting operations.
- Overtime will be paid after completion of forty (40) hours worked in one week.
- Seasonal per diem staff will work three full 12 – hour shifts per week or five full 8-hour shifts per week and will be scheduled according to the need by the department leadership.
- If the seasonal per diem staff member calls off for a shift, the number of called off shifts will be added to the end of their assignment. This will apply to both protected and unprotected absences.
- Absences will be managed under SVMC's Attendance and Punctuality Policy.
- Seasonal per diem staff can work extra shifts beyond the minimum of the three shifts if available.

SVMC reserves the right to flex Seasonal per diem staff according to SVMC's flexing policy.
Once the seasonal per diem program is designated and approved, Human Resources will work with key stakeholders to expedite the onboarding and clearance required while still ensuring compliance and proper clearance for each new hire.

Any per diem employee currently employed at SVMC is eligible to apply for a seasonal per diem assignment as long as they meet the eligibility and pre-screening criteria which will be discussed as part of the recruitment process.

Full-time employees who are employed during the seasonal PD period will not be eligible for participation for the next twelve-month period. At the end of each seasonal period, a needs assessment will be conducted to determine FT eligibility.

At the end of the seasonal PD assignment, the PD employee will either be placed on inactive status or remain active in the seasonal PD role as approved by senior leadership team for another eight week or thirteen-week assignment. Seasonal PD staff who are placed on inactive status, leave SVMC and return for an additional assignment within the year, are not required to go through onboarding and orientation.

CROSS REFERENCES:

Flexing Staffing Protocol

SUBJECT: **REQUEST TO OPERATE UNDER A CMS 1135 WAIVER PROCEDURE**	SECTION: *Emergency Management* **Page 1 of 4**

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

PURPOSE:

To provide instructions for submitting a request to operate under the Centers for Medicare & Medicaid Services (CMS) 1135 waiver when the President of the United States declares a disaster or emergency under the Stafford Act or National Emergencies Act and the Secretary of the Department of Health and Human Services (HHS) declares a public health emergency under Section 319 of the Public Health Service Act.

DEFINITIONS:

The CMS 1135 Waiver is for waiving or modifying the regulations that speak to the *provision of care* and does not apply to *conditions of payment.* Waivers may be administered during an emergency by regulatory agencies. Waivers allow health care providers to temporarily streamline their work and ensure patients continue to have safe access to care. Waivers are time limited in scope and allow flexibility to meet deadlines and offer possibility of extending deadlines, but not eliminating them.

POLICY:

Applies to any facility located in a county included in a presidential declaration of emergency or disaster and 1135 waiver scope when unable to operate in compliance with Centers for Medicare and Medicaid Services (CMS) requirements due to impact of a disaster.

AFFECTED PERSONNEL/AREAS: *GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES*

PROCEDURE:

If Sierra View Medical Center (SVMC) is impacted by a disaster to a degree that compliance to CMS requirements is not possible, at the request of the Incident Commander (HICS), the Vice President of Quality and Regulatory Affairs, or designee will submit a request to operate under an 1135 waiver authority to the nearest CMS Regional Office and State Survey Agency via email:

A. Incident Commander:

- Contact Vice President of Quality and Regulatory Affairs and request the 1135 waiver.

B. Vice President of Quality and Regulatory Affairs:

- Draft email to local CMS Regional Office and State Survey Agency that contains

  a) Facility name
  b) Full mailing address (including county)
  c) CMC Certification Number (CCN)
  d) Facility contact name and information
  e) Explanation of why the waiver is needed.

Example: SVMC is the sole community provider without reasonable transfer options at this point during the specified emergent event (e.g. flooding, fires, flu outbreak). Facility needs a waiver to exceed its bed limit by X number of beds for Y days/weeks (be specific).

f) The scope of the issue and the impact it has on SVMC.
g) The type of relief that SVMC is seeking or the regulatory requirement(s)/reference(s) that the hospital is seeking to have waived.

Example:

1. *Requests by hospitals to provide screening/triage of patients at a location offsite from the hospital's campus.*
2. *Hospital will be housing patients in units not otherwise appropriate under the Medicare Conditions of Participation or for duration that exceeds regulatory requirements.*
3. *Hospital requesting increase to their certified bed capacity.*

h) Assure processes are in place to keep careful records of CMS beneficiaries to whom services are provided to assure proper payment may be made.
i) Return to Quality and Regulatory Affairs as soon as possible and by the end of the approved operational period or the end of the emergency period.
j) Submit email request to operate under an 1135 waiver authority to local CMS Regional Office and State Survey Agency.

C. PROCEDURE INFORMATION:

- If the required emergency declarations have been satisfied, the HHS assistant secretary for preparedness and response will coordinate with HHS and Centers for Medicare and Medicaid Services (CMS) offices to determine the need for and scope of the 1135 waiver. The assistant secretary considers requests from governor's office, individual healthcare providers and associations and regional and field HHS and CMS offices.

- At least two days before formally exercising Section 1135 waiver authority, the secretary must provide a certification and notice to Congress that describes the specific provision to be waived or modified, the healthcare providers to whom the waiver will apply, the geographic area in which the waiver or modification will apply, the period of time the modification will be in effect, and statement that the waiver or modification is necessary to achieve the purposes of the Social Security Act.

- Social Security Act Section 1135 does not provide immunity from liability. Section 1135 waivers are intended to temporarily reduce administrative burdens and increase flexibility of service providers during a declared emergency with the goal of promoting greater access to care by individuals affected by the emergency.

- Once the 1135 waiver has been authorized, service provider's requirements are not automatically waived or modified:

1) CMS implements the waiver by determining on a case-by-case basis whether and the extent to which sufficient grounds exist for waiving requirements with respect to a particular provider, a group or class of providers, or a geographic area.

2) Only certain federal requirements relating to Medicare, Medicaid, SCHIP and HIPPA may be waived or modified under Section 1135. A waiver does not affect state laws or regulations, including those for licensure and conditions of participations.

3) Examples of 1135 waiver or modifications include:

- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure)
- Emergency Medical Treatment and Labor Act (EMTALA) sanctions for redirection of an individual to receive medical screening examination in an alternative location pursuant to a state emergency preparedness plan (or in the case of a public health emergency involving pandemic infectious disease, a state pandemic preparedness plan) or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency.
- A waiver of EMTALA requirements is effective only if actions under the waiver do not discriminate on the basis of a patient's source of payment or ability to pay.
- HIPPA sanctions arising from non-compliance with HIPPA privacy regulations relating to:

    1) Obtaining a patient's agreement to speak with family or friends or honoring a patient's request to opt out of the facility directory
    2) Distributing a notice of privacy practices
    3) The patient's right to request confidential communications

4) The waiver is effective only if actions under the waiver do not discriminate as to source of payment or ability to pay.

- Physician self-referrals sanctions
- Performance deadlines and timetables may be adjusted (but not waived)
- Limitations on payment to permit Medicare enrollees to use out of network providers in an emergency situation.

WAIVER TIME LIMITS:

- Waivers typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.
- Waivers for EMTALA (for public health emergencies that do not involve a pandemic disease) and HIPPA requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol.
- Waiver for EMTALA requirements for emergencies that involve a pandemic disease last until the termination of the pandemic-related public health emergency.
- The 1135 waiver authority applies only to Federal requirements and does not apply to State requirements for licensure or conditions of participation.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. EM.12.01.01 EP9 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- EMERGENCY OPERATIONS PLAN

SUBJECT: **RESPONSE TO WILDFIRES**	SECTION: *Special Circumstances* **Page 1 of 1**

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

PURPOSE:

To be aware of the hazards associated with a variety of large scale exterior fire situations. Forest fires and large residential fire storms have the ability to affect and alter how the organization functions and provides treatment to affected patients. This policy follows Sierra View Medical Center's all hazards approach to a variety of emergency situations contained within the Emergency Management Program and Emergency Operations Plan.

Wild fires have the potential to impact the facility with an influx of patients. Residential fire storms can occur when extreme low humidity levels, coupled with strong wind conditions and careless acts, occur.

POLICY:

For unusual influx of patients due to wild fires, refer to the Emergency Operations Plan and Surge Capacity Plan policies for direction on managing the event.

When extreme low humidity conditions coupled with high winds (Santa Ana effect) occur, a cessation of smoking in public sidewalks shall be considered. Processes that create an open flame condition will also be reviewed for suspension. Examples may include welding, cutting and other construction practices.

Sierra View Medical Center will rely on the City of Porterville Fire Department for direction for sheltering in place, suspension of specific practices and possible evacuation orders during residential fire events near the hospital complex.

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

PROCEDURE:

For situations involving wild fires or residential fire storms, refer to the Emergency Management Program for specific direction and actions to be implemented in an emergency situation.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards EM.09.09.01. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Surge Capacity Plan
- Emergency Operations Plan

SUBJECT: **USE OF ELECTRICAL EXTENSION CORDS**	SECTION: *Safety Management* **Page 1 of 2**

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

POLICY:

Patient Care Areas:

- External extension cords used in patient areas will be used only temporarily to meet an immediate need (1 to 2 hours).

Construction of Electrical Extension Cords:

- Will have three (3) conductors of copper.
- Will be type SO (service oil resistant), ST (service thermoplastic) or STO (service thermoplastic oil resistant). Type SH (shielded) is not acceptable.
- Will be 16 gauge or larger, depending on the electrical load and length.
- Will have UL tested hospital grade, male and female caps, rated at 20 amps.
- No electrical cord will be longer than 25 feet.

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

PROCEDURE:

1. The Engineering Department will be responsible for the storage and issuing of electrical extension cords as needed to the departments, excluding the Environmental Services Department.

2. Each department will contact the Engineering Department in the event of a requirement for an electrical extension cord. The department will give the following information:

   a. Location of use
   b. What equipment will be used
   c. How long the requirement will be

3. The Engineering Department will determine:

   a. What the electrical load will be
   b. The length of the extension cord and the size OS wire

   The above is to be determined by the following:

   - Loads up to 10 amps. or 1.2 kilowatts:

     - A number 16 gauge cord, not longer than 15 feet, will be used.
     - In the use of cords 15 to 20 feet, a number 14 gauge will be used.

- Loads up to 20 amps, or 2.2 kilowatts:
  - A number 14 gauge cord, not longer than 15 feet, will be used.
  - In the use of cords 15 to 20 feet, a number 12 gauge will be used.

    Note: No equipment with greater loads than 20 amps or 2.2 kilowatts will be operated with an electrical extension cord.

REFERENCES:

- The Joint Commission (2020). Hospital accreditation standards. EC.02.05.01 EP24 Joint Commission Resources. Oak Brook, IL.
- National Fire Protection Association (NFPA) 99 Health Care Facilities Code (2012). Retrieved from https://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards/detail?code=99.

SUBJECT:	SECTION:
UTILITY SYSTEM OPERATIONAL PLANS AND FAILURE PROCEDURES	*Utilities Management* **Page 1 of 32**

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

PURPOSE:

Utility system operational plans are written to help ensure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

Written Operational Plans

- *Management of failure*
- *User and operator training*

As part of utility system operational plans, planned or preventive maintenance is a key factor in assuring the ongoing performance and reliability of utility systems whereby each system is properly identified, operated, and maintained. A system is no more reliable than the individual pieces of equipment, or components, within it. Each component within a system must be evaluated to determine the content and frequency of testing procedures, inspections, calibrations, and the servicing and replacement of parts. In the development of preventive maintenance programs, a review is made from various sources of information, such as manufacturer's recommendations, codes, standards, and federal, state, and local laws and regulations. The basic sources of information are invaluable as start-up aids; however, over time it is essential that local operating experience be factored in to modify the program. Through this process, initial levels of risk are maintained or reduced.

The preventive maintenance program consists of training of operating and maintenance personnel to familiarize them with the program and to train them to acquire data useful for analyzing the performance of utility systems. Management of the utility systems must identify key indicators of equipment and personnel performance.

Job training is provided by individuals with appropriate technical and/or educational backgrounds in the organization, along with outside training seminars and educational programs. The training is designed to customize basic technical skills to the medical center's needs. Training is central to maintaining system reliability and to protecting the health and safety of all those affected by the systems

- The Administrative Director of General Services is responsible for the proper and safe functioning of all equipment within the facility and the condition of the facility generally. It is therefore the responsibility of the Engineering Manager to maintain awareness of the activities within the facility.

- Engineering Services requires that written procedures shall be developed that specify the action to be taken during the failure of essential equipment and major utility services. The written procedures shall include a call system for summoning essential personnel and outside assistance when required. The following essential equipment and services shall be included: Major air conditioning equipment, air handling systems (ventilation, filtration, quantitative exchanges, and humidity), boilers, electrical power services, fire alarm and extinguishing systems, water supply, all waste disposal systems, and medical gas and vacuum systems. Qualified engineering consultative advice should be available as needed.

- The Administrative Director of General Services should be notified first when a disruption of service occurs, but in the event of his absence, this system gives Administration and other department heads a greater idea of who is best qualified to handle the situation.

- In the event that the in-house personnel cannot correct the problem and restore the operation of the equipment, then Administration, the Administrative Director of General Services, or their designated representative shall have full authorization to call in an outside resource to correct the situation.

UTILITY FAILURE DEFINITIONS:

Equipment/Utilities Failures Reports should be completed for the following Utilities Failures:

Loss of Electrical Power

- One breaker in a distribution panel which would shutdown a whole area.

Failure of Emergency Generator and/or Emergency Power Distribution System

- Any contamination of fuel source, switch gear malfunction, or power interruption lasting 10 seconds or more. Any failure or shutdown during weekly testing or actual use.

Failure of Fire Alarm System

- Loss or unscheduled shutdown of a zone.

Failure of Fire Protection System

- Loss or unscheduled shutdown of a zone.

Elevator Failure

- When more than two out of four elevators are inoperable for more than eight hours.

Failure of Vertical Lifts

- When a dumbwaiter is inoperable for more than 72 hours.

Failure of Communication System

- PBX and Paging System: Any area loss of overhead paging.
- Telephone System: Failure of any one switch on the telephone system or loss of any card.

Failure of Nurse Call System

- Any zone failure of more than eight rooms.

Failure of Blood, Bone, and Tissue Storage Systems

- Any loss of temperature above 6 degrees C for longer than two hours.

Failure of HVAC System

- Any unscheduled total shutdown of chillers or a major air handling unit.

Failure of Medical Air System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Medical Vacuum System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Medical Gas Oxygen System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Medical Gas Nitrous Oxide System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Natural Gas System

- Any unscheduled shutdown of the system.

Failure of Boiler System

- When water temperature falls 15 degrees below steeping or when alarm goes off.

Failure of Water Distribution System

- Contamination of the potable water supply or an unscheduled shutdown of the main riser for more than one hour.

Failure of Plumbing System

- Unscheduled shutdown of the main riser for more than one hour.

SUBJECT: OUTSIDE VENDOR ASSISTANCE

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

OUTSIDE VENDOR ASSISTANCE:

Outside vendor assistance may be used should an emergency occur beyond the scope of the Engineering Department or if assistance is required due to a utility system failure.

PROCEDURE:

During normal working hours (8:00 A.M. - 5:00 P.M.) (Monday through Friday) notify the Administrative Director of General Services and obtain permission to use outside vendor.

If Administrative Director of General Services is unavailable or does not respond within 15 minutes, notify the Administrator On Call and obtain permission to use outside vendor.

SUBJECT: LOSS OF ELECTRICAL POWER

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The normal/emergency/critical systems for the medical center are supplied by Southern California Edison (SCE) through substations which provide the normal (primary) power source and the alternate (secondary) power source. The emergency distribution is supplied by two (2) sources, normal SCE power and emergency generator power.

Warning signs or indicators of loss of power and failure of emergency power include:

- Total loss of power and lights in all areas
- Warning signs or indicators of loss of external power only include:
    - Loss of most lighting and power in all areas

Reasons for loss of electrical power:

- Disruption in all or part of internal electrical distribution system
- Disruption of external power (utility company equipment)

PROCEDURE: **(For loss of power to primary and secondary power sources)**

Containment:

- A failure of the normal power source will result in the emergency generators automatically starting and emergency loads automatically transferring to the emergency generators. The generator is managed through an automatic paralleling system and all are diesel powered.
- The Engineer on duty will ensure generator is running properly.
- Notify the Administrative Director of General Services and the Administrator On Call.
- Check to ensure that the generator is running and supplying power to essential areas.
- Monitor generator for any load-shedding requirements.

Resolution:

Determine whether loss of power is due to internal or external disruption.

- Check main electrical distribution panel
- Call utility company

If power loss is due to disruption in the external power source, the Administrative Director of General Services or his designee will contact Southern California Edison to determine and estimate how long outage will last.

Administrative Director of General Services or his designee will notify the following:

- Administrator On Call
- Nursing House Supervisor (after normal business hours)

If power loss is due to disruption in the internal electrical distribution system, identify the problem.

- If emergency generator is on line, identify the distribution panel(s) serving the affected area(s).
- Trace and correct the problem.
- If the problem cannot be resolved immediately, notify the following: Administrative Director of General Services Administrator On Call, Nursing House Supervisor, Engineering Manager, and the affected areas.
- If repairs are beyond the scope of the Engineering Department, request assistance from the licensed electrical contractor on the call list.

- Request other outside assistance as necessary.
- Distribute emergency extension cords so power can be supplied from one area to another if there is a critical need (determined by Administrative Director of General Services, Nursing House Supervisor, Administrator On Call).
- When normal utility power has been restored, restart and reset all affected equipment in the power plant, mechanical rooms and other parts of the hospital affected by the power outage.

Evaluation:

- Record incident on Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the loss of electrical power include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF EMERGENCY GENERATOR AND/OR EMERGENCY POWER DISTRIBUTION SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

A failure of the normal power source will result in the emergency generator automatically starting and emergency loads automatically transferring to the emergency generator.

PROCEDURE:

In the event of failure of the emergency generator, or if emergency power is not supplied to the essential emergency power system during an electrical power outage, the following procedures as outlined below are to be followed:

Containment:

- Call for assistance and notify key personnel.
- Call generator repair service/request immediate dispatch of service tech
- Notify Administrative Director of General Services
- Notify Nursing Supervisor
- Notify Administrator On Call

Determine reason for generator failure:

- If engine failure, attempt to manually start generator.
- If engine does not start, check starter system.
- Check fuel system for fuel in day tank; refuel from main supply if necessary.
- If generator can be started, check transfer switch for tripping.
- If transfer switch is not tripped, check control panel for fault indicators.
- If no fault indicators, attempt to manually throw transfer switch.
- If transfer switch cannot be manually thrown or a fault is indicated on control panel, call an electrician.
- If transfer switch can be thrown, notify Nursing Supervisor and Administration that the medical center is on emergency power.
- If no malfunction of generator or transfer switch, check for fuel contamination.
- If fuel contaminated, call for immediate dispatch of mobile fuel tanker.

Resolution:

- If directed, call generator supplier for portable generator(s), cables and lugs.
- Notify Nursing Supervisor and Administration for estimated length of power outage.
- Assist service technician to resolve and repair problem.

Evaluation:

- Record incident on Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the failure of the Emergency Generators or the Emergency Power Distribution System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF FIRE ALARM SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

The fire alarm system provides fire detection services to all parts of all areas of the medical center. Warning signs or indicators of failure include:

- Audible alarms
- Visual observance

Reasons for fire alarm systems failure:

- Neglect
- Vandalism
- Computer malfunction
- Failure in electrical system

PROCEDURE:

Containment:

In the event of fire alarm systems failure, notify all affected areas including:

- Fire Department
- Administrative Director of General Services or his designee
- Alarm service company
- Alarm monitoring company
- If repairs are beyond scope of service of Engineering Service's staff, call the alarm company and request immediate dispatch of service technician.

Resolution:

- Administrative Director of General Services will post fire watch.
- A log of all fire watch activities will be maintained by Engineering Services.
- Notify Administration and all affected departments of estimated time fire alarm system will be out of service.
- Notify Fire Department, Alarm Monitoring Company, Administration, and all affected departments when repairs have been completed.
- Check with alarm monitoring company to ensure alarm signal is being received.
- Discontinue fire watch.
- File fire log watch activities in Engineering Services.

Evaluation:

- Record incident on Utility Disruption Form.
- Determine cause of failure and immediate steps taken to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the failure of the Fire Alarm System include:

- Maintenance Engineers on all shifts

SUBJECT: ELEVATOR FAILURE/PASSENGER EVACUATION

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

Employees of the medical center who become aware of individuals detained in an elevator, due to an elevator failure, should respond immediately by reporting the incident to maintenance and the Nursing House Supervisor. Maintenance staff will respond to meet the needs of the situation caused by the elevator failure.

ELEVATOR FAILURE:

Elevators serve vertical transportation in all areas throughout the medical center. Warning signs of an elevator failure include:

- Audible alarm
- Sounds of passenger(s) yelling or banging on elevator doors
- Elevator not responding to call buttons

Reasons for elevator failure:

- Power failure
- Failure of relay switches to reset

PROCEDURE:

Containment:

In the event of elevator failure with passenger(s) on board, notify the following:

- Maintenance and Administrative Director of General Services
- Maintenance staff will respond immediately to site of elevator failure.
- If no alarms or signals have been received from the disabled elevator(s), determine if passengers are on board by yelling at the approximate level elevator has stopped.

- Assure passengers that help is on the way.
- If patients are in elevator, communicate with escorting staff to determine if patient must be immediately evacuated.

Resolution:

EMERGENCY EVACUATION:

- If unclear to urgency of evacuation, contact Emergency Room Physician on duty. If the patient must be evacuated immediately, refer to the Emergency Evacuation Plan.
- When it is determined that a patient must be evacuated immediately, contact the elevator service company and request immediate dispatch of a service technician. Stress the urgency of the situation. Call the fire department and notify them that an emergency elevator evacuation is needed.
- Instruct passengers on board (if any) to remain calm and inform them not to attempt to restart elevators with reset button.
- Inform passengers that the Elevator Service Company and Fire Department have been notified and that help is on the way.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure and/or Passenger Evacuation of Elevator(s) include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF COMMUNICATION SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and

train users and operators of the systems.

POLICY:

The communication system provides telephone and paging services to all parts of all areas of the medical center. Warning signs or indicators of failure include:

- No dial tones
- Poor transmission quality

Reasons for communication systems or paging system failure:

- Equipment malfunction
- Broken transmission lines
- Switch malfunction
- Failure in electrical system

PROCEDURE:

In the event of a malfunction and/or failure of the communications system (telephone and/or paging system), the following procedure will be followed:

Containment:

In the event of communication systems failure, notify all affected areas including:

- Information Technology (IT)
- Maintenance
- Telephone company
- Notify Administrative Director of General Services, who will determine amount of down time and inform Administration, Nursing Services, and all affected departments.
- IT staff with the assistance of maintenance staff will try to identify and correct the problem.

Resolution:

- If repairs are beyond scope of service of IT and Maintenance Service's staff, the Administrative Director of General Services will call the telephone company or the paging system service company and request immediate dispatch of service technician.

- Administrative Director of General Services will assign priority departments with 2 way radios for communication.
- Notify affected departments on estimated repair time.
- Notify affected departments when service has been restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Communication System or the Paging System include:

- Information Technology staff
- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF NURSE CALL SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The nurse call system provides audible communication between patients and nursing staff for assistance in routine or emergency situations. Warning signs or indicators of failure include:

- Lack of audible communication

- Call lights not illuminated
- Lack of system response
- Inability to cancel audible or visual alarms

Reasons for nurse call system failure:

- Equipment malfunction
- Individual component failure
- Power supply failure in call system control panel
- Circuit breaker trip

PROCEDURE:

In the event of a malfunction and/or failure of the nurse call system, the following procedure will be followed:

Containment:

In the event of nurse call system failure, notify all affected areas.

- When notified by nursing of a failure in the nurse call system, instruct staff members to set up an alternative method of communication.
- Identify the cause of the failure and attempt to repair.

Resolution:

- If the nurse call system has been disabled and the problem is not remedied immediately, notify nurse call system vendor to dispatch immediate emergency service technician.
- Notify House Supervisor.
- Notify affected departments on estimated repair time.
- Notify affected departments when service has been restored.

Evaluation:

- Record incident on the Utility Disruption Form.

- Determine cause of failure and immediate steps taken to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Nurse Call System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF BLOOD, BONE, AND TISSUE STORAGE SYSTEMS

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The electrical and alarm system provides utilities and detection services to refrigerators used in the storage of blood, bone, and tissue. The Blood Bank refrigerator should maintain a temperature of 2-6 degrees C. When the temperature rises above 6 degrees C, the alarm at the Blood Bank will sound. Warning signs or indicators of failure include:

- Audible alarms
- Visual observance

Reasons for systems failure:

- Mechanical malfunction
- Failure in electrical system

PROCEDURE:

Containment:

In the event of systems failure, notify all affected areas including:

- Laboratory Director

- Administrative Director of General Services or his designee
- Notify maintenance that there is a utility or equipment failure.
- Notify the Nursing Supervisor on duty.
- Identify the cause of failure and attempt to repair.

Resolution:

- If repairs cannot be completed by Biomed and Engineering Services Staff, call equipment repair Service Company.
- If repairs cannot be completed in a timely manner, the Laboratory Director will make arrangements for an alternate location for refrigerated storage.
- Notify Laboratory Director and Nursing Supervisor of estimated time system will be out of service.
- Notify affected departments when service has been restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Blood, Bone and Tissue Storage Systems include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF THE HVAC SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The HVAC system provides control of the desired temperature, humidity and air purity for the health, safety and comfort of patients and employees. Warning signs or indicators of failure include:

- Sudden drop or rise of temperatures in any area of the facility
- Audible alarms
- Inability to control humidity
- Loss of air balance (positive and negative airflow)

Reasons for HVAC system failure:

- Mechanical malfunction
- Failure in electrical system
- Extreme temperatures

PROCEDURE:

Containment:

In the event of systems failure, notify all affected areas including:

- Administrative Director of General Services
- Engineering Manager
- If repairs are beyond scope of the Engineering Services staff, call the appropriate vendor to request immediate dispatch of a service technician.

Resolution:

- The Engineering staff will determine the cause of the failure.
- The time for repair will be estimated and departments will be notified of period that the system will be out of service.
- In the event of a prolonged failure, the Engineering Department will coordinate with affected units to mitigate temperature extremes.

- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the HVAC system include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL AIR SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical air system provides medical air to patient care areas on nursing units, surgery, recovery, labor and delivery, special procedure rooms and the emergency department. Warning signs or indicators of failure include:

- Audible alarm
- Drop in pressure
- Call from user staff

Reasons for medical air system failure:

- Equipment malfunction
- Rupture of air lines

- Contamination of system
- Electrical failure

PROCEDURE:

In the event of medical air system failure, notify all affected areas.

Containment:

- Check compressors to ensure they are functioning properly.
- If one compressor has failed, switch valves and isolate the defective unit.
- Check filter to ensure they are not plugged.
- If the main supply line has ruptured, attempt to repair or request outside emergency assistance from our certified medical gas testing and repair vendor.
- If a total loss of medical air has occurred, notify the Respiratory Therapy Department, House Supervisor, and Administrative Director of General Services.
- The Director of Respiratory Services shall be responsible for ordering additional medical air supplies until the failure has been corrected and purity tests have been completed if necessary.

Resolution:

- If service cannot be restored by Maintenance Staff, call for assistance from our certified medical gas testing and repair vendor.
- Notify affected departments of estimated time system will be out of service.
- Nursing will monitor and support patients during the interim period. Assist with the relocation of patients if necessary.
- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.

- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Medical Air System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL VACUUM SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical vacuum system provides medical vacuum to patient care areas on nursing units, surgery, recovery, labor and delivery, special procedure rooms and the emergency department. Warning signs or indicators of failure include:

- Audible alarm
- Drop in suction
- Call from user staff

Reasons for medical vacuum system failure:

- Equipment malfunction
- Rupture of vacuum lines
- Contamination of system
- Electrical failure

PROCEDURE:

In the event of medical vacuum system failure, notify all affected areas.

Containment:

- Check pumps to ensure they are functioning properly.

- If one pump has failed, switch valves and isolate the defective unit.
- If the main supply line has ruptured, attempt to repair or request outside emergency assistance from our certified medical gas testing and repair vendor.
- If a pump failure occurs to the vacuum system, notify the Administrative Director of General Services or designee and Administrator on Call.
- Deliver portable vacuum pumps to Special Care Units, Surgery and Medical/Surgical floors as needed.

Resolution:

- Notify affected departments as to the length of time required to make repairs for their planning purposes. If repairs are beyond the scope of the Maintenance Department, call for outside assistance from SVMC's certified medical gas testing and repair vendor.
- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Medical Vacuum System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL GAS OXYGEN SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical gas piping systems provides oxygen to all parts of all inpatient and nursing units, labor and delivery, surgery and recovery, emergency area, radiology, and other clinical areas of the medical center. Warning signs or indicators of failure include:

- Audible alarm
- Drop in pressure
- Call from user staff

Reasons for medical gas oxygen system failure:

- Equipment malfunction
- Depletion of oxygen
- Rupture of oxygen line
- Shut-off of zone valve

PROCEDURE:

In the event of medical gas oxygen systems failure, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee.
- Identify the cause of the failure. Use extreme caution as the risks of combustion are much greater in an environment of pure oxygen. Avoid skin contact with liquid oxygen due to its extremely low temperature. No smoking.
- If both the oxygen supply and the reserve have been disabled and the problem is not remedied immediately, notify Respiratory Therapy Department to deliver portable cylinders to the critical care areas immediately.
- Ensure that the reserve supply is on line.
- Notify Nursing Services and request that it alert all affected areas.
- Call and request immediate emergency delivery of oxygen as needed.

Resolution:

- Make minor repairs and request outside assistance from SVMC's certified medical gas testing and repair vendor as required.

- If tests of the medical gas oxygen system are necessary, coordinate them with the Respiratory Therapy Department.
- Notify affected departments, House Supervisor, and Respiratory Therapy when medical gas oxygen system is back online.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the failure of the medical gas oxygen system include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL GAS NITROUS OXIDE SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical gas piping systems provides nitrous oxide to Labor and Delivery and Surgery. Warning signs or indicators of failure include:

- Audible alarm
- Drop in pressure
- Call from user staff

Reasons for medical gas nitrous oxide system failure:

- Equipment malfunction

- Depletion of nitrous oxide
- Rupture of nitrous oxide line
- Shut-off of zone valve

PROCEDURE:

In the event of medical gas nitrous oxide systems failure, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee.
- Identify the cause of the failure. Check the nitrous oxide bulk supply tank to be sure that the manifold valve and regulator are properly aligned and correct as necessary.
- Replace empty tanks as necessary.
- If the tanks are not empty and the alignment is correct, check for point of disruption in the system.
- If Engineering Services staff are unable to correct the problem, request outside assistance from our certified medical gas testing and repair vendor.
- If the problem cannot be corrected immediately, notify the affected departments.

Resolution:

- Notify the House Supervisor.
- Call and request immediate emergency delivery of nitrous oxide.
- If tests of the medical gas nitrous oxide system are necessary, coordinate them with the Surgery Department.
- Notify affected departments, House Supervisor, and Surgery when medical gas nitrous oxide system is back on-line.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.

- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Medical Gas Nitrous Oxide System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF NATURAL GAS SUPPLY SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The natural gas supply system provides natural gas to the central plant and the kitchen areas. Warning signs or indicators of failure include:

- Drop in pressure
- Call from user staff

Reasons for natural gas supply system failure:

- Equipment malfunction
- Rupture of gas line
- Shut-off of valve

PROCEDURE:

In the event of natural gas supply system failure, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee immediately.
- Identify the cause of the failure. Use extreme caution as the risks of combustion are much greater in an environment of natural gas.

- If the natural gas supply has been disabled and the problem is not remedied immediately, notify the gas company to dispatch immediate emergency service technician.
- Notify Dietary Services, House Supervisor, Laboratory, and Administration.

Resolution:

- Make minor repairs and request outside assistance as required.
- Notify affected departments, House Supervisor, Laboratory, Dietary and Administration when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Natural Gas Supply System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF BOILER SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The boiler equipment generates hot water and heating water. Warning signs or indicators of failure include:

- Loss of hot water
- Pressure gauge readings

- Call from user staff

Reasons for boiler steam system failure:

- Equipment malfunction
- Disruption of supply lines (water or fuel)

PROCEDURE:

In the event of boiler system failure of all boilers at the same time, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee immediately.
- Check operation of fuel supply valves.
- Check boiler control panel.
- Check boiler water level.
- If boiler is functioning properly but water is not being supplied to end user, check circulating loop distribution system or valve closure for restriction and end user's equipment.
- If boiler system is estimated to be out of service during critical time frame of departmental activities, notify Administration, Surgery, Nursing, Housekeeping and Dietary Services.

Resolution:

- Attempt to repair or request outside emergency assistance from boiler service contractor.
- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Boiler Steam System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF WATER DISTRIBUTION SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The water distribution system serves all areas of the medical center. Warning signs or indicators of failure include:

- Decreased water pressure or flow at the delivery points
- Pressure gauge readings
- Call from user staff
- Change of color, odor, taste, and texture

Reasons for water distribution system failure:

- Disruption or breakage of main water line into medical center
- Contamination of outside water supply

PROCEDURE:

In the event of water distribution system failure, notify all affected areas.

Containment:

If breakage or disruption of main water line into medical center:

- Begin distribution of reserve water supplies
- Notify Administration that the reserve water supply is in use and that water rationing must be placed into effect
- Get estimate of length of time medical center will be without water from water company

- Secure boilers and follow procedures under "Failure of Boiler System"

If the breakage or disruption of water line is inside the building:

- Isolate and locate the point of breakage or disruption
- Notify all affected areas of disruption and estimated time of disruption
- Make necessary repairs or call for emergency assistance from outside plumbing contractor
- Notify affected areas upon restoration of service

If the water supply has been contaminated:

- Turn off the main domestic entry water valve
- Instruct all personnel and visitors through the Communications Department public address system not to drink the water or flush toilets
- Contact Administration or the House Supervisor to notify the Department of Health immediately about the water supply contamination

Resolution:

- Request delivery of additional potable water in accordance with the outside vendor's agreement
- Under guidance of Department of Health and Water Company, sanitize water lines
- Notify all affected areas upon completion of sanitizing and approval from Department of Health
- Notify the City of Porterville Public Works (559) 782-7518.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving

the Failure of the Water Distribution System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF PLUMBING SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The plumbing system serves all areas of the medical center. Warning signs or indicators of failure include:

- Overflowing of toilets
- Slow drainage in sinks
- Call from user staff
- Back-up in sinks and floor drains

Reasons for water distribution system failure:

- Blockage of the main sewer line
- Blockage of internal waste lines and mains
- Failure of sewage ejectors or sump pumps
- Breakage of internal sewer line

PROCEDURE:

In the event of plumbing system failure, notify all affected areas.

Containment:

In the event of failure of the external sewer main line:

- If failure is significant, notify Department of Public Health
- Limit available bathrooms for public and staff to compensate for flow of waste water in affected areas

- Post restriction signs or lock bathrooms as necessary
- Instruct Housekeeping Services to place red plastic liners in available bathrooms
- If failure results in flooding, Housekeeping Services will remove water with wet vacuums
- If major flooding caused by storm drain overflow, request emergency pumping by the City of Porterville

If the breakage or disruption of water line is inside the building:

- Notify affected areas by public address system or, if isolated area of failure, by telephone
- Isolate and locate the point of breakage or disruption
- Make necessary repairs or call for emergency assistance from outside plumbing contractor

Resolution:

- Limit available bathrooms for public and staff to compensate for flow of waste water in affected areas
- Post restriction signs or lock bathrooms as necessary
- Instruct Housekeeping Services to place red plastic liners in available bathrooms
- If failure results in flooding, Housekeeping Services will remove water with wet vacuums
- Notify affected areas upon restoration of service

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Plumbing System include:

- Maintenance Engineers on all shifts

AFFECTED PERSONNEL/AREAS:

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

REFERENCES:

- The Joint Commission (2024). Hospital Accreditation Standards. EC.02.05.01. EP10. Joint Commission Resources. Oak Brook, IL.

SIERRA VIEW MEDICAL CENTER **EMERGENCY DEPARTMENT CONSENT TO TREATMENT**

CONSENT TO TREATMENT

The undersigned patient consents to the procedures which may be performed during this emergency room visit, including emergency treatment of services, and which may include but are not limited to laboratory procedures, X-ray examination, medical and surgical treatment or procedures, anesthesia, or hospital services rendered under the general and special instructions of the patient's physician or surgeon.

Patient/Authorized Person _____ Relationship _____ Witness _____

Date/Time _____

CONSENTIMIENTO PARA TRATAMIENTO

El paciente abajo firmante da su consentimiento para recibir los procedimientos que puedan ser realizados durante su visita a esta sala de emergencias, incluyendo tratamientos o servicios de emergencia, los cuales pueden incluir pero sin limitarse a procedimientos de laboratorio, exámenes con rayos x, tratamiento o procedimientos médicos o quirúrgicos, anestesia, o servicios hospitalarios prestados bajo loas ordenes generales e instrucciones espéciales del medico o el cirujano del paciente.

Paciente/Persona Autorizada _____ Parentesco _____ Testigo _____

Fecha/Hora _____

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

EMERGENCY DEPARTMENT CONSENT TO TREATMENT

Form #014276 REV 2/24

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

PATIENT'S LABEL

This Page Intentionally Left Blank

MINUTES OF A REGULAR MEETING OF THE
BOARD OF DIRECTORS OF
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The Annual meeting of the Board of Directors of Sierra View Local Health Care District was held **April 23, 2024 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 5:04 p.m.

Directors Present: **REDDY, LOMELI, MARTINEZ, KASHYAP, PANDYA**

Others Present: Hefner, Donna, President/Chief Executive Officer, Hudson, Jeffery, VPPCS/CNO/DIO, Canales, Tracy, VP of Human Resources, Dickson, Doug, Chief Financial Officer, Mitchell, Melissa, VP Quality and Regulatory Affairs, Gomez, Cindy, Parsons, Malynda, Public Relations, Reed-Krase, Alex, Legal Counsel Sandhu, Harpreet, Chief of Staff, Johnson, Dianne, PUSD Scholarship Chairman, Ojeda, Abel, PAHS Advisory Board Chairman, Suorsa, Tim, PUSD Scholarship Treasurer, Echeveste, Maggie, Academy Leader,

I. Approval of Agenda:

Chairman REDDY 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:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:05 p.m. to discuss the following items:

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update – Quality Report

D. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation: Conference with Legal Counsel. BETA Claim No. 24-000528

E. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation: Conference with Legal Counsel. BETA Claim No. 23-001587

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to General Strategic Planning for Outpatient Ophthalmology & Podiatry Surgical Services. Estimated date of Disclosure 4/23/24.

Closed Session Items F, G and H were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:38 p.m., reconvening in Open Session at 5:39 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 – the Quality of Care/Peer Review

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director KASHYAP, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Quality Division Report – Quality Repot

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes

LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

D. Conference with Legal Counsel Re: BETA Claim No. 24-000528

Following review and discussion, it was moved by Vice Chair LOMELI, seconded by Director MARTINEZ, and carried to deny BETA Claim No. 24-000528 as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

E. Conference with Legal Counsel Re: BETA Claim No. 23-001587

Following review and discussion, it was moved by Vice Chair LOMELI, seconded by Director MARTINEZ, and carried to deny BETA Claim No. 24-001587 as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Discussion Regarding Trade Secrets Pertaining to General Strategic Planning for Outpatient Ophthalmology & Podiatry Surgical Services
Recommended Action: Information Only; No Action Taken

IV. Public Comments
No public Comments

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 MARTINEZ, seconded by, Director KASHYAP and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes

MARTINEZ Yes
PANDYA Yes
KASHYAP Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Director MARTINEZ and seconded by Director KASHYAP to approve the March 26, 2024 Regular Board Meeting Minutes as presented. The motion carried and the vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes
KASHYAP Yes

VII. Business Items

A. Porterville Academy of Health Science (PAHS) Health Career Scholarship

Following review and discussion, it was moved by Director PANDYA, seconded by Director KASHYAP and carried to approve the donation of $10,000 to the Porterville Academy of Health Science. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes
KASHYAP Yes

B. Resolution 04-23-2024/01 Dissolution Of Outpatient Ophthalmology Surgical Service Line

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ and carried to approve Resolution 04-23-2024/01 for the dissolution of the outpatient ophthalmology surgical service line as presented. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes
KASHYAP Yes

C. Resolution 04-23-2024/02 Dissolution Of Outpatient Podiatry Surgical Service Line

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve Resolution 04-23-2024/02 for the dissolution of the outpatient podiatry surgical service line as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

D. Resolution 04-23-2024/03 Ordering Even-Year Board of Directors Election; Consolidation of Elections; and Specification of the Election Order

Following review and discussion, it was moved by Director PANDYA, seconded by Director KASHYAP and carried to approve Resolution 04-23-2024/03 Ordering even-year board of directors election: consolidation of elections: and specification of the election order as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

E. March 2024 Financials

Doug Dickson, CFO presented the Financials for March 2024. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $13,728,944. Supplemental Funds were $2,079,631. Total Operating Expenses were $13,728,944. Loss from operations of $867,905.

Following review and discussion, it was moved by Director PANDYA, seconded by Director KASHYUP and carried to approve the March 2024 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VIII. CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View.

IX. Closed Session: Board adjourned Open Session at 6:30 p.m. and went into Closed Session at 6:30 p.m. to discuss the following items:

F. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter – One (1) Item. Estimated Date of Disclosure January 1, 2025 for materials that are not part of an individual's private personnel file.

G. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning

H. Pursuant to Gov. Code Section 54956.9(d)(2), Conference with Legal Counsel about recent work product (b)(1) and (b)(3)(F): significant exposure to litigation; privileged communication (1 Item).

X. Open Session: Board adjourned Closed Session at 7:25 p.m. and went into open Session at 7:25 p.m. to discuss the following items:

F. Discussion Regarding Confidential Matter
Information Only; No Action Taken

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

H. Conference with Legal Counsel
Information Only; No Action Taken

XI. Announcements:

A. Regular Board of Directors Meeting – May 28, 2024 at 5:00 p.m.

The meeting was adjourned 7:26 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: tv

This Page Intentionally Left Blank

FINANCIAL PACKAGE
April 2024

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

	Pages
Statistics	1-2
Balance Sheet	3-4
Income Statement	5
Statement of Cash Flows	6
Monthly Cash Receipts	7

Sierra View Medical Center
Financial Statistics Summary Report
April 2024

Statistic	Apr-24 Actual	Apr-24 Budget	Apr-24 Over/ (Under)	Apr-24 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 23 YTD	Increase/ (Decrease) Apr-23	% Change
Utilization											
SNF Patient Days											
Total	-	108	(108)	-100.0%	450	1,080	(630)	-58.3%	1,269	(819)	-64.5%
Medi-Cal	-	28	(28)	-100.0%	450	667	(217)	-32.5%	927	(477)	-51.5%
Sub-Acute Patient Days											
Total	954	871	83	9.5%	9,685	8,710	975	11.2%	8,529	1,156	13.6%
Medi-Cal	882	560	322	57.5%	8,405	5,848	2,557	43.7%	5,728	2,677	46.7%
Acute Patient Days	1,657	1,848	(191)	-10.3%	16,646	18,482	(1,836)	-9.9%	18,210	(1,564)	-8.6%
Acute Discharges	434	480	(46)	-9.6%	4,309	4,800	(491)	-10.2%	4,616	(307)	-6.7%
Medicare	178	187	(9)	-4.7%	1,683	1,832	(149)	-8.2%	1,762	(79)	-4.5%
Medi-Cal	197	214	(17)	-8.0%	2,104	2,324	(220)	-9.5%	2,235	(131)	-5.9%
Contract	54	76	(22)	-28.6%	491	621	(130)	-20.9%	594	(103)	-17.3%
Other	5	3	2	45.5%	31	26	5	17.7%	25	6	24.0%
Average Length of Stay	3.82	3.85	(0.03)	-0.8%	3.86	3.85	0.01	0.3%	3.94	(0.08)	-2.1%
Newborn Patient Days											
Medi-Cal	160	172	(12)	-6.9%	1,654	1,709	(55)	-3.2%	1,755	(101)	-5.8%
Other	35	33	2	5.5%	293	341	(48)	-14.0%	317	(24)	-7.6%
Total	195	205	(10)	-4.9%	1,947	2,050	(103)	-5.0%	2,072	(125)	-6.0%
Total Deliveries	94	116	(22)	-19.0%	998	1,160	(162)	-14.0%	1,146	(148)	-12.9%
Medi-Cal %	81.91%	82.81%	-0.90%	-1.1%	84.51%	82.81%	1.70%	2.0%	82.94%	1.57%	1.9%
Case Mix Index											
Medicare	1.5856	1.6395	(0.0539)	-3.3%	1.6184	1.6395	(0.0211)	-1.3%	1.6520	(0.0336)	-2.0%
Medi-Cal	1.2308	1.1881	0.0427	3.6%	1.2130	1.1881	0.0249	2.1%	1.1869	0.0261	2.2%
Overall	1.3835	1.3732	0.0103	0.8%	1.3784	1.3732	0.0052	0.4%	1.3732	0.0052	0.4%
Ancillary Services											
Inpatient											
Surgery Minutes	8,644	9,041	(397)	-4.4%	83,162	90,410	(7,248)	-8.0%	86,398	(3,236)	-3.7%
Surgery Cases	89	104	(15)	-14.4%	932	1,040	(108)	-10.4%	1,033	(101)	-9.8%
Imaging Procedures	1,499	1,479	20	1.4%	14,169	14,793	(624)	-4.2%	15,058	(889)	-5.9%
Outpatient											
Surgery Minutes	14,831	12,448	2,383	19.1%	125,448	124,480	968	0.8%	125,587	(139)	-0.1%
Surgery Cases	221	190	31	16.3%	2,024	1,900	124	6.5%	1,872	152	8.1%
Endoscopy Procedures	187	141	46	32.6%	1,816	1,417	399	28.2%	1,830	(14)	-0.8%
Imaging Procedures	4,516	3,715	801	21.6%	39,844	37,152	2,692	7.2%	38,908	936	2.4%
MRI Procedures	320	295	25	8.5%	3,052	2,950	102	3.5%	2,909	143	4.9%
CT Procedures	1,334	1,178	156	13.2%	12,409	11,780	629	5.3%	11,906	503	4.2%
Ultrasound Procedures	1,483	1,102	381	34.6%	12,757	11,020	1,737	15.8%	10,345	2,412	23.3%
Lab Tests	33,743	33,247	496	1.5%	319,436	332,470	(13,034)	-3.9%	337,768	(18,332)	-5.4%
Dialysis	4	3	1	33.3%	38	30	8	26.7%	47	(9)	-19.1%

Sierra View Medical Center
Financial Statistics Summary Report
April 2024

	Apr-24				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 23 YTD	(Decrease) Apr-23	% Change
Cancer Treatment Center											
Chemo Treatments	2,335	1,713	622	36.3%	16,987	17,130	(143)	-0.8%	16,385	602	3.7%
Radiation Treatments	2,214	1,653	561	33.9%	18,648	16,530	2,118	12.8%	16,570	2,078	12.5%
Cardiac Cath Lab											
Cath Lab IP Procedures	13	10	3	30.0%	128	100	28	28.0%	95	33	34.7%
Cath Lab OP Procedures	26	28	(2)	-7.1%	291	280	11	3.9%	281	10	3.6%
Total Cardiac Cath Lab	39	38	1	2.6%	419	380	39	10.3%	376	43	11.4%
Outpatient Visits											
Emergency	3,416	3,411	5	0.1%	34,282	34,110	172	0.5%	33,467	815	2.4%
Total Outpatient	15,282	12,811	2,471	19.3%	135,964	128,110	7,854	6.1%	129,536	6,428	5.0%
Staffing											
Paid FTE's	863.39	841.56	21.83	2.6%	861.21	841.56	19.65	2.3%	896.48	(35.27)	-3.9%
Productive FTE's	747.33	735.98	11.35	1.5%	737.47	735.98	1.49	0.2%	767.14	(29.67)	-3.9%
Paid FTE's/AOB	4.74	4.90	(0.15)	-3.1%	5.02	4.96	0.06	1.2%	5.26	(0.24)	-4.5%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	10,546	11,032	(486)	-4.4%	10,657	11,032	(375)	-3.4%	10,854	(197)	-1.8%
Cost/Adj.Patient Day	2,630	2,592	38	1.5%	2,680	2,620	60	2.3%	2,715	(35)	-1.3%
Revenue/Adj. Discharge	51,736	53,107	(1,371)	-2.6%	53,325	53,108	217	0.4%	53,523	(199)	-0.4%
Cost/Adj. Discharge	12,901	12,476	425	3.4%	13,410	12,613	797	6.3%	13,389	21	0.2%
Adj. Discharge	1,113	1,071	42	3.9%	10,419	10,704	(285)	-2.7%	10,508	(89)	-0.8%
Net Op. Gain/(Loss) %	-3.35%	-1.09%	-2.27%	208.8%	-5.71%	-1.09%	-4.62%	425.4%	-12.18%	6.48%	-53.2%
Net Op. Gain/(Loss) $	(465,712)	(143,477)	(322,235)	224.6%	(7,541,300)	(2,968,242)	(4,573,058)	154.1%	(15,280,594)	7,739,294	-50.6%
Gross Days in Accts Rec.	93.39	88.87	4.52	5.1%	93.39	88.87	4.52	5.1%	92.00	1.39	1.5%
Net Days in Accts. Rec.	49.81	72.82	(23.01)	-31.6%	49.81	72.82	(23.01)	-31.6%	76.26	(26.45)	-34.7%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	APR 2024	MAR 2024
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 9,469,940	$ 7,155,955
SHORT-TERM INVESTMENTS	0	1,001
ASSETS LIMITED AS TO USE	61,795	64,189
PATIENT ACCOUNTS RECEIVABLE	175,472,439	174,251,911
LESS UNCOLLECTIBLES	(23,403,888)	(24,584,721)
CONTRACTUAL ALLOWANCES	(130,362,934)	(126,024,102)
OTHER RECEIVABLES	26,126,223	28,783,595
INVENTORIES	4,186,395	4,130,182
PREPAID EXPENSES AND DEPOSITS	3,380,596	3,099,170
LEASE RECEIVABLE - CURRENT	299,577	299,577
TOTAL CURRENT ASSETS	65,230,142	67,176,758
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	35,180,291	34,592,655
LONG-TERM INVESTMENTS	127,316,902	127,293,578
PROPERTY, PLANT AND EQUIPMENT, NET	79,051,159	79,896,509
INTANGIBLE RIGHT OF USE ASSETS	447,276	459,249
SBITA RIGHT OF USE ASSETS	2,683,718	2,789,316
LEASE RECEIVABLE - LT	1,044,144	1,069,378
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,552,491	1,573,471
TOTAL ASSETS	$ 312,756,122	$ 315,100,914

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	APR 2024	MAR 2024
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 522,467	$ 391,850
CURRENT MATURITIES OF BONDS PAYABLE	4,055,000	4,055,000
CURRENT MATURITIES OF LONG TERM DEBT	1,201,171	1,201,171
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	3,898,593	4,691,190
ACCRUED PAYROLL AND RELATED COSTS	7,072,186	7,925,727
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	4,056,945	4,131,945
LEASE LIABILITY - CURRENT	133,974	133,974
SBITA LIABILITY - CURRENT	1,272,203	1,272,203
TOTAL CURRENT LIABILITIES	22,212,539	23,803,060
SELF-INSURANCE RESERVES	1,239,219	1,304,374
CAPITAL LEASE LIAB LT	1,107,643	1,191,348
BONDS PAYABLE, LESS CURR REQT	37,510,000	37,510,000
BOND PREMIUM LIABILITY - LT	2,819,201	2,877,771
LEASE LIABILITY - LT	333,247	344,597
SBITA LIABILITY - LT	1,605,470	1,713,060
OTHER NON CURRENT LIABILITIES	0	187,927
DEFERRED INFLOW - LEASES	1,276,547	1,302,848
TOTAL LIABILITIES	68,103,866	70,234,984
UNRESTRICTED FUND	245,134,891	245,134,891
PROFIT OR (LOSS)	(482,634)	(268,961)
TOTAL LIABILITIES AND FUND BALANCE	$ 312,756,122	$ 315,100,914

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

APR 2024 ACTUAL	APR 2024 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,328,809	5,730,675	401,866	(7)%	INPATIENT - NURSING	53,351,965	57,306,750	3,954,785	(7)%
17,176,220	19,760,695	2,584,475	(13)%	INPATIENT - ANCILLARY	176,850,900	197,609,917	20,759,017	(11)%
22,505,029	25,491,370	2,986,341	(12)%	TOTAL INPATIENT REVENUE	230,202,865	254,916,667	24,713,802	(10)%
35,068,776	31,363,372	(3,705,404)	12%	OUTPATIENT - ANCILLARY	325,378,559	313,549,539	(11,829,020)	4%
57,573,806	56,854,742	(719,064)	1%	TOTAL PATIENT REVENUE	555,581,424	568,466,206	12,884,782	(2)%
				DEDUCTIONS FROM REVENUE				
(19,970,022)	(17,105,659)	2,864,363	17%	MEDICARE	(181,670,212)	(171,056,590)	10,613,622	6%
(18,602,604)	(20,103,940)	(1,501,336)	(8)%	MEDI-CAL	(176,101,339)	(201,039,400)	(24,938,061)	(12)%
(5,778,387)	(6,634,411)	(856,024)	(13)%	OTHER/CHARITY	(66,055,119)	(66,344,110)	(288,991)	0%
(18,346)	(13,158)	5,188	39%	DISCOUNTS & ALLOWANCES	(94,768)	(131,580)	(36,812)	(28)%
120,950	(439,236)	(560,186)	(128)%	BAD DEBTS	(4,954,714)	(4,392,360)	562,354	13%
(44,248,409)	(44,296,404)	(47,995)	0%	TOTAL DEDUCTIONS	(428,876,152)	(442,964,040)	(14,087,889)	(3)%
13,325,397	12,558,338	(767,059)	6%	NET SERVICE REVENUE	126,705,272	125,502,166	(1,203,106)	1%
565,107	654,369	89,262	(14)%	OTHER OPERATING REVENUE	5,468,825	6,543,690	1,074,865	(16)%
13,890,504	13,212,707	(677,797)	5%	TOTAL OPERATING REVENUE	132,174,097	132,045,856	(128,241)	0%
				***** OPERATING EXPENSE *****				
5,625,656	5,283,318	342,338	7%	SALARIES	56,194,860	52,882,534	3,312,326	6%
586,461	563,373	23,088	4%	S&W PTO	7,077,313	5,648,016	1,429,297	25%
1,370,478	1,441,083	(70,605)	(5)%	EMPLOYEE BENEFITS	13,949,871	14,992,113	(1,042,243)	(7)%
1,580,726	1,393,848	186,878	13%	PROFESSIONAL FEES	14,125,228	13,963,590	161,638	1%
844,410	819,947	24,463	3%	PURCHASED SERVICES	8,654,758	8,451,190	203,568	2%
2,226,590	1,972,475	254,115	13%	SUPPLIES & EXPENSES	20,442,365	19,750,310	692,055	4%
213,258	224,131	(10,873)	(5)%	MAINTENANCE & REPAIRS	2,415,411	2,449,552	(34,141)	(1)%
209,975	263,897	(53,922)	(20)%	UTILITIES	2,456,781	2,638,970	(182,190)	(7)%
29,776	11,257	18,519	165%	RENT/LEASE	315,341	135,738	179,603	132%
88,116	118,267	(30,151)	(26)%	INSURANCE	1,209,508	1,182,670	26,838	2%
1,117,603	952,428	165,175	17%	DEPRECIATION/AMORTIZATION	9,842,848	9,718,110	124,738	1%
463,167	312,160	151,007	48%	OTHER EXPENSE	3,031,115	3,201,305	(170,190)	(5)%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
14,356,216	13,356,184	1,000,032	8%	TOTAL OPERATING EXPENSE	139,715,396	135,014,098	4,701,298	4%
(465,711)	(143,477)	322,234	225%	NET GAIN/(LOSS) FROM OPERATIONS	(7,541,299)	(2,968,242)	4,573,057	154%
116,558	116,558	0	0%	DISTRICT TAXES	1,165,580	1,165,580	0	0%
451,636	277,386	(174,250)	63%	INVESTMENTS INCOME	3,321,836	2,773,860	(547,976)	20%
50,182	43,282	(6,900)	16%	OTHER NON OPERATING INCOME	553,683	432,820	(120,863)	28%
(87,820)	(105,592)	(17,772)	(17)%	INTEREST EXPENSE	(897,045)	(976,192)	(79,147)	(8)%
(90,002)	(36,775)	53,227	145%	NON-OPERATING EXPENSE	(471,900)	(367,750)	104,150	28%
440,554	294,859	(145,695)	49%	TOTAL NON-OPERATING INCOME	3,672,154	3,028,318	(643,836)	21%
(25,157)	151,382	176,539	(117)%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	(3,869,145)	60,076	3,929,221	(6,540)%
(188,517)	0	188,517		NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	3,386,511	0	(3,386,511)	
(213,674)	151,382	365,056	(241)%	NET GAIN/(LOSS)	(482,634)	60,076	542,710	(903)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
04/30/24

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(465,711)	(7,541,299)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	1,117,603	9,842,848
Provision for bad debts	(1,180,833)	(4,337,914)
Change in assets and liabilities:		
Patient accounts receivable, net	3,118,308	8,620,034
Other receivables	2,657,372	(10,449,549)
Inventories	(56,213)	(168,436)
Prepaid expenses and deposits	(281,426)	(997,617)
Advance refunding of bonds payable, net	20,980	209,797
Accounts payable and accrued expenses	(792,597)	(1,872,336)
Deferred inflows - leases	(26,301)	(415,436)
Accrued payroll and related costs	(853,541)	(284,775)
Estimated third-party payor settlements	(75,000)	901,675
Self-insurance reserves	(65,155)	(426,737)
Total adjustments	3,583,197	621,554
Net cash provided by (used in) operating activities	3,117,486	(6,919,745)
Cash flows from noncapital financing activities:		
District tax revenues	116,558	1,165,580
Noncapital grants and contributions, net of other expenses	(53,335)	(68,203)
Net cash provided by (used in) noncapital financing activities	63,223	1,097,377
Cash flows from capital and related financing activities:		
Purchase of capital assets	(260,280)	(3,624,313)
Proceeds from lease receivable, net	25,234	406,435
Principal payments on debt borrowings	-	(3,880,000)
Interest payments	(2,257)	(1,680,242)
Net change in notes payable and lease liability	(284,975)	(1,142,026)
Net changes in assets limited as to use	(585,242)	(296,760)
Net cash provided by (used in) capital and related financing activities	(1,107,520)	(10,216,906)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(211,841)	7,828,895
Investment income	451,636	3,321,836
Net cash provided by (used in) investing activities	239,795	11,150,731
Net increase (decrease) in cash and cash equivalents:	2,312,984	(4,888,543)
Cash and cash equivalents at beginning of month/year	7,156,956	14,358,483
Cash and cash equivalents at end of month	9,469,940	9,469,940

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
April 2024

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
May-23	13,011,917	3,474,340	16,486,257
Jun-23	10,589,289	5,045,026	15,634,315
Jul-23	9,542,222	1,209,276	10,751,498
Aug-23	11,411,456	2,278,509	13,689,964
Sep-23	11,153,141	297,374	11,450,515
Oct-23	10,806,912	1,614,798	12,421,710
Nov-23	11,048,937	5,395,178	16,444,115
Dec-23	9,261,593	1,749,227	11,010,820
Jan-24	12,040,509	3,417,973	15,458,481
Feb-24	10,531,309	1,474,392	12,005,701
Mar-24	11,275,398	3,178,205	14,453,603
Apr-24	**13,314,378**	**6,920,700**	**20,235,078**

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

- Medi-Cal OP Supplemental and DSH funds
- Medi-Cal and Medi-Care Tentative Cost Settlements
- Grants, IGT, HQAF, & QIP
- Medicare interim payments

April 2024 Summary of Other Activity:

542,255	Property Taxes
2,675,839	Health Net Rate Range IGT CY22
1,089,605	M-Cal IP DSH 02/24 - 03/24
1,104,957	Health Net IGT QIP 01/22 - 06/22
1,104,957	Health Net IGT QIP 07/22 - 12/22
70,016	Beta Healthcare Group Dividend 2nd Installment
333,071	Miscellaneous
6,920,700	04/24 Total Other Activity