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

AGENDA
January 28, 2025

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b):

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54954.5(c) and 54956.9(d): Conference with Legal Counsel Regarding Significant Exposure to Litigation

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2026

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

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

B. Quality Review

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

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

C. Conference with Legal Counsel Regarding Significant Exposure to Litigation
Recommended Action: Information Only; No Action Taken

D. Discussion Regarding Trade Secret
Action Recommended: Information Only; No Action Taken

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

VI. Public Comments

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. This is the time for the public to make a request to move any item on the consent agenda to the regular agenda. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for the Public Comment period. Please state your name and address for the record prior to making your comment. Written comments submitted to the Board prior to the Meeting will 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. **December 17, 2024 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove December 17, 2024 Minutes of the Regular Meeting of the Board of Directors

B. **January 20, 2025 Minutes of the Special Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove January 20, 2025 Minutes of the Special Meeting of the Board of Directors

IX. Business Items

A. **Sierra View Foundation Check Presentation**
Recommended Action: Information only; no action taken

B. **Vote to Appoint Director to Fill Vacancy for Zone 3. Board will Review Applications and Interview Applicants who are Present Prior to Vote**
Recommended Action: Appoint Director to Vacancy for Zone 3

C. **Administer Oath of Office for Director Appointed to Fill Zone 3**
Recommended Action: Motion directing hospital administration to immediately notify the Tulare County Elections Official of the appointment.

D. **December 2024 Financials**
Recommended Action: Approve/Disapprove Report as Given

E. **Investment Report - Quarter Ending December 31, 2024**
Recommended Action: Approve/Disapprove Investment Report

F. **Capital Report - Quarter Ending December 31, 2024**
Recommended Action: Approve/Disapprove Capital Report

G. **Annual Appointments**

1. **Food and Dietetic Services Director – Zaelin Stringham**
Recommended Action: Approve Appointment

2. **Environmental Safety/Security Officer – Gary Wilbur**
Recommended Action: Approve Appointment

3. **Patient Safety Officer – Melissa Mitchell**
Recommended Action: Approve Appointment

4. **Infection Control Officer – Rosalva Gonzalez**
Recommended Action: Approve Appointment

H. ***Board Self Evaluation and 2025 Goals According to 4.2 Bylaw Requirement***
Recommended Action: Information Only; No Action Taken

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – February 25, 2025 at 5:00 p.m.

XII. Adjournment

PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa 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.

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Senior Leadership Team	1/28/2025
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	1/28/2025

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
January 28, 2025
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	Action
Policies:		Approve ↓
• Applicant References and Requests for References	1-2	
• Cashless System	3-6	
• Contamination with Radioactive Materials	7-10	
• Food Purchasing and Receiving	11-12	
• Food Service Cleaning and Sanitation	13	
• Food Supplies and Storage	14-18	
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• Injury and Illness Prevention Program	21-26	
• Leave of Absence – Administrative	27-28	
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• Maximum Salary Grades, Meeting or Exceeding (Lump Sum Payments)	34	
• Radioactive Waste Disposal	35-36	
• Recognition – Staff Achievements Milestones	37-39	
• Scope of Service – Food and Nutrition	40-41	
• Service Awards	42	
• Shift Differential Pay	43	
• Training and Meeting Time Pay	44-45	
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Plans:		
• Food Service Emergency Plan	47-58	
• Workplace Violence Prevention Plan	59-73	
Forms		
• 025592 Sepsis Alert Checklist	74-75	

SUBJECT: **APPLICANT REFERENCES AND REQUESTS FOR REFERENCES**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define the procedure for verifying employment, educational references and personal references for prospective employees, contracted employees, volunteers, and in some cases, individual contractors and employees of contractors, while ensuring confidentiality of information regarding salary, job performance, disciplinary actions, etc., for present employees.

POLICY:

As part of the background screening, and in order to determine eligibility for placement within the hospital, reference checks are initiated prior to the hire date or selection as a contracted employee, volunteer, individual contractor or employee of a contractor. References include but are not limited to verification and investigation of past and present employment, educational references (if applicable), and personal references.

Requests for references on present employees are handled in such a way as to ensure confidentiality of information regarding salary, job performance, disciplinary actions, etc.

AFFECTED PERSONNEL/AREAS:

ALL EMPLOYEES, VOLUNTEERS, INDIVIDUAL CONTRACTORS AND EMPLOYEES OF CONTRACTORS

PROCEDURE:

Applicant References:

It is the responsibility of the Human Resources Department to:

- Obtain written authorization from prospective applicants to check references during pre-screening interview.
- Notify applicants that references will be requested prior to employment.
- Ensure verification of references is completed.
- Ensure confidentiality of information obtained during reference verification process.

1. If applicant will not permit contact with his/her current employer for fear of jeopardizing their present position, he/she must be told that employment is contingent upon receipt of suitable reference checks.

2. References for all prospective employees will be completed prior to employment. Reference checks may be requested from past and present employers, schools, universities, and personal references of applicants.

3. If selected for employment or placement, reference data received from the applicant's employer(s), school, etc. will be placed in the employee's personnel file.

4. All reference material received will be directed to Human Resources.

Outside Reference Requests:

1. Telephone requests for reference checks requested by outside entities will be handled as follows:

   a. The caller must always be referred to the Human Resources Department. No information may be given by anyone other than the Human Resources Designee.

   b. SVMC does not provide information regarding salary, job performance, disciplinary action, etc. via telephone.

   c. The only information that can be provided via telephone is verification of employment dates, position held and department.

2. Sierra View Medical Center (SVMC) will respond to a written request for reference as follows:

   a. All written requests must be accompanied by a release, which is signed by the employee or previous employee, for whom the reference is requested. Human Resources will then release the employees' dates of employment, position held and hourly rate of pay.

   b. Written requests for reference that are not accompanied by a signed release will be returned with an explanation of Sierra View Medical Center's policy.

   Access to reference data will be limited to Human Resources or Designee, and a Department Director who is considering an employee for promotion, transfer, or other personnel action.

REFERENCES:

- Title XXII
- The Joint Commission (7/2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- OMH CLAS Standard 6

SUBJECT: **CASHLESS SYSTEM**	SECTION: **Page 1 of 4**

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

PURPOSE:

To define the protocol for Sierra View Medical Center's Cashless System.

POLICY:

Sierra View Medical Center personnel may elect to utilize the Cashless System plans for purchases at the Café. Personnel may choose one or multiple plans available.

AFFECTED PERSONNEL/AREAS:

ALL EMPLOYEES, VOLUNTEERS AND EMERGENCY ROOM PHYSICIANS

PROCEDURE:

Available Plans:

1. A Cashless Payroll Deduction Authorization form must be completed and signed by staff members and submitted to Payroll prior to use of the cashless system. If the staff member desires to terminate participation in the Cashless System program, he/she must complete a new "Cashless System Payroll Deduction Authorization Form" and check the declination box. This form must be submitted to Payroll and will not take effect until the next pay period.

2. Cashless System plans available:

    a. Payroll Deduction (Employees only):

    - Purchases are deducted directly from an employee's payroll check. A maximum limit is permitted based on the employee's status as indicated below or to the extent permitted under state and federal wage and hour laws.

        – Full time – a maximum of $200.00 per pay period
        – Part time – a maximum of $100.00 per pay period
        – Per diem- not eligible for payroll deduction

    - Unused amounts will not roll over to the next pay period.

    - If the employee's earnings do not cover the charges incurred, the Cashless System privileges will be suspended until the balance is paid in full.

    b. Prepaid Declining Balance (Employees only):

    - An amount may be prepaid at the Café register. This amount declines with purchases. There are no maximum limits on this plan.

c. Gift Cards:

- A gift card is purchased at the Café register. The staff member pays with cash or credit card, electing the amount desired. Upon depleting the card's balance, the card may be restored in the same process with the exception of a non-reloadable card.
- Non-reloadable cards will be collected by the cashier at the close of the transaction.
- Payroll Deduction or Prepaid Declining Balance cannot be utilized to purchase gift cards.

d. Credit Card:

- Visa, Master Card, Discover and American Express credit cards will be accepted at the registers with proper identification, which may include the staff member's identification badge.

Identification Badges:

1. Staff members must present their hospital identification badge to receive their discount and to utilize the Payroll Deduction and/or Prepaid Declining Balance plans.

2. It is against policy for an employee to allow another employee to use his/her badge for any reason, which includes making a Cashless System purchase.

3. Personnel who lose their badge will not be able to utilize Payroll Deduction or Prepaid Declining Balance plans until the next day after replacement of their badge.

   a. Replacement badges may be obtained from Human Resources.

Exceptions for Designated Staff:

1. Emergency Department (ED) Physicians, Hospitalists, Intensivists, and Adult Volunteers are not employees of the hospital and receive complimentary meals during their scheduled work shift. These designated staff will present hospital issued identification badges to receive their meals. Complimentary meals are limited to line items with the exception of milk and bottled water. Convenience food items such as chips, energy drinks, bottled beverages, etc. are excluded and must be paid using cash, credit card or a gift card.

2. Food & Nutrition Service (FNS) personnel are eligible for complimentary meals and limited to line items with the exception of milk and bottled water. Convenience food items such as chips, energy drinks, bottled beverages, etc. are excluded and must be paid using one of the available plans or cash. The FNS personnel must be working a scheduled shift and present their hospital identification badge to receive their complimentary meal.

3. Employees returning from a leave will not be able to utilize the cashless system or payroll deduction for 24 hours upon their return to work.

Gift Cards Purchased with Hospital Funds:

1. Only management personnel may purchase departmental gift cards for their employees with Hospital funds as a form of employee recognition or appreciation.

    a. Gift Cards must be purchased at the Café register with cash or credit cards. Hospital-issued American Express cards should not be used.

    b. Gift cards given to employees for amounts $25 or greater using SVMC funds are taxable to the employee, and therefore must be reported to Payroll. A Gift Card Receipts form must be completed with the employee's name and the amount received and submitted to Payroll.

    c. Payroll will include this amount as taxable wages to the employee and withhold appropriate taxes.

2. Gift cards cannot be redeemable for cash.

Discrepancies

1. Receipts will be required to substantiate any and all discrepancies, and must be addressed with the Food and Nutrition Director within the same meal period that the purchase was made. No refund credits will be made to an account without a receipt, and cash refunds will not be made for a credit purchase.

Termination of Employment:

1. If an employee provides notice to terminate employment, all privileges will be removed and they will not be eligible to continue in the Cashless System program.

2. Payroll Deduction (Employees only) – All charges are due and payable upon termination. The Hospital reserves the right to recover the balance of any outstanding charges owed by a terminated employee to the extent permitted under state and federal law.

3. Prepaid Declining Balance (Employees only) – Remaining balances will be reimbursed on the employee's final payroll check.

Abuse of the Cashless System program may lead to disciplinary action, up to and including termination.

Sierra View Medical Center (SVMC) reserves the right to change the requirements for participation in this program at any time.

SUBJECT:	SECTION:
CONTAMINATION WITH RADIOACTIVE MATERIALS	***Special Circumstances*** **Page 1 of 4**

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

PURPOSE:

To establish guidelines for the identification, decontamination, management, and reporting of patients exposed to radioactive material.

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

PROCEDURE:

LEVEL: Independent

SUPPORTIVE DATA: The primary objectives will be to care for the patient's immediate life threatening health care needs, to prevent contamination of personnel and the environment, and to decontaminate the patient. Patients may present from outside the hospital or from within as in the case of radiation accident in the Radiology or Cancer Treatment Center areas of the hospital.

ASSESSMENT:

1. Obtain thorough history about the accident, type of radiation exposure, length of exposure, etc.

2. There are four types of Radiation accident patients:

    a. The patient who has received whole or partial EXTERNAL RADIATION may have received a lethal dose of radiation but is of no hazard to others. This would be comparable to having received radiation therapy for treatment or diagnostic purposes.

    b. The patient who has received INTERNAL CONTAMINATION by inhalation or ingestion. This patient is also of no hazard to attendants or the environment. They are similar to a case of chemical poisoning. Any external contamination must be removed. Body wastes must be collected and saved for measurements of the amounts of radiation to assist in determination of appropriate therapy.

    c. The patient with EXTERNAL CONTAMINATION of body surfaces and/or clothing by liquids or by dirt particles require STRICT isolation technique to protect others and the hospital environment.

    d. The patient with EXTERNAL CONTAMINATION COMPLICATED BY A WOUND must have care taken not to cross contaminate surrounding surfaces from the wound and vice-versa. The wound and surrounding surfaces are cleaned separately and sealed off when cleaned. Early debridement of crushed dirty tissues may be indicated. Good wound irrigation is important.

3. All contaminated or possibly contaminated patients should receive appropriate physical assessment to rapidly identify any potential life or limb threatening problem.

4. Assess for signs and symptoms of toxicity related to radiation exposure such as nausea and vomiting, diarrhea, hematemesis, tremors, muscle weakness, burns.

NOTIFICATION:

1. Upon notification of the impending arrival of a patient contaminated with radioactive material, the nurse will:

    a. Notify the Emergency Department physician and nursing staff.

    b. Notify the House Supervisor, who should then notify Administrator on Call (AOC).

    c. Notify the Radiation Safety Officer, Radiologist and X-Ray Department. X-Ray should secure the Survey Meter from Nuclear Medicine and report to the Emergency Department.

    d. Notify Plant Operations to obtain "Spill Cart" from Maintenance Department and bring to Decontamination Entrance to Emergency Department. Plant Operations will clear the Decontamination Entrance of all non-essential personnel and control traffic to the area.

IDENTIFICATION OF LEVEL OF CONTAMINATION:

1. Upon arrival, the patient should be directed to the Decontamination entrance to the Emergency Department. The Survey Meter should be used to identify and record levels of radiation. Documented readings should identify time and specific areas checked.

2. If the patient is determined to be safe and of no threat to contamination of personnel or environment, they may proceed for evaluation and treatment.

3. If unsafe levels of contamination are detected and the patient requires EXTERNAL DECONTAMINATION, they should be placed in the Decontamination Room for thorough decontamination procedure. (see below).

4. If the patient is in need of immediate life saving measures, they should be moved to Room #8 by way of the Decontamination Room Entrance. Remove all unnecessary items of furniture, etc. before the patient enters. Room #8 and the surrounding hall should be cordoned off with yellow warning tape as a Contaminated Zone.

5. If radioactive dust is suspected, maintenance should turn off the air circulation system to this area to prevent the spread of contamination.

6. All personnel who come in contact with the patient should change into scrub suits and then dress in gown, mask, gloves, cap, and booties from the "Spill Cart". They must stay within the restricted "Contaminated" zone.

7. The entire area surrounding the "Contaminated" zone should be kept clear of any persons not directly required for the care of the patient and decontamination procedure.

DECONTAMINATION PROCEDURE:

1. Assign teams - one for Decontamination to stay in the "Contaminated" zone and one to stay outside in the Clean area to procure needed supplies and equipment.

2. Ambulance attendants or persons accompanying the patient should remain outside the Emergency Department at the Decontamination Entrance to await checking with the Survey Meter to determine whether or not they are also contaminated and require a Decontamination Procedure.

3. If EXTERNAL CONTAMINATION is involved, save all clothing, bedding from the ambulance, blood, urine, stool, vomitus, etc. Place in red plastic bags or containers and label with name, body location, time and date. Save each in appropriate containers and further label as "RADIOACTIVE - DO NOT DISCARD".

4. Decontamination should start, if medical status permits, with cleansing and scrubbing the areas of highest contamination first. If an extremity alone is involved, clothing may serve as an effective barrier and the affected limb alone may be scrubbed and cleansed. Initial cleaning should be done with soap and warm water. Wash water waste, unless markedly radioactive (check with Survey Meter), may be flushed into the community sewage system where dilution will obviate any hazard effect. If the body as a whole is involved or clothing generally permeated contaminated material, showering and scrubbing in the Decontamination Room will be necessary. Wash water waste will collect in the holding tank for later disposal. Pay special attention to hair parts, body orifices, and body skin fold areas. REMEASURE with Survey Meter and RECORD measurements after each washing until safe levels are reached.

5. If a wound is involved, prepare and cover the wound with self-adhering disposable surgical drape. Cleanse neighboring surfaces of skin. Seal off cleansed areas with self-adhering drape. Remove the wound covering and irrigate the wound with sterile water. Catch and dispose of water as described above. Each step in the decontamination should be proceeded and followed by monitoring with the Survey Meter, and recording of the location and measurements of radiation activity.

6. The protective clothing of personnel and the papers on the floor must be saved as described above for the patient. These personnel must follow the same monitoring with the Survey Meter and decontamination as indicated.

7. After adequate decontamination is verified by the Survey Meter, the patient may be moved to a clean gurney to a clean room.

8. The "Contaminated" zone should remain secured until arrangements are made by Engineering and the Director of Environmental Services for final clean up.

INTERVENTION:

1. Contamination by ionizing radiation may cause nausea and vomiting within 3 hours of significant exposure. The higher the dose, the earlier the onset. Exposure may also cause DNA and tissue damage which may not be evident for several hours to years.

2. IV fluids and medication may be indicated for the symptomatic treatment of persistent vomiting, diarrhea, and orthostatic changes, and to promote rapid turnover and excretion.

3. Inform and educate patient or significant others regarding the immediate plan of care and follow-up.

REPORTING:

1. Upon receipt of any victim of a Radiation Accident, Administration must notify immediately:

    a. Tulare County Health Department - Environmental Health Division

    b. United States Department of Energy Coordinating Office (415-273-4237). Trained personnel will be available to give assistance in aiding with the disposal of collected materials, terminal clean up, and other advice on handling the situation as needed.

    c. All phone numbers are on file in the Environmental Services Department

DOCUMENTATION:

All assessments, intervention, measurements, and decontamination efforts should be carefully documented on the Patient Care Record.

REFERENCE:

- The Joint Commission (2024). Hospital accreditation standards. EC.02.02.01 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **FOOD PURCHASING AND RECEIVING**	SECTION: **Page 1 of 2**

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

PURPOSE:

To be utilized as guidelines for all purchasing and receiving food and supplies for the Food and Nutrition Service (FNS) Department.

POLICY:

All food items shall be purchased from reliable vendors that meet regulations specified by federal, state, and local health care agencies. Only high quality food products will be accepted when receiving deliveries.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. All food items shall be purchased from a reputable vendor.

2. All dairy and egg products shall be pasteurized.

3. Special request food items shall be purchased from a local supermarket.

4. Special nutritional supplements are purchased from a reputable vendor.

5. The quantity of foods shall be purchased to meet inventory and the planned menus' needs.

6. At the time of delivery, the food items shall be checked for accuracy against the invoice. Only quality food will be received. Products deemed unsatisfactory will be refused and returned for credit.

7. Items requiring refrigeration or those that are frozen will be put away immediately.

8. Dry storage items will be put away as soon as possible.

9. All empty boxes, crates and other packaging shall be disposed of immediately to eliminate potential harboring places for vermin. Original product packaging shall be retained for lot and manufacturing information identification needed for recall items.

10. Invoices are processed and sent to accounts payable weekly for payment.

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov.

- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/regulations-and-guidance/regulations-and-guidance.html.

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- Food and Drug Administration (2023). Retail Food Protection. Retrieved from https://www.fda.gov/food/retail-food-protection/fda-food-code.

SUBJECT: **FOOD SERVICE CLEANING AND SANITATION**	SECTION: **Page 1 of 1**

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

PURPOSE:

To define the protocol for clean and sanitary conditions in all Food and Nutrition Service (FNS) areas.

POLICY:

The FNS areas are maintained in a clean and sanitary condition. Assigned cleaning schedules are posted in the kitchen.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, ENGINEERING DEPARTMENT*

PROCEDURE:

1. All tableware, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas.

2. Tableware that is unsanitary or hazardous because of chips, cracks or loss of glaze are discarded.

3. Ice used in connection with food or drink is from a sanitary source and is handled and dispensed in a sanitary manner. The kitchen ice machine is kept free from organic and foreign matter. Preventative maintenance for the ice machines are performed by the Engineering Department according to manufacturer's guidelines.

4. Kitchen waste not disposed of by mechanical means are kept in leak proof, nonabsorbent, tightly closed containers and are disposed of as frequently as necessary to prevent a nuisance or unsightliness.

5. Cleaning schedules are posted on the dry storage room door. FNS staff will initial upon assigned cleaning task completion. The FNS Director or designee will routinely check cleaning schedules and kitchen cleanliness.

6. Detailed cleaning will not be performed during food preparation and service periods.

7. Cleaning solutions are used in the proper concentration and dilution. All second container chemical spray bottles will be labeled with the manufacturer's label.

REFERENCES:

- GACH Title 22 Regulations § 70273 (i) Sanitation

SUBJECT: **FOOD SUPPLIES AND STORAGE**	SECTION: **Page 1 of 5**

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

PURPOSE:

Food and supplies will be stored within regulatory guidelines to maintain optimal nutritional composition and prevent all sources of contamination.

POLICY:

The Food and Nutrition Service (FNS) Department shall ensure that all foods, non-foods and supplies shall be stored in a manner to prevent physical, chemical and bacterial contamination. All food shall be of good quality and procured from sources approved or considered satisfactory by federal, state, and local regulatory agencies.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. At least one week's supply of staple foods and at least two (2) days' supply of perishable foods shall be maintained on the premises.

2. Emergency food for 96 hours shall be stored separate *(Please refer to FOOD SERVICE EMERGENCY PLAN Link)*.

3. The storage areas are well ventilated and clean.

4. Food storage refrigerators, walk-ins, and freezers are provided with reliable thermometers. Temperatures are inspected/recorded daily to ensure proper temperature control. Temperature records are retained for reference for one (1) year.

5. Perishables are stored at 41°F or below after delivery.

6. Frozen foods are stored at 0°F or below after delivery.

7. Dry or staple items are stored a minimum of 12 inches above the floor and 18 inches from the ceiling.

8. Food overages held in storage areas are clearly identified, dated, and appropriately covered. Food items will be labeled with the expiration date and will not be re-used more than once.

9. Chemical materials used for cleaning purposes and pesticides are clearly labeled and stored separately, away from food and supplies.

10. All cans that are dented, bulging or leaking shall be considered a possible health risk and will be placed in a designated area for return or discarded.

11. The store room stock is rotated using the FIFO (first in first out) method.

12. Milk is served in individual containers. All liquid beverages are served capped.

13. Foods refrigerated or in other storage areas shall be stored appropriately, clearly labeled if not easily identifiable, and dated.

14. Hermetically sealed foods or beverages shall have been processed in compliance with applicable federal, state and local codes. No home canned foods will be used.

15. The storeroom is an integral part of the kitchen design and opens directly to the food preparation area. It is in close proximity to the delivery area. It has sufficient light and ventilation, and is of solid construction to discourage rodents and insects. The storeroom is maintained at a temperature between 50-70°F.

16. Only Food & Nutrition Service (FNS) employees are authorized to enter the storeroom. Any person(s) needing to access or survey the storeroom will be escorted by an authorized hospital employee.

17. The storeroom shelves are cleaned and checked weekly. The floor is swept and mopped daily.

18. The outside storage area is organized and cleaned monthly. All paper products used for eating purposes shall be well-wrapped and stored in boxes. Any uncovered containers shall be discarded to avoid possible contamination.

19. All refrigerators in the FNS department are constructed to maintain a temperature at or below 41°F. Freezers will be at 0°F or colder. The temperatures are recorded for all freezers and refrigerators daily.

20. Each refrigeration unit will house an internal thermometer. The inside thermometer is the primary method of recording temperatures and will be used when documenting temperatures. The outside temperature gauges are not utilized to verify temperatures.

21. Shelving will be constructed to allow for adequate air circulation.

22. All refrigerators and freezers are cleaned weekly.

23. All raw food is stored below cooked foods.

24. All foods in process will be covered, labeled when not clearly identifiable, and dated with expiration date.

25. All foods are dated when received to ensure proper rotation.

26. All frozen foods removed from original packaging will be clearly identified with date received. *Example: An eighty (80) pound case of ground beef may contain eight (8) 10 pound tubes. If six (6) tubes were pulled for production, the remaining two (2) may be removed from the original*

box and placed on the freezer shelf if they are each labeled (ground beef) and with the date received.

27. All meat and egg products are thawed in the refrigerator. In an emergency, frozen meat may be thawed under continuous running potable water.

28. Open cans are not stored in the refrigerator.

29. Items that have been thawed are not refrozen.

30. Foods predated with an expiration date such as milk, sour cream, etc. will be dated the day the container was opened. The pre-dated product will be disposed on the manufacturer expiration date on the container.

31. Prepared items such as mayonnaise, pickles, dressings, etc. will be dated with a 30 day expiration date.

32. Canned or perishable items such as peaches, olives, luncheon meat, etc. will be dated with a three (3) day expiration date after opened.

33. Food will be discarded when it exceeds the established standards based on the date listed on the label, or as stated on the preprinted expiration date on the food item.

Non-definitive Food Dating Labels such as “Best By” and “Enjoy by”:

Food labels other than “Use by” may be used on food products received, printed by the manufacturer.

- Per FDA, “Consumers should examine foods for signs of spoilage that are past their “Best if used by” date. If the products have changed noticeably in color, consistency or texture, consumers may want to avoid eating them.”- https://www.fda.gov/media/101389/download
- Per USDA, “A "Best if Used By/Before" date indicates when a product will be of best flavor or quality. It is not a purchase or safety date.”-: https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-product-dating

At SVMC, freshness labels will be treated as an expiration date for dry stock items. However for perishable items, such as produce, foods may be used past the “best by” date, if they are inspected for freshness and no signs of spoilage are present, per USDA and FDA guidelines.
No items may be used past an expiration, or “use by” date.

FOOD STORAGE

FROZEN FOOD

Meats
- Uncooked beef, lamb, veal, chicken ..... 6 - 12 months
- Ground meats, sausage, turkey, pork ..... 1 – 3 months
- Cooked ..... 1 month
- Meat casserole ..... 2 – 6 months

Baked goods
- Baked ..... 3 – 6 months
- Unbaked rolls ..... 2 months
- Unbaked cookies ..... 6 months

Ice Cream Products ..... 6 months

Vegetables ..... 8 – 12 months
- Potatoes ..... 2 – 6 months

Fruit juices ..... 8 months

REFRIGERATOR FOODS

Eggs
- Whole raw in shell ..... 30 days
- Cooked whole ..... expiration date

Milk ..... not after date on carton

Cheese ..... 45 – 60 days
- Hard ..... not after date on carton
- Cottage ..... not after date on carton

Juice (thawed) ..... 2 weeks

Canned fruits ..... 3 days

Margarine and butter ..... 30 days

Desserts
- Gelatin (Jell-O) ..... 3 days
- Pudding and custards ..... 3 days

Produce ..... 1 – 2 weeks

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- FDA, Food Facts - How to Cut Food Waste and Maintain Food Safety, Retrieved on 01.16.2023 https://www.fda.gov/media/101389/download
- USDA, Food Product Dating, , Retrieved on 01.16.2023 https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-product-dating

CROSS REFERENCES:

- FOOD SERVICE EMERGENCY PLAN Link

SUBJECT: **HOLIDAY PAY**	SECTION: ***Human Resources*** **Page 1 of 2**

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

PURPOSE:

To define the days designated as holiday for purposes of time off and for determining holiday pay for all employees.

POLICY:

The following holidays are recognized by SVMC for purposes of this policy:

- New Year's Day
- President's Day
- Memorial Day
- Fourth of July
- Veterans' Day
- Labor Day
- Thanksgiving Day
- Christmas

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL EMPLOYEES*

PROCEDURE:

COMPENSATION

Non-Exempt Staff

A premium of 100% in addition to the non-exempt employee's actual base hourly rate will be paid for employees who work on New Year's Day, Thanksgiving Day, and Christmas (24-hour period beginning on the eve of the Holiday.) A premium of 50% in addition to the non-exempt employee's actual base hourly rate will be paid for employees who work President's Day, Memorial Day, Fourth of July, Veteran's Day, and Labor Day (24-hour period beginning on the eve of the Holiday.)

Exempt Staff

Exempt employees are not eligible for Holiday premium pay. Exempt employees working in a secondary job code on a Holiday must have preapproval from their respective Vice President (VP). If approved to work the holiday by the VP, the exempt employees working in their secondary job code will receive Holiday premium pay.

DESIGNATION OF HOLIDAY

1. If the Holiday falls on a Saturday, the Hospital will designate the preceding Friday as the day to observe the Holiday for staff who are scheduled Monday through Friday.

2. If the Holiday falls on a Sunday, the Hospital will designate the following Monday as the day to observe the Holiday for staff who are scheduled Monday through Friday.

3. Holiday pay is deducted from the Vacation/Holiday accrual hours and shall conform to procedures referenced by the "Vacation/Holiday" policy. Employees are not eligible to utilize Vacation/Holiday time within 90-days of hire.

4. For those employees working 12-hours on a night shift , the holiday shall begin with the 6:45PM shift scheduled on the preceding day before the holiday and end twenty-four hours later at 7:15PM.

For all other employees, the holiday shall begin with the 11:00PM shift scheduled on the preceding day before the holiday and end twenty-four hours later at 10:59PM.

5. Holiday pay shall be limited exclusively to the twenty-four hour period as defined above.

6. Employees called back on any of the paid holidays will be eligible for both holiday and Call-Back pay.

7. Exempt employees within their 90-day introductory period will not be eligible to receive holiday pay if they choose to not work on the designated holiday. Exempt staff should report to work on the holiday to avoid a deduction in pay. For greater detail, please refer to the policies Exempt Employee Compensation and Vacation/Holiday policy.)

9. If a non-exempt employee within his/her 90-day introductory period is not scheduled to work, he/she will not be paid due to his/her inability to utilize Vacation/Holiday under the Vacation/Holiday policy. If a non-exempt employee receives authorization from his/her Director to work on a holiday, he or she will be paid as designated in this policy for premium pay.

10. Department Directors are responsible for scheduling employees who will be required to work on a designated Holiday, closing the department and/or reducing staff scheduled to work.

CROSS REFERENCES:

- On-Call/Call Back Policy
- Vacation/Holiday Policy
- Exempt Employee Compensation

SUBJECT:	SECTION:
INJURY AND ILLNESS PREVENTION PROGRAM	***Safety Management***

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

PURPOSE:

To prevent injuries, illnesses and accidents within the facility. To ensure the safety and health of all personnel and to provide a safe and healthful work environment.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that the personal safety of each employee is of primary importance. Prevention of occupationally-induced injuries and illness of such consequence is that it will be given precedence over operations, whenever necessary. To the greatest degree possible, management will provide all mechanical and physical activities required for personal safety and health, in keeping with the highest standards.

We will maintain a safety and health program conforming to the best practices available. To be successful, such a program must embody proper attitudes toward injury and illness prevention on the part of the supervisors and employees. It also requires cooperation for all safety and health matters; not only between supervisors and employees, but also between each employee and his or her co-workers. Only through such a cooperative effort can a safety program in the best interest of all be established and pursued.

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

PROCEDURE:

OBJECTIVES:

1. To identify and assign responsibilities to the person(s) to implement the program.

2. To provide means to identify and evaluate occupational safety and health hazards through periodic scheduled inspections and investigations of occupational injuries and illnesses.

3. To institute methods for timely correction of unsafe conditions detected based on severity of the hazard.

4. To provide safety training to current, new, and reassigned personnel.

5. To provide a system for communicating with employees on safety matters by clearly indicating how compliance with safe work practices will be ensured.

6. To encourage employees to participate in reporting unsafe conditions without fear of reprisal.

7. To coordinate the functions of this program with an Employee Health Program, the Infection Control Program, and Risk Management through the Safety Management Program.

SUBJECT:	SECTION:
INJURY AND ILLNESS PREVENTION PROGRAM	***Safety Management***

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

AUTHORITY:

1. The Chief Financial Officer (CFO) and the Board of Directors (BOD) of Sierra View Medical Center are responsible for providing the financial support necessary for specific services, equipment and personnel required to maintain the Injury/Illness Prevention Program.

2. The Sierra View Medical Center Chief Executive Officer (CEO) delegates the management and implementation of the program to the Safety Committee.

3. The Safety Officer is responsible for reviewing all applicable general industry safety orders and other safety orders applicable to the operations of this program.

HAZARD SURVEILLANCE/LIFE SAFETY ROUNDS
SUBJECT: ACCIDENT, ILLNESS AND INJURY INVESTIGATIONS

It is the policy of the Injury and Illness Prevention Program to establish a protocol for employees to follow in the event of a work-related injury or illness and to investigate and correct any significant hazards.

PROCEDURES:

1. Any employee who becomes injured or ill on duty must report his or her condition to the department manager or supervisor immediately.

2. The Employee or Supervisor must enter an electronic event report.

3. If the supervisor or employee believes that an evaluation by a physician is required, the Employee must report to Employee Health during the hours of 7:00 a.m. to 3:30 p.m. Monday through Friday. After hours and on weekends or holidays, the employee should report to the Emergency Department if medical treatment is urgent or necessary.

4. The Manager/Director of the employee's department will complete a review and action plan in the electronic event report.

5. When an employee identifies a hazard, they will report it in the electronic event reporting system.

6. Employee Health will compile reports on occupational injury and illness and report significant trends and incidents to the Safety Committee and Management.

7. The Safety Committee, with the assistance and input of Directors and Managers of affected areas will investigate the causes of the incidents, make corrective recommendations and carry out corrective actions based on reports provided by Employee Health.

SUBJECT: ACCIDENT INVESTIGATION

Accident investigations will be conducted by trained individuals. The primary focus will be on understanding why the accident or near miss occurred and what actions can be taken to preclude its recurrence. Furthermore, the investigation will be in writing and identify the cause(s) of the accident or near miss.

The following questions will be answered during the investigation of an occurrence:

1. WHAT HAPPENED? WHAT NORMALLY HAPPENS? WHAT DOES PROCEDURE REQUIRE? (IF APPLICABLE)

   The investigation must obtain all the facts surrounding the occurrence. For example, what caused the situation to occur, who was involved; was/were the employee(s) qualified to perform the function involved in the accident; were they properly trained; were proper operating procedures established for the task involved; were those procedures followed, and if not, why not; does this situation exist in other departments; how can it be corrected?

2. WHY DID IT HAPPEN?

   The Safety Officer or designee must determine which aspects of the operation or process require additional attention. It is important to note that the purpose here is not to establish blame, but to determine what type of constructive action can eliminate the cause(s) of the accident or near miss.

3. HOW WAS THE ORGANIZATION MANAGING THE RISK?

   Actions already taken to reduce or eliminate the exposures being investigated will be noted, along with those remaining to be addressed. Any interim or temporary precautions will also be noted. Additionally, any pending corrective action or reason for delay will be noted.

JUST CULTURE:

Sierra View Medical Center's philosophy for building and supporting the culture of patient safety includes promoting a fair, just and supportive environment for those employees that self-report potential or actual safety risk, hazard events and/or ethical risks.

COACHING:

Coaching discussions are recommended for making constructive suggestions to improve individual competency or skills where some improvement is required to improve performance, and formal discipline may not yet be appropriate. Employee coaching is considered to be educational and is not considered to be disciplinary. However, if the employee's performance does not improve following coaching, disciplinary action may result per SVMC policy.

SUBJECT: EMPLOYEE TRAINING AND DOCUMENTATION

It is the policy of Sierra View Medical Center to define the requirements and responsibilities for safety education and training as means to minimize injuries, illnesses and accidents.

PROCEDURES:

1. Mandatory Education – all Sierra View Medical Center Department Leaders will ensure that their employees will complete the E-learning modules specified below:

   A. Fire Safety (annually)

   B. Safe Lifting Procedures and Use of Mechanical Aids To Decrease Risk of Injury (annually)

   C. Infection Control/Universal Precautions and Blood Borne Pathogen Standard (annually)

   D. Safe Patient Handling

   E. Electrical Safety (annually)

   F. Equipment Safety (annually)

   G. Hazardous Materials and Waste Safety Communication (annually)

   H. Workplace Violence Prevention (annually)

   I. Health and Safety Handbook (annually)

   J. Worker's Compensation (annually)

2. Departmental Specific Training

   A. Department Leaders must orient their employees to any potential occupational hazards related to their departments and conduct a refresher orientation at least annually.

   B. Department Leaders must in-service employees of new hazards introduced by a change in equipment, processes, raw materials, etc.

   C. Department Leaders must provide safe work conditions, practices and personal protective equipment as a means of minimizing departmental specific hazards.

3. Education Records

   Records of all completed education programs are maintained by the employee's department managers and/or the Education Department.

SUBJECT: EMPLOYER-EMPLOYEE SAFETY COMMUNICATION SYSTEM

It is the policy of Sierra View Medical Center to establish a communication network between staff and appropriate administrative contacts regarding any safety concerns.

PROCEDURES:

1. Employee compliance with safe work practices is assessed through his or her annual job performance evaluation.

2. Safety rules and information on occupational hazards are communicated through the following means:

   A. Annual or as needed

   B. Department's specific training

   C. Self-study modules

   D. Other means of communication

3. Employees are encouraged to report safety concerns to their immediate supervisor.

4. Employees are also encouraged to inform the Safety Officer about workplace hazards without fear of reprisal or other discrimination.

5. Employees may use the Electronic Reporting System anonymously to report safety concerns or workplace hazards.

6. The Safety Officer will discuss and evaluate the Employee Safety Reports on a quarterly basis at the Safety Committee meeting.

SUBJECT: GENERAL SAFETY RULES

1. Department Leaders are responsible for maintaining safety standards, developing safety rules, and supervising and training personnel in the department standards.

2. Department Leaders are responsible for notifying the Safety Officer in case of any unsafe condition or hazard.

3. All department employees will report defective equipment, unsafe conditions, acts, or safety hazards to their supervisor. This may be done using the Electronic Reporting System.

4. Employees will keep all electrical cords clear of passageways. Electrical extension cords will not be used without written approval of Engineering.

5. All equipment and supplies must be properly stored. All personal electrical appliances will be safety inspected by Engineering prior to use.

6. Scissors, knives, pins, razor blades and other sharp instruments must be safely stored and used.

7. All electric machines with heat producing elements must be turned off when not in use.

8. Smoking is prohibited on Hospital property.

9. Rubbish or trash will not be permitted to accumulate.

10. Advise Engineering immediately of improper illumination and ventilation.

11. Furniture and equipment must be arranged to allow passage and access to exits at all times.

12. Minor spills (i.e., water) should be cleaned by the employee who discovers the spill. This should be done immediately. Major spills will be cleaned by the Environmental Services (EVS) Department. Spill kits are available for spills involving hazardous waste.

13. Report all faulty equipment to the Engineering Department and apply “defective-Do Not Use” tag.

14. All warning signs will be obeyed.

15. File drawers and cabinet doors should be kept closed when not in use.

16. Suitable clothing will be worn (High heels or jewelry that may catch in machinery will be avoided).

REFERENCES:

- The Joint Commission (2024) Hospital accreditation standards. EC.04.01.05 EP1 Joint Commission Resources. Oak Brook, IL.

- Occupational Safety and Health. (n.d.). Injury and Illness Prevention Program . Retrieved from https://www.dir.ca.gov/dosh/etools/09-031/.

- Giso. (n.d.). Retrieved from https://www.dir.ca.gov/title8/3203.html.

SUBJECT: **LEAVE OF ABSENCE - ADMINISTRATIVE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define the requirements and procedures for Sierra View Medical Center's Administrative Leave process.

POLICY:

Sierra View Medical Center will provide employees with time off for situations as stated below.

AFFECTED PERSONNEL/AREAS: *ALL SVMC EMPLOYEES*

PROCEDURE:

ELIGIBILITY:

This leave applies to all employees who:

- have been placed on leave during severance payment periods
- are non-exempt and are on leave due to a pending investigation
- have a license or certification that has lapsed
- are precluded from working in their current position due to new licensure

BENEFITS

Once an employee is placed on an Administrative Leave, health, dental and vision benefits stop the first of the month following an absence of earnings from which to deduct benefit premiums, or more than 14 days has passed since the Administrative Leave began. In some circumstances, such as staff waiting on new licensures, the hospital will continue to subsidize benefits. Health insurance is not hospital-subsidized while an employee is on Administrative Leave, unless they are within the above guidelines. However, employees may continue coverage at full cost through the Consolidated Omnibus Budget Reconciliation Act (COBRA). The employee will be notified by Human Resources and the SVMC Benefits Administrator.

- Vacation/Holiday time cannot be used during a pending investigation or license expiration. (See VAC/HOLIDAY Policy)

- Vacation/Holiday time may be used if the employee is precluded from working due to new licensure.

- The employee's position may be posted and filled during an Administrative Leave if the employee is out for more than 14 days.

Department Directors/Managers must notify Human Resources of any employees that may qualify for Administrative Leave.

Human Resources is responsible for maintaining documentation, completion of the appropriate documents, and follow-up with the employee regarding his/her Administrative Leave.

REFERENCES:

- Vacation/Holiday Leave

SUBJECT: **LEAVE OF ABSENCE - CALIFORNIA MANDATED**	SECTION: **Page 1 of 5**

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

PURPOSE:

To define the requirements and procedures for Sierra View Medical Center (SVMC)'s California's mandated leaves process.

POLICY:

Sierra View Medical Center will provide its employees with time off for situations as stated below.

AFFECTED PERSONNEL/AREAS: *ALL ELIGIBLE EMPLOYEES*

PROCEDURE:

ELIGIBILITY:

All regular employees employed by Sierra View Medical Center may be eligible.

REQUESTING A MANDATED LEAVE:

It is the employee's responsibility to obtain prior authorization with his or her Director/Manager regarding scheduling of any Mandated Leave. The employee shall give reasonable advance written notice of the intention to take time off, unless the advance notice is not feasible. Directors/Managers must notify Human Resources of any employees that are absent more than three days, without prior approval, as they may qualify for other protected leave of absences (See LEAVE OF ABSENCE - FMLA/CFRA, and LEAVE OF ABSENCE - PERSONAL Policies).

If Paid Sick Leave and/or Vacation/Holiday time is available, you must use Paid Sick Leave first then Vacation/Holiday time to complete your full schedule.

California Mandated leaves include:

Victims Leave: This unpaid leave provides time off of work to an employee who is a victim or whose "family member" is a victim of a qualifying act of violence.. This does not create a right for an employee to take unpaid leave that exceeds (12 weeks) the unpaid leave time allowed under, or is in addition to the unpaid leave time permitted by the federal Family and Medical Leave Act of 1993 (29 U.S.C. Sec. 2601 et seq). Leave may run concurrently with FMLA/CFRA if qualified. Leave taken to assist a family member with relocating, securing housing, or arranging for school/childcare may be limited to 5 days. Leave taken to assist a family member generally may be limited to 10 days. An employee eligible for above leave may request a reasonable accommodation for their own safety at work.

A qualifying act of violence includes any of the following:

1. Stalking, domestic violence, or sexual assault.

2. An act, conduct, or pattern of conduct where an individual,

   a. Causes bodily injury or death to another
   b. Exhibits, draw, brandishes, or uses a firearm or other dangerous weapon against another
   c. Making a reasonably perceived or actual threat to use of force against another to cause physical injury or death

Family Member is defined as employee's spouse, child, parent, grandparent, sibling, domestic partner, or "designated person." A designated person is someone who is not necessarily related to the employee but is associated with them in a way that is similar to a family relationship.

Time off for a qualifying reason includes:

- To attend, obtain, or participate in judicial proceedings including but not limited to complying with a subpoena or other court order as a witness
- To obtain a restraining order including a temporary restraining order
- To seek medical attention for injuries caused by the crime or abuse.
- To obtain services from a domestic violence shelter, program, rape crisis center, or victim services organization or agency as a result of the crime or abuse.
- To obtain psychological counseling or mental health services related to an experience of crime or abuse.
- To participate in safety planning and take other actions to increase safety from future crime or abuse, including temporary or permanent relocation, as well as enrolling child in school or childcare.
- To provide care to a "family member."

An employee must provide a certification when an unscheduled absence occurs within a reasonable amount of time. Certification shall be sufficient in the form of any of the following:

- A police report indicating that the employee was a victim.
- A court order protecting or separating the employee from the perpetrator of the crime or abuse, or other evidence from the court or prosecuting attorney that the employee appeared in court.
- Documentation from a licensed medical professional, domestic violence advocate or advocate for victims of sexual assault, licensed health care provider, or counselor that the employee was undergoing treatment or receiving services for physical or mental injuries or abuse resulting in victimization from the crime or abuse.
- Any other form of documentation that reasonably verifies that the crime or abuse occurred, including but not limited to, a written statement signed by the employee, or an individual acting on the employee's behalf, certifying that the absence is for a purpose authorized under "Victims Leave."

- **School Activities Leave:** Sporting, social, academic, or other activities for which students' attendance or participation is sponsored, organized, or funded in whole or in part by a school or school district. This will also include time off to find childcare, enroll, or re-enroll child(ren) in school and participate in activities of a licensed childcare provider. This unpaid leave provides time off for eligible employees with up to 40 hours of leave per year. However, no more than 8 hours per month can be taken to participate in school activities with their children. This monthly limitation does not apply, however, if the reason for the leave is due to an emergency. The eligible employee must also give reasonable prior notice. Eligible employees include: Parents, guardians, grandparents, stepparents, foster parents, and persons in Loco Parentis. If both parents work for SVMC, only one (1) must be provided this leave at a time. Leaders may require proof of event/activity in the form of documentation by the school or licensed care provider.

- **School Appearance Leave**: This unpaid leave provides employees with time off in order to appear at school on a child's behalf with regard to school suspension. An employee who is the parent or guardian of a pupil taking time off to appear in the school of a pupil pursuant to a request made under Section 48900.0 of the Education Code must give reasonable notice to employer (if able) that he or she is requested to appear at the school. The following are covered instances:

    - Behavioral or Discipline issues
    - Provider has requested child to be picked up, or has an attendance policy, excluding planned holidays, that prohibits the child from attending or requires the child to be picked up from the school or child care provider.
    - Closure or unexpected availability of the school or childcare provider (excluding planned holidays)
    - A natural disaster (flood, fire, earthquake)

- **Volunteer Firefighter, Reserve Peace Officer, and Emergency Rescue Personnel Leave.** This unpaid leave permits qualified employee to take unpaid leave to perform emergency duty as a volunteer firefighter, emergency rescue personnel, emergency rescue training or reserve peace officer.

- **Civil Air Patrol Employment Protection:** This unpaid leave permits employees who have been employed 90 or more days to take a leave of absence to respond to an emergency operational mission of the California Wing of the Civil Air Patrol. An eligible employee may take up to 10 days per year. Leave is limited to three days on any one occasion, but can be extended if authorized by the government entity that called for the mission and if SVMC agrees. An employee who takes Civil Air Patrol leave will be reinstated to the same position they had prior to commencing leave with equivalent seniority status, benefits, pay and other terms and conditions, unless the employer can prove the failure to do so was unrelated to the leave. The employee is guaranteed to return to the same position.

- **Organ & Bone Marrow Donor Leave:** Organ donors must be provided a paid leave of absence of up to 30 business days in any one-year period. The one year period is measured from the date the employee's leave begins and shall consist of 12 consecutive months. A leave of absence, not

exceeding five (5) business days in a one-year period, to an employee who is a bone marrow donor. An employer shall grant an additional unpaid leave of absence, not exceeding 30 business days in a one-year period.

Employees must provide written verification to the employer that the employee IS an organ or bone marrow donor and that there is a medical necessity for the donation of the organ or bone marrow. An employer may require, as a condition of an employee's initial receipt of bone marrow or organ donation leave, that an employee take up to five days of earned but unused sick leave or vacation/holiday that is available to the employee for bone marrow donation and up to two weeks of earned but unused sick leave or vacation/holiday, or paid time off for organ donation. Bone marrow and organ donation leave shall not be taken concurrently with any leave taken pursuant to the federal Family and Medical Leave Act of 1993. Leave may be taken in one or more periods, but in no event shall exceed the amount of leave prescribed above.

- **Reproductive Loss Leave**: Eligible employees may take leave for up to five days when they suffer a reproductive loss event, which is the day, or the final day for a multiple day event, of one of the following:

Failed adoption, failed surrogacy, Miscarriage, Stillbirth, Unsuccessful assisted reproduction. The five days of leave don't need to be consecutive. Plus, if an employee experiences more than one reproductive loss event within a 12-month period, an employee can receive another five days of leave. There is a cap on reproductive loss leave of 20 days within a 12-month period. Leave must be taken within three months of the reproductive loss event; however, if prior to or immediately following a reproductive loss event, an employee is on or chooses to go on leave under another leave entitlement (e.g., PDL, CFRA, etc) then the employee may complete their reproductive loss leave within three months of the end of the other leave.

Leave is unpaid, but employees can use existing sick leave, or Vacation/Holiday leave that has been accrued and available to them.

Employees do not need to provide documentation to certify reproductive loss leave.

CROSS REFERENCES:

- Leave of Absence – Personal
- Leave of Absence – FMLA/CFRA
- Vacation/Holiday Leave
- Paid Sick Leave

REFERENCES:

- California Labor Code. Employment Regulation and Supervision. (2010). https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=LAB&division=2.&title=&part=5.&chapter=&article=.
- California Assembly Bill No. 2992. Chapter 224. (2020). https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201920200AB2992&showamends=false.
- California Labor Code. Employment Regulation and Supervision. Article 1: General Occupations. 230.4.(2015).https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=230.4
- California Labor Code. Employment Regulation and Supervision. Article 1: General Occupations (230.8). (2016). http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=230.8.
- Government Code section 12945.8- Part of AB 2499- https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2499
- California Labor Code. Employment Regulations and Supervision. Part 5.5 Organ and Bone Marrow Donation (1508-1513)
- Senate Bill No. 848 – Employment: Leave for reproductive loss.

SUBJECT:	SECTION:
MAXIMUM SALARY GRADES, MEETING OR EXCEEDING (LUMP SUM PAYMENTS)	*Human Resources* **Page 1 of 1**

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

PURPOSE:

To establish a method for offering compensation for merit to exempt and non-exempt employees who have reached the top of their assigned salary pay grade yet continue to achieve performance expectations.

AFFECTED PERSONNEL/AREAS:

ALL HOSPITAL EMPLOYEES

PROCEDURE:

Salary pay grades are established for exempt and non-exempt positions and shall contain a grade minimum, and maximum. Each position, both exempt and non-exempt will be indexed within a salary pay grade.

Employee's hourly rate of pay shall not exceed the maximum hourly rate of pay for their pay grade.

Pay grade ranges shall be published annually and distributed to Department Directors, who shall identify and advise their employees reaching or approaching the maximum of their salary grade range.

Employees who have reached the cap or maximum of their position's pay grade will be eligible to receive a lump sum payment equal to 100% of the merit amount recommended in their annual performance review. The lump sum payment is paid at the time of the performance review and does not increase or change the existing base hourly rate of pay.

Employees approaching the top of their salary pay grade, where the full extent of the recommended merit amount is not realized, will be brought to the pay grade maximum to the fullest extent allowable. The actual base hourly rate of pay is changed to reflect the top of the pay grade not to exceed the maximum hourly rate of the pay grade. The remaining increase amount is then paid as a lump sum payment amount.

To process merit increases and lump sum payments, the Human Resources Department must receive the original employee annual evaluation indicating competencies have been completed and placed in the employee's department competency file and the evaluation score sheet.

CROSS REFERENCES:

- SALARY GRADES AND RANGES
- PERFORMANCE REVIEW PROCESS

SUBJECT: **RADIOACTIVE WASTE DISPOSAL**	SECTION: ***Hazardous Materials and Waste Mgt*** **Page 1 of 2**

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

POLICY:

All radioactive materials are disposed of in accordance with the Nuclear Regulatory Commission regulations.

PROCEDURE:

Note: WHEN HANDLING RADIONUCLIDES, WEAR RUBBER GLOVES.

1. Remove all expired radionuclides from the active storage area to the radioactive decay vault.

2. Enter into the indicated log book the date of transfer, the activity transferred, the volume transferred and initial the entry.

3. Place all radioactive waste materials such as used syringes, needles, test tubes and other contaminated items into containers labeled for such waste.

4. On a daily basis, remove and seal the plastic bags, which contain the radioactive waste from the containers, and place in the decay vault.

5. Dispose of the radioactive waste materials in accordance with the instructions given in the Nuclear Regulatory Commission regulations.

6. Enter into the designated log book details showing radioactive materials disposed of, the date of disposal and the radioactivity present at the time of disposal.

7. Perform the final disposal of all radioactive materials in accordance with the prescribed methods given by the Nuclear Regulatory Commission regulations.

8. Enter into the designated log book showing all disposals of radioactive materials, date of disposal, radioactivity present and the method used for disposal.

LIQUID WASTE:

1. Liquid waste will be disposed of in the sanitary sewer system only in accordance with Section 20.303 of 10 Code of Federal Regulation part 20.

2. All unused radioactive liquids will be stored in lead wells located in Nuclear Medicine, until safe for disposal.

3. All liquid waste will be monitored with Lab Monitor or Dose Calibrator. If any radioactivity remains:

    - Determine amount of activity.

- Enter in log the:
  - Date
  - Radionuclide
  - Activity
  - Volume disposed of by sewage
- Remove all radioactive labels and wash containers after liquid has been disposed of.
- Dispose of empty containers with solid waste, as per item 3 below.

4. Mo-99 / Tc - 99m Generators:

- Returned to the manufacturer for disposal.

SOLID WASTE:

1. Solid waste, such as syringes, sponges, liners, test tubes, empty bottles, etc., will be placed in bags that will be labeled "Radioactive" and held for decay.

2. When radiation levels have reached background levels, as measured with a low level survey meter with shielding removed, remove or obliterate all radiation labels and dispose in normal trash to be buried at the landfill.

3. Linens contaminated with radioactivity will be placed in plastic bags and held for decay until no radioactivity over background can be detected with a low-level survey meter before sending them to the Laundry.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. EC.02.02.01 Joint Commission Resources. Oak Brook, IL.
- 10 Code of Federal Regulation, Section 20.303 part 20. https://www.nrc.gov/reading-rm/doc-collections/cfr/. Accessed 2018.

SUBJECT:	SECTION:
RECOGNITION - STAFF ACHIEVEMENTS/MILESTONES	***Human Resources*** **Page 1 of 3**

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

PURPOSE:

To recognize and honor staff member's professional achievements and milestones which contribute to their professional growth while serving at Sierra View Medical Center (SVMC).

POLICY:

Staff members at SVMC obtaining national professional certifications and/or academic degrees from an accredited college related to their current position or which supports their future healthcare career goals will be recognized for their achievements.

AFFECTED PERSONNEL/AREAS:

FULL TIME EMPLOYEES ONLY

PROCEDURE:

A. Staff members who obtain national professional certifications or a two-year college degree related to their area of expertise will be eligible to receive the following recognition from SVMC:

1. Public recognition at the Town Hall Meetings.
2. Public recognition published on SVMC's digital communication boards and SVMC's intranet and website pages.
3. A congratulatory email communication will be sent to SVMC's User Group from the President/CEO.
4. A congratulatory letter mailed to their home.
5. Recognition by Department Leader and peers at departmental staff meeting.
6. Accomplishments published through social media platforms.
7. Accomplishments published in SVMC's Annual CEO Report.

B. Staff members who obtain an undergraduate, graduate, or postgraduate college degree, in addition to the above-listed items, will also receive the following recognition:

1. A gift commemorating their academic achievements or significant milestone.
2. Recipient of an "Enjoy the Day on Us" voucher redeemable for one paid day off. Note: The paid day off will be based on the employee's regular base rate of pay and their regularly scheduled shift. The process for requesting the day off under this program will follow the department's current approval process. Staffing and operational needs will still be considered when accommodating this request. Voucher will expire twelve months from the date issued.

C. To ensure individual privacy and preferences related to public recognition, the Human Resources staff will pre-screen all eligible recipients of this program prior to their participation in the public announcements or publications.

D. To become eligible to receive the rewards under this recognition program, staff members must first complete and submit the Recognition Eligibility form, a copy of their certification and/or college degree to the Human Resources Department within 60 days of receipt or as soon as is reasonably possible. Any questions related to eligibility for awards in this program will be reviewed by the Vice President of Human Resources and the President/CEO for final approval.

E. Staff members submitting other significant milestones outside of certifications or college degrees for consideration under this program will be reviewed and approved at the discretion of the Vice President of Human Resources and the President/CEO.

APPENDIX: Recognition- Staff Achievements/Milestones
Recognition Eligibility Form

Recognition-Staff Achievements/Milestones

Recognition Eligibility Form

Date: _____ Employee Name: _____

Department: _____ Position: _____

Degree or National Certification obtained: _____

Is this degree or National Certification related to your current position? Yes No

Please tell us how this degree or National Certification supports your future healthcare career goals?

_____

_____

_____

Eligibility will be reviewed for approval by HR Manager and/or VP of HR and you will be notified of decision via SVMC email.

Reminder: you must submit a copy of your certification or degree to Human Resources Department within 60 days of receipt or as soon as is reasonably possible.

HR Office Use Only:

Date received: _____ Date reviewed: _____

Approved: Yes No By: _____

Notes: _____

Date Employee Notified: _____

SUBJECT: **SCOPE OF SERVICE - FOOD AND NUTRITION**	SECTION: **Page 1 of 2**

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

PURPOSE:

The Food and Nutrition Service (FNS) Department demonstrates a consistent endeavor to provide safe, healthy, and satisfying food to patients, staff and visitors and deliver optimal patient care within available resources and consistent with achievable goals.

POLICY:

The FNS Department of Sierra View Medical Center (SVMC) will be open daily from 0500 to 2100 and provide the following services:

1. Patient/Resident Meals – Patients/Residents are provided with three (3) meals a day according to their physician's orders.

2. Nourishment – Patients/Residents are provided with additional nourishment and snacks as ordered by the doctors or as deemed appropriate for their nutritional care plan by the dietitian. A variety of juices and light snacks (puddings, crackers, soups, etc.) are also available at the unit's nourishment stations. The FNS Department replenishes snacks daily.

3. Cafe Services – Breakfast, lunch, and dinner meals are available for purchase in the cafe for staff and guests.

4. Catered Meals – Catered meals are provided for Board Meetings, Administrative Meetings, Medical Staff Meetings, and other hospital functions noted in the CATERING SERVICES guidelines upon request and approval.

AFFECTED PERSONNEL/AREAS: *FOOD & NUTRITION SERVICES STAFF*

PROCEDURE:

1. To serve attractive, satisfying meals prepared under high standards of sanitation and safety.

2. To plan appetizing, well-designed menus that meet the nutritional and therapeutic needs of patients/residents in accordance with physicians' orders.

3. To operate a department that meets and exceeds the standards of federal, state, and local regulatory agencies and The Joint Commission.

4. To foster good interdepartmental relations to enhance the overall quality of patient/resident care.

5. To provide continuing in-service education for all FNS employees to increase employee understanding of required job tasks and improve overall skills and performance.

6. To offer nutrition consultation and educational services for patients.

7. To provide nutrition assessments and develop nutrition care plans for those patients/residents requiring nutrition intervention and care.

8. To provide optimum nutrition care while keeping within the prescribed fiscal budget.

Position Corresponding Schedule #	Monday – Friday	Weekend
Director Food & Nutrition Service	0800-1630	On Call
Clinical Nutrition Manager	0800-1630	On Call
Clinical Dietitian	0730-1600	0800-1630 /On Call
Clinical Dietitian	0830-1700	
Food Service Lead - Clerk	0600-1430	
Food Service Lead - #20	1030-2100	1030-2100
Cook #2	0530-1400	
Cook #3	0500-1330	0500-1330
Cook #4	1030-1900	1030-1900
Diet Aide #7	0530-1400	0530-1400
Diet Aide #8	0630-1500	0630-1500
Diet Aide #9	1230-2100	1230-2100
Cater/Prep #10	0600-1430 FLEX	0600-1430
Cafe` Cashier #11	0530-1400	0530-1400
Cafe` Cashier #14	1130-2000	1130-2000
Food Service Worker #16	0600-1430	0600-1430
Food Service Worker #17	0630-1500	0630-1500
Food Service Worker #18	1230-2100	1230-2100
Food Service Informatics System Specialist	0700-1530	

Scheduled hours may be periodically updated. Current schedules for all food service positions are posted in the kitchen.

REFERENCES:

- California Department of Public Health (2024). Retrieved from https://www.cdph.ca.gov.

- The Joint Commission (2024). Hospital accreditation standards. PC.02.02.03, PC.01.02.01, HR.01.06.01. Joint Commission Resources, Oak Brook, IL.

CROSS REFERENCE:

- CATERING SERVICES

SUBJECT: **SERVICE AWARDS**	SECTION: **Page 1 of 1**

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

POLICY:

Recognize and honor employees' years of service

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

The Board of Directors recognizes and values the long term commitment from employee service and demonstrates appreciation through their annual recognition event. Employees are recognized at designated milestone anniversaries.

AWARDS

Five Year	Service pin or approved gift
Ten Year	Pen Set or approved gift
Fifteen Year	Desk Clock or approved gift
Twenty Year	Trophy or approved gift
Twenty Fifth Year	Employee Choice Gift
Thirtieth Year	Employee Choice Gift
Thirty Fifth Year	Employee Choice Gift
Fortieth Year	Employee Choice Gift

Service anniversary dates are the date on which the employee was last hired. If an employee terminates employment and is later rehired, the rehire date is the new service anniversary date. Approved leaves of absence do not change the employee's anniversary date, providing the leave does not exceed one year.

Service anniversary dates and calculation methods mentioned in this policy are for service award presentations and influence no other policy or employee standing for benefits.

Responsibility:

Human Resources

REFERENCES:

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

SUBJECT: **SHIFT DIFFERENTIAL PAY**	SECTION: ***Human Resources Department*** **Page 1 of 1**

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

PURPOSE:

To define what constitutes a shift that is eligible for shift differential pay and the compensation process associated with those shifts.

POLICY:

To give extra compensation to all full time and part time employees who work on evening and night shifts.

Definitions:

1. Evening Shift:

    a. 8-hour shift: 2:45 PM to 11:15 PM
    b. 10-hour shift: 12:45 PM to 11:15 PM
    c. 12-hour shift: 10:45 AM to 11:15 PM

2. Night Shift:

    a. 8-hour shift: 10:45 PM to 7:15 AM
    b. 10-hour shift: 8:45 PM to 7:15 AM
    c. 12-hour shift: 6:45 PM to 7:15 AM

AFFECTED PERSONNEL/AREAS: *ALL FULL TIME & PART TIME SVMC EMPLOYEES*

PROCEDURE:

1. A shift differential equal to 8% of the employee's actual base hourly rate will be paid for all hours worked on the evening shift.

2. A shift differential equal to 12% of the employee's actual base hourly rate will be paid for all hours worked on the night shift.

3. The shift differential will apply to the entire shift, based on the shift that the majority of the hours are worked.

4. The shift differential applies to full and part time classifications of employees only.

5. Shift differentials are calculated using the actual base hourly rate of pay for hours worked.

6. Differentials will not be added to Vacation/Holiday hours.

SUBJECT: **TRAINING AND MEETING TIME PAY**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define the process to provide uniform wage practices for the payment of training and meeting time as hours worked.

DEFINITIONS:

- **In-Service Training** – Required training that is the Hospital's responsibility to provide to employees to comply with licensing regulations.

- **Continuing Education Units (CEU's)** – Required training that is the Employee's responsibility to obtain in order to comply with licensing regulations.

POLICY:

Payment of wages by Sierra View Medical Center (SVMC) during training and meeting times will be determined based on whether or not the training or meeting is designated as mandatory. Mandatory trainings and meetings are those in which the employee participates as a requirement of their job position as determined by their department director or the senior leadership team.

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

PROCEDURE:

Not all training or meeting time is required to be paid. Factors to consider if the training or meeting is paid or not are:

- Whether or not it is voluntary. If SVMC requires the employee to attend the training or meeting, it must be paid. If the employee is voluntarily attending, then it does not need to be paid.

- Whether or not it is the employee's responsibility to obtain or the Hospital's responsibility to provide.

    a. If it is required as a result of a licensing issue, such as Certified Nurse Aids who require in-service training to maintain their certification, then it is paid time.

    b. If it is required by regulation or licensing, i.e. continuing education units (CEUs), it does not need to be paid time as it is viewed as for the benefit of the employee.

    c. Training for the benefit of SVMC, such as internal policy training, must be paid.

- Whether or not any other work must be performed at the meeting. If an employee is asked to perform work while they are receiving training or attending a meeting and the work is used by SVMC, it must be considered as paid work time.

- Whether or not the training or meeting is held outside of the normal work schedule. If so, and it is voluntary, required by regulation or licensing (please see "b." above), or no other work must be performed, then the time does not need to be paid.

If the mandatory training or meeting is to take place during a time in which the employee is not scheduled to work, off-duty employees are required to punch-in at the start of the meeting and punch-out at the end of the meeting. Because this time is considered paid work time, employees must follow all SVMC policies, including the Dress Code Standards policy, while attending the training or meeting. Employees will be paid their regular rate of pay for their attendance at mandatory training or meetings as defined above.

For exempt employees, please refer to the Exempt Employee Compensation policy.
For employees on SVMC Service Teams, please refer to Employee Participation on Service Teams policy.

REFERENCES:

- Fair Labor Standards Act

CROSS REFERENCES:

- RECORDING HOURS WORKED
- DRESS CODE STANDARDS
- EXEMPT EMPLOYEE COMPENSATION
- EMPLOYEE PARTICIPATION ON SERVICE TEAMS

SUBJECT: **VOTING**	SECTION: **Page 1 of 1**

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

PURPOSE:

To define the process by which SVMC allows employees to vote in public elections.

POLICY:

SVMC encourages employees to vote in public elections. Responding to public statute, employees are permitted time away from work to vote following the guidelines listed below. Time away from work may be withheld when election polling places are open for two (2) consecutive hours before or after the employee's scheduled shift.

AFFECTED PERSONNEL/AREAS: *ALL ELIGIBLE EMPLOYEES*

PROCEDURE:

If employees do not have sufficient time outside of working hours due to their work schedule to vote at a statewide election, the employee may, without loss of pay, take off enough working time that, when added to the voting time available outside of working hours, will enable the employee to vote.

Employees can be given as much time as they need in order to vote, but only a maximum of two hours is paid. The time off for voting shall be only at the beginning or end of the regular working shift, whichever allows the most free time for voting and the least time off from the regular working shift, unless otherwise mutually agreed.

Requests shall be no less than two days (48 hours) in advance of the requested time off. Requests may be denied for scheduling, staffing ratios and patient care concerns when requests are received in less than 48 hours.

Non-exempt staff may elect Vacation/Holiday time for time off in excess of the two hour period being paid for voting purposes.

Staff are encouraged to take advantage of absentee voting opportunities.

It is the responsibility of the Department Directors to comply with this policy.

No employee is to be threatened or disciplined when complying with this policy and voting. Time taken off to vote is to be reported using our timekeeping system under pay code "VOTING".

REFERENCE:

- California Elections Code Sec. § 14000. (n.d.). Retrieved October 06, 2020, from https://california.public.law/codes/ca_elec_code_section_14000.

SUBJECT: **FOOD SERVICE EMERGENCY PLAN**	SECTION: ***Emergency Management Plan*** **1 of 11**

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

PURPOSE:

Sierra View Medical Center (SVMC) will have the means to provide nutritional assistance to staff and patients for ninety six (96) hours in the event of a disaster or emergency situation.

DEFINITIONS:

Emergency: An 'unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in sudden, significantly changed or increased demand for the organization's services.'

POLICY:

The facility maintains at least a seven days staple and two days perishable foods in inventory. In addition the facility maintains four days (96 hour) emergency meals, potable water and disposable supplies in the facility's secured, temperature-controlled warehouse.

A Nutrition Service disaster and emergency plan is prominently posted in the food service department and reviewed by all department employees at least annually. This plan will be referred to when the facility experiences a loss of water supply, electricity, natural gas, or experiences an emergency/disaster. It is possible that any one or all of these services may be interrupted.

The Food & Nutrition Service Director or Dietitian or Food Service staff member in charge will consult with the House Supervisor or Administrator to determine the nature of the emergency and the anticipated duration.

If needed, all or part of this emergency meal plan will be implemented to ensure provision of nutritious meals to patients despite the limitations of the disaster. The ***Meals for All*** Emergency Solution menu may be used during an emergency/disaster at the discretion of the Food & Nutrition Service Department, House Supervisor or Administration. In the event the emergency/disaster is anticipated to last beyond one meal, the Registered Dietitian will be notified.

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

PROCEDURE:

At least once a year, the Food & Nutrition Department conducts an in-service session on disaster plans and emergency procedures in regards to the nutritional assistance that will be provided to patients. The *Quick Guide to Emergency Feeding* guidelines will be posted in food service and the house supervisor office. A copy of the disaster and emergency procedures will be stored with the *Meals for All* emergency food and supplies ready reference. (*See attachment I - Quick Guide to Emergency Feeding Guidelines)*

HEATING SOURCE FOR WATER:

If no heating source is available, *Meals for All* may be reconstituted using unheated potable water. All food items are fully cooked and safe to serve at room temperature.

Do not attempt to cook or boil water over an open flame whenever gas leaks are possible.

FOOD TEMPERATURES / FOOD SAFETY:

For best palatability, hot foods are best served at 135°F or more, cold foods are best served at 41° or colder. However, all foods on this menu may be safely served at room temperature between 41° - 135° if opened, prepared and served within two hours.

HANDWASHING FOR FOOD PREPARERS:

Proper hand washing when water is scarce requires the use of two basins, one with an approved sanitizing agent, and one with clear rinsing water. Approved hand sanitizer may also be utilized.

FOOD PREPARATION:

Follow instructions on the *Meals for All* containers for proper preparation. *See attachment II*

EMERGENCY FOOD ITEMS STORAGE:

The *Meals for All* emergency meals and other emergency supplies will be secured in the facility storage warehouse and easily accessible during an emergency or disaster situation. All food items are dated by the manufacturer and have a ten year shelf life. During the final year of the expected shelf-life, SVMC will determine if the facility will donate the *Meals for All* to a charitable organization or utilize for a facility disaster exercise.

EQUIPMENT FOR FOOD PREPARATION:

The equipment needed for food preparation is secured and stored in the facility storage warehouse in the Food Preparation Tool Box. The equipment is in its own marked container and located next to the *Meals for All* pallets. The equipment toolbox includes but not limited to:

- 4 gray scoops (4oz), 4 green scoops (3oz), 4 spoodles (4oz), 2 serving spoons, 2 slotted serving spoons, 4 ladles (3oz), 2 rubber spatulas, 4 tongs, 2 sets measuring spoons, 2 measuring cups, 4 mixing bowls, 2 containers (12 quart), disposable aluminum pans, 2 spot lights, 6 headlamps; 3 lanterns, 10 flashlights, 72 (D) batteries, disposable gloves, 2 can openers, 4 thermometers, 2 boxes storage bags, 2 boxes hairnets, 2 box cutters & extra blades, black markers, 2 scissors, 2 lighters, masking tape 72 (D) batteries, 2 boxes storage bags, 2 cases disinfectant wipes, 2 boxes alcohol wipes, 4 bottles hand sanitizer, black markers, 2 scissors, 2 lighters, masking tape , garbage bags.

INVENTORY AND VERIFICATION:

The *Meals for All* Emergency Menu Inventory and Supply list will be maintained in the Food & Nutrition Service Director's Office, and a copy will be placed in the Emergency Operations Procedures manual.

The inventory and supply list will be inspected on a semi-annual basis to determine all items are present in the quantities specified. The Emergency Supply Inventory Verification form (attached) will be utilized for documenting the inventory, which will include:

- Date of inventory check.
- Results of the inventory.
- Corrective action if needed.
- Signature of person performing the supply inventory.

The Emergency Supply Inventory Verification form will be kept in the Director of Food & Nutrition office and available upon request. (*See attachment IV: Inventory Verification form*.)

DECENTRALIZED FOOD PREPARATION:

The Food & Nutrition Service Director or designee in charge may designate some or all of the emergency food preparation to be conducted at a decentralized location or on each nursing unit or at a remote locations from the facility. The *Meals for All* are packaged to be easily transportable in the event of an evacuation and can be set up in any decentralized location.

MEAL SERVING HOURS:

The meal serving hours for the *Meals for All* will be modified or staggered depending on the emergent situation and will be determined by the Incident Commander, Food & Nutrition Service Director, or designee. The necessary amount of batch cooking to prepare in order to serve in large quantities to the patients and staff members will be taken into consideration. The meals may be served tableside to facilitate having a limited staff to efficiently prepare and serve during an emergency situation. If emergency circumstances warrant, the meals may be served directly from the cooking container directly to the patient / staff.

USE OF EMERGENCY MENUS:

Depending on the time of day and expected duration of the emergency, the Food & Nutrition Service Director or designee may implement the *Meals for All* emergency menus and may be used for a single meal or for several days. (*See attachment III - 4 Day Emergency Menu.)*

MENUS AND THERAPEUTIC DIETS:

The *Meals for All* menus have been planned to provide basic nutrients and meet the needs of most therapeutic healthcare diets. The *Meals for All* menu and products have been specially prepared to allow their use for most healthcare therapeutic diets. The therapeutic menu is appropriate for *Regular, Mechanical Soft, Cardiac, Sodium Restricted, Diabetic and Renal diets.* Specific Therapeutic Diet modifications are as follows:

- Consistent Carbohydrate, Diabetic Gestational Diabetes and Low/No concentrated Sweets Diets may be served all menu items except the pudding. Offer sugar substitute and diet jelly, if available.

- Low Cholesterol/ Low Fat Diets may be served on all menu items.
- No Added Salt/Low Salt Diets may be served on all menu items, but the salt packets are omitted.
- 2 Gram Sodium Diets may be served on all menu items, but the salt packets are omitted.
- Calorie Controlled diets, 1500 Calorie or less, and Consistent Carbohydrate or Diabetic Diets may be served on all menu items except portions of milk, cracker-biscuits and snacks are reduced and the puddings are omitted. Offer sugar substitute and diet jelly if available.
- Renal and Hepatic Diets may be served on all menu items except the milk, pudding and salt packets are omitted. Limit beverages if fluid restriction is prescribed.
- Resident's allergies will be accommodated by knowledgeable staff by offering suitable foods from the *Meals for All* Emergency menu. Diets may be deficient in one or more nutrients.
- Powdered milk is included in the *Meals for All* to meet nutritional needs.

Clear Liquid Diets shall receive broth, gelatin, and clear soda stocked on the nursing units. Nutritional supplements may be ordered to increase calories and nutrient values.

BEVERAGES / CONDIMENTS:

Beverages will be provided as requested or available during an emergency situation. Patients needing thickened liquids will be served beverages thickened to the appropriate level. Substitute dehydrated milk mixed with water for fluid milk if needed. Condiments such as salt, pepper and sugar are made available when possible and not contraindicated by the prescribed diet order. Consistent Carbohydrate or Diabetics shall receive sugar substitute. Sodium-Restricted, Hepatic and Renal diets will not receive salt packets.

WATER STORAGE GUIDELINES:

The facility will maintain designated emergency water in SVMC's secured, temperature controlled warehouse. The water will be stored in a cool, dry area, away from heat sources, and staff will be instructed not to utilize it for any other purpose except an emergency situation. One gallon of water per person per day for proper hydration will be stored. This allows two quarts for drinking water and two quarts for food preparation. However, *Meals for All* dehydrated emergency foods require approximately one quart of water per person per day for reconstitution. *Refer to Water Requirements Appendix in 4-Day Meal Plan Guide* for water requirements table for exact amounts of water per can. Storing one gallon of water per person per day is adequate to meet emergency water needs.

Although the bottled water packaging may indicate an expiration date, the United States Food and Drug Administration (FDA), which regulates bottled water as a packaged food, has determined that there is no limit to the shelf life of bottled water.

MEAL / WATER ALLOCATION

DAY 1		DAY 2		DAY 3		DAY 4	
Patients	165	Patients	165	Patients	165	Patients	165
Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400
EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85
Water (gallons)	650	Water gallons)	650	Water gallons)	650	Water (gallons)	650

A MINIMUM OF 1 GALLON PER PERSON PER DAY ON SITE.

A MINIMUM OF 2600 GALLONS STORED ON SITE.

Meals for All

Day 1	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 2	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 3	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 4	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)

Emergency Tool Box

Disposables / Dry Supplies

ATTACHMENTS:

- *Attachment I: Quick Guide to Emergency Feeding*
- *Attachment II: Meal Preparation*
- *Attachment III: Four Day Emergency Meal Menu*
- *Attachment IV: Inventory Verification Form*

REFERENCES:

- GACH Title 22 Regulations: Article 3: § 70277 (b) Food Supplies. (1) At least one week's supply of staple foods and at least two (2) days' supply of perishable foods shall be maintained on the premises. Supplies shall be appropriate to meet the requirements of the menu.

- Title 22 – Section 70741 further specifies that each hospital shall have a disaster and mass casualty program that includes provisions for the availability of adequate basic utilities and supplies, including gas, water, food, and essential medical and supportive materials. As each hospital's services and situation are different, the definition of adequate is subject to those differences

- CMS - Emergency Preparedness (EP) Tags https://www.cms.gov/medicare/provider-enrollment-and%20certification/surveycertemergprep/emergency-prep-rule
  - EP Tags 0001, 0004, 0006, 0007, 0009 Emergency Preparedness (EP) Program
  - EP Tags 0013 Policies and Procedures
  - EP Tag 0015 Subsistence needs for staff and patients
  - EP Tag 0036 EP Training and Testing
  - EP Tag 0037 EP Training Program
  - EP Tag 0041 Emergency Power

- International Bottled Water Association (2021). Retrieved from https://www.bottledwater.org/education/bottled-water-storage.

ATTACHMENT I

QUICK GUIDE TO EMERGENCY FEEDING

1. Notify Food & Nutrition Service Director or Clinical Nutritional Manager using the emergency call back list or appoint an alternate to be in charge.

2. Determine nature of emergency or interruption:

   - ELECTRICITY - Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - NATURAL GAS - Use alternate heating source if safe. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - WATER SUPPLY - Affects ware washing and cooking, so conserve water and liquids. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - NO POWER OR WATER - Use alternate heating source if safe. Affects ware washing and cooking, so conserve water and liquids. Substitute *Meals for All* as needed.

3. SELECT MENU PLAN TO FOLLOW:

   - Usual menu with needed adaptations (uses perishable supplies first)
   - Meals for All emergency solution.

4. DIET MODIFICATIONS: Refer to usual menu, if using.

   - Follow “Emergency Menu Serving Instructions” when using *Meals for All*.
   - Be aware of those with food allergies.
   - Modify texture for chewing/swallow needs (e.g. mince or mash foods, serve thickened liquids.)

5. LOCATE NEEDED ITEMS:

   - Emergency procedures and menus are posted in Nutrition/Food/Dietary Department, Emergency food storage area, and House Supervisor’s office.
   - Emergency food supplies are located at the SVMC warehouse.
   - Emergency disposable supplies are located at the SVMC warehouse.
   - Preparation supplies are located in emergency toolbox at the SVMC warehouse.

- Water supply is located at the SVMC warehouse.

ATTACHMENT II

MEAL PREPARATION

Refer to the label on each product for specific instructions.

General Instructions for Hot Foods:

1. Open can and discard oxygen absorber* packet.
2. Boil water amount as directed, OR mix with room temperature water if there is no heating source.
3. Stir dry contents of can or cans into boiling water.
4. Cover and remove from heat.
5. Allow to stand for 15 minutes for boiling water, 1 hour if room temperature water utilized.
6. Stir and serve 1 1/3 cup (2 x No. 6 Scoop) or as directed

Instructions for Ready to Eat Items (Fruit, Vegetables, Crackers):

1. Remove oxygen absorber* packet.
2. Ready to eat from packaging.
3. If desired, rehydrate as above using cold water for fruit.

Instructions for Pudding Preparation:

1. Open can and discard oxygen absorber* packet.
2. Stir dry contents of one can into cold water, amount as directed.
3. Whisk thoroughly to mix. Allow to stand for 15 minutes.
4. Stir and serve #8 scoop for ½ cup or as directed.

Non-Fat Milk, to prepare:

1. Add water as directed on label, allow to stand 15 minutes, stir and serve 8 ounces or as directed.

Notes:

- Food Safety Note: Food should be consumed within 2 hours of preparation unless maintained at 135° or higher or below 41° for cold foods.
- No heating methods: Allow 1 hour to rehydrate when using cold or room temperature water.
- Product shelf life is ten years when properly stored in a cool, dry environment.

*Contains a non-toxic oxygen

ATTACHMENT III

MEALS FOR ALL EMERGENCY MENU FOUR DAY				
DAY ONE	**DAY TWO**	**DAY THREE**	**DAY FOUR**	**VEGETARIAN**
BREAKFAST				
Apple Cereal, Fortified	**Apple Cereal, Fortified**	**Apple Cereal, Fortified**	**Apple Cereal, Fortified**	**Apple Cereal, Fortified**
Cracker-Biscuits	**Cracker-Biscuits**	**Cracker-Biscuits**	**Cracker-Biscuits**	**Cracker-Biscuits**
Milk (NFDM)	**Milk (NFDM)**	**Milk (NFDM)**	**Milk (NFDM)**	**Milk (NFDM)**
MID-MEAL				
Beef & Mushrooms with Noodles	**Turkey & Potatoes with Cranberries**	**Southwestern Style Chicken & Rice**	**Sweet Asian Style Chicken with Rice**	**Spaghetti with Mushrooms**
Green Peas	**Corn Niblets**	**Green Beans**	**Garden Mixed Vegetables**	**Vegetable***
Apples Diced	**Peaches Diced**	**Applesauce**	**Peaches Diced**	**Fruit***
Cracker-Biscuits	**Cracker-Biscuits**	**Cracker-Biscuits**	**Cracker-Biscuits**	**Cracker-Biscuits**
Milk (NFDM)	**Milk (NFDM)**	**Milk (NFDM)**	**Milk (NFDM)**	**Milk (NFDM)**
DINNER				
Sweet Asian Style Chicken with Rice	**Spaghetti with Mushrooms**	**Beef Stew with Potatoes & Gravy**	**Macaroni & Cheese**	**Macaroni & Cheese**
Carrots	**Garden Mixed Vegetables**	**Broccoli**	**Green Peas**	**Vegetable***
Cracker-Biscuits	**Cracker-Biscuits**	**Cracker-Biscuits**	**Cracker-Biscuits**	**Cracker-Biscuits**
Chocolate Pudding	**Banana Pudding**	**Vanilla Pudding**	**Banana Pudding**	**Pudding***
Beverage	**Beverage**	**Beverage**	**Beverage**	**Beverage**
SNACK				
Peanut Butter and Crackers	**Peanut Butter and Crackers**	**Peanut Butter and Crackers**	**Peanut Butter and Crackers**	**Peanut Butter and Crackers**

ATTACHMENT IV

25 Person Serving Unit

Inventory List (Four Day Emergency Menu)

Case Number	Day	Meal	4-Day Emergency Menu items	Servings Per Can	Number of Cases in Inventory
1-A	1	Breakfast	Apple Cereal, Fortified	25	25
	1	Breakfast	Cracker-Biscuits	25	
	1	Mid-meal	Beef & Mushrooms with Noodles	12.5	
	1	Mid-meal	Beef & Mushrooms with Noodles	12.5	
	1	Mid-meal	Green Peas	25	
	1	Mid-meal	Apples, Diced	25	
1-B	1	Mid-meal	Cracker-Biscuits	25	25
	1	Evening	Sweet Asian Style Chicken with Rice	12.5	
	1	Evening	Sweet Asian Style Chicken with Rice	12.5	
	1	Evening	Carrots	25	
	1	Evening	Cracker-Biscuits	25	
	1	Evening	Chocolate Pudding	25	
2-A	2	Breakfast	Apple Cereal, Fortified	25	25
	2	Breakfast	Cracker-Biscuits	25	
	2	Mid-meal	Turkey & Potatoes with Cranberries	12.5	
	2	Mid-meal	Turkey & Potatoes with Cranberries	12.5	

	2	Mid-meal	Corn	25	
	2	Mid-meal	Peaches, Diced	25	
2-B	2	Mid-meal	Cracker-Biscuits	25	
	2	Evening	Spaghetti & Mushrooms	12.5	
	2	Evening	Spaghetti & Mushrooms	12.5	
	2	Evening	Garden Mixed Vegetables	25	
	2	Evening	Cracker-Biscuits	25	
	2	Evening	Banana Pudding	25	25
3-A	3	Breakfast	Apple Cereal, Fortified	25	
	3	Breakfast	Cracker-Biscuits	25	
	3	Mid-meal	Southwestern Style Chicken & Rice	12.5	
	3	Mid-meal	Southwestern Style Chicken & Rice	12.5	
	3	Mid-meal	Green Beans	25	
	3	Mid-meal	Applesauce	25	25
3-B	3	Mid-meal	Cracker-Biscuits	25	
	3	Evening	Beef Stew with Potatoes & Gravy	12.5	
	3	Evening	Beef Stew with Potatoes & Gravy	12.5	
	3	Evening	Broccoli	25	
	3	Evening	Cracker-Biscuits	25	
	3	Evening	Vanilla Pudding	25	25
4-A	4	Breakfast	Apple Cereal, Fortified	25	
	4	Breakfast	Cracker-Biscuits	25	25

	4	Mid-meal	Sweet Asian Style Chicken with Rice	12.5	
	4	Mid-meal	Sweet Asian Style Chicken with Rice	12.5	
	4	Mid-meal	Garden Mixed Vegetables	25	
	4	Mid-meal	Peaches, Diced	25	
4-B	4	Mid-meal	Apple Cereal, Fortified	25	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Green Peas	25	
	4	Evening	Cracker-Biscuits	25	
	4	Evening	Banana Pudding	25	25
Milk	1	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 1A/1B
	2	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 2A/2B
	3	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 3A/3B
	4	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 4A/4B
Snack	1	Snack	Peanut Butter	25	
	1	Snack	Cracker-Biscuits	25	incl 1A/1B
	2	Snack	Peanut Butter	25	
	2	Snack	Cracker-Biscuits	25	incl 2A/2B
	3	Snack	Peanut Butter	25	
	3	Snack	Cracker-Biscuits	25	incl 3A/3B
Snack	4	Snack	Peanut Butter	25	
	4	Snack	Cracker-Biscuits	25	incl 4A/4B
				EXPIRATION DATE:	June 2034

SUBJECT: **WORKPLACE VIOLENCE PREVENTION PLAN**	SECTION: ***Security Management*** **Page 1 of 15**

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

PURPOSE:

Violence is occurring all throughout the world and over time has filtered into the workplace. Overall, violent assaults remain fairly rare, although healthcare workers may be at higher risk for attacks compared to other professions. With this in mind, Sierra View Medical Center (SVMC) is committed to providing a work environment that is safe, and every effort is made to reduce or eliminate threats or acts of workplace violence.

In late 2016, the Cal/OSHA Standards Board adopted SB 1299, a new health care workplace violence prevention regulation. The first phase of the regulation went into effect on April 1, 2017 related to reporting requirements and recordkeeping, followed by the final phase that became fully effective April 1, 2018. The Workplace Violence Prevention Plan, assessments of the workplace, hazards identified, corrective measures put into place, and staff training was implemented by the 2018 due date.

The Workplace Violence Prevention Plan (WVPP) is part of the organization's Injury and Illness Prevention Plan (IIPP). The WVPP is in effect at all times in every unit (including Outpatient areas), services and operations.

Key Elements of the WVPP include:

1. Identifying management positions with the responsibility for administering the WVPP
2. Coordination with other employers of employees (contractors, registries, vendors) regularly working at SVMC
3. Identifying and evaluating safety and security risks
4. Investigating acts of violence/violent incidents
5. Hazards corrections/mitigations
6. Communication plan with employees and others
7. Designing, coordinating and implementing the training
8. Incident reporting by employees, contracted labor, registries, and regularly on-site vendors
9. Incident reporting to Cal/OSHA, Law Enforcement and the California Department of Public Health (CDPH)
10. Recordkeeping/Incident Log
11. Annual Program Review

A. DEFINITIONS:

1. Workplace Violence: Any act of violence, threat of violence or aggressive behavior that occurs in the work setting. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:

    a. The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;

    b. An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;

    c. Examples of violent acts may include, but are not limited to, assault, battery, beatings, stabbings, shooting, rape, psychological traumas, threatening or obscene phone calls, stalking, being sworn or shouted at, intimidation, or harassment of any kind

    d. Threat of violence means a statement or conduct that causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured, and that serves no legitimate purpose.

2. Four workplace violence types:

    a. “Type 1 violence” means workplace violence committed by a person who has no legitimate business in the worksite, and includes violent acts by anyone who enters the workplace with the intent to commit a crime

    b. “Type 2 violence” means workplace violence directed at employees by customers, clients, patients, students, inmates, or any other for whom an organization provides services

    c. “Type 3 violence” means workplace violence against an employee by a present or former employee, supervisor, or manager

    d. “Type 4 violence” means workplace violence committed in the workplace by someone who does not work there, but has, or is known to have had, a personal relationship with an employee

3. Risk Factors:

   a. Environmental risk factors in the facility or area in which health care services or operations are conducted may contribute to the likelihood or severity of a Workplace Violence incident. Environmental risk factors include risk factors associated with the specific task being performed.

   b. Patient specific risk factors are specific to a patient that may increase the likelihood or severity of a Workplace Violence incident, such as the use of drugs or alcohol, psychiatric condition or diagnosis associated with increased violence, and condition or disease process that would cause confusion and/or disorientation, or history of violence.

4. Work Practice Controls: Procedures, rules and staffing that are used to effectively reduce Workplace Violence hazards. Work practice controls include, as applicable, but are not limited to:

   a. Appropriate staffing levels.

   b. Provisions of dedicated safety personnel (e.g., Security Officers).

   c. Employee training on Workplace Violence prevention methods.

   d. Employee training on procedures to follow in the event of a Workplace Violence incident.

POLICY:

B. **RESPONSIBILITIES**

1. The Safety Officer is responsible to initiate, implement, maintain and administer the WVPP. The Safety Officer may delegate duties, tasks and assignments via the Environmental Safety Committee.

2. The Director of Quality & Patient Safety or designee is responsible to initiate, implement, maintain and administer the IIPP.

3. Each Department Director/Manager/Supervisor and Employers (On-site Contractors/Vendors) of other employees is responsible for implementing, complying and supporting the WVPP.

4. Each employee and other employees (contractors/vendors) are responsible for

implementing, complying and supporting the WVPP.

C. **PLAN DEVELOPMENT**

1. WVPP development requires a multidisciplinary team approach, which includes Leadership and Management, along with employees and their representatives in developing, implementing, and reviewing the plan.

2. The development, implementation, and annual review of the plan will be coordinated through the Environmental Safety Committee in conjunction with active involvement of employees and their representatives.

D. **COMMUNICATION**

WVPP information and updates are communicated through the following means:

1. Annual WVPP evaluation and review

2. Annual training (type of training is dependent on the roles, departments and specific risks associated with the job duties or environment)

3. Department Specific Training (example: CPI Non-Violent Crisis Intervention)

4. E-Learning self-learning module

5. Department Staff Meetings

6. SVMC will document and communicate to other employees, employers and between shift and units, information that may increase the potential for Workplace Violence incidents.

Employees are encouraged to report safety concerns to the Safety Officer, Security, Risk Management, Employee Health and their Director, Manager or Supervisor.

Attempts will be made throughout the year to solicit active participation of employees and their representatives in the review, creation, design and implementation of the WVPP and all training materials and sessions. The following methods will be used to solicit active participation:

1. E-Learning modules

2. Training session debriefings

3. Staff meetings

E. **TRAINING**

All employees working in the facility, units, service lines, or operations shall be provided initial

training, that includes an online module in E-Learning which covers the types of Workplace Violence, personal safety and reporting, followed by annual refresher training on the WVPP.

Initial employee training will address the workplace violence risks that the employees are reasonably anticipated to encounter in their jobs, the workplace violence hazards identified in the facility, unit, service or operation, and the corrective measures SVMC has implemented. The initial training was provided when the Workplace Violence Prevention Plan was first established and when an employee is newly hired, assigned to perform duties for which required training was not previously required, and new or reassigned employees.

Initial training includes:

1. An explanation of the Workplace Violence Prevention Plan, including the hazard identification and evaluation procedures, general and personal safety measures implemented, how the employee may communicate concerns about workplace violence without fear of reprisal, how workplace violence incidents will be addressed, and how employees can participate in reviewing and revising the plan.

2. How to recognize potential violence, factors contributing to the escalation of violence and how to counteract them, and when and how to seek assistance to prevent or respond to violence.

3. Strategies to avoid physical harm.

4. How to recognize alerts, alarms, or other warnings about emergency conditions and how to use identified escape routes or locations for shelters, as applicable.

5. The role of private security personnel, if any.

6. How to report violent incidents to law enforcement.

7. Resources available to employees for coping with incidents of violence, including but not limited to, critical incident stress debriefing or employee assistance program.

8. An opportunity for interactive questions and answers with a person on knowledge about the Workplace Violence Prevention Plan.

In addition to District employees, WVPP training is required for:

- Contracted/Contingent Workforce
- On-Site Contractors that conduct regular business on SVMC property (i.e., On-Site Security, Renovo)
- Licensed Independent Professionals not employed by the District and volunteers are not required to be trained by Cal/OSHA, but are highly encouraged to be familiar with the WVPP

The level of training on WVPP depends on the workplace or job position risk level:

- Low risk: E-Learning self-learning module
- High risk: Non-violent crisis intervention training

Employees performing patient care contact activities in higher-risk areas (example: Emergency Department), and those employees' supervisors are required to attend annual formal Non-Violent Crisis Intervention training. Non-Violent Crisis Intervention training (CPI) is a focused training on de-escalation techniques as well as restrictive and non-restrictive interventions. The training reviews the topics included in the initial training and the results of the annual Workplace Violence Prevention Plan review and/or any review conducted due to new procedures or new information.

Employees assigned to respond to alarms or other notifications of violent incidents or whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior (i.e., Security Officers) shall be provided training prior to initial assignment and at least annually thereafter that will include.

1. General and personal safety measures.

2. Aggression and violence predicting factors.

3. The assault cycle.

4. Characteristics of aggressive and violent patients and victims.

5. Verbal interventions and de-escalation techniques and physical maneuvers to defuse and prevent violent behavior.

6. Strategies to prevent physical harm.

7. Appropriate and inappropriate use of restraining techniques in accordance with Title 22.

8. Appropriate and inappropriate use of medication as chemical restraints in accordance with Title 22.

9. An opportunity to practice the maneuvers and techniques included in the training with other employees, including a meeting to debrief the practice session. Problems found are corrected.

SVMC provides additional training when new equipment, work practices or hazards are introduced, or when a new, or previously unrecognized, workplace violence hazard has been identified.

F. **RISK ASSESSMENTS**

1. A risk assessment is required for all departments, units, service lines, (including outpatient areas), and services that include:

   - Environmental risk factors;
   - Community-based risk factors;
   - Operation area surrounding the facility such as employee parking areas and other outdoor surroundings;

2. Include a review of workplace violence incidents that have occurred in each facility, department, unit, operations, (including outpatient areas), and services within the previous year, whether or not an injury occurred;

3. Risk assessments will be conducted annually or whenever conditions change that could affect safety;

4. The risk assessment shall be used to identify locations and situations where violent incidents are more likely to occur;

5. Active engagement of employees and their representatives.

Patient-Specific Risk Factors:

Create procedures to identify and evaluate factors specific to patients that may increase the likelihood or severity of violence or the threat of violence (e.g. alcohol, psychiatric condition or diagnosis associated with increased risk of violence, any condition or disease process that would cause confusion and/or disorientation, or history of violence.

1. Procedures for paramedics/emergency medical services to communicate with receiving facility to identify risk factors associated with patients being transported to the receiving facility

2. Procedures for receiving facilities to communicate with law enforcement and paramedics/emergency medical services to identify risk factors associated with patients being transported to the receiving facility.

Risk factors must include, but not limited to:

1. Patient's mental status and condition that may cause the patient to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively;

2. A patient's treatment and medication status, type, and dosage, as is known to the health facility and employees;

3. A patient's history of violence;

4. Any disruptive or threatening behavior displayed by the patient.

Visitors or Other Persons Who Are Not Employees

Create procedures to assess visitors or other persons who are not employees who display disruptive behavior or otherwise demonstrate a risk of committing workplace violence.

1. Policies outlining the circumstances under which a person will not be permitted to enter or remain in the facility. Hospital should train staff on what to do if such a person comes into the facility or becomes angry when asked to leave.

2. Develop criteria for discontinuing the flagging of a visitor for risk of violence potential if the risk is due to a temporary situation.

3. Develop process to credential and manage vendors.

4. Develop a plan to communicate the violence potential of a visitor to staff.

G. HAZARD CORRECTION

1. Engineering and work practice controls shall be used to eliminate or minimize employee exposure to the identified hazards to the extent feasible.

2. SVMC shall take measures to protect employees from imminent hazards immediately, and shall take measures to protect employees from identified serious hazards within seven business days of the discovery of the hazard.

3. When an identified corrective measure cannot be implemented within the seven business day timeframe, such as a project that requires OSHPD approval, SVMC shall take interim measures to abate the imminent or serious nature of the hazard while completing the permanent control measures.

4. Active engagement of employees and their representatives will be included in the hazard corrective measures whenever feasible. Employees will be informed of the results and corrective actions taken.

5. Examples of Hazard Corrections include, but are not limited to, the following:

    a. Emergency Department:

a. Electronic access control
b. Closed Circuit Television (CCTV) cameras
c. Security Officer Station – Posted 24 hours per day

b. Maternal Child Health Unit:

a. Electronic access control
b. Access Control System
c. CCTV
d. Department policy in place for identifying visitors
e. Department procedure for uniquely identifying mother-infants
f. Security Officer Station – Posted 24 hours per day

c. Pharmacy Department:

a. Electronic access control
b. CCTV

d. Human Resources department:

a. Access Control System
b. CCTV

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

PROCEDURE:

H. **VIOLENT INCIDENT REPORTING (Internal and External to Cal/OSHA)**

A. Internal reporting of workplace violence incidents may be accomplished by several means:

1. During normal business hours Monday – Friday, employees may contact Employee Health Services (EHS) by dialing ext. 6174 or visiting the EHS office. They may also contact the Environment of Care/Safety and Security Manager at ext. 6008.

2. After hours and weekends, incidents may be reported by using the electronic Incident Reporting System.

3. For serious incidents, such as a death or injury requiring hospitalization, the employees' supervisor, manager or director shall be contacted and that individual will immediately contact the administrator on-call and the Environment of Care/Safety and Security Manager or Safety Officer.

4. External reporting of workplace violence incidents to Cal/OSHA shall be completed for incidents involving any of the following:

   - The use of physical force against a hospital employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.

   - An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.

   - An incident involving the death of an employee, hospitalization greater than 24 hours, one or more days away from work (which includes the day of the incident), restricted work or transfer to another job, medical treatment beyond "First Aid", loss of consciousness, significant injury, or psychological trauma or stress as a result of the workplace violence incident.

5. Timeframes for reporting to Cal/OSHA:

   1) Shall be reported online to Cal/OSHA within 24 hours if the incident involves:

      a. A fatality or an injury that requires inpatient hospitalization for a period in excess of 24 hours.
      b. Any incidents involving a firearm, dangerous weapon, loss of limb, or serious degree of permanent disfigurement.
      c. An urgent or emergent threat to the welfare, health, or safety of hospital personnel (potential exposure to death or serious physical harm)

   2) Shall be reported online to Cal/OSHA within 72 hours if the incident involves:

      a. All other incidents not listed above in section 3.a. b. c.

      b. The hospital shall submit an initial report with all information available within the allotted timeframe. There are no obligations by Cal/OSHA for the hospital to update the report online if additional information is made available at a later date.

   3) Reports to Law Enforcement

      a. Within 72 hours of an incident, the employer must report acts of assault or battery against on-duty hospital personnel to the local law enforcement agency if the incident results in injury or

involves the use of a firearm or other dangerous weapon, even if there is no injury.

4) Reports to the California Department of Public Health (CDPH)

a. The death or significant injury of a staff member resulting from a physical assault that occurs within or on the grounds of a facility is an adverse event that must be reported to CDPH no later than five days after the adverse event has been detected. If the event is an ongoing urgent or emergent threat to the welfare, health or safety of patients, personnel or visitors, the report must be made not later than 24 hours after the adverse event has been detected.

6. Telephone reports to Cal/OSHA

The Cal/OSHA WVP regulations states that employers must continue to report immediately by telephone to the nearest District Office of the Division of Occupational Safety & Health any serious work-connected injury, illness or death as required by Title 8, California Code of Regulations, Section 342(a).

A. Local District Office:

Fresno District Office
2550 Mariposa St. Room 4000
Fresno, CA. 93721
Telephone: 559-445-5302

B. Cal/OSHA does not accept telephone reporting in place of the online reporting noted in 3.a.b. The telephone reporting is a separate requirement for incidents involving death or serious work-connected injury.

C. "Immediately" means as soon as practically possible, but no longer than 8 hours after the hospital knows of the death or serious injury. In extreme exigent circumstances, the timeframe for reporting to Cal/OSHA may be extended up to 24 hours maximum.

D. Information required when completing a telephone report:

1. Time and date of accident/event
2. Employer's name, address and telephone number
3. Name and job title of the person reporting the accident
4. Address of accident/event site
5. Name of person to contact at accident/event site
6. Name and address of injured employee(s)

7. Nature of injuries
8. Location where injured employee(s) was/were taken for medical treatment
9. List and identity of other law enforcement agencies present at the accident/event site
10. Description of accident/event and whether the accident scene or instrumentality has been altered.

B. VIOLENT INCIDENT LOG/RECORD KEEPING

1. Records of workplace violence hazards identification, evaluation, and correction shall be created and maintained in accordance with Title 8, California Code of Regulations, Section 3203(b) & 5120(e)(1)(B).

2. Training records shall be created and maintained for a minimum of 1 year. Per Title 8, California Code of Regulations, Section 3203(b). The records must include details with date of training, contents or summary of the training sessions, names and qualifications of persons conducting the training, and the names and job titles of all the persons attending the training sessions. In addition, Title 22, California Code of Regulations, Section 70214 states that orientation and competency validation must be documented in the employee's file for the duration of their employment.

3. Violent Incident Logs must be maintained for a minimum of five years, per Title 8, California Code of Regulations, Section 3342(h)(3). The Violent Incident Logs shall include:

1) The date, time, specific location and department of the incident.

2) A detailed description of the incident.

3) A classification of who committed the violence, including whether the perpetrator was a patient/client/customer, family/friend of a patient/client/customer, stranger with criminal intent, coworker, supervisor/manager, partner/spouse, parent/relative, or other perpetrator.

4) A classification of circumstances at the time of the incident, including whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, in a high-crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances.

5) A classification of where the incident occurred, including whether it was in a patient or client room, emergency room or urgent care, hallway, waiting room, rest room or bathroom, parking lot or other area outside the building, personal residence, break room, cafeteria, or other area.

6) The type of incident, including whether it involved:

a. Physical attack, including biting, choking, grabbing, hair pulling, kicking, punching, slapping, pushing, pulling, scratching or spitting;

b. Attack with a weapon or object, including a knife, gun, or other object;
c. Threat of physical force or threat of the use of a weapon or other object;

d. Sexual assault or threat, including rape/attempted rape, physical display, or unwanted verbal/physical sexual contact;

e. Animal attack;

f. Other

7) Consequences of the incident, including:

a. Whether medical treatment was provided to the employee;

b. Who, if anyone, provided necessary assistance to conclude the incident;

c. Whether security was contacted and whether law enforcement was contacted;

d. Amount of lost time from work, if any; and

e. Actions taken to protect employees from continuing threat, if any.

8) Information about the person completing the Log, including the person's name, job title, phone number, email address, and the date completed.
4.

5. All records required by this subsection shall be made available upon request to the Chief of the Division of Occupational Safety and Health or his/her representative (Cal/OSHA Investigators) for examination and copying.

6. All records required by this section shall be made available to employees and their representatives, on request, for examination and copying (at no charge to the employee).

C. **VIOLENT INCIDENT INVESTIGATION**

A. A post-incident response and investigation shall be completed for any employee, contractor, or other individuals that are covered by the WVPP, and have been involved in an act of violence or threat of violence. Steps that shall be taken in the event of an incident of violence (include, but not limited to):

1. Provide immediate medical care or first aid to employees or covered individuals who have been injured in the incident;

2. Identify all employees involved in the incident.

3. Making available individual trauma counseling to all employees affected by the incident.

4. Reviewing any patient-specific risk factors and any risk reduction measure that were specified for that patient.

5. Reviewing whether appropriate corrective measures developed under the Workplace Violence Prevention Plan were – such as adequate staffing, provisions and use of alarms or other means of summoning assistance, and response by staff or law enforcement were effectively implemented.

7. Soliciting from the injured employee and other personnel involved in the incident their opinions regarding the cause of the incident, and whether any measure would have prevented the injury.

8. Conduct a post-incident debriefing as soon as possible after the incident with all employees, supervisors, and security involved in the incident.

9. Completion of the Workplace Violent Incident Report form.

4. The Security Department will conduct a Security Incident Report for any incidents that cause injury or have a high probability of causing injury, psychological trauma or stress.

5. All violent incidents will be reviewed through the Environmental Safety Committee and reported to Senior Leadership, and finally up to the Board of Directors (annually).

D. **ANNUAL REVIEW OF THE WVPP**

A. An annual review of the WVPP must be completed at the end of each fiscal year. The goal of the annual evaluation is to evaluate the effectiveness of the plan and any actions implemented throughout the plan year. The annual review of the WVPP shall include:

1. Staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence;

2. Sufficiency of security systems, including alarms, emergency response, and security personnel availability;

3. Job design, equipment, and facilities;

4. Security risk associated with specific units, areas of the facility with uncontrolled access, late-night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas and other outdoor areas;

5. Review of the Violent Incident Log.

6. Additional limited review may be required following new procedures, processes

or information. An updated review of the plan shall be completed whenever necessary, as follows:

- To reflect new or modified tasks and procedures, changes in staffing, engineering controls, construction or modifications of the facilities, evacuation procedures, alarm systems and emergency responses;
- To include newly recognized workplace violence hazards;
- To review and evaluate workplace violence incidents that result in a serious injury or fatality; or
- To review and respond to information indicating that the WVPP is deficient in any area.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. EC.02.01.01, EC.04.01.01, HR.01.05.03, LD.03.01.01 Joint Commission Resources. Oak Brook, IL.
- Cal/OSHA Workplace Violence Prevention in Healthcare (2019).
- Title 8, California Code of Regulations, Section 3203(b); 5120(e)(1)(B); 3342(h)(3). (2019) Retrieved from https://www.dir.ca.gov/samples/search/query.htm.
- Title 22, California Code of Regulations, Section 70214 (2019). Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- California Hospital Association. (January 2017). Healthcare Workplace Violence Prevention: How to comply with the Cal/OSHA regulations. Retrieved from https://www.calhospital.org/sites/main/files/file-attachments/workplaceviolenceprevention_preview_0.pdf.

CROSS REFERENCES:

- SECURITY MANAGEMENT PLAN
- INJURY AND ILLNESS PREVENTION PROGRAM

STANDARD OPERATING PROCEDURE: MATERNAL SEPSIS
Sepsis Alert and Initial Screen: suspected infection AND ≥ 2 SIRS criteria

Maternal SIRS Criteria (2 or more): HR > 110 (15 min), RR > 24 (15 min), WBC > 15,000, <4000, or > 10% Bands, Temp > 100.4°F or < 96.8°F

- Maternal Sepsis = post-miscarriage, post-abortion, pregnancy, & post-partum up to 42 days
- DO NOT take VS during contractions
- SEPSIS= positive initial screen + 1 organ dysfunction (on back)

Form has 2 sides

Actions – if repeat maternal sepsis alert, contact provider to update orders

Upon initiation of the maternal sepsis alert, initiate the Maternal Sepsis Alert order set:

☐ Initial Lactic Acid Level (time drawn_____ Result_____)

☐ UA, C & S (time obtained_____ Result (positive or negative)_____

☐ Blood cultures, ORDERED & drawn (Time_____)

Date:_____
Alert Initiation done
Yes or No

☐ Portable CXR – only if pulmonary source is suspected (order time: _____)

Contact the provider for the following orders:

☐ Antibiotics (any) - Goal to infuse = ONE HOUR (Time_____) Admin irregardless of blood culture status, if antibiotics are immediately available. *Lactation-friendly

DUE 3 HRS. FROM ALERT

Within 6 hrs of presentation of severe sepsis, the patient must have:

☐ Repeat Lactic Acid (will reflex in 3 hrs if 1st value > 2) – Time drawn_____ Result_____

DUE 6 HRS. FROM ALERT

Septic Shock
Initial Hypotension (>=2 SBPs <85 or MAP <65)
A MAP less than 65 (x15min) is considered a maternal septic shock patient
**persistent hypotension = 2 consecutive BP readings with MAP ≤65 or SBP ≤85 in the hour following IV bolus, and/or a (valid) lactic acid > 4.0

Within 3 hrs presentation of **septic shock**, the patient must have:

☐ 30 ml/kg (use current weight) crystalloid IV Fluid– Prefer LR

If the patient has a diagnosis such as (examples)CHF, kidney disease, or cardiomyopathy, MD may use less fluid but must document the reason why, and how much was ordered. May use IBW

_____weight in pounds / 2.2 = _____ kilograms

kg x 30 ml = _____ ml; or specific volume: Time Started _____

DUE 3 HRS. FROM ALERT

THIS IS NOT PART OF THE PERMANENT MEDICAL RECORD" "RETURN TO THE STROKE/SEPSIS COORDINATOR

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
SEPSIS ALERT CHECKLIST

PATIENT'S LABEL

Form # 025592 REV 1/25

Within 6 hrs presentation of septic shock, the patient must have:	DUE 6 HRS. FROM ALERT
☐ Repeat lactic acid (as above) ☐ Vasopressors, for persistent hypotension** - Levophed (Norepinephrine) preferred ☐ Repeat volume status and tissue perfusion assessment, (AFTER IVF began) consisting of: ☐ A focused exam (VS, CP exam, Cap Refill, Pulses, Skin, shock index value) (M.D. CAN DOCUMENT "SEPSIS REASSESSMENT COMPLETED" WITH A TIME)	

Evidence of Organ Dysfunction

Measure of End Organ Injury	Criteria (need 1)
Respiratory	Invasive or non-invasive mechanical ventilation
Coagulation Status	Platelets < 100 OR INR > 1.5, OR PTT > 60
Liver	Bili > 2
Cardiac	Initial or persistent hypotension (after fluids) • SBP < 85 or • MAP < 65 OR • > 40 MMhG decrease in SPB (documented)
Renal	Creat > 1.2 or Doubling of creatinine, or Urine output < 0.5 ml/kg/hr (x 2 hrs)
Mental status	Agitation, confusion, or unresponsiveness
Lactic Acid	➢ 2 in absence of labor

THIS IS NOT PART OF THE PERMANENT MEDICAL RECORD" "RETURN TO THE STROKE/SEPSIS COORDINATOR

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257
SEPSIS ALERT CHECKLIST

PATIENT'S LABEL

Form # 025592 REV 1/25

MEDICAL EXECUTIVE COMMITTEE	01/08/2025
BOARD OF DIRECTORS APPROVAL	
	01/28/2025
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
January 28, 2025 BOARD APPROVAL

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

	Pages	Action
I. Policies:		**APPROVE**
• Admission Review	1-2	
• Blood and Blood Components-Transfusion Reaction-DP/SNF	3-5	
• Bowel and Bladder Training	6-7	
• Care Planning	8-10	
• Change in Condition-Significant	11-12	
• Cleaning and Storage of Bedside Commodes and Bedpans	13	
• Clinical Dietitian Scope of Practice	14-16	
• Diet Orders	17-18	
• Guidelines for Product Dating	19-24	
• IV Preparation and Dispensing	25-40	
• Intravenous Therapy: General Administration Guidelines for Pediatrics	41-42	
• Linen Handling	43-44	
• Menu Planning	45-47	
• Nutritional Screening and Assessment/Reassessment	48-51	
• Operating Room Cleaning	52-55	
• Orders-Physician Telephone/Verbal	56	
• PM Care	57	
• Patient Education for Modified Diet	58-59	
• Physician Ordered Consultation	60	
• Transfer, Interfacility Resident	61-62	
• Tube Feeding	63-65	

SUBJECT: **ADMISSION REVIEW**	SECTION:

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

PURPOSE:

To define the manner in which all admissions will be reviewed to verify the appropriateness and medical necessity of the admission.

POLICY:

Each designated patient will be reviewed within one working day following admission to ensure that:

1. The admission is medically necessary
2. Actual or potential delays in treatment are not present

AFFECTED AREAS/ PERSONNEL: *UTILIZATION REVIEW*

PROCEDURE:

1. Utilization Management Department personnel are available to perform reviews Monday through Friday of every calendar week, excluding holidays observed by Sierra View Medical Center. The Utilization Reviewer UR reviews the medical record within one working day following admission to determine:
    a. the criteria for admission is met, using InterQual guidelines and/or MCG-Milliman Care Guidelines.
    b. all consults, tests and surgical procedures are scheduled timely and in the proper sequence
    c. if there are any environmental or social factors which could extend the length of stay
    d. admission orders do reflect test or services related to the admitting diagnosis
2. If, based on the admitting diagnosis or information provided during the review, it appears that there may be environmental or social factors, which could extend the length of stay, the UR will refer the case to the Social Services staff.
3. If any of the above cannot be determined by the information provided, the UR will talk with the attending physician for further information.
4. Cases that do not meet criteria for admission and for whom the attending physician is unable to provide adequate reason for admission will be referred to the Physician Advisor or an outside physician review group.

5. If it is determined that the admission is not medically necessary, or that the services are not covered by the payor, the Physician Advisor or outside physician reviewer will request that a denial be issued in accordance with Centers for Medicare and Medicaid Services (URS) guidelines. (See policy Hospital Issued Notice of Non-Coverage Guidelines).

6. If the admission is medically necessary, and all services are scheduled in a timely manner, the case is approved.

7. If the patient is still hospitalized on day five, their case will be reviewed in the weekly outlier meeting and thereafter.

REFERENCES:

- 42 CFR 482.30 - Conditions of Participation: Utilization Review. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.30
- 42 CFR Part 456 – Utilization Control. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-456
- The Joint Commission (2024). Hospital accreditation standards. PC.01.01.01. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Case Management Policy Hospital Issued Notice of Non-Coverage Guidelines

SUBJECT: **BLOOD AND BLOOD COMPONENTS- TRANSFUSION REACTION- DP/SNF**	SECTION:

PURPOSE:

To establish guidelines for the handling, determining and reporting of adverse transfusion reactions.

POLICY:

All transfusion reactions shall be handled as an emergency and documented accordingly on the specified transfusion reaction form and submitted to the laboratory.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RNs), LICENSED VOCATIONAL NURSES (LVNs)*

EQUIPMENT:

- 500 cc 0.9% Normal Saline Solution
- Primary IV tubing set

PROCEDURE:

1. If a transfusion reaction is suspected, immediately clamp off the blood unit.
2. Keep blood unit and tubing set intact, but disconnect from the IV port.
3. Connect a 500 cc bag of 0.9% Normal Saline with new primary tubing set to the injection port closest to the patient.
4. Regulate the IV to keep a vein open rate (25cc/hr).
5. Report symptoms to the physician and notify the blood bank.
6. If the physician elects to stop the transfusion:
    a. Complete the blood transfusion reaction form and call the lab to draw a blood sample.
    b. Prepare the blood component bag and blood tubing and return to Blood Bank.
    c. Collect a urine sample properly labeled and send to the Lab.
    d. Return a copy of the completed "Transfusion Record" form with blood component bag and tubing.
    e. Write and administer orders as given by the physician.
    f. Complete an Occurrence Report.

7. If the physician elects to continue the transfusion:
   a. Notify the Blood Bank of the physician's decision.
   b. Write the order that physician elects to continue transfusion in the EMR.
   c. Administer medications (if ordered).
   d. Observe the patient and continue to take and record the patient's vital signs.

Documentation:

1. On the "Transfusion Record in the EMR"
   a. Note the reactions in the portion entitled "Patient Response to Transfusion"
   b. The most common symptoms are:
      - Fever (2 degree increase from baseline) with or without chills
      - Chest pain
      - Hypotension
      - Nausea
      - Flushing
      - Dyspnea
      - Bleeding
      - Hemoglobinuria
      - Rapid onset of rales

   ***The above common symptoms often occur within the first 15 minutes.**

2. Nurses Progress Notes should include:
   a. Date and time of the reaction.
   b. Description of objective and subjective symptoms of the patient
   c. Condition of the patient

d. M.D. notified

e. Vital signs every 15 minutes until stable or as ordered by the physician

f. Persons contacted and time contacted

g. Samples drawn, e.g. urine/lab draws with times taken

h. Patient's response to the reaction and to interventions, if taken

3. Complete the Occurrence Report

a. Submit to the Department Director

REFERENCE:

- Blood Transfusion Reactions: Symptoms and Treatment-Medical News Today, Joy Choquette: July 31, 2020. https://www.medicalnewstoday.com.

CROSS REFERENCES:

- Blood & Blood Transfusion, Transfusion Reaction
- DP/SNF policy : "Administration of Blood and Blood Components"

SUBJECT: **BOWEL AND BLADDER TRAINING**	SECTION: **Page 1 of 2**

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

PURPOSE:

To ensure attempts are made to achieve residents' highest level of independent functioning in the area of bowel and bladder control.

Note: Bowel training should be initiated prior to bladder training because residents' patterns will be easier to determine and manage.

POLICY:

It is the policy of this facility to maintain a method of bowel and bladder retraining that includes attempts to remove indwelling catheters whenever possible and to assist residents in their attempts at continence and personal hygiene so that they may maintain the highest level of personal independence.

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

EQUIPMENT:

- Gloves
- Bed pan/urinal
- Appropriate call light
- Measuring device for urine
- Foley catheter clamp
- 10cc syringe

PROCEDURE:

1. Assess resident at least quarterly for readiness to begin bowel and/or bladder retraining. Notify physician of resident's progress.

2. Bowel and bladder retraining may be discontinued if resident is alert and refuses after initial assessment.

3. Attempt bowel retraining first, offering bed pan at regular intervals and utilizing bowel protocols. Make sure that appropriate call light is within reach. Make attempts for 72 hrs. Continue if progress is made by resident.

4. Assist resident as needed with skin hygiene.

5. Note pattern and type of evacuations.

6. Foley catheter removal attempts begin with clamp/release to reintroduce bladder tone and capacity. Release clamp at regular intervals of four hours or as resident tolerates. Encourage resident to push down with abdominal muscles to expel urine if possible.

7. Continue to clamp/unclamp every four hours for 24-48 hours then remove the foley catheter (see policy for removal). Proceed as for resident without catheter. Take into account resident's ability to maintain personal hygiene. Assist with ADLs as needed.

8. If resident is placed on bowel and bladder training, every 3 months for 12 months, and remains unsuccessful, it may be discontinued for further training at that time.

9. May initiate bowel and bladder retraining if resident's condition changes.

DOCUMENTATION:

1. Maintain accurate I & O records.

2. Document incontinence episodes and ability of resident to participate in the management program.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, §72315, Section I-3, 72315 (1) (2) San Francisco, California, Title 22.

- Bladder Training Techniques- WebMD, https://www.webmd.com

SUBJECT: **CARE PLANNING**	SECTION:

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

PURPOSE:

To ensure a coordinated, personalized and comprehensive written plan is developed based on the resident assessment instrument and on the individual needs of the resident.

POLICY:

On admission, the facility will initiate a Basic Care Plan Summary based on the resident assessment and on the individual needs of the resident. A personalized comprehensive care plan must be developed within 48-72 hours after admission. Resident care planning includes participation from all health care disciplines involved at resident care conferences with continual reassessment, and updating at least quarterly, and upon change of condition, until resident's discharge.

AFFECTED PERSONNEL/AREAS: *INTERDISCIPLINARY TEAM*

PROCEDURE:

1. Resident Care Plans in the EMR will be maintained as part of the resident health record.

2. Each diagnosis will be listed and updated as necessary.

3. The long term goal is stated in relation to the expected outcome of the resident's condition and is determined collectively by the health care team as part of the review of the care plan. Reviews will be recorded by date in number sequence.

4. Identify the problems or needs. After information has been gathered, the data is analyzed to determine what problems and needs exist.

5. The following guidelines should be employed when identifying, selecting, and recording problems:

    a. The date recorded should reflect when the problem was identified.

    b. A problem is a difficulty or concern experienced by the resident.

    c. The problems include currently existing difficulties, as well as potential problems, as identified by the minimum data set:

        - The date recorded should reflect when the problem was identified.
        - Medical status measurements: labs, diagnostic reports, vital signs, etc.
        - Functional status
        - Sensory and physical impairments

- Nutritional status/requirements
- Special treatments
- Psychosocial status
- Dental condition
- Activity potential
- Rehabilitation potential
- Cognitive status
- Drug therapy

6. Problem statements should be followed with a "related to" or secondary phrase, which relates to the problem when appropriate.

7. The "FOCUS" (goals) are expectations, within the residents' abilities, that can be realistically achieved. Each problem should have a FOCUS goal that is simple, specific and measurable within a specified time frame.

8. Select actions/approaches. When selecting appropriate actions or approaches toward resolving the resident's problems, the following must be remembered:

   a. Actions must be clearly stated and be specific as to "how."

   b. Some actions or approaches may be more appropriate to defer, or may be medically deferred until a later time.

   c. Although specific actions are performed by individual disciplines, the interdisciplinary team's collective actions provide the most effective effort toward resolution of the resident's problems.

9. Determine the responsible discipline. The discipline with expert knowledge is the one that can best meet the resident's needs or accomplish the selected actions.

10. Evaluating the Plan. When evaluating and reassessing the plan of care for the resident, the following shall be considered:

    a. Are the resident's problems still current? Are there new problems?

    b. Are the actions/approaches appropriate and effective?

    c. Are the objectives being met within the designated time frames?

d. Are all appropriate members of the interdisciplinary team involved in the plan of care as needed?

11. Document resolution of the problem. When a problem is resolved, the appropriate date will be indicated on the resident care plan, then inactivated in the EMR.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 (D) (K)United States of America, Med Pass Inc.

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72311 (a), (1A-C), San Francisco, California, Title 22.

SUBJECT: **CHANGE IN CONDITION- SIGNIFICANT**	SECTION:

PURPOSE:

To recognize significant changes in condition which require initiation of new Minimum Data Set (MDS) and Protocol information.

POLICY:

It is the policy of Sierra View Medical Center Distinct Part Skilled Nursing Facility (DP/SNF) that all significant changes of condition will trigger a new Minimum Data Set to be completed and Care Area Assessment (CAA) review of triggered sections.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), MDS COORDINATOR, SOCIAL SERVICES*

PROCEDURE:

1. Document, in the progress notes, the significant change in condition, date and time.
2. Notify physician using SBAR (Situation, Background, Assessment, and Recommendation) report format.
3. Notify the responsible party.
4. Initiate new Minimum Data Set form and complete within 14 days. Complete Care Area Assessment review on triggered areas.
5. Update the care plan to reflect the resident's current status.

A significant change in condition is identified as:

- An acute condition (i.e., stroke, broken hip).
- Deterioration in health condition which is life threatening, such as congestive heart failure (CHF) or cancer.
- Clinical complications, such as advanced skin breakdown.
- Recurrent urinary tract infections.
- Deterioration in two or more activities of daily living (ADLs), communication, and/or cognitive abilities.
- Permanent loss of ability to freely ambulate or to use hands.
- Deterioration in behavior, mood or relationships not reversed by interventions.

- A new diagnosis likely to affect the resident's physical, mental, and psychosocial wellbeing over a prolonged period of time (e.g. Alzheimer's disease, diabetes).
- Significant weight loss (3% in 1-2 weeks, 5% in 30 days or 10% in 6 months).
- Marked and sudden improvement in resident's status (e.g. a comatose resident regaining consciousness).

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.20 (b) (2) United States of America, Med Pass, Inc.
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72311 (3-B) , San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **CLEANING AND STORAGE OF BEDSIDE COMMODES AND BEDPANS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To ensure adequate cleaning and storing of the residents' bedside commodes and bedpans.

POLICY:

Proper procedures must be followed and appropriate agents used when cleaning bedside commodes and personal resident bedpans.

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

PROCEDURE:

Cleansing and Decontamination:

1. It is Nursing's responsibility to empty contents of commode and bedpans.

2. The commode/bedpan is removed from the patient care area and taken to the dirty utility room or bathroom.

    a. Bedpan or commode receptacle contents are rinsed into toilet.

    b. Receptacle or bedpan is wiped thoroughly with a clean, damp cloth or hospital-approved disinfectant only and allowed to air dry.

    c. The bedpan should be marked with the resident's name, room number and dated. Keep in bathroom away from other personal equipment.

    d. Bedpans are to be changed weekly every Sunday on day shift and as needed.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, §72323, San Francisco, California, Title 22.

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

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  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: **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 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 PO 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),
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  Retrieved from https://www.cms.gov/Regulations-and-Guidance.

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SUBJECT: **GUIDELINES FOR PRODUCT DATING**	SECTION: **Page 1 of 6**

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

GENERAL:

All medications at Sierra View Medical Center (SVMC) will be stored in accordance with the most recent guidelines as established by the United States Pharmacopoeia (USP) and the National Formulary (NF) as well as manufacturer recommendations, and recommendations from the Centers for Disease Control and Prevention (CDC).

PURPOSE:

To define the appropriate use/duration for an agent in order to maintain compliance with the pharmaceutical industry standards.

POLICY:

All medications will be stored in accordance with the manufacturer, USP, or NF guidelines. It is the responsibility of the pharmacist to determine the expiration date to be placed on the package, taking into account the nature of the drug repackaged, the characteristics of the package, and the storage conditions to which the drug may be subjected. This date must not be beyond that of the original package.

AFFECTED AREAS/ PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

1) Multi-dose vials

   a) All multi-dose medication containers shall display the concentration of the preparation made, dated (with the expiration date, not the date first opened), and initialed when opened.

   b) All multi-dose injectable medication containers will be refrigerated after opening, unless specifically labeled "DO NOT REFRIGERATE"

   c) Inspect prior to each use for suspected or visible contamination. Discard if contamination is suspected.

   d) If a multi-dose vial enters an immediate patient care area, it should be dedicated for single-patient use only.

   e) All multi-dose vials should be discarded after being used for a single patient whenever possible.

2) Warming of solutions

a) Once the containers have been removed from the warmer, they should be identified as having been warmed and should not be returned to the warmer. If unopened, the plastic bottles may continue to be used until the manufacturer's expiration date, provided that they have not been warmed more than once.

i) Large volume intravenous (IV) solutions (VIAFLEX plastic containers):

(1) IV solutions greater than 150ml to 1000ml may be warmed in their over pouches to temperatures and periods not exceeding:

40°C (104°F) for 14 days if greater than or equal to 3 months expiry remain on the product. If less than 3 months expiry remaining, the product should not be warmed.

ii) Irrigation Solutions packaged in Arthromatic and Uromatic Containers:
(1) Solution Fill Volumes 1000mL to 5000mL
- o Glycine for Irrigation, USP, UROMATIC Plastic Container
- o Lactated Ringer's for Irrigation, ARTHROMATIC Plastic Container
- o Sodium Chloride for Irrigation, USP, ARTHROMATIC Plastic Containers
- o Sodium Chloride for Irrigation, USP, UROMATIC Plastic Containers
- o Sorbitol Urologic Irrigation Solution, UROMATIC Plastic Container
- o Sterile Water for Irrigation, USP, UROMATIC Plastic Container

Table 1. Warming parameters for Irrigation Solutions in ARTHROMATIC or UROMATIC Plastic Containers in the plastic overwrap[2]

Irrigation Solution Fill Volumes	Warming Parameters
1000 mL to 5000 mL	Up to 40°C (104°F) and for a period of no longer than 14 days if greater than or equal to 3 months expiry remain on the product
	50°C (122°F) and for a period no longer than 72 hours

Products should not be warmed if there is less than 3 months expiry remaining. If not used within the maximum warming period they should be discarded.

(2) Irrigation solutions in Plastic Pour Bottles:
- Acetic Acid Irrigation, USP, Plastic Pour Bottle
- Lactated Ringer's Irrigation, Plastic Pour Bottle
- Sodium Chloride Irrigation, USP, Plastic Pour Bottle
- Sterile Water Irrigation, USP, Plastic Pour Bottle
- TIS-U-SOL Solution (Pentalyte Irrigation), Plastic Pour Bottle

i) May be warmed to temperatures and periods not exceeding:

Table 1. Warming parameters for Irrigation Solutions in Plastic Pour Bottle

Irrigation Solution Fill Volumes	Warming Parameters per Product Labeling
250 mL to 1000 mL	Warm in oven to not more than 50°C (122°F) for a maximum of 60 days. Discard after 60 days of warming.

If product not used within maximum warming period, the product should be discarded. The product should not be returned to room temperature or to the warmer.

2) Refrigerated Solutions

a) Large volume intravenous (IV) solutions (VIAFLEX plastic containers) that have not been spiked or admixed prior to refrigeration:

o 5% Dextrose Injection, USP, in VIAFLEX plastic container
o 0.9% Sodium Chloride Injection, USP, in VIAFLEX plastic container
o Lactated Ringer's Injection, USP, in VIAFLEX plastic container
o PLASMA-LYTE A Injection pH 7.4 (Multiple Electrolytes Injection, Type 1, USP)

Table 1. Refrigerated (2°C to 8°C) Storage Duration of Injection Solutions in VIAFLEX Containers

Container Volume	Refrigerated Storage Duration	
	Product removed from overwrap	Product remains in the overwrap
50 mL	15 days	Up to the expiry date printed on the individual container
100 mL – 1000 mL	30 days	

Once solutions removed from overwrap have been stored under refrigeration, they should be used within the "product removed from the overwrap" storage times listed above. Once refrigerated solutions should not be returned to room temperature for storage for later use or returned to the refrigerator.

3. Room temperature solutions

a) Large volume intravenous (IV) solutions (VIAFLEX plastic containers) that have not been spiked or admixed prior but were removed from overwrap:

- o Dextrose Injection, USP
- o Dextrose Injection, USP, MINI-BAG Plus Container (Quad Pack)
- o Dextrose and Sodium Chloride Injection, USP
- o Dextrose and Electrolyte No. 48 Injection, USP
- o Lactated Ringer's Injection, USP
- o Lactated Ringer's and 5% Dextrose Injection, USP
- o OSMITROL Injection (Mannitol Injection, USP)
- o PLASMA-LYTE A pH 7.4 Injection (Multiple Electrolytes Injection, Type 1, USP)
- o Potassium Chloride in Dextrose Injection, USP
- o Potassium Chloride in Sodium Chloride Injection, USP
- o Potassium Chloride in Dextrose and Sodium Chloride Injection, USP
- o Potassium Chloride in Lactated Ringer's and Dextrose Injection, USP
- o Sodium Chloride Injection, USP
- o Sodium Chloride Injection, USP, MINI-BAG Plus Container (Quad Pack)
- o Sterile Water Injection, USP

Table 1. Out of Overwrap Stability Parameters for Injection Solutions packaged in VIAFLEX Plastic Container (excluding MINI-BAG Plus Single Pack configurations)

Injection Solution Fill Volumes	Stability Out of the Overwrap
≤ 50 mL	15 days
≥100 mL and ≤ 1000 mL	30 days

It should be noted the information in Table 1 is NOT applicable to select Baxter Injection solutions packaged in MINI-BAG Plus VIAFLEX Container Single Pack configurations. MINI-BAG Plus Single Pack configurations are recommended for Point Of Care (POC) use and should be used immediately (up to 24 hours) when removed from the overwrap, extended stability out of overwrap is not supported for Single Pack configurations listed in Table 2 due to the differences in product design and materials.

Table 2. Out of Overwrap Stability Parameters for select MINI-BAG Plus VIAFLEX Containers, Single Pack

NDC (Product Code)	Product Description	Stability Out of the Overwrap
NDC 0338-9143-30 (EZPB0040)	5% Dextrose Injection, USP, 50 mL MINI-BAG Plus Container Single Pack	Use Immediately (up to 24 hours)
NDC 0338-9147-30 (EZPB0041)	5% Dextrose Injection, USP, 100 mL MINI-BAG Plus Container Single Pack	
NDC 0338-9151-30 (EZPB0042)	0.9% Sodium Chloride Injection, USP, 50 mL MINI-BAG Plus Container Single Pack	
NDC 0338-9159-30 (EZPB0043)	0.9% Sodium Chloride Injection, USP, 100 mL MINI-BAG Plus Container Single Pack	

PRODUCT EXPIRATION DATING

Description	Requires Date & Initials (yes/no)	Expiration Date
Injectables		
Ampules	No	Discard immediately after use. Use filter needles as per policy.
Single Dose Vials (without preservatives)	No	4 hours after initial entry into closed container; 12 hours in ISO Class 5 or cleaner
Multi-Dose Vials (with preservative)	Yes	28 days after opening or manufacturer expiration whichever is earlier.
Insulin	Yes	28 days after opening or manufacturer expiration whichever is earlier.
IV Solutions Mixed		
Mixed on unit/Patient care area	No if administered by user who prepared it or administration is witnessed by preparer	Administration should begin as soon as possible and not to exceed 4 hours or according to medication stability data whichever is shorter.
Mixed in pharmacy	Yes	As indicated by the date on the IV label which is determined by the pharmacist
Irrigation solutions		
Pour bottles once opened.	No	Discard according to package insert, otherwise discard any unused portion that was not used during irrigation.
Ophthalmic	Yes	Discard according to package insert. If product is conventionally manufactured product in a multiple dose container & intended to contain more than one dose, then after initially entering the container the container is not to be used for more than 28 days. If ophthalmic solution is compounded refer to Category 1 prep BUD.
Oral Medications		
Oral liquids - elixirs, solutions, suspensions, syrups	Yes	Discard according to package insert, otherwise 14 days for nonpreserved aqueous dosage forms stored at refrigerated temp or 35 days for preserved aqueous dosage forms. If oral liquid is nonaqueous per USP 795 the beyond use date may be set to 90 days at controlled room temp or refrigeration temp.
Solids- capsules, tablets	Yes	Discard according to package insert, otherwise the dating period used does not exceed (1) 6 months from the date of repackaging; or (2) the manufacturer's expiration date; or (3) 25% of the time between the date of repackaging and the expiration date shown on the manufacturer's bulk article container of the drug being repackaged, whichever is earlier.

Nitroglycerin tablets	Yes	Discard according to package insert, otherwise the dating period used does not exceed (1) 6 months from the date of repackaging; or (2) the manufacturer's expiration date; or (3) 25% of the time between the date of repackaging and the expiration date shown on the manufacturer's bulk article container of the drug being repackaged, whichever is earlier.
Topicals		
Solutions, ointments, creams, nasal & otic included etc.	Yes	Discard according to package insert, otherwise 14 days for nonpreserved aqueous dosage forms stored at refrigerated temp or 35 days for preserved aqueous dosage forms. If preparation is nonaqueous beyond use date may be set to 180 days per USP 795. Medication is patient specific and is to be discarded upon patient discharge if opened.

REFERENCES:

- "Revised USP Standards for Product Dating, Packaging, and Temperature Monitoring," Am J Health-System Pharmacy Volume 57, Aug 1, 2000: 1441-1445.
- USP <7> Labeling. Retrieved May 20,2024 from https://doi.org/10.31003/USPNF_M4908_11_01.
- USP <795> Pharmaceutical Compounding- Nonsterile Preparations. Retrieved November 13th , 2024 from https://online.uspnf.com/uspnf/document/1_GUID-98DCB48D-DC23-4A63-AD2E-01CA8979FB7E_6_en-US?source=
- USP <797> Pharmaceutical Compounding-Sterile Preparations. Retrieved May 20, 2024 from https://doi.org/10.31003/USPNF_M99925_08_01.
- USP/NF<695>Packaging and Storage Requirements. Retrieved November 30, 2022 from https://www.uspnf.com/sites/default/files/usp_pdf/EN/USPNF/revisions/659_rb_notice.pdf.
- USP <1178> Good Repackaging Practices. Retrieved November 13th, 2024 from https://online.uspnf.com/uspnf/document/1_GUID-0381AAEC-2353-46FC-8A5C-DE056B930ECC_5_en-US?source=Quick%20Search&highlight=good%20
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SUBJECT: **IV PREPARATION AND DISPENSING**	SECTION: *Pharmaceutical Services* **Page 1 of 16**

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

PURPOSE:

To provide guidelines to ensure quality sterile compound products are produced by using consistent validated methods and outline guidelines for the dispensing of medications and maintenance of records in accordance with law and regulation, licensure, and professional standards of practice.

DEFINITION:

Designated Persons- The pharmacist in charge (PIC) will serve as the designated person who is assigned to be accountable and responsible for the operation and performance of the compounding facility and personnel.

PEC-Primary Engineering Control- A device that provides an International Organization for Standardization (ISO) Class 5 or better environment through the use of non-turbulent, unidirectional high efficiency particulate air (HEPA)-filtered first air for compounding sterile preparations.

Segregated Compounding Area (SCA)- A designated space for sterile-to-sterile compounding where a PEC is located.

Aseptic Processing/Preparation- The technique involving procedures designed to preclude contamination (of drugs, packaging, equipment, or supplies) by microorganisms during processing.

ISO Class 5 Environment- One that contains no more than 3,520 particles per cubic meter that are 0.5 microns or larger in size.

Vertical Laminar Airflow Hoods- A device used to achieve the ISO Class 5 environment that sweeps filtered air from top to bottom.

CAI- Compounding Aseptic Isolator- A unidirectional HEPA-filtered airflow isolator that creates a positive pressure controlled environment. It is designed to provide worker protection from exposure to undesirable levels of airborne drug and to provide an aseptic environment for compounding sterile preparations.

CACI- Compounding Aseptic Containment Isolator- A unidirectional HEPA-filtered airflow isolator that creates a negative pressure controlled environment. It is designed to provide worker protection from exposure to undesirable levels of airborne drug and to provide an aseptic environment for compounding sterile preparations.

High-Efficiency Particulate Air (HEPA) filter - A filter composed of pleats of filter medium separated by rigid sheets of corrugated paper or aluminum foil that direct parallel flow that removes air particles 0.3 micrometers or larger.

CSP- Compounded sterile preparation

Critical Site – Any direct pathway through which contaminants may enter a sterile product (e.g. the point at which a needle pierces a vial stopper).

First Air – First air is the uninterrupted flow of air from the HEPA filter.

Beyond use date (BUD) – Beyond Use Date is the date and hour after which a CSP must not be used.

In-Use Time –The time before which a conventionally manufactured product or a CSP must be used after it has been opened or needle punctured (e.g. after a container closure of a vial has been penetrated). It cannot exceed the BUD or the manufacturer's expiration date.

Category 1 Compounded Sterile Product (CSP)- Category 1 is a risk-based approach defined in USP 797 that establishes a specific BUD for products, personnel qualifications, environmental monitoring, release testing required for sterile compounding. It assigns a BUD of 12 hours at room temperature and 24 hours refrigerated. SVMC BUD for products made in the main hospital pharmacy will not exceed 12 hours.

Category 2 Compounded Sterile Product (CSP)- Category 2 is a risk-based approach defined in USP 797 that establishes a specific BUD for products, personnel qualifications, environmental monitoring, release testing required for sterile compounding. It assigns a BUD of greater than 12 hours at room temperature or greater than 24 hours when refrigerated.

POLICY STATEMENT:

It is the policy of Sierra View Medical Center (SVMC) that sterile pharmaceutical products will be prepared using accepted standards of practice. Medications prepared & administered are in accordance with orders of a licensed practitioner who is responsible for the patient's care & in accordance with hospital policies.

PROCEDURE:

A. Sterile compounded products should be made in pharmacy in an ISO Class 5 PEC environment. The area used is to be maintained in a clean, uncluttered, and functionally separate area.

   a. Sterile compounded products may be made outside of an ISO Class 5 environment only in the case of an emergency where waiting could result in harm to a patient.

      i. These preparations shall be labeled "for immediate use only" and administration shall begin no later than one hour following the start of the compounding process.

ii. Unless the immediate use preparation is immediately and completely administered by the person who prepares it or is witnessed by the preparer, then the preparation shall bear a label with the following information:

1. Patient identification unless preparation is done at patient's bedside
2. Names and amounts of all ingredients, may not exceed three ingredients.
3. Name or initials of person preparing it
4. Exact one hour beyond use date and time
5. If administration has not begun within the one hour, then the preparation will be discarded.
6. Any unused source containers with residual drug shall be properly discarded.

iii. The segregated compounding area in the main hospital pharmacy provides ONLY category 1 sterile-to-sterile preparations.

iv. Only staff who have completed the training module for aseptic technique, processes, and procedures may compound for immediate use or pharmacy personnel who have completed the full sterile compounding training course.

b. All active and inactive ingredients used in sterile compounding at SVMC shall be procured from a supplier registered with the Food and Drug Administration (FDA).

c. Category 1 or 2 CSP's may be prepared at SVMC's Cancer Treatment Center's Suite B nonhazardous sterile product IV room.

B. Master Formulation Records must be present before the pharmacy can compound any sterile preparations. They must contain the following elements:

a. Name, strength, dosage form

b. Quantity prepared

c. Active ingredients and amounts

d. Inactive ingredients and amounts

e. Equipment to be used

f. The maximum allowable beyond use date for the preparation and the rationale or reference source justifying its determination.

g. Sierra View Medical Center's main pharmacy has a maximum BUD per USP 797's Category 1 specifications.

h. Sierra View's Cancer Treatment Suite B is a nonhazardous product room is a Category 2 facility. The maximum BUD will not exceed 10 days for refrigerated items.

i. Specific and essential compounding steps used to prepare the drug.

j. Quality reviews required at each step in the preparation of the drug.

k. Post-compounding process and any required post-compounding process and procedures, qualitative checks, including visual check and pharmacist initials that signify final product check.

l. Instructions for storage and handling of the compounded drug preparation.

m. Physical description of final preparation and final container to be used.

n. Where the pharmacy does not routinely compound a preparation, then the record may be documented on the prescription itself.

o. Any other information that may be needed to describe the operation and ensure its reproducibility.

p. Professional reference to cite where the compounding information can be found.

C. The methodology for determining the formulation of the sterile product shall be:

a. Consulting appropriate professional references

i. USP 797
ii. American Society of Health System Pharmacist
iii. Trissel's Drug Compatibility
iv. Lexi Comp Drug Information
v. Drug manufacturer package insert

D. A Compounding Record will be present and contain all of the following elements:

a. Name, strength, and dosage form of the compounded sterile preparation

b. Date and time that the preparation was compounded

c. Identity of pharmacy technician and pharmacist who performed the PRE check and POST compounding check.

d. Name and amount of each component

e. Manufacturer, expiration date, and lot number of each component

f. A pharmacy assigned unique reference or lot number

g. BUD: SVMC main pharmacy (Category 1) and CTC Suite B (Category 2)

h. The final quantity or amount of drug preparation compounded for dispensing

i. Visual check of final product. Review for particulates, discoloration, or other loss of integrity.

j. Master formula recorded as reference.

k. The log will be separated alphabetically by active ingredient. All logs will be kept for three years and will be filed alphabetically by the active ingredient's generic name. The last year's compounded drugs will be kept in the pharmacy. Any previous years will be kept at a designated pharmacy storage site as per approved Board of Pharmacy waiver to store records off site.

E. The most common source of contamination of sterile products is from personnel. The two most common causes of these contaminations are via particle shedding from personnel and improper manipulation of equipment.

a. Contamination from personnel due to shedding can be reduced by proper hand hygiene, gowning and gloving.

i. Personnel who are experiencing rashes, sunburn, weeping sores, conjunctivitis, or active respiratory infections shall not compound sterile products.

b. Another common source of contamination is from products as they move into SEC/PEC/SCA areas.

i. Introducing Items into the SEC
Before any item is introduced into the clean side of anteroom(s), placed into pass-through chamber(s), or brought into the SCA, providing that packaging integrity will not be compromised, it must be wiped with a sporicidal disinfectant, EPA-registered disinfectant, or sterile 70%IPA using low-lint wipers by personnel wearing gloves. If an EPA-registered disinfectant or sporicidal disinfectant is used, the agent must be allowed to dwell for the minimum contact time specified by the manufacturer. If sterile 70%IPA is used, it must be allowed to dry. The wiping procedure should not compromise the packaging integrity or render the product label unreadable.

ii. Introducing Items into the PEC

Just before any item is introduced into the PEC, it must be wiped with sterile 70%IPAusing sterile low-lint wipers and allowed to dry before use. When sterile items are received in sealed containers designed to keep them sterile until opening, the sterile items may be removed from the covering as the supplies are introduced into the ISO Class 5PEC without the need to wipe the individual sterile supply items with sterile 70% IPA. The wiping procedure must not render the product label unreadable.

iii. Use of Sterile 70% IPA on Critical Sites within the PEC
Critical sites (e.g., vial stoppers, ampule necks, and intravenous bag septum's) must be wiped with sterile 70% IPA in the PEC to provide both chemical and mechanical actions to remove contaminants.

F. Compounding personnel shall not wear cosmetics, hand, wrist, or other visible jewelry, artificial nails, or extenders. Natural nails shall be kept neat and trimmed. Do not wear earbuds or headphones. Do not bring unnecessary electronic devices into the compounding area. Wipe eyeglasses, if worn.

G. Hand hygiene and donning of personal protective equipment (PPE) will take place in the anteroom:

a. Shoe covers.

b. Hair/beard cover should contain all hair.

c. Mask should be worn to cover from bridge of nose to chin.

d. Hands and forearms will be vigorously washed with soap (and water for at least 30 seconds.

- Remove debris from under fingernails, if present, using a nail cleaner (pick) under warm water.
- Hands and forearms shall be washed vigorously with soap and water for at least 30 seconds.
- Dry hands and forearms up to the elbows with low-lint disposable towels.
- Gown is to be donned next.
  - For a Category 1 & 2: Low-lint (non-shedding) garment with sleeves that fit snugly around the wrists and an enclosed neck (e.g., gown or coverall)

- Visibly soiled gowns must be changed immediately. Gowns and garbing items must be segregated and stored before use in an enclosure to prevent contamination (away from sinks to avoid splashing).

- If compounding Category 1 and Category 2 CSPs, gowns may be reused within the same shift by the same person if the gown is maintained in a classified area or adjacent to, or within, the SCA in a manner that prevents contamination.

- Prior to donning sterile gloves, use Sterillium© and allow hands to dry thoroughly.

- Put on appropriate sized sterile gloves and apply sterile 70% alcohol and allow to dry.

e. Gloves should be disinfected immediately before compounding begins, before inserting hands into CAI, and before entering or re-entering the PEC and after contact with non-sterile objects.

f. Gloves that become contaminated by contact with non-sterile surfaces should be disinfected with sterile 70% isopropyl.

g. Gloves should be changed whenever contaminated (spills, etc.), torn or every 30 minutes.

h. The CAI fixed glove assembly shall don sterile gloves OVER the CAI isolator gloves immediately before non-hazardous compounding. These sterile gloves must be changed by each individual whenever continuous compounding is ceased and before compounding starts again or when a rip or tear is visible.

H. Personnel will not prepare compounded sterile products until training is complete and competency validated as per SVMC policy STERILE PRODUCTS:EDUCATION AND COMPETENCY.

a. Personnel will be validated every 6 months for garbing competency (including GFT) and media fill with post-GFT and surface sampling. Furthermore, they will be validated every 12 months for training and competency in sterile compounding principles and practices. There will be dates and signatures reflecting all annual reviews of the policies and procedures by the pharmacist-in-charge.

b. Periodic quality checks will be performed per policy. Failure of any quality test will result in the employee being unable to compound sterile products until retrained and competency validated.

I. Proper conduct in the sterile processing area also protects from contamination.

a. Food and drink are prohibited in all areas of the SCA or cleanroom.

b. Actions such as talking and coughing should be directed away from the work area.

c. Any unnecessary motion within the hood should be avoided to minimize the turbulence of air flow.

d. Activities in the sterile products room should only be related to the procedures for parenteral preparations.

e. No cardboard boxes may be in the ante-room or segregated compounding area. Supplies shall be wiped down with sterile alcohol before placing them in the anteroom and buffer room.

J. Proper technique in the ISO Class 5 environment is required to prevent contamination.

a. The critical principle in using laminar airflow hoods is that nothing should interrupt the flow of air between the HEPA filter and the critical site.

b. To maintain sterility, nothing should pass behind a sterile object in a vertical flow hood. Materials placed within the laminar flow hood disturb the patterned flow of air blowing from the HEPA filter. When laminar air flow is moving on all sides of an object, the zone of turbulence is created that may extend six times the diameter of the object. For these reasons, it is advisable to work with objects at least six inches from the sides and front of the hood without blocking air vents, so that unobstructed airflow is maintained between the HEPA filter and sterile objects.

c. Overcrowding of the critical work area may interfere with airflow and increase the potential for compounding errors. Only one individual may work in a hood at one time.

d. Items introduced into the CAI/Hood and their critical sites (vial stopper, IV bag septum) or hood shall be disinfected with 70% sterile alcohol and allowed to dry before aseptic manipulations begin.

K. Although the laminar air flow hood provides an aseptic environment that is safe for the manipulation of sterile products, it is essential that strict aseptic technique be used in conjunction with proper hood preparation.

L. All equipment (syringes, needles, bags, devices) will be used according to standard references to ensure quality, stability and compatibility. Up-to-date references are available in the pharmacy.

M. Ampule Use

a. Before an ampule is opened, any solution visible in the top portion (head) should be moved to the bottom (body) by swirling the ampule in an upright position.

b. To make an ampule break properly, the ampule neck is cleansed with an alcohol swab and the swab should be left in place. Pressure should be exerted on both thumbs, pushing away from oneself in a quick motion to snap open the ampule.

c. Ampules should not be opened toward the HEPA filter of the laminar flow hood or toward other sterile products within the hood.

d. To withdraw medication from an ampule, the ampule should be tilted and the bevel of the needle placed in the corner space (or shoulder) near the opening. As fluid is withdrawn, increase the angle of tilt so that more of the ampule contents flows into the shoulder.

e. Use a filter needle or filter straw to withdraw the ampule contents, and then switch to a regular needle before expelling the solution from the syringe. Alternatively, a regular needle may be used to draw the solution from the ampule, but a filter needle must be used when expelling the solution from the syringe.

f. All ampules are to be immediately discarded and are not to be stored for any length of time.

N. Vial Use

a. Vials with drugs in solution can be multi dose or single dose.

b. Multi dose vials contain a small amount of preservative agent. The presence of these substances does not make the solution self-sterilizing and the use of strict aseptic technique is still required. Common substances used as preservatives include benzyl alcohol, parabens, phenol and benzalkonium chloride. Due to their toxicity, solutions with preservatives should not be used in preparations for pediatric or neonatal patients or for epidural or intrathecal dosage forms.

c. Unless otherwise specified by the manufacturer, a multi-dose container stored according to the manufacturer's specifications is used in its entirety or its remaining contents are labeled with a BUD and discarded within 28 days from initial opening or puncture. Any multidose container not stored properly or not labeled with a BUD or if BUD is incorrect, the container and drug must be immediately discarded.

d. Single-dose vials do not contain preservative.

i. Most protective covers do not guarantee sterility of the rubber stopper. Before the stopper is penetrated, it must be swabbed with 70% isopropyl alcohol and allowed to dry.

ii. Needle entry into vials with rubber stoppers should be done cautiously to avoid the creation of rubber core particles.

d. Single-dose containers of a compounded sterile drug preparation, other than an ampule, such as a bag, bottle, syringe, or vial, are used in their entirety or their remaining contents are to be labeled with a BUD and discarded within the following time limit, depending on the environment:

i. When needle-punctured in an environment with air quality worse than ISO Class 5,will be discarded after four hours.
ii. When needle-punctured in an environment with ISO Class 5 or better air quality, within twelve hours, unless otherwise specified by the manufacturer.

O. The Role of the Pharmacist

a. As physician's orders are received, the pharmacist will enter the order into the computer, preferably selecting premixed preparations.

b. Medications not available in premixed form will be entered in the computer as part of a multiple item compound that includes the appropriate volume of a compatible base solution.

c. A label will be generated from the computer system.

d. The pharmacist will check ALL ingredients (and calculations) prior to a pharmacy technician commencing any compounding. This PRE check will be documented on the compounding log.

e. Upon completion of the compounding, the pharmacist will visually inspect the product for visible turbidity, cloudiness, i.e., qualitative inspection of the final product and document this on the compounding log, a POST Check.

P. The Role of the Pharmacy Technician

a. Disposal of Supplies Upon Completion of Sterile Compounding

i. Needles will be discarded in puncture-resistant, sealable containers, often called "sharp" containers.
ii. Do NOT recap needles before discarding them into the "sharps" container.
iii. Syringes and containers that do not have medication in them that is not considered to be Resource Conservation and Recovery Act (RCRA) waste shall be disposed of in appropriate pharmaceutical waste bins.
iv. Nonhazardous, empty vials may be discarded in the regular trash.

b. Intravenous Piggyback Set-Up Procedures

i. An intravenous admixture ward list will be printed once a day by pharmacy technicians. This list will create intravenous admixture labels that will need to be affixed to either premixed (from the manufacturer) admixtures. If there are no premixed solutions available, then the admixture will be compounded in the compounding aseptic isolator.
ii. Any frozen solutions shall be thawed from the Pharmacy service freezer.
iii. Using the oldest frozen preparation that will not expire within the 24-hour dispensing period, the technician will label each solution specifically for the patient, drug, and dose.
iv. Expiration dates on the frozen solutions will be checked to assure the oldest acceptable date.
v. Docking of proprietary bag to vial systems for future activation must be done in accordance with USP 797.

c. Pediatric Syringe Preparation Procedure

i. The intravenous admixture ward list will be printed once a day.
ii. Patients with doses due before the next list is printed will have those labels segregated from the worklist.
iii. The amount of drug needed for compounding based on total patient requirements shall be determined.
iv. Materials required for aseptic medication transfer should be gathered and placed in the CAI antechamber and wiped with sterile alcohol.
v. The supplies and drug shall be transferred into the CAI mixing chamber and allowed to sit undisturbed for at least three minutes to allow for the CAI to purge any airborne particles.
vi. The technician will call the pharmacist into the IV room for a PRE check on the materials and calculations for the preparation to be compounded. The identity and quantity of each component will be validated by the pharmacist BEFORE the addition is performed.
vii. After the pharmacist signs off on the PRE check on the compounding log, the appropriate amount of medication for syringe preparation shall be diluted (in the CAI) by the technician.
viii. The calculated amount of drug shall be drawn into the syringe.
ix. Aseptically, the technician will inject the syringe contents into the predetermined base solution and affix the patient-specific label.
x. The patient-specific label is immediately applied and the product is removed from the CAI and made available for the pharmacist to do a final quality check.
xi. The remaining drug in the source container shall be discarded.

d. Large volume parenteral preparation procedure:

i. Solution fill list and labels are obtained as described in the pediatric syringe preparation.
ii. Labels are assembled according to additive type.
iii. The outer wraps of solutions are removed upon reintroduction into the PEC. The large volume bags are wiped with sterile alcohol in the CAI antechamber.
iv. The materials for compounding (drugs and syringes, etc.) are placed in the mixing chamber in the CAI and allowed to sit for a minimum of three (3) minutes to allow for the particulate to return to an ISO class 5 state.
v. The pharmacist is called into the IV room, and the identity, quantity, and calculations are reviewed with the technician prior to the pharmacist signing the compounding log and prior to the technician compounding the sterile product.
vi. The patient specific label is immediately applied and the product is removed from the CAI and made available for the pharmacist to do a final quality check.

Q. Sterile product preparation and verification PRE procedure to be done by the technician BEFORE and during the pharmacist's PRE compounding check:

a. Drugs and equipment and patient specific label (needles/syringes/alcohol wipes/etc.) necessary to prepare and mixture will be assembled for the pharmacist to review with the technician.

b. Ingredients will be carefully checked for accuracy using the master formulation record and label. All products selected for use in compounding shall be verified by the pharmacist prior to any compounding activity. In addition, calculations will be verified with the pharmacist during the PRE CHECK phase of compounding.

c. The pharmacist will then sign and date the compounding log acknowledging the technician has assembled all proper materials, drugs, equipment and has reviewed any and all pertinent calculations.

R. Procedure for transferring necessary ingredients and equipment into the PEC. All items will be carefully wiped down with sterile alcohol and allowed to dry before being placed in the PEC.

a. Only ingredients to make one admixture should be in the PEC.

b. Items will be arranged in a manner that does not block or disrupt airflow.

c. After the compounding materials are in the PEC, a purge time of three (3) minutes will pass before beginning any compounding activities.

d. Gloves will be disinfected with sterile alcohol and allowed to dry.

e. A pharmacist will check ingredients and calculations prior to compounding.

f. Admixture will be prepared using aseptic technique.

g. Trash will be managed in a way that does not obstruct airflow.

h. Admixture will be removed from the PEC and labeled.

i. Label will be signed by the employee and the beyond use date will be written on the label.

j. Employee preparing and pharmacist checking the IV will inspect the IV for leakage, foreign matter, precipitate, or cloudiness.

k. All ingredients and supplies will be removed from PEC and kept together for verification by a pharmacist.

S. Sterile product labels must contain the following elements:

a. The generic names of the drugs

b. The quantity or volume and strength of the active ingredient(s)

c. The name of the patient

d. The direction for use

e. The date of dispensing

f. The name and address of the compounding pharmacy and dispensing pharmacy if different.

g. An order number to identify the prescription, e.g., lot number or pharmacy reference number (prescription number).

h. The name of the prescriber

i. Beyond Use Date (BUD)

j. Date compounded

k. Route of administration

l. Rate of administration for IV admixtures

m. Instructions for storage & handling or warning labels if needed

n. All hazardous drugs shall bear a label which states, "Chemotherapy-Dispose of Properly" or "Hazardous-Dispose of Properly"

T. Statement the "Drug was compounded in pharmacy" if preparation was not outsourced.

U. Beyond Use Dating (BUD) will be assigned to all drug products based on manufacturer's chemical stability recommendations or in accordance with the standards for sterility testing found in USP 797, whichever is shorter.

a. SVMC's main pharmacy exclusively prepares sterile-to-sterile transfers in an ISO class 5 PEC that is located in a segregated compounding area, i.e., Category 1 classification.

b. The Cancer Treatment Center (CTC) suite B prepares hazardous and non-hazardous compounded sterile products by using sterile to sterile transfers in a negative pressure hood and room and a positive pressure room and hood, respectively. The products produced at this location will qualify for Category 2 and MAY have a BUD of not greater than 4 days at room temperature and 10 days refrigerated.

U. Single-dose and multi-dose container dating

a. A single-dose container (not an ampule) must be used entirely or discarded:

i. Within twelve hours, if needle-punctured or opened in an ISO Class 5 environment. If a puncture time is not noted on the container, the container must be immediately discarded.

ii. Within four hours, if needle-punctured or opened in a worse than ISO Class 5 environment.

b. An ampule is a single-dose container that must be used immediately and not stored for any timeframe.

c. A multi-dose container must be used or discarded within 28 days (or shorter if specified by manufacturer).

V. Documentation Retention

a. All records of compounding and materials used to compound sterile preparations shall

be maintained in a readily retrievable form for three (3) years from the date the record was last in effect. They will be maintained in a manner to provide an audit trail for revisions and updates of each record document.

b. The pharmacy will maintain records of the acquisition, storage, and destruction of any component used in compounding.

W. Whenever a change in a policy or procedure occurs, the pharmacist in charge will notify the staff via a meeting or email. Staff shall sign off on changes acknowledging changes and intent to comply. Any material failure to follow the pharmacy's written policies and procedures shall constitute a basis for disciplinary action by the Board of Pharmacy.

X. This policy and all policies related to sterile compounding will be reviewed annually by the pharmacist-in-charge, and recordation of the annual review shall be present on each policy and be readily retrievable upon request by the Board of Pharmacy.

Y. All pharmacy staff who compound sterile products or who are responsible for training staff who work in the sterile product environment shall review all policies related to sterile products annually. Documentation of the annual staff review shall be readily retrievable for the State Board of Pharmacy.

Z. In the event of a drug recall, the written plan found in DRUG RECALL PROCEDURE shall be followed.

AA. The Department of Pharmacy will not handle or compound any infectious materials in the sterile compounding area.

BB. Pharmacy will run a "batch" for all IV compounds needed to compound within the next 24hrs once daily in the morning. Dispensing of the IV's are done in a manner to ensure the BUD date is not before their due time.

CC. All medications that are retrievable from Pyxis are immediately available for "dispense" after pharmacy verification. Any medication that does not require compounding and not dispensed via Pyxis will be dispensed prior to first dose upon pharmacy notification. 3 days' supply of medications are sent for medications not in Pyxis and are to be delivered as soon as possible and before the next due time.

EDUCATION:

SVMC Staff: All pharmacist and pharmacy technicians will receive education regarding sterile product preparation and aseptic technique.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
  - MM.05.01.07
    - EP1
    - EP2
    - EP3
    - EP4
    - EP5
  - MM.05.01.11
    - EP3
- Pharmacy Law: California Edition (2024) San Clemente, California: Law Tech Publishing Group.
- USP 797. (n.d.). Retrieved March 4th 2024 from http://www.usp.org/compounding/general-chapter-797.

SUBJECT: **INTRAVENOUS THERAPY: GENERAL ADMINISTRATION GUIDELINES FOR PEDIATRICS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To ensure appropriate administration of fluids to the pediatric patient.

POLICY:

1. Administration of IV fluids must be given only as specifically ordered by physician. The physician's order must be specific as to the solution and volume, medications to be added and rate of administration.

2. All pediatric patients defined as children 13 years old and younger receiving IV Therapy shall be administered only with the use of control volume buretrol and will always be on an infusion pump.

3. Administer solutions in quantities not greater than 1000 mls.

4. No more than two (2) hours' worth of fluid may be put into the volume chamber at one time.

5. Bags and tubing must be labeled with the date and time hung, and the nurse's initials.

6. All IV bags will be changed every 24 hours and all IV tubing must be changed every 72 hours.

7. Intake and output must be recorded for all pediatric patients in I & O record

8. All IVs are to be thoroughly examined every hour to ensure correct rate and IV site is intact.

9. The nurse must immediately discontinue an IV if obviously infiltrated presence or phlebitis.

10. An IV that is ordered KVO is to run at a rate of 3ml per hour using a 250 ml solution bag, if available.

11. A nurse may initiate IV Therapy after obtaining an order from the physician on a pediatric patient with the following consideration:

    a. A new sterile cannula is used for each attempt. The assigned nurse may attempt to insert an IV two times before seeking assistance.

    b. When selecting a vein for IV insertion, the factors to consider are:

        - Age of child
            - In infant, the scalp, foot and hand veins are most accessible. Do not use scalp veins after 18 months of age.
            - For older children, the hand, arm, leg, and foot veins are most accessible.

- Mobility of the child
- Handedness
- Need for restraint
- Areas of risk
    - Sites to be avoided includes:
        - Areas of infection, previous infiltration, phlebitis, or bruising;
        - Areas where circulation may be compromised, such as extremities with fractures, cast, fistulas, shunts;
        - Areas on bony prominence, fontanel, antecubital fossae, near V-P shunts.
    - When possible, avoid leg and foot veins of adolescents to reduce risk of thrombophlebitis.
    - Use distal sites first so more proximal sites are available for later use.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN)s*

REFERENCE:

- Bowden, G.V. & Greenberg, C.S. (2016). Pediatric Nursing Procedures (4th ed.) Philadelphia: Lippincott Williams & Wilkins
- National Institute for Health and Care Excellence (NICE). (2020, June 11). Intravenous fluid therapy in children and young people in hospital. NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK563449/

SUBJECT: **LINEN HANDLING**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose is to protect against the transmission of organisms from one location to another through the use of proper linen handling techniques.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to provide procedures for the proper handling of clean and soiled linens and to ensure procedures are followed.

AFFECTED PERSONNEL/AREAS: *LICENSED STAFF, EVS, CNA*

PROCEDURE:

CLEAN LINEN

1. Clean linen is obtained from the linen closet/cart.
2. Only the linen needed for an individual resident is taken to the resident unit.
3. Linen is to be carried in such a manner as not to have contact with the employee's uniform.
4. Clean linen may be placed at the foot of the bed when used immediately.
5. Linens considered clean and to be used by the resident at a later time may be folded neatly and stored on the shelf in the resident's closet (i.e. blanket, bedspread, pillow, etc.) or in their dresser.
6. Avoid shaking linens or fluffing them in the air, as this spreads lint and dust, which can contain microorganisms.
7. If clean linen is dropped on the floor, it will be considered contaminated and handled as soiled linen.
8. If clean linen is placed on another resident's bed or overbed table, it must be used for that resident or considered contaminated and handled as soiled linen.

SOILED LINEN

1. Soiled linen shall be placed immediately into a soiled linen hamper. If a linen hamper is not immediately available, the linen may be rolled up tightly and placed at the foot of the bed between the mattress and frame until it can be removed to the soiled linen hamper.
2. Soiled linen must never be put onto the floor.

3. Residents' soiled personal linen will be placed into the cart in the shower room for pick up by contracted service to be laundered.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.65 © United States of America, Med Pass Inc.
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 73669, San Francisco, California, Title 22.

CROSS REFERENCES:

- Infection Prevention and Control- DP/SNF Policy

SUBJECT: **MENU PLANNING**	SECTION: **Page 1 of 3**

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:

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.

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: NUTRITIONAL SCREENING AND ASSESSMENT/REASSESSMENT	SECTION: Page 1 of 4

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

PURPOSE:

Sierra View Medical Center (SVMC) is committed to providing a comprehensive nutrition care program that includes medical nutrition therapy in a timely, effective and efficient manner. The nutrition care program is integrated with nursing and other appropriate disciplines as needed.

POLICY:

The nutrition assessment evaluates the patient's nutrition status, develops a plan of nutrition care and evaluates the efficiency of nutrition support.

AFFECTED PERSONNEL/AREAS:

FOOD AND NUTRITION SERVICE, PHYSICIAN, NURSING, OTHER DISCIPLINES AS REQUIRED

Food and Nutrition Service: The Registered Dietitian (RD) will prioritize the nutritional risk level of patients. The RD assesses the patient for medical nutrition therapy, develops, implements and evaluates the effectiveness of the nutrition therapy plan, identifies potential risks to the nutrition care of the patient. A diet aide will visit patients for menu selections, cultural/religious food preferences, and refers the patient to the dietitian if needed.

Physician: The physician assumes the responsibility for the overall nutrition management of the patient.

Nursing: Nursing identifies patients at nutritional risk through the general nursing admission assessment. Monitor and report the effect of nutrition care on an ongoing basis. Monitor nutrition and fluid intake.

Other Disciplines: As required. *Example: Speech Therapy will perform swallow evaluations.*

PROCEDURE:

A. NURSING NUTRITION ADMISSION SCREEN:

All patients *(see Maternal Child Health for exceptions)* will be screened for nutritional risk by nursing staff using criteria established by a Registered Dietitian.

1. Nursing completes nutrition screening on the General Admission Assessment within 24 hours of patient admission.

2. Included in the "Nutrition Screen" section is the presence of the following, which triggers a referral to the dietitian:
   - Vomiting/Diarrhea ≥ 3 days prior to admit
   - Unintentional weight gain or loss
   - Difficulties in chewing/swallowing/feeding self
   - Enteral feeding/parenteral nutrition (PN)
   - Pregnant or Lactating and ≤ 17 years old
   - Pressure ulcer ≥ stage II
   - NPO (nothing by mouth), > 3 days
   - New onset diabetes
   - Age >80 with planned surgery
   - Recent change in diet
   - New start Warfarin

3. Included in the "Pediatric Nutrition Screen" section is the presence of the following, which triggers a referral to the dietitian:
   - Failure to thrive/malnutrition
   - Enteral feeding
   - Food allergies/intolerances
   - New onset diabetes
   - Vomiting/diarrhea >3 days prior to admit
   - Difficulties in chewing/swallowing/feeding self/delayed feeding skills
   - Weight loss in last 3 months
   - Chronic GI problems/reflux
   - Cancer
   - Metabolic disorder
   - Chronic kidney disease
   - Eating disorder

4. Maternal and Child Health patients are not automatically assessed by the RD to respect the patient's privacy during her labor. The patient will be referred to the dietitian if any of the following triggers are present:
   - Gestational DM
   - ≤17 years of age
   - Hyperemesis gravidarum
   - Nutrition education needed/requested

B. DIETITIAN NUTRITION ASSESSMENT:

1. Nutritional Prioritization Schedule
   a. Nutrition Assessment within **24 hours** of admission.
      a. Physician-ordered nutritional consults
   b. Nutrition Assessment within **48 hours** of admission.
      a. Nursing referrals identified in the nutrition admission screening via general admission assessment
      b. Patients with the following primary medical diagnosis (high nutritional risk): malnutrition/failure to thrive, ulcerative colitis/Crohn's disease, pregnancy/lactation < 17 years old, hyperemesis gravidarum, decubitus ulcer ≥ stage II, ileus, hepatic encephalopathy, multi-system organ failure, NPO/clear liquid >/ 72 hours.
   c. Nutrition Assessment within **72 hours** of admission.
      a. Patients with the following primary medical diagnosis (moderate nutritional risk): diabetic ketoacidosis (DKA), acute respiratory failure without ventilator support, bowel surgery, cirrhosis, body mass index (BMI) <18.5 (underweight), cancer with recent chemo/radiation, 80 years old with planned surgery, pancreatitis, renal failure, gestational diabetes mellitus (GDM), peritonitis, cerebrovascular accident (CVA) with dysphagia, general dysphagia, small bowel obstruction (SBO), GI bleed, gastroparesis.
   d. Nutrition Assessment are completed for all patients within **96 hours** of admission.
      a. Patients with the following primary medical diagnosis (low nutritional risk) may include, but is not limited to: multiple food allergies, eating >50% of meals, dental difficulties, substance abuse, pneumonia, COPD, TB, coronary artery disease (CAD), congestive heart failure (CHF), hyperlipidemia, colostomy, gastritis/peptic ulcer, gall bladder disease, hypothyroidism, obesity, musculoskeletal disorder, anemia, amputation of limb, total hip arthroplasty, TKA, seizures, appendicitis, bronchiolitis, comfort measures.
   e. Prioritization for nutrition assessment may change depending on acuity and RD professional judgement.

2. Nutritional Assessment (Nutrition Care Process)
   a. Assessment
      i. The RD may include information collected from medical, social and dietary histories, anthropometric data, biochemical data, and review of prescribed drugs.

ii. Where applicable, include a summary of what the current nutrition support provides and if it is appropriate

b. Diagnosis
   i. Statement of Problem, Evaluation, Signs/Symptoms (PES)

c. Intervention
   i. Central goal or desired outcome, where appropriate
   ii. A breakdown of the nutrient composition of any recommendations for parenteral/enteral feedings

d. Monitoring and Evaluation
   i. Nutrition risk level- high, moderate or low
   ii. Appropriateness of diet

C. REGISTERED DIETITIAN & NUTRITIONAL REASSESSMENT/RE-EVALUATION:

1. Nutritional reassessment will be conducted using the following guidelines, as indicated by assigned risk level by the RD:
   a. High risk: 2-3 days (Parenteral nutrition [PN] assessments will be completed in collaboration with lab data ordered twice weekly)
   b. Moderate risk: 4-5 days
   c. Low risk: 7 days or as deemed appropriate at the last evaluation
   d. New physician order, or more often as deemed necessary by the RD
2. The reassessment will document the patient's response to care. At the time of reassessment, the dietitian may change nutritional risk level. This change of nutritional risk will be documented in the medical record.
3. Ongoing monitoring of patients occurs daily for indications of nutritional status changes. This is accomplished through monitoring the parenteral nutrition support census and diet census, as well as physician, nurse or diet aide referrals.

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **OPERATING ROOM CLEANING**	SECTION: **Page 1 of 4**

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

PURPOSE:

This document provides guidance on cleaning procedures, personnel education, competency verification, and monitoring cleanliness through performance improvement processes. All perioperative team members have a responsibility to provide a **clean** and safe environment for patients. Perioperative and environmental services leaders can cultivate an environment in which perioperative and environmental services personnel work collaboratively to accomplish cleanliness in a culture of safety and mutual support.

POLICY:

All employees will follow consistent cleaning, according to established routine.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR), MATERNAL CHILD HEALTH (MCH) OR, AMBULATORY SURGERY DEPARTMENT (ASD), CATH LAB, INTERVENTIONAL RADIOLOGY OR / ALL SCRUB PERSONNEL, CARDIAC CATH LAB PERSONNEL*

PROCEDURE:

1. Patients will be provided with a safe, clean environment, free from dust and organic debris.
   a. Performing terminal cleaning or closing the OR after a contaminated or dirty/infected procedure
   b. Furniture, surgical lights and equipment will be damp-dusted before the first scheduled procedure of the day. Damp dusting will be done with a clean, lint free material moistened with a hospital grade chemical germicide.
   c. Preparation of the surgical suites will include a visual inspection of the room for cleanliness before the case carts, supplies, and instrument sets are brought into the room.
   d. Operating and procedure rooms must be cleaned and disinfected after each patient procedure.

2. During the surgical procedure, activities will be directed to confine and contain contamination.
   a. Have an interdisciplinary team determine cleaning procedures and frequencies based on the type of surfaces and tasks to be performed
   b. Identify high-touch objects and surfaces to be cleaned and disinfected
   c. Determine the frequency and extent of cleaning required when areas are not occupied (eg, unused rooms, weekends
   d. Assign responsibility for cleaning perioperative areas and equipment to competent personne

e. Areas outside the sterile field, contaminated by organic debris, will be cleaned as contamination occurs.

f. Contaminated disposable items will be discarded into leak proof containers.

g. Items contaminated with potentially infectious waste will be handled using protective barriers.

h. All blood, body fluids and tissue specimens will be placed in a clean, leak proof container for transport.

i. All items that come in contact with the patient and/or sterile field during a procedure will be considered contaminated.

j. Disposable items will be disposed of according to policy and procedure of medical waste disposal.

k. Reusable items will be processed according to the established policy and procedure.

l. Disposable items contaminated with blood and body fluids are placed in closable, leak proof containers or red biohazard bags.

m. Gowns and gloves will be removed (inside out) and placed into the appropriate receptacle before leaving the surgical suite.

n. Contaminated linen will be handled as little as possible and with minimal agitation.

o. All disposable sharps will be placed in puncture resistant containers.

p. Contaminated instruments, basins, trays and other items shall be handled only by personnel wearing personal protective equipment/attire, until the items are decontaminated.

q. Disposable suction tubing and containers will be used.

r. After each surgical procedure, equipment and furniture used during the surgical procedure will be cleaned with tuberculocidal, hospital-grade chemical germicide.

s. Mechanical friction will be used while cleaning.

t. Patient transport vehicles will be cleaned with a hospital-grade disinfectant/detergent.

u. Floors will be cleaned using hospital-grade disinfectant/detergent.

3. At the conclusion of the day's schedule, operating rooms, scrub/utility areas, corridors, furnishings and equipment shall be terminally cleaned with mechanical friction and a hospital-grade disinfectant/detergent which will include:

   a. Surgical lights and tracks

   b. Fixed ceiling-mounted equipment

   c. All furniture, including wheels and casters

   d. Face plates of vents

   e. Horizontal surfaces (e.g., tops of counters, autoclaves, fixed shelving)

   f. Entire floor

   g. Scrub sinks

4. All of the following areas and equipment in the surgical area shall be cleaned on a routine scheduled basis:

   a. Air conditioning grills and/or filters

   b. Cabinets

   c. Shelves

   d. Walls

   e. Ceiling

   f. Offices

   g. Lounges

   h. Locker Rooms

   i. Flash sterilizer shall be cleaned by Central Processing Department personnel on a routinely scheduled basis.

5. Cleaning equipment shall be disassembled, cleaned with a hospital-grade disinfectant/detergent and dried before storage.

REFERENCE:

- AORN Standards and Recommended Practices (Jan 2020). Retrieved from https://aornguidelines.org/guidelines/content?sectionid=173715702&view=book#236401528

- The Joint Commission 2023. Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCE:

- Surgery Between Case Cleaning
- Surgery End of Day Terminal Cleaning

SUBJECT: **ORDERS- PHYSICIAN TELEPHONE / VERBAL**	SECTION: **Page 1 of 1**

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

PURPOSE:

To document all orders received by telephone/or verbally from the physician into Meditech.

POLICY:

It is the policy of this facility to obtain a signed order from the physician within 5 days from the time that the initial order was received by telephone or verbally.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RNs), LICENSED VOCATIONAL NURSES (LVNs)*

PROCEDURE:

1. When a telephone/verbal order is received by licensed staff, it is recorded into Meditech with date, time and using T.O.R.B. (Telephone Order Read Back) or V.O.R.B. (Verbal Order Read Back).

2. The order is then flagged to the physician to sign on Meditech.

3. The unit clerk maintains audits to monitor the timely signing of physician's orders with the ultimate responsibility for compliance.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20(a) United States of America, Med Pass Inc.

SUBJECT: **PM CARE**	SECTION: **Page 1 of 1**

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

PURPOSE:

The purpose is to prepare resident for the night by providing cleanliness and comfort.

POLICY:

It is the policy of this facility to provide P.M. care to each resident daily.

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

PROCEDURE:

1. Wash hands thoroughly/wear gloves. Explain procedure to the resident. Provide privacy.
2. Offer bed pan, urinal or take to the bathroom.
3. Assist residents in areas of oral hygiene, care of dentures and peri-care (CHANGE GLOVES & WASH HANDS WITH EACH ACTIVITY OF DAILY LIVING (ADL) DONE).
4. Assist residents to undress and put on night clothes.
5. Assist residents to bed, make comfortable, and utilize any positioning devices needed according to the plan of care.
6. Offer fluids if indicated or as prescribed.
7. Apply postural support if indicated.
8. Position side rails as indicated in the plan of care.
9. Place call lights within easy reach of resident.

DOCUMENTATION:

1. Report and document any unusual observations.
2. Document care given on nurse assistant flow sheet in the EMR.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, § 72315 (d), San Francisco, California, Title 22. Register 2022, No.23

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

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

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.

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: **TRANSFER, INTERFACILITY RESIDENT**	SECTION:

PURPOSE:

Interfacility transfer planning provides for continuity of care when a resident is transferred to acute or another health care facility. To ensure continuity of nursing care when a resident is transferred to a new health care facility, discharge planning forms are completed to assess and communicate resident's needs.

POLICY:

It is the policy of this facility that:

- Residents may be transferred only with a physician's order.
- The resident family, responsible party, or public agency must be notified of transfer.
- A completed Interfacility transfer form, medication reconciliation list and other pertinent information must accompany resident on transfer to an acute health care area.
- A completed Post Discharge Plan of Care form must accompany the resident on transfer to a long-term care health facility or when discharged to home.
- Call the receiving facility or acute floor prior to transfer in order to inform the facility of resident's immediate needs.
- Only personal items should be sent with the resident when transferred to an acute care facility. Clothing and other articles should be reconciled with the Personal Inventory List and the belongings secured until the resident returns or until claimed by the resident/family/responsible party.

AFFECTED PERSONNEL/AREAS:

ALL

PROCEDURE:

1. Obtain physician order for transfer.
2. Notify resident/family of impending transfer.
3. For transfer to an acute health care facility, initiate the Interfacility Transfer Form and complete. Include diagnosis, prognosis, rehabilitation potential, allergies and current significant findings with complete vital signs. Copies of physician orders and medical record face sheet should accompany transfer form but these do not replace information which must be documented on transfer form.

4. For transfer to a long-term health care facility, the Interdisciplinary Team will initiate and complete the interdisciplinary Discharge Planning Assessment and Post Discharge Plan of Care. Copies of physician orders and medical record face sheet should accompany the Post Discharge Plan of Care Summary, but these do not replace information which must be documented on the discharge form (see Discharge Planning Policy).

5. When resident is transferred, maintain a copy of the Interfacility Transfer Form, Discharge Planning Assessment and Post Discharge Plan of Care in the resident's medical record.

6. Notify the Business Office, Housekeeping, and Dietary Departments.

DOCUMENTATION:

Nursing notes must include the following discharge information:

1. Date and time of resident transfer or discharge.

2. Date and time of persons notified, including responsible parties and/or public agency.

3. Condition of resident when transferred.

4. How resident was transferred and by whom.

5. Disposition of the resident's itemized personal belongings.

REFERENCE:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72519, San Francisco, California, Title 22. Retrieved from : https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.12 United States of America, Med Pass Inc.

SUBJECT:	SECTION:
TUBE FEEDING	**Page 1 of 3**

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

PURPOSE:

To standardize enteral feeding administration and promote patient safety while receiving enteral feeding.

POLICY:

Enteral feeding products will be ordered, received, and stored by the Food and Nutrition Services Department. Any damaged products will be disposed and customer service will be notified.

1. Enteral feeding containers will be rotated using first in, first out (FIFO).

2. Tube Feedings (enteral feedings) are handled and administered using methods that minimize the risk of contamination of the feeding. Formulas are purchased from approved vendors and closed system feedings are used as part of Hazard Analysis Critical Control Point (HACCP) procedures per Enteral Formulary endorsed by Pharmacy and Therapeutics Committee. Modular nutrient components, food grade coloring, medications or water (formula dilution) are not added to enteral formula containers. Full strength formulas are used.

3. Modality:

    a. Continuous Feeding: Pump-assisted continuous drip infusion.

    b. Cyclic Feeding: Pump or gravity drip over a time period that is less than 24 hours. Nocturnal feeding is a form of cyclic feeding.

    c. Intermittent Feeding: Feeding by pump or gravity drip, administered in a timeframe ranging from 20-60 minutes, provided anywhere from 4-6 times per day.

    d. Bolus Feeding: Providing a set volume of formula at specified times over a very short period of time. A typical feeding regimen might provide 240 mL of formula over a 4 to 10 minute timeframe, with infusions 3-6 times per day. Bolus feedings typically mimic normal meal patterns.

4. Open vs Closed Systems:

    a. Closed System: Ready to hang sterile closed system formulas can hang up to 48 hours per manufacturer's guidelines. If more than one feeding set is used or if more than one RTH container is used with a single feeding set, the maximum safe hang time is 24 hours.

    b. Open System (sterile decanted formula) are limited to a hang time of (8) eight hours. Reconstituted powder formula is limited to a hang time of (4) four hours. Administration sets, and feeding bag, for open system enteral feedings should be changed at least every 24 hours.

5. Formulas reconstituted in advance should be immediately refrigerated and discarded within 24 hours of preparation if not used. Formulas should be exposed to room temperature for no longer than 4

hours after which they should be discarded. Use purified water or sterile water for irrigation supply and formula reconstitution.

6. Orders for non-formulary products are substituted per protocol as approved by Pharmacy and Therapeutics Committee. If there is no equivalent formulary product, or "no substitution" is indicated by the ordering physician, the product will be special ordered, if able. Expired formulas are not used.

7. ICU Standard of Care order set: Please see electronic orders for TF regimen

8. Critical Care Area Guidelines for gastric residuals:
   Gastric residual volume (GRV) will be checked once per shift
   If < 500ml with **no** evidence of intolerance, continue infusion
   If > 500ml with symptoms of intolerance, replace 250ml of aspirate, continue infusion, and consult physician for prokinetic agent
   If ≥ 500ml or evidence of intolerance, hold tube feeding, return 250ml GRV and discard remaining volume, consult physician and recheck GRV after 2 hrs, if < 500ml restart feeds. Consult physician to consider post pyloric feeding tube.

9. Non-Critical Care Area Guidelines for gastric residuals:
   Gastric residual volume (GRV) will be checked once per shift
   If <250ml, then return residual, continue infusion
   If >250ml **and** symptoms of intolerance are present (abdominal distention, nausea, vomiting, diarrhea) hold feeding and notify MD. Return up to 250ml GRV
   If >250ml **without symptoms** of intolerance, return up to 250ml GRV, continue feeding and recheck in 2 hrs. If still greater than 250ml, hold feeding and notify MD

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

PROCEDURE:

1. Food and Nutrition Services is notified of any patient/resident on enteral feeding via the electronic medical record as a Diet order, in the Dietary Special Needs category.

2. Nursing will order an enteral pump and tubing set from Distribution.

3. The enteral tube feeding order should specify the modality, feeding rate or amount per feeding, total number of feedings per (24) hours and water flushes. Food and Nutrition Services supplies the enteral products. The dietitian must be consulted for all enteral feeding orders.

4. Any pouring or mixing of a powdered product is done by Nursing or Nutrition Services according to the product label. Any mixed product is immediately placed in the delivery container in a quantity that would limit hang time to four hours. The formula should be labeled with the patient's/resident's name, room number, date, time, formula, #ml per hour, and strength.

5. All tube feedings are administered using clean technique.

6. Tube feedings should be started as per the physician's order. The rate should be increased to goal rate over the next 24 - 48 hours as tolerated.

7. DPSNF: The dietitian is responsible for completing a nutrition assessment on the patient/resident within 72 hours of the tube feeding initiation. Recommendations regarding the appropriateness of the product, volume, calories, protein, fluid needs, and percentage of the Dietary References Intake (DRI) for all vitamins and minerals will be addressed.

   Drug-Nutrient Interactions: All patients shall be monitored for potential drug-food interactions. Dietitians will calculate accordingly and change to bolus feeds if necessary. *Refer to policy: "Drug Nutrient Interaction and Enteral Tube Feeding Interaction."*

8. Cranberry juice and/or soda shall not be used to unclog a feeding tube. To unclog a tube, use warm water, or crushed sodium bicarbonate 325 mg tablets or crushed pancrease MT 10.

CROSS REFERENCES:

- DRUG/NUTRIENT INTERACTIONS AND ENTERAL TUBE FEEDING DRUG/NUTRIENT INTERACTION

REFERENCES:

- **Krames on Demand: Gastroenterology ->Tube Feeding**
- CIHQ Acute care Accreditation, Nutrition Assessment and Care Plans (2023) California Department of Public Health, Retrieved from https://www.cdph.ca.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- American Society of Enteral/Parenteral Nutrition (ASPEN) Guidelines for the Provision and Assessment of Nutrition 2016
- 2019 Abbott Nutrition Best Practice for Managing Tube Feeding, A Nurse's Pocket Manual
- American Society of Enteral and Parenteral Nutrition (ASPEN) Critical Care Guidelines 2021
- The ASPEN Adult Nutrition Support Curriculum 3rd ed. 2017
- ASPEN 2014 Gastric Residual Volume in Critically Ill Patients: A Dead Marker or Still Alive?

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MINUTES OF A REGULAR MEETING OF THE BOARD OF DIRECTORS OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly **December 17, 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 5:02 p.m.

Directors Present: **REDDY, LOMELI, MARTINEZ, PANDYA**

Others Present: Donna Hefner, President/Chief Executive Officer, Melissa Mitchell, VP of Quality and Regulatory Affairs, Craig McDonald, Chief Financial Officer, Jeffery Hudson, VPPCS/CNO/DIO, Ron Wheaton, VP of Professional Service, Tracy Canales, VP of Human Resources and Marketing, Terry Villareal, Executive Assistant and Clerk to the Board, Malynda Parsons, Senior Marketing and Community Relations Specialist, Cindy Gomez, Compliance Privacy Officer, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

Chairman REDDY motioned to approve the Agenda. The motion was moved by Vice Chairman LOMELI, seconded by, Director PANDYA and carried to approve the agenda. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:04 p.m. to discuss the following items:

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update – Quality Report

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (2 Item). Estimated date of Disclosure: January 1, 2026

D. 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).

III. Open Session: Chairman REDDY adjourned Closed Session at 5:35 p.m., reconvening in Open Session at 5:35 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report provided by Chief of Staff Sandhu.
Information Only; No Action Taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ and carried to approve the Evaluation – Quality of Care/Peer Review/Credentials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

2. Quality Division Update – Quality Report

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ, and carried to approve the Quality Division Update – Quality Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

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

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

IV. Public Comments

None

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). It was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ, and carried to approve the Consent Agenda. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director MARTINEZ and seconded by Vice Chairman LOMELI to approve the November 26, 2024 Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

VII. Business Items

A. November 2024 Financials

Craig McDonald, CFO presented the Financials for November 2024. A copy of this presentation is attached to the file copy of these minutes.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve the November 2024 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

B. Annual Nursing Report

Jeff Hudson, VP of Patient Care Services and Chief Nurse Executive presented the annual nursing report. Following review and discussion, it was moved by Vice

Chairman LOMELI, seconded by Director PANDYA and carried to approve the Annual Nursing Report as presented. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes

C. Retirement Planning Advisory Committee Report

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve the Retirement Planning Advisory Report as presented. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes

D. Resolution 12.17.24/01 Escrow of Westwood Property

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve the resolution ratifying the sale of the Westwood property to the Burton School District. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes

E. Board Seat Vacancy – Zone 3; Appointment of New Director by the January 28, 2025 Regular Board Meeting.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve leaderships plan to obtain applicants to fill the vacancy by the January 28, 2025 Regular Meeting. The Vote of the board is as follows:

REDDY Yes
LOMELI Yes
MARTINEZ Yes
PANDYA Yes

F. Election of Officers – Board Organization

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ and carried to approve Liberty Lomeli as Chairman of the Board. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

Following review and discussion, it was moved by Chair LOMELI, seconded by Director MARTINEZ and carried to approve Bindusagar Reddy as Vice Chairman of the Board. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

Following review and discussion, it was moved by Chair LOMELI, seconded by Director PANDYA and carried to approve that Areli Martinez continue to be Secretary of the Board. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

G. Appointment of CFO as Treasurer of the Board; Resolution No. 12-17-2024/02

Following review and discussion, it was moved by Chair LOMELI, seconded by Director MARTINEZ and carried to approve Craig McDonald, CFO, as the Treasurer of the Board by Resolution No. 12-17-2024/02. The Vote of the board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes

VIII. CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View.

IX. Announcements:

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

XII. Adjournment

The meeting was adjourned at 6:17 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

MINUTES OF A SPECIAL MEETING OF THE BOARD OF DIRECTORS OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The special meeting of the Board of Directors of Sierra View Local Health Care District was held **January 20, 2025 at 1:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California.

Directors Present: LOMELI, MARTINEZ, REDDY
Director Recused: PANDYA

Others Present: Donna Hefner, President/Chief Executive Officer, Melissa Mitchell, VP of Quality and Regulatory Affairs, Terry Villareal, Executive Assistant and Clerk to the Board, Harpreet Sandhu, Chief of Staff, Jennifer Hansen, Legal Counsel, David Balfour, Legal Counsel.

I. Call to Order: Chairman LOMELI called the meeting to order at 1:18 p.m.

II. Approval of Agendas: Chairman LOMELI asked for approval of the agenda. It was moved by Director MARTINEZ and seconded by Vice Chairman REDDY and carried to approve the agenda as presented. The vote of the Board is as follows:

LOMELI Yes
REDDY Yes
MARTINEZ Yes

III. Closed Session: Board adjourned Open Session and went into Closed Session at 1:19 p.m. to discuss the following items:

A. Pursuant to Gov. Code Section 54956.9: Conference with Legal Counsel Regarding Threatened Litigation

IV. Open Session: Board adjourned Closed Session at 2:12 p.m. and went into Open Session at 2:12 p.m. to discuss the following items:

A. Pursuant to Gov. Code Section 54956.9: Conference with Legal Counsel Regarding Threatened Litigation

Action Item
Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Director MARTINEZ, that the Board and Medical Executive Committee (MEC) jointly approve the plan of correction as discussed. The vote of the Board is as follow:

LOMELI Yes
REDDY Yes
MARTINEZ Yes

V. Public Comments
None.

XIII. Announcements:

A. Regular Board of Directors Meeting – January 28, 2025

Adjournment: There being no further business, the meeting was adjourned at 2:14 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors
AM: trv

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Outlook

SVLHCD Board of Directors Application

From noreply@formstack.com <noreply@formstack.com>
Date Wed 1/22/2025 8:13 AM
To Marketing Department <marketing@sierra-view.com>; Terry Villareal <tvillareal@sierra-view.com>

Formstack Logo

Formstack Submission For: 2025 SVLHCD Application

Submitted at 01/22/25 11:13 AM

Candidate Name:	Christopher Peterson
Contact Phone Number:	[redacted]
Cell Number:	[redacted]
Email:	[redacted]
Address in District 3:	[redacted] Porterville, CA 93257
Please describe your relevant experience and/or employment. :	I have worked as an I.T. specialist and consultant in the area for over 25 years, and made the transition to owning my own business. I have helped businesses to grow, and to see problems from a different perspective. Whether it is problem solving, or planning for the future, I am able to be part of the solution.
Please describe the area(s) of expertise/contribution you feel you can make to	Having a strong base in technology, I feel that my experience in the field can help with the growth and future of the hospital and its outreach. My years of experience in working with others to find solutions has made me a strong listener, and purpose driven

further the mission of SVLHCD.:	in my actions. Growing up in this community, I have experience with the hospital as a patient, and those moments help to provide a basis on what our community needs from our hospital. I can be part of the process to make our healthcare, and therefore, our community better.
Why are you interested in serving as a Board member for SVLHCD?:	It is necessary to have someone on the Board that is outside of direct healthcare. I have some experience in working with healthcare providers, but I have more experience of being a healthcare patient, or caregiver. Having taken care of my parents as their health failed and they tried to navigate the healthcare system in their final days, I know what my family experienced, and to a degree what the public needs out of our healthcare system. I'm invested in this community. Raising a family here has made me aware of what my family needs in healthcare. I'd like to be a part of making sure that happens for our community.
Resume:	

SVLHCD BOARD OF DIRECTORS APPLICATION

Thank you for your interest in joining the Sierra View Local Health Care District Board. Use this form to provide useful information about yourself, to ensure the best match between you and the district.

Candidate Name: Hans Kashyap

Contact Phone Number: _____ Cell number: [redacted]

Home Address: [redacted], Porterville, CA 93257

E-mail address (please write it carefully): [redacted]

Please describe your relevant experience and/or employment. You may also attach a resume.

Board of Directors, Sierra View Medical Center (2022-2024)
Chair, Ad Hoc Operational Efficiency , BOD--SVMC (2022--2023)
Non-Linear Forecasting, Strategic Planning, Economic Analysis,
C-Suite Experience, Management & Financial Analysis

Please describe the area(s) of expertise/contribution you feel you can make to further the mission of SVLHCD:

Improving Operational Efficiencies, Streamlining Ops, Finance, Investments,
Accurate Forecasts, Trade-Off Analysis, Management Consulting

Why are you interested in serving as a Board member for SVLHCD?:

In Pursuit of helping SVMC to be recognized as a First Choice hospital in
the Central Valley, where patients know they will be treated with courtesy,
and competence, with low wait times, and to help SVMC maintain a solid
financial foundation to serve residents of Porterville for decades to come.

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SIERRA VIEW MEDICAL CENTER

Appointment of Food and Dietetic Services Director
2025

In compliance with CMS A-0620, Section 482.28(a) (1), Zaelin Stringham is hereby appointed to the position of *Food and Dietetic Services Director* by the Board of Directors and President/CEO of Sierra View Local Health Care District dba Sierra View Medical Center for 2023.

Zaelin Stringham, MS, RD, is a full-time employee who has worked in the field of Food and Nutrition for eight plus years, Ms. Stringham holds a Master's Degree in Nutrition and Dietetics, is a Registered Dietetian, certified by the Commission on Dietetic Registration holds a national certification as a ServSafe Food Protection Manager, and ServSafe Instructor and Proctor. Ms. Stringham is granted the authority and delegated responsibility by the Sierra View Local Health Care District Board of Directors for the operation of the Food and Dietetic Services Department.

Authority:

The Food and Dietetic Services Director has the authority and responsibility for daily management of dietary services, implementing training programs for dietary staff and ensuring that established policies and procedures are maintained to address at least the following:

Responsibility:

The Director of Food & Nutrition Service will:

- Ensure appropriate safety practices for food handling;
- Ensure appropriate emergency food supplies;
- Ensure department orientation, work assignments, supervision of work and personnel performance;
- Ensure menu planning, purchasing of foods and supplies, and retention of essential records (e.g. cost, menus, personnel, training records, Quality Assurance/Performance Improvement – QA/PI Reports, etc.); and,
- Chair the Food and Nutrition Service Department QA/PI Program.

_____ _____

President/CEO Date Chairman of the Board Date

SIERRA VIEW MEDICAL CENTER

Appointment of Environmental Safety/Security Officer
2025

Mr. Gary Wilbur has been appointed to the position of *Environmental Safety/Security Officer* by the Board of Directors and President/CEO of Sierra View Local Health Care District.

Qualifications:

Mr. Gary Wilbur has over five (25) years of experience in the field of; Fire Protection, Installation and maintenance of Security Systems, Telecommunication Engineering, and Facility Project Management. In addition, he has installed Fire Alarm Systems and Surveillance Cameras.

Mr. Wilbur has participated in Facility Master Plan design. Furthermore he has, and currently serves as Director of our IT and Project Management departments. He has immense knowledge of the facility plant and its infrastructure.

Mr. Wilbur is a member of:
National Fire Protection Agency
Project Management Institute

Mr. Wilbur has certifications from:
California State Fire Marshall
Fire Protection Agency
Governor's Office of Emergency Services
California Specialized Training Institute for HAZMAT Awareness
Global Information Assurance Certification

Authority:

The Environmental Safety/Security Officer, through the Environmental Safety Committee, has the authority to intervene whenever conditions exist that pose an immediate threat to life, health or pose an immediate threat of damage to equipment, buildings and assets.

Responsibility:

The Environmental Safety/Security Officer will:

- Chair the Environmental Safety Committee Meetings;
- Participate in and oversee hazard surveillance and reporting of the findings to the Environmental Safety Committee, and will ensure that any problems identified are effectively corrected and reported to the Environmental Safety Committee;
- Participate in the Safety Education Orientation Program for new employees and continuing education for all employees, physicians and volunteers;
- Monitor, evaluate and oversee the Hazardous Materials and Hazardous Waste Management Program and Hazard Communication Program;
- Implement and enforce the physical Security Plan and Program, and report on Security Program actions and incident occurrence findings at least quarterly to the Environmental Safety Committee;

- Will assist in the development, implementation and continued assessment of the facility's Emergency Management Program and Emergency Operation Plan in conjunction with the Environmental Safety Committee;
- Will be responsible for the Life Safety Management Program, and report monthly fire drill and quarterly fire alarm system testing analysis to the Environmental Safety Committee;
- Will be responsible for reviewing Incident Reports in conjunction with Risk Management and Employee Health when applicable;
- Ensure that findings generated from the Environmental Safety Committee's Program activities are communicated at least quarterly to the Performance Improvement Council, Hospital Leadership, Medical Staff, CEO and the Board of Directors;
- Participate in the development of organization-wide Safety, Emergency Operations and Environment of Care policies and procedures, in addition to department specific safety policies and procedures; and
- Develop and provide annual evaluations of the effectiveness for all Environment of Care programs to the Environmental Safety Committee, CEO and the Board of Directors.

_____		_____	
President/CEO	Date	Chairman of the Board	Date

SIERRA VIEW MEDICAL CENTER

Appointment of Patient Safety Officer
2025

Melissa Crippen, DHA, LCSW, CCM, CPHQ, Vice President of Quality and Regulatory Affairs has been appointed to the position of *Patient Safety Officer* by the Board of Directors and President/CEO of Sierra View Local Health Care District.

Qualifications:

Ms. Melissa Crippen has over 19 years of experience in the healthcare field, in a variety of settings. Within that time she has experience working in the Emergency Room in a level 1 Trauma/Burn facility, substance abuse treatment, and mental health assessment and intervention. Ms. Mitchell is currently the VP of Quality and Regulatory Affairs and is the executive sponsor of the Beta Heart initiative – focused on reducing medical harm.

Authority:

The Patient Safety Officer, through the Patient Safety Committee, has the authority to intervene whenever conditions exist that pose a threat to patient safety.

Responsibility:

The Patient Safety Officer will:

- Integrate a patient safety program throughout the organization that provides oversight, ensures alignment of patient safety activities and provides opportunities for all individuals who work in the organization to be educated and participate in patient safety and quality initiatives;
- Serve as the primary point of contact for questions about patient safety and who coordinates patient safety for education and the deployment of system changes;
- Foster a just culture environment in which frontline personnel feel comfortable in disclosing errors, including their own, while maintaining professional accountability;
- Participate in and oversee the patient occurrence reporting function and ensure that identified patient safety issues are effectively corrected and reported to the Patient Safety Committee, MEC and Board of Directors;
- Co-Chair the interdisciplinary Patient Safety Committee Meetings whose focus is to create, implement and administer mechanisms to oversee root cause analysis of every appropriate incident;
- Provide feedback to frontline staff about lessons learned, disclose the organization's progress toward implementing safe practices and provide professional training and teamwork techniques;
- Assist in the development, implementation and continued assessment of the facility's Risk Management Plan and Patient Safety Plan; and
- Maintain compliance with reporting of Adverse Events to the appropriate external mandatory programs.

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President/CEO Date Chairman of the Board Date

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FINANCIAL PACKAGE
December 2024

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
December 2024

Statistic	Dec-24 Actual	Budget	Over/ (Under)	% Var.	YTD Actual	Budget	Over/ (Under)	% Var.	Fiscal 24 YTD	Increase/ (Decrease) 12/2023	% Change
Utilization											
SNF Patient Days											
Total	-	56	(56)	-100.0%	127	338	(211)	-62.4%	391	(264)	-67.5%
Medi-Cal	-	56	(56)	-100.0%	127	336	(209)	-62.2%	391	(264)	-67.5%
Sub-Acute Patient Days											
Total	1,008	970	38	4.0%	6,107	5,818	289	5.0%	5,804	303	5.2%
Medi-Cal	488	877	(389)	-44.4%	3,078	4,899	(1,821)	-37.2%	4,894	(1,816)	-37.1%
Acute Patient Days	1,778	1,648	130	7.9%	9,760	9,886	(126)	-1.3%	10,045	(285)	-2.8%
Acute Discharges	442	427	15	3.6%	2,633	2,561	72	2.8%	2,589	44	1.7%
Medicare	178	163	15	9.0%	1,026	976	50	5.1%	986	40	4.1%
Medi-Cal	208	223	(15)	-6.8%	1,256	1,277	(21)	-1.7%	1,291	(35)	-2.7%
Contract	55	39	16	39.8%	335	287	48	16.7%	291	44	15.1%
Other	1	1	-	0.0%	16	21	(5)	-22.2%	21	(5)	-23.8%
Average Length of Stay	4.02	3.86	0.16	4.2%	3.71	3.86	(0.15)	-4.0%	3.88	(0.17)	-4.5%
Newborn Patient Days											
Medi-Cal	155	161	(6)	-3.7%	918	958	(40)	-4.1%	1,078	(160)	-14.8%
Other	34	31	3	9.7%	225	195	30	15.2%	175	50	28.6%
Total	189	192	(3)	-1.6%	1,143	1,153	(10)	-0.9%	1,253	(110)	-8.8%
Total Deliveries	102	99	3	3.0%	597	594	3	0.5%	623	(26)	-4.2%
Medi-Cal %	83.33%	83.43%	-0.10%	-0.1%	81.27%	83.43%	-2.16%	-2.6%	85.05%	-3.78%	-4.4%
Case Mix Index											
Medicare	1.6393	1.6368	0.0025	0.2%	1.6279	1.6368	(0.0089)	-0.5%	1.5724	0.0555	3.5%
Medi-Cal	1.2589	1.1975	0.0614	5.1%	1.1948	1.1975	(0.0027)	-0.2%	1.1874	0.0074	0.6%
Overall	1.4001	1.3724	0.0277	2.0%	1.3658	1.3724	(0.0066)	-0.5%	1.3451	0.0207	1.5%
Ancillary Services											
Inpatient											
Surgery Minutes	7,116	8,224	(1,108)	-13.5%	45,703	49,344	(3,640)	-7.4%	50,628	(4,925)	-9.7%
Surgery Cases	93	94	(1)	-0.8%	548	563	(15)	-2.6%	570	(22)	-3.9%
Imaging Procedures	1,536	1,404	132	9.4%	8,887	8,426	462	5.5%	8,317	570	6.9%
Outpatient											
Surgery Minutes	14,561	12,775	1,786	14.0%	81,979	76,651	5,329	7.0%	72,769	9,210	12.7%
Surgery Cases	196	204	(8)	-3.8%	1,133	1,223	(90)	-7.3%	1,204	(71)	-5.9%
Endoscopy Procedures	166	192	(26)	-13.3%	1,057	1,149	(92)	-8.0%	1,125	(68)	-6.0%
Imaging Procedures	3,982	3,886	96	2.5%	24,282	23,315	968	4.1%	23,061	1,221	5.3%
MRI Procedures	284	302	(18)	-5.9%	1,785	1,810	(25)	-1.4%	1,784	1	0.1%
CT Procedures	1,229	1,237	(8)	-0.6%	7,457	7,422	36	0.5%	7,544	(87)	-1.2%
Ultrasound Procedures	1,281	1,244	37	3.0%	7,831	7,462	369	4.9%	7,320	511	7.0%
Lab Tests	28,994	32,140	(3,146)	-9.8%	184,953	192,841	(7,888)	-4.1%	188,307	(3,354)	-1.8%
Dialysis	5	6	(1)	-21.1%	20	38	(18)	-47.4%	23	(3)	-13.0%

Sierra View Medical Center
Financial Statistics Summary Report
December 2024

Statistic	Dec-24 Actual	Dec-24 Budget	Dec-24 Over/ (Under)	Dec-24 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 24 YTD	Increase/ (Decrease) 12/2023	% Change
Cancer Treatment Center											
Chemo Treatments	1,506	1,924	(418)	-21.7%	11,671	11,543	129	1.1%	9,292	2,379	25.6%
Radiation Treatments	1,428	1,836	(408)	-22.2%	11,460	11,015	446	4.0%	10,155	1,305	12.9%
Cardiac Cath Lab											
Cath Lab IP Procedures	10	11	(1)	-11.1%	67	68	(1)	-0.7%	71	(4)	-5.6%
Cath Lab OP Procedures	38	30	8	27.0%	210	180	31	17.0%	184	26	14.1%
Total Cardiac Cath Lab	48	41	7	16.6%	277	247	30	12.1%	255	22	8.6%
Outpatient Visits											
Emergency	3,609	3,415	194	5.7%	20,624	20,488	137	0.7%	20,885	(261)	-1.2%
Total Outpatient	13,408	13,994	(586)	-4.2%	82,895	83,966	(1,071)	-1.3%	78,828	4,067	5.2%
Staffing											
Paid FTE's	869.01	855.00	14.01	1.6%	872.18	855.00	17.18	2.0%	852.47	19.71	2.3%
Productive FTE's	739.02	734.21	4.81	0.7%	743.40	734.21	9.19	1.3%	732.34	11.06	1.5%
Paid FTE's/AOB	5.02	4.98	0.04	0.8%	5.17	4.93	0.24	4.9%	5.04	0.13	2.7%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,136	10,552	584	5.5%	11,168	10,552	616	5.8%	10,580	588	5.6%
Cost/Adj.Patient Day	2,881	2,627	254	9.7%	2,770	2,635	136	5.1%	2,626	144	5.5%
Revenue/Adj. Discharge	57,109	53,065	4,043	7.6%	54,331	53,065	1,266	2.4%	53,220	1,111	2.1%
Cost/Adj. Discharge	14,772	13,210	1,562	11.8%	13,476	13,250	227	1.7%	13,212	264	2.0%
Adj. Discharge	1,046	1,057	(12)	-1.1%	6,378	6,345	34	0.5%	6,190	189	3.0%
Net Op. Gain/(Loss) %	-7.28%	-4.63%	-2.65%	57.1%	-3.71%	-4.63%	0.92%	-19.8%	-6.06%	2.35%	-38.7%
Net Op. Gain/(Loss) $	(1,047,935)	(618,584)	(429,351)	69.4%	(3,078,211)	(3,962,362)	884,151	-22.3%	(4,672,290)	1,594,079	-34.1%
Gross Days in Accts Rec.	85.27	95.03	(9.76)	-10.3%	85.27	95.03	(9.76)	-10.3%	98.30	(13.03)	-13.3%
Net Days in Accts. Rec.	41.43	57.75	(16.32)	-28.3%	41.43	57.75	(16.32)	-28.3%	61.32	(19.89)	-32.4%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	DEC 2024	NOV 2024
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 13,026,237	$ 12,494,173
SHORT-TERM INVESTMENTS	0	66,902
ASSETS LIMITED AS TO USE	3,292,615	2,818,039
PATIENT ACCOUNTS RECEIVABLE	162,112,303	155,674,625
LESS UNCOLLECTIBLES	(15,489,450)	(17,505,315)
CONTRACTUAL ALLOWANCES	(128,241,181)	(119,289,769)
OTHER RECEIVABLES	27,955,672	27,588,631
INVENTORIES	4,441,080	4,409,275
PREPAID EXPENSES AND DEPOSITS	3,164,140	3,027,887
LEASE RECEIVABLE - CURRENT	339,208	339,208
TOTAL CURRENT ASSETS	70,600,624	69,623,656
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	31,745,341	31,655,530
LONG-TERM INVESTMENTS	135,485,326	135,029,761
PROPERTY, PLANT AND EQUIPMENT, NET	72,973,020	74,694,438
INTANGIBLE RIGHT OF USE ASSETS	351,323	363,334
SBITA RIGHT OF USE ASSETS	2,209,745	2,120,919
LEASE RECEIVABLE - LT	970,383	999,344
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,384,655	1,405,634
TOTAL ASSETS	$ 315,970,416	$ 316,142,615

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	DEC 2024	NOV 2024
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 693,525	$ 577,938
CURRENT MATURITIES OF BONDS PAYABLE	4,235,000	4,235,000
CURRENT MATURITIES OF LONG TERM DEBT	1,635,911	1,720,304
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	4,817,040	5,501,316
ACCRUED PAYROLL AND RELATED COSTS	6,597,959	7,877,089
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,434,136	3,464,136
LEASE LIABILITY - CURRENT	140,323	141,812
SBITA LIABILITY - CURRENT	1,085,400	1,011,087
TOTAL CURRENT LIABILITIES	22,639,294	24,528,682
SELF-INSURANCE RESERVES	2,165,227	2,208,572
BONDS PAYABLE, LESS CURR REQT	33,275,000	33,275,000
BOND PREMIUM LIABILITY - LT	2,390,319	2,442,276
LEASE LIABILITY - LT	234,141	244,441
SBITA LIABILITY - LT	1,306,610	1,295,748
DEFERRED INFLOW - LEASES	1,237,162	1,266,518
TOTAL LIABILITIES	63,247,753	65,261,236
UNRESTRICTED FUND	248,385,511	248,385,511
PROFIT OR (LOSS)	4,337,152	2,495,868
TOTAL LIABILITIES AND FUND BALANCE	$ 315,970,416	$ 316,142,615

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

DEC 2024 ACTUAL	DEC 2024 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,872,585	5,253,784	(618,801)	12%	INPATIENT - NURSING	32,141,188	31,522,704	(618,484)	2%
19,540,863	17,396,289	(2,144,574)	12%	INPATIENT - ANCILLARY	111,319,676	104,377,740	(6,941,936)	7%
25,413,448	22,650,073	(2,763,375)	12%	TOTAL INPATIENT REVENUE	143,460,864	135,900,444	(7,560,420)	6%
34,294,917	33,463,072	(831,845)	3%	OUTPATIENT - ANCILLARY	203,085,980	200,778,430	(2,307,550)	1%
59,708,366	56,113,145	(3,595,221)	6%	TOTAL PATIENT REVENUE	346,546,843	336,678,874	(9,867,969)	3%
				DEDUCTIONS FROM REVENUE				
(19,185,067)	(18,243,309)	941,758	5%	MEDICARE	(103,989,943)	(109,459,854)	(5,469,911)	(5)%
(18,084,570)	(18,032,202)	52,368	0%	MEDI-CAL	(105,709,077)	(108,193,212)	(2,484,135)	(2)%
(8,330,751)	(6,660,852)	1,669,899	25%	OTHER/CHARITY	(43,609,320)	(39,965,112)	3,644,208	9%
4,182,920	(9,556)	(4,192,476)	(43,873)%	DISCOUNTS & ALLOWANCES	(13,509,226)	(57,336)	13,451,890	23,462%
(4,511,363)	(499,610)	4,011,753	803%	BAD DEBTS	(249,010)	(2,997,660)	(2,748,650)	(92)%
(45,928,832)	(43,445,529)	2,483,303	6%	TOTAL DEDUCTIONS	(267,066,575)	(260,673,174)	6,393,401	3%
13,779,533	12,667,616	(1,111,917)	9%	NET SERVICE REVENUE	79,480,268	76,005,700	(3,474,568)	5%
617,013	682,482	65,469	(10)%	OTHER OPERATING REVENUE	3,399,231	4,094,892	695,661	(17)%
14,396,546	13,350,098	(1,046,448)	8%	TOTAL OPERATING REVENUE	82,879,499	80,100,592	(2,778,907)	4%
				***** OPERATING EXPENSE *****				
5,732,205	5,580,837	151,368	3%	SALARIES	33,890,809	33,291,512	599,297	2%
717,744	681,782	35,962	5%	S&W PTO	3,718,879	4,059,756	(340,877)	(8)%
1,648,974	1,441,323	207,651	14%	EMPLOYEE BENEFITS	8,885,212	8,757,047	128,165	2%
1,951,416	1,400,469	550,947	39%	PROFESSIONAL FEES	9,812,892	8,519,469	1,293,423	15%
915,048	821,975	93,073	11%	PURCHASED SERVICES	5,011,406	5,003,865	7,541	0%
2,403,511	2,028,102	375,409	19%	SUPPLIES & EXPENSES	12,518,137	12,187,200	330,937	3%
299,275	267,296	31,979	12%	MAINTENANCE & REPAIRS	1,608,095	1,647,044	(38,949)	(2)%
116,251	277,064	(160,813)	(58)%	UTILITIES	1,687,598	1,662,384	25,214	2%
39,646	19,605	20,041	102%	RENT/LEASE	204,034	117,626	86,408	74%
120,245	121,228	(983)	(1)%	INSURANCE	724,666	727,368	(2,702)	0%
956,087	1,003,034	(46,947)	(5)%	DEPRECIATION/AMORTIZATION	5,754,793	6,135,479	(380,686)	(6)%
367,949	325,967	41,982	13%	OTHER EXPENSE	1,965,058	1,954,204	10,854	1%
176,131	0	176,131		IMPAIRED COSTS	176,131	0	176,131	
15,444,481	13,968,682	1,475,799	11%	TOTAL OPERATING EXPENSE	85,957,710	84,062,954	1,894,756	2%
(1,047,935)	(618,584)	429,351	69%	NET GAIN/(LOSS) FROM OPERATIONS	(3,078,211)	(3,962,362)	(884,152)	(22)%
138,253	138,253	0	0%	DISTRICT TAXES	829,518	829,518	0	0%
387,913	343,454	(44,459)	13%	INVESTMENTS INCOME	2,321,857	2,060,726	(261,131)	13%
2,334,493	54,011	(2,280,482)	4,222%	OTHER NON OPERATING INCOME	2,589,585	324,063	(2,265,522)	699%
(77,102)	(80,573)	(3,471)	(4)%	INTEREST EXPENSE	(461,260)	(483,440)	(22,180)	(5)%
(29,402)	(36,954)	(7,552)	(20)%	NON-OPERATING EXPENSE	(224,760)	(221,719)	3,041	1%
2,754,156	418,191	(2,335,965)	559%	TOTAL NON-OPERATING INCOME	5,054,940	2,509,148	(2,545,792)	102%
1,706,221	(200,393)	(1,906,614)	(951)%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	1,976,730	(1,453,214)	(3,429,944)	(236)%
135,063	100,000	(35,063)	35%	NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	2,360,423	600,000	(1,760,423)	293%
1,841,284	(100,393)	(1,941,677)	(1,934)%	NET GAIN/(LOSS)	4,337,152	(853,214)	(5,190,366)	(608)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
12/31/24

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(1,047,935)	(3,078,211)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	956,087	5,754,793
Provision for bad debts	(2,015,865)	(8,056,825)
Change in assets and liabilities:		
Patient accounts receivable, net	2,513,734	13,490,148
Other receivables	(367,041)	(9,705,489)
Inventories	(31,805)	(150,428)
Prepaid expenses and deposits	(136,253)	(842,736)
Advance refunding of bonds payable, net	20,979	125,877
Accounts payable and accrued expenses	(684,275)	(1,506,551)
Deferred inflows - leases	(29,356)	13,246
Accrued payroll and related costs	(1,279,130)	(1,961,860)
Estimated third-party payor settlements	(30,000)	(222,809)
Self-insurance reserves	(43,345)	(23,773)
Total adjustments	(1,126,270)	(3,086,407)
Net cash provided by (used in) operating activities	(2,174,205)	(6,164,618)
Cash flows from noncapital financing activities:		
District tax revenues	138,253	829,518
Noncapital grants and contributions, net of other expenses	7,071	9,771
Net cash provided by (used in) noncapital financing activities	145,324	839,289
Cash flows from capital and related financing activities:		
Purchase of capital assets	(191,960)	(1,810,571)
Proceeds from sale of assets	3,255,420	3,255,420
Proceeds from lease receivable, net	28,961	(16,700)
Principal payments on debt borrowings	-	(4,055,000)
Interest payments	(1,569)	(794,241)
Net change in notes payable and lease liability	(99,833)	(602,482)
Net changes in assets limited as to use	(564,387)	1,396,187
Net cash provided by (used in) capital and related financing activities	2,426,632	(2,627,387)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(320,502)	(4,389,542)
Investment income	387,913	2,321,857
Net cash provided by (used in) investing activities	67,411	(2,067,685)
Net increase (decrease) in cash and cash equivalents:	465,162	(10,020,401)
Cash and cash equivalents at beginning of month/year	12,561,075	23,046,638
Cash and cash equivalents at end of month	13,026,237	13,026,237

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
December 2024

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
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
May-24	11,564,879	10,488,610	22,053,489
Jun-24	10,598,225	7,664,994	18,263,219
Jul-24	13,499,837	278,849	13,778,686
Aug-24	10,684,807	298,095	10,982,902
Sep-24	12,800,001	1,611,606	14,411,607
Oct-24	14,933,404	1,420,062	16,353,466
Nov-24	11,872,571	1,402,779	13,275,350
Dec-24	**13,002,191**	**6,026,303**	**19,028,494**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - Receipts for Café, rebates, refunds, and miscellaneous funding sources

- Non-Operating Revenues - rental income, property tax revenues, sale of assets

- Medi-Cal OP Supplemental and DSH Funds
- Medi-Cal and Medi-Care Tentative Cost Settlements
- Grants, IGT, HQAF, & QIP Supplemental Funds
- Medicare interim payments

December 2024 Summary of Other Activity:

907,726	M-Cal HQAF8 Direct Grant CY24
552,679	M-Cal IP DSH 10/24 - 11/24
959,173	Property Taxes
3,245,933	Sale of Westwood Property
360,792	Miscellaneous
6,026,303	12/24 Total Other Activity