SAN GORGONIO
MEMORIAL HOSPITAL

AGENDA

REGULAR MEETING OF THE BOARD OF DIRECTORS
Tuesday, August 4, 2020
4:00 PM

IN AN EFFORT TO PREVENT THE SPREAD OF COVID-19 (CORONAVIRUS), AND IN ACCORDANCE WITH THE GOVERNOR'S EXECUTIVE ORDER N-29-20, THERE WILL BE NO PUBLIC LOCATION FOR ATTENDING THIS BOARD MEETING IN PERSON. MEMBERS OF THE PUBLIC MAY JOIN THE MEETING BY FOLLOWING THE INSTRUCTIONS BELOW:

Meeting Information

Meeting link: https://sangorgoniomemorialhospital-ajd.my.webex.com/sangorgoniomemorialhospital-ajd.my/j.php?MTID=m59e2c413a204a225087fe513d5c5fa67
Meeting number: 126 662 9071
Password: 1234

More ways to join

Join by video system
Dial 1266629071@webex.com
You can also dial 173.243.2.68 and enter your meeting number.

Join by phone
+1-510-338-9438 USA Toll
Access code: 126 662 9071
Password: 1234

Emergency phone number if WebEx tech difficulties
951-846-2846
code: 3376#

THE TELEPHONES OF ALL MEMBERS OF THE PUBLIC LISTENING IN ON THIS MEETING MUST BE "MUTED".

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the Administration Office at (951) 769-2160. **Notification 48 hours prior to the meeting** will enable the Hospital to make reasonable arrangement to ensure accessibility to this meeting. [28 CFR 35.02-35.104 ADA Title II].

TAB

I. Call to Order S. DiBiasi, Chair

San Gorgonio Memorial Hospital
Board of Directors Regular Meeting
August 4, 2020

II. Public Comment

Members of the public who wish to comment on any item on the agenda may submit comments by emailing publiccomment@sgmh.org on or before 1:00 PM on Tuesday, August 4, 2020, which will become part of the board meeting record.

OLD BUSINESS

III.	***Proposed Action - Approve Minutes** • July 7, 2020 regular meeting	S. DiBiasi	A

NEW BUSINESS

IV.	Hospital Board Chair monthly report	S. DiBiasi	verbal
V.	***Proposed Action – elect new Board Treasurer** ▪ **ROLL CALL**	S. DiBiasi	verbal
VI.	Board Chair to appoint members to committee vacancies	S. DiBiasi	verbal
VII.	August, September & October Board/Committee meeting calendars	S. DiBiasi	B
VIII.	CEO monthly report	S. Barron	verbal
IX.	Foundation monthly report (informational)		C
X.	Committee Reports:		
	• Finance Committee o July 28, 2020 meeting minutes *** Proposed Action – Approve June 2020 Financial Statement** (approval recommended by Finance Committee 07/28/2020) ▪ **ROLL CALL**	H. Yonemoto	D
XI.	Chief of Staff Report *** Proposed Action - Approve Recommendations of the Medical Executive Committee** ▪ **ROLL CALL**	S. Hildebrand, MD Chief of Staff	E
XII.	***Proposed Action - Approve Policies and Procedures** ▪ **ROLL CALL**	Staff	F

XIII. Community Benefit events/Announcements/ and newspaper articles — S. DiBiasi — G

***** ITEMS FOR DISCUSSION/APPROVAL IN CLOSED SESSION** — S. DiBiasi

- Proposed Action - Approve Medical Staff Credentialing
  (Health & Safety Code §32155; and Evidence Code §1157)
- Receive Quarterly Emergency Preparedness/Environment Safety report
  (Health & Safety Code §32155; and Evidence Code §1157)
- Receive Quarterly Corporate Compliance Committee report
  (Health & Safety Code §32155; and Evidence Code §1157)

XIV**. ADJOURN TO CLOSED SESSION**

*** The Board will convene to the Open Session portion of the meeting approximately 2 minutes after the conclusion of Closed Session.**

RECONVENE TO OPEN SESSION

***** REPORT ON ACTIONS TAKEN DURING CLOSED SESSION** — S. DiBiasi

XV. Future Agenda Items

XVI. **ADJOURN** — S. DiBiasi

***Action Required**

In accordance with The Brown Act, *Section 54957.5*, all public records relating to an agenda item on this agenda are available for public inspection at the time the document is distributed to all, or a majority of all, members of the Board. Such records shall be available at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Certification of Posting

I certify that on July 31, 2020, I posted a copy of the foregoing agenda near the regular meeting place of the Board of Directors of San Gorgonio Memorial Hospital, and on the San Gorgonio Memorial Hospital website, said time being at least 72 hours in advance of the regular meeting of the Board of Directors (*Government Code Section 54954.2*).

Executed at Banning, California, on July 31, 2020

Ariel Whitley

Ariel Whitley, Administrative Assistant

TAB A

MINUTES: Not Yet Approved By Board

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

July 7, 2020

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors was held on Tuesday, July 7, 2020. In an effort to prevent the spread of COVID-19 (coronavirus), and in accordance with the Governor's Executive Order N-29-20, there was no public location for attending this board meeting in person. Board members and members of the public participated via WebEx.

Members Present: Lynn Baldi, Phillip Capobianco III, Susan DiBiasi (Chair), Estelle Lewis, Ron Rader, Steve Rutledge, Lanny Swerdlow, Dennis Tankersley

Absent: Ehren Ngo

Required Staff: Steve Barron (CEO), Holly Yonemoto (CBDO), Annah Karam, (CHRO), Pat Brown (CNO), Steven Hildebrand, MD (Chief of Staff), Bobbi Duffy (Executive Assistant), Ariel Whitley (Administrative Assistant), Karan Singh, MD (CQO), Margaret Kammer (Controller)

AGENDA ITEM		ACTION / FOLLOW-UP
Call To Order	Chair Susan DiBiasi called the meeting to order at 4:01 pm.	
Public Comment	Members of the public who wished to comment on any item on the agenda were encouraged to submit comments by emailing publiccomment@sgmh.org prior to this meeting. No public comment emails were received.	
OLD BUSINESS		
Proposed Action - Approve Minutes **June 2, 2020 regular meeting and June 22, 2020 special meeting.**	Chair DiBiasi asked for any changes or corrections to the minutes of the June 2, 2020 regular meeting and the June 22, 2020 special meeting as included on the board tablets. There were none.	**The minutes of the June 2, 2020 regular meeting and the June 22, 2020 special meeting will stand correct as presented.**
NEW BUSINESS		

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Proposed Action – Approve 4 Hospital Board Members</td><td>Chair DiBiasi noted that there are now four community members that will serve on the Hospital Board of Directors along with the five elected Healthcare District Board of Directors for a total of 9. The four community members are Susan DiBiasi, Ehren Ngo, Ron Rader, and Steve Rutledge.

BOARD MEMBER ROLL CALL:

<table>
<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr>
<tr><td>DiBiasi</td><td>Yes</td><td>Lewis</td><td>Yes</td></tr>
<tr><td>Ngo</td><td>Absent</td><td>Rader</td><td>Yes</td></tr>
<tr><td>Rutledge</td><td>Yes</td><td>Swerdlow</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Yes</td><td></td><td></td></tr>
</table>
Motion carried.</td><td>M.S.C, (Baldi/Lewis), the SGMH Board of Directors approved the four (4) community members to serve on the Hospital Board.</td></tr>
<tr><td>Recognition of departing Hospital Board Members</td><td>Chair DiBiasi reported that three (3) Hospital Board of Directors have departed. Steve Cooley, Andrew Gardner, and Olivia Hershey will no longer serve on the Hospital Board. The fourth position in which Georgia Sobiech held, will not be filled. The Hospital Board is now made up of nine (9) Board members, five (5) elected Healthcare District Board members and four (4) community members.

Chair DiBiasi thanked the departing board members for their service and announced that they will be given a plaque as a token of appreciation.</td><td></td></tr>
<tr><td>Hospital Board Chair monthly report</td><td>Chair DiBiasi reported that she is looking to appoint committee members to the Finance Committee and the HR Committee due to the departing Board members leaving the Hospital Board.</td><td></td></tr>
<tr><td>July, August, & September Board/Committee meeting calendars</td><td>Calendars for July, August, and September were included on the board tablets.</td><td></td></tr>
<tr><td>CEO Monthly report</td><td>Steve Barron, CEO, noted that there has been a spike in hospitalizations as a result of COVID-19. Steve mentioned that most elective surgeries have been cancelled due to an increase in positive COVID-19 patients.</td><td></td></tr>
</table>

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td></td><td>Steve mentioned that Dave Recupero is retired as of June 30, 2020 and that Holly Yonemoto will replace Dave as the CFO of San Gorgonio Memorial Hospital. Pat Brown, CNO, will add Chief Operating Officer (COO) to her title. Dr. Karan Singh, CQO, will oversee Performance Improvement, Medical Staff Services, and Physician Recruitment. Steve announced that Bobbi Duffy is retiring as Executive Assistant effective August 3, 2020. Bobbi will be replaced with Ariel Whitley. Steve also noted that Amanda Flores from the Foundation department will join Administration.

Steve reported that the ED is picking up since the start of the COVID-19 pandemic.</td><td></td></tr>
<tr><td>Bi-monthly Patient Care Services report</td><td>Chair DiBiasi noted that the bi-monthly Patient Care Services report was included on the board tablets.

Pat Brown, CNO, reported that recent patient activity has been centered on providing care and treatment to COVID-19 patients and patients under investigation. She mentioned that the ED volumes are back up to around 85% of the pre-COVID-19 volumes.

Pat Brown noted that most elective surgeries have been cancelled as a result of an increase in positive COVID-19 patients. As part of the SGMH Surge Plan, PACU can be converted to patient rooms to treat COVID-19 patients.</td><td></td></tr>
<tr><td>Proposed Action – Approve 2021 Plan for Provision of Care</td><td>Pat Brown reviewed the 2021 Plan for Provision of Care as included on the board tablets noting that this plan is updated annually.

BOARD MEMBER ROLL CALL:

<table>
<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr>
<tr><td>DiBiasi</td><td>Yes</td><td>Lewis</td><td>Yes</td></tr>
<tr><td>Ngo</td><td>Absent</td><td>Rader</td><td>Yes</td></tr>
<tr><td>Rutledge</td><td>Yes</td><td>Swerdlow</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Yes</td><td></td><td></td></tr>
</table>
Motion carried.</td><td>M.S.C., (Rader/Baldi), the SGMH Board of Directors approved the 2021 Plan for Provision of Care.</td></tr>
</table>

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td>Foundation monthly report – informational</td><td>Chair DiBiasi noted that the written Foundation monthly report was included on the board tablets.</td><td></td></tr>
<tr><td colspan="3">COMMITTEE REPORTS:</td></tr>
<tr><td>Finance Committee

Proposed Action – Recommend Approval of the May 2020 Financial Statement.</td><td>At the request of Steve Barron, CEO, Margaret Kammer, Controller, reviewed the Executive Summary of the May 2020 Financial report which was included on the board tablet. A copy of the Finance Committee's June 30, 2020 meeting minutes were also included on the board tablet. It was noted that the Finance Committee recommends approval of the May 2020 Financial report as presented.

BOARD MEMBER ROLL CALL:

<table>
<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr>
<tr><td>DiBiasi</td><td>Yes</td><td>Lewis</td><td>Yes</td></tr>
<tr><td>Ngo</td><td>Absent</td><td>Rader</td><td>Yes</td></tr>
<tr><td>Rutledge</td><td>Yes</td><td>Swerdlow</td><td>No Response</td></tr>
<tr><td>Tankersley</td><td>Yes</td><td></td><td></td></tr>
</table>
Motion carried.</td><td>M.S.C., (Rader/Lewis), the SGMH Board of Directors approved the May 2020 Financial Statement as presented.</td></tr>
<tr><td>Proposed Action – Recommend Approval to the Healthcare District Board of the FY2021 Operating budget and FY2021 Capital budget</td><td>Steve Barron, CEO reviewed the Healthcare District & Hospital FY2021 Operating budget and FY2021 Capital budget as included in the board packets.

He discussed the "San Gorgonio Memorial Hospital Budget 2021 Assumptions – Over-all Objectives in 2021."

Steve also discussed the "Key Initiatives accomplished in the FY 21 Budget."

Steve referred Board members to page 12, "Capital Budget." He discussed the need for the purchase of capital equipment to provide safe and quality patient care.

It was noted that the Finance Committee recommends approval of the FY2021 Operating budget and the FY2021 Capital budget as presented.

BOARD MEMBER ROLL CALL:</td><td>M.S.C., (Rutledge/Rader), the SGMH Board of Directors approved the recommendation of the FY2021 Operating budget and the FY2020 Capital budget by the SGMHD Board of Directors as presented.</td></tr>
</table>

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td></td><td>
<table>
<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr>
<tr><td>DiBiasi</td><td>Yes</td><td>Lewis</td><td>Yes</td></tr>
<tr><td>Ngo</td><td>Absent</td><td>Rader</td><td>Yes</td></tr>
<tr><td>Rutledge</td><td>Yes</td><td>Swerdlow</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Yes</td><td></td><td></td></tr>
</table>
Motion carried.
</td><td></td></tr>
<tr><td>Chief of Staff Report</td><td>Steven Hildebrand, MD, Chief of Staff had no report for July 2020.</td><td></td></tr>
<tr><td>Proposed Action – Approve Policies and Procedures</td><td>There were seventy-nine (79) policies and procedures included on the board tablets presented for approval by the Board.

BOARD MEMBER ROLL CALL:

<table>
<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>No</td></tr>
<tr><td>DiBiasi</td><td>Yes</td><td>Lewis</td><td>Yes</td></tr>
<tr><td>Ngo</td><td>Absent</td><td>Rader</td><td>Yes</td></tr>
<tr><td>Rutledge</td><td>Yes</td><td>Swerdlow</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Yes</td><td></td><td></td></tr>
</table>
Motion carried.
</td><td>M.S.C., (Baldi/Rader), the SGMH Board of Directors approved the policies and procedures as submitted.</td></tr>
<tr><td>Community Benefit events/Announcements/and newspaper articles</td><td>Miscellaneous information was included on the board tablets.

Chair DiBiasi reminded Board members to make Ariel Whitley aware of any vacations or time away in the event that special meetings need to be planned.</td><td></td></tr>
<tr><td>Adjourn to Closed Session</td><td>Chair DiBiasi reported the items to be reviewed and discussed and/or acted upon during Closed Session will be:

➢ Proposed Action – Recommend approval to the Healthcare District Board – Medical Staff Credentialing
➢ Receive Quarterly Environment of Care/Life Safety/Utility Management report

The meeting adjourned to Closed Session at 5:30 pm.</td><td></td></tr>
<tr><td>Reconvene to Open Session</td><td>The meeting reconvened to Open Session at 5:35 pm.</td><td></td></tr>
</table>

AGENDA ITEM		ACTION / FOLLOW-UP
	At the request of Chair DiBiasi, Ariel Whitley reported on the actions taken/information received during the Closed Session as follows: ➢ Recommended approval to the Healthcare District Board – Medical Staff Credentialing ➢ Received Quarterly Environment of Care/Life Safety/Utility Management report	
Future Agenda Items	None at this time.	
Adjourn	The meeting was adjourned at 5:36 pm.	

In accordance with The Brown Act, *Section 54957.5*, all reports and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Respectfully submitted by Ariel Whitley, Administrative Assistant

TAB B

August 2020

SAN GORGONIO MEMORIAL HOSPITAL

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
2	**3**	**4** **4:00 pm Hospital Board mtg.** **6:00 pm Healthcare District Board mtg.**	**5**	**6**	**7**	**1** **8**
9	**10**	**11**	**12**	**13**	**14**	**15**
16	**17**	**18** **CANCELLED** ~~**9:00 Community Planning Committee**~~	**19** **MOVED TO SEPTEMBER** ~~**9:00 HR Committee**~~	**20**	**21**	**22**
23	**24**	**25** **9:00 am Finance Committee**	**26**	**27**	**28**	**29**
30	**31**					

As of July 28, 2020 Items in **bold** = Board/Committee meetings Items with * = Associate functions that Board members are invited to attend

September 2020

SAN GORGONIO MEMORIAL HOSPITAL

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1 **4:00 Hospital Board mtg.** **6:00 Healthcare District Board mtg.**	**2**	**3**	**4**	**5**
6	**7** **Labor Day Holiday** Admin. Closed	**8**	**9**	**10** **POSSIBLE** **HR Committee mtg**	**11** **POSSIBLE** **HR Committee mtg**	**12**
13	**14**	**15**	**16**	**17**	**18**	**19**
20	**21**	**22**	**23**	**24**	**25**	**26**
27	**28**	**29** **9:00 am Finance Committee**	**30**			

As of July 28, 2020 Items in **bold** = Board/Committee meetings Items with * = Associate functions that Board members are invited to attend

October 2020

SAN GORGONIO MEMORIAL HOSPITAL

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6 **4:00 pm Hospital Board mtg.** **6:00 pm Healthcare District Board mtg.**	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27 **9:00 am Finance Committee**	28	29	30	31

As of July 28, 2020 Items in **bold** = Board/Committee meetings Items with * = Associate functions that Board members are invited to attend

TAB C

July 29, 2020

Foundation Finances as of 7/29/2020

- $286,275.11 (Bank of Hemet Business checking account) as of 07/29/2020
- $127,660.55 (Bank of Hemet Money market account) as of 07/29/2020
- $81,863.95 (I.E. Community Foundation as of 07/29/2020)

$495,799.61 Total Funds

Foundation Update

The COVID19 RESPONSE FUND- to date the fund is at $73,178.00 (a total of 47 donations)

SGMH Foundation Director is continuing to work on building a schematic of equipment approved and purchased by the Foundation. Research is from 2012 to current (review of SGMHF minutes)

The Foundation office is working on:

- Researching and applying for grants for the imaging/stroke center, The Covid19 Response Fund and other grants that will off-set some hospital expenses.
  - Robert E. and Evelyn McKee Foundation (potential Imaging/Stroke grant)
  - I.E. Community Foundation (Covid grant)
  - Paul Coverdell National Acute Stroke program (potential Imaging/Stroke grant)
  - Waste Management grant *(Grant to off-set any expenses the Dietary Dept. has incurred due to going green)*
  - City of Banning "Go Green" grant *(Grant to off-set any expenses the Dietary Dept. has incurred due to going green)*

- Creating a Direct mail campaign "Thank The Frontline Worker"

This campaign allows SGMH service area residents to say Thank you to anyone at SGMH. Thank you letters will be displayed in the lobby of the hospital. Donors will then be solicited for a gift towards the Covid19 Response Fund.

TAB D

MINUTES: Not Yet Approved By Committee

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

FINANCE COMMITTEE
Tuesday, July 28, 2020

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors Finance Committee was held on Tuesday, July 28, 2020. In an effort to prevent the spread of COVID-19 (coronavirus), and in accordance with the Governor's Executive Order N-29-20, there was no public location for attending this committee meeting in person. Committee members, staff members, and members of the public participated telephonically.

Members Present: Susan DiBiasi, Lanny Swerdlow, Ehren Ngo

Members Absent: None

Required Staff: Steve Barron (CEO), Pat Brown (CNO/COO), Holly Yonemoto (CFO), Bobbi Duffy (Executive Assistant), Ariel Whitley (Administrative Assistant), Margaret Kammer (Controller)

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
Call To Order	Hospital Board Chair, Susan DiBiasi, called the meeting to order at 9:02 am.	
Public Comment	Members of the public who wished to comment on any item on the agenda were encouraged to submit comments by emailing publiccomment@sgmh.org prior to this meeting. No public comment emails were received.	
OLD BUSINESS		
Proposed Action - Approve Minutes **June 30, 2020 regular meeting**	Susan DiBiasi asked for any changes or corrections to the minutes of the June 30, 2020 regular meeting. There were none.	**The minutes of the June 30, 2020 regular meeting will stand correct as presented.**
NEW BUSINESS		
Proposed Action – Recommend	Holly Yonemoto reviewed the June 2020 finance report as included in the board packets.	**M.S.C. (Swerdlow/Ngo),**

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td>Approval to Hospital Board of Directors - Monthly Financial Report – June 2020</td><td>Holly referred committee members to page 2, “San Gorgonio Memorial Hospital Financial Report – Executive Summary.” She noted that June EBIDA was negative due to a reduction in Net Revenue of $728,675. She also noted that YTD EBIDA had a positive variance of $126,078 as a result of funding opportunities through governmental sources.

She noted that in general, our revenues were down due to COVID-19. Since March 2020, our year-end projected revenue shortfall has totaled $5,113,065.

Holly referred committee members to page 7, “Statement of Revenue and Expense – Current Month.”

On line 41, “Total Net Surplus/(Loss)”, the Actual was $2,107,432 compared to a budgeted $158,814, reflecting a negative variance of $1, $1,948,618. Holly noted that IGT funding was significant for other months as opposed to June.

Holly referred committee members to page 8, “Statement of Revenue and Expense – Year-to-Date”.

She noted as shown on line 34, “EBIDA”, there was an Actual of $813,645 versus a Budgeted amount of $687,566, reflecting a positive variance of $126,078.

Holly referred committee members to page 12, “Gross Days in AR by Payor.”

She noted that lines 24 and 25, “Blue Cross and MediCal”, play a large role in Total Gross Days in AR increasing since March 2020. Holly mentioned that she will analyze this increase to determine its root cause as well as ways to correct it.

ROLL CALL:

<table>
<tr><td>DiBiasi</td><td>Yes</td><td>Ngo</td><td>Yes</td></tr>
<tr><td>Swerdlow</td><td>Yes</td><td colspan="2">Motion carried.</td></tr>
</table>
</td><td>the SGMH Finance Committee voted to recommend approval of the June 2020 Financial report to the Hospital Board of Directors.</td></tr>
<tr><td>Future Agenda Items</td><td>None.</td><td></td></tr>
<tr><td>Next Meeting</td><td>The next Finance Committee meeting will be held on August 25, 2020.</td><td></td></tr>
</table>

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
Adjournment	The meeting was adjourned at 9:41 am.	

In accordance with The Brown Act, *Section 54957.5*, all reports and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue,

Minutes respectfully submitted by Ariel Whitley, Administrative Assistant

SAN GORGONIO MEMORIAL HOSPITAL

BANNING, CALIFORNIA

Unaudited Financial Statements

for

TWELVE MONTHS ENDING JUNE 30, 2020

Certification Statement:

To the best of my knowledge, I certify for the hospital that the attached financial statements, except for the uncertainty of IGT revenue accruals, do not contain any untrue statement of a material fact or omit to state a material fact that would make the financial statements misleading. I further certify that the financial statements present in all material respsects the financial condition and results of operation of the hospital and all related organizations reported herein.

Certified by:

Holly Yonemoto

CFO

San Gorgonio Memorial Hospital
Financial Report – Executive Summary
For the month of June 2020 (Twelve months in FY 20)

Profit/Loss (EBIDA) Summary

In the current month, there was an unfavorable budget variance in Earnings before Interest, Depreciation and Amortization (EBIDA). June EBIDA actual was negative due to a reduction in Net Revenue of $728,675 related to operations, while expenses were over budget in multiple categories due to Covid 19. The current month of June also did not realize significant funding for the additional increase in expense and decrease in revenue, which will cover the shortfall. The resulting Month-to-Date (MTD) EBIDA was a negative $2.1M and a Year-to-Date (YTD) EBIDA positive variance of $126,078 better than budget, with continued funding opportunities through governmental sources. On July 20th we received **$2.8M** of funding for covid-19 through the CARES Provider Relief Funding to cover related expense increases and revenue shortfall to assist in financial stability during these unprecedented times.

Analysis

The updated covid-19 financial impact for SGMH is not close to break-even without the CARES Act funding as well as other funding related to the covid-19 impact.

In general, our revenues were still down for the month (-$728,675 lower than budget) but improved over the prior month. Since the month of March our Year-end projected revenue shortfall has totaled 5,113,065, which is being covered by funding:

San Gorgonio Memorial Hospital					FISCAL YEAR 20
COVID-19 FINANCIAL IMPACT	MARCH	APRIL	MAY	JUNE	TOTALS
Net Patient Revenue Normal (expected)	4,567,808	4,610,028	4,484,406	4,075,169	17,737,356
Act/PROJ Net Patient Revenues	3,247,093	2,698,425	3,332,335	3,346,493	12,624,346
Lost REVENUES due to COVID-19	(1,320,715)	(1,911,603)	(1,152,071)	(728,676)	(5,113,065)

Net Patient Revenues (YTD unfavorable $2.98M) which is a 6.1% variance that is lower than budget. The net figure came in slightly better than the year to date net gross revenues that were 11.9% lower than budget. The covid-19 inpatient census as well as higher acuity patients have increased the Medicare case mix index and will result in higher projected reimbursement. The higher the case mix index the more complex the cases are, and will result in improved projected reimbursement.

Total Operating Revenues (YTD favorable $4.9M) . Supplemental revenues for the year is now $4.9M positive compared to the budget as the large rate range IGT payment expected $18.0M came in slightly over $19.0 million. The $5.0 million Cares Act results in $7.0 M favorable supplemental revenue as well as $500k in the month of June related to IEHP covid-19 supplemental revenue has resulted in a positive variance. Due to the funding to offset lost revenue and increased expenses related to covid-19 the total operating revenues are favorable by $4.9M for the use of offsetting expenses that have been higher than the increase.

Expenses for the month (unfavorable $902K) Expenses were higher than budget with legal fees and physician fees accounted and other expenses accounting for approximately $700k as well as increased supplies due to covid-19 were was over by $173k. The higher physician fees category is likely to be reduced significantly with a new Beaver anesthesia contract.

BALANCE SHEET/CASH FLOW

Cash Balances made a nice improvement due to the IGT funding as well as covid-19 funding coming in. The line of credit balance is currently at $6.0 million to keep cash available and accounts payable is currently at $4.9M at year end.

The FY 20 fiscal year-end projected cash is now significantly higher than budgeted partially due to the $2.5 million Medicare advance as well as the $5M in CARES act funding as well as the line credit balances still owed.

Key patient statistics variances included:

Average Daily Census (ADC) in the month June was 28.0 actual vs 29.3 budget, which was slightly under budget. YTD ADC actual= 25.2 vs budget 29.0
YTD ED visits averaged 90 in June vs. budget of 123 and YTD actual was 108 vs 121 budgeted.

Concluding Summary

Positive takeaways:

1) IGT and funding over expected amounts budgeted for
2) EBIDA now better than budget for Year to Date ending at $813,645
3) Patient volumes seem to be rising on both inpatient and outpatient for the month of June comparative to prior covid-19 impact months

Negative takeaways:

1) Slow down third party payments and higher days in AR.
2) Higher than expected physician fees and legal fees – both will be reduced in coming months due to new contract as well as management agreement structure completion.

SAN GORGONIO MEMORIAL HOSPITAL
EXECUTIVE FINANCIAL SUMMARY
TWELVE MONTHS ENDING JUNE 30, 2020

	STATEMENT OF REVENUE AND EXPENSES - CURR & YTD					
		06/30/20 ACTUAL	*06/30/20 BUDGET*	*YTD ACTUAL*	*YTD BUDGET*	*YTD DIFFERENCE*
	Revenue:					
[10]	Gross Patient Revenues	$21,539,669	$25,443,157	$268,987,846	$305,317,884	-$36,330,038
[11]	Deductions From Revenue	(18,193,176)	(21,367,989)	(223,069,298)	(256,415,862)	33,346,564
[12]	Net Patient Revenues	3,346,493	4,075,169	45,918,548	48,902,022	(2,983,474)
[13]	Other Operating Revenue	1,626,118	1,964,792	31,331,378	23,422,415	7,908,963
[14]	**Total Operating Revenues**	**4,972,611**	**6,039,961**	**77,249,926**	**72,324,437**	**4,925,489**
	Expenses:					
[15]	Salaries, Benefits & Contract Labor	4,006,975	3,917,513	46,931,548	47,009,343	77,795
[16]	Purchased Serv. & Physician Fees	1,200,057	872,293	12,461,874	10,467,517	(1,994,357)
[17]	Supply Expenses	895,005	721,487	8,851,044	8,657,846	(193,198)
[18]	Other Operating Expenses & Clinic Loss	740,259	371,003	6,878,015	4,297,761	(2,580,254)
[19]	Intergovernmental Transfer Expense	29,528	100,367	1,313,802	1,204,404	(109,398)
[20]	Depreciation & Interest Expense	975,500	899,445	11,245,080	10,793,339	(451,741)
[21]	**Total Expenses**	**7,847,325**	**6,882,108**	**87,681,362**	**82,430,210**	**(5,251,152)**
[22]	**NET OPERATING SURPLUS**	**(2,874,714)**	**(842,147)**	**(10,431,436)**	**(10,105,773)**	**(325,663)**
[23]	Non-Operating Revenue/(Exp.)	767,281	683,333	7,998,198	8,200,000	(201,802)
[24]	**TOTAL NET SURPLUS (LOSS)**	**($2,107,432)**	**($158,814)**	**($2,433,238)**	**($1,905,773)**	**($527,465)**

SAN GORGONIO MEMORIAL HOSPITAL
EXECUTIVE FINANCIAL SUMMARY
TWELVE MONTHS ENDING JUNE 30, 2020

BALANCE SHEET

Line Ref #		YTD 06/30/2020	Prior FYE 06/30/2019
	ASSETS		
[1]	Current Assets	$36,175,733	$27,281,468
[2]	Assets Whose Use is Limited	9,394,161	8,867,208
[3]	Property, Plant & Equipment (Net)	91,678,839	96,966,928
[4]	Other Assets	1,449,675	1,522,444
	Total Unrestricted Assets	**138,698,408**	**134,638,048**
[5]	Restricted Assets	0	0
	Total Assets	**$138,698,408**	**$134,638,048**
	LIABILITIES AND NET ASSETS		
[6]	Current Liabilities	$22,073,425	$10,422,106
[7]	Long-Term Debt	108,213,822	112,856,547
[8]	Other Long-Term Liabilities	0	0
	Total Liabilities	**130,287,247**	**123,278,653**
	Net Assets	8,411,161	10,844,398
[9]	**Total Liabilities and Net Assets**	**$138,698,409**	**$134,638,048**

SAN GORGONIO MEMORIAL HOSPITAL
EXECUTIVE FINANCIAL SUMMARY
TWELVE MONTHS ENDING JUNE 30, 2020

	KEY STATISTICS AND RATIOS				
		06/30/20 ACTUAL	*06/30/20 BUDGET*	*YTD ACTUAL*	*YTD BUDGET*
[25]	Total Acute Patient Days	841	880	9,205	10,626
[26]	Average Acute Length of Stay	4.1	4.1	3.4	3.5
[27]	Total Emergency Room Visits	2,704	3,679	39,293	43,975
[28]	Outpatient Visits	3,106	4,454	45,669	53,307
[29]	Total Surgeries	63	102	863	1,232
[30]	Total Worked FTE's (w/o JV)	430.8	455.7	435.8	455.7
[31]	Total Paid FTE's (w/o JV)	458.6	489.6	468.7	489.6
[32]	Days of Cash on Hand			58.7	
[33]	AP Days			47.3	

Statement of Revenue and Expense
SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
TWELVE MONTHS ENDING JUNE 30, 2020

		DISTRICT ONLY	CURRENT MONTH			
			COMBINED		Positive	Prior
		Actual 06/30/20	Actual 06/30/20	Budget 06/30/20	(Negative) Variance	Year 06/30/19
Gross Patient Revenue						
[1]	Inpatient Revenue	$0	$7,602,063	$8,016,188	($414,125)	$7,404,390
[2]	Inpatient Psych/Rehab Revenue	0	0	0	0	0
[3]	Outpatient Revenue	0	13,937,607	17,426,969	(3,489,363)	16,073,225
[4]	Long Term Care Revenue	0	0	0	0	0
[5]	Home Health Revenue	0	0	0	0	0
[6]	Total Gross Patient Revenue	0	21,539,669	25,443,157	(3,903,488)	23,477,615
Deductions From Revenue						
[7]	Discounts and Allowances	0	(17,441,232)	(20,240,230)	2,798,998	(18,818,433)
[8]	Bad Debt Expense	0	(595,948)	(1,019,397)	423,450	(387,328)
[9]	Prior Year Settlements	0	0	(58,333)	58,333	0
[10]	Charity Care	0	(155,996)	(50,028)	(105,968)	(77,584)
[11]	Total Deductions From Revenue	0	(18,193,176)	(21,367,989)	3,174,813	(19,283,345)
[12]			84.46%	83.98%		82.14%
[13]	Net Patient Revenue	0	3,346,493	4,075,169	(728,675)	4,194,270
Non Patient Operating Revenues						
[14]	IGT/DSH Revenues	0	573,661	1,326,369	(752,708)	1,836,281
[15]	Tax Subsidies Measure D	188,750	188,750	205,228	(16,478)	175,000
[16]	Tax Subsidies Prop 13	112,500	112,500	123,322	(10,822)	105,000
[17]	Tax Subsidies County Supplemental Funds	23	23.42	16,250	(16,227)	96,724
[18]	Other Operating Revenue	2,765	773,000	252,947	520,052	196,192
[19]	Clinic Net Revenues	(21,816)	(21,816)	27,753	(49,569)	30,153
	Non- Patient Revenue	282,223	1,626,118	1,951,868	(325,750)	2,439,351
	Total Operating Revenue	**282,223**	**4,972,611**	**6,027,036**	**(1,054,425)**	**6,633,621**
Operating Expenses						
[20]	Salaries and Wages	0	3,161,543	3,109,924	(51,619)	3,578,754
[21]	Fringe Benefits	0	793,541	752,011	(41,530)	646,466
[22]	Contract Labor	0	51,892	55,579	3,687	174,387
[23]	Physicians Fees	0	303,660	195,483	(108,177)	219,145
[24]	Purchased Services	34,258	896,397	676,810	(219,587)	603,918
[25]	Supply Expense	0	895,005	721,487	(173,517)	594,295
[26]	Utilities	0	95,364	71,386	(23,978)	131,714
[27]	Repairs and Maintenance	10,283	53,140	45,038	(8,102)	61,439
[28]	Insurance Expense	0	174,683	101,452	(73,231)	64,399
[29]	All Other Operating Expenses	23,741	209,208	0	(209,208)	171,247
[30]	IGT Expense	0	29,528	100,367	70,839	0
[31]	Leases and Rentals	0	107,987	68,138	(39,849)	93,368
[32]	Clinic Expense	73,464	99,877	72,064	(27,813)	53,387
[33]	**Total Operating Expenses**	**141,745**	**6,871,825**	**5,969,739**	**(902,086)**	**6,392,516**
[34]	**EBIDA**	**140,478**	**(1,899,213)**	**57,297**	**(1,956,511)**	**241,105**
Interest Expense and Depreciation						
[35]	Depreciation	558,911	558,911	500,000	(58,911)	494,513
[36]	Interest Expense and Amortization	387,548	416,590	399,445	(17,145)	416,675
[37]	**Total Interest & depreciation**	946,459	975,500	899,445	(76,055)	911,188
Non-Operating Revenue:						
[38]	Contributions & Other	168,652	168,652	16,667	151,985	0
[39]	Tax Subsidies for GO Bonds - M-A	598,629	598,629	666,667	(68,038)	585,613
[40]	**Total Non Ope**	**767,281**	**767,281**	**683,333**	**83,948**	**585,613**
[41]	**Total Net Surplus/(Loss)**	**($38,700)**	**($2,107,432)**	**($158,814)**	**($1,948,618)**	**($84,470)**
[42]	Extra-ordinary loss on FInancing					
[43]	**Increase/(Decrease in Unrestricted Net A**	**($38,700)**	**($2,107,432)**	**($158,814)**	**($1,948,618)**	**($84,470)**
[44]	**Total Profit Margin**	**-13.71%**	**-42.38%**	**-2.64%**		**-1.27%**
[45]	**EBIDA %**	**49.78%**	**-38.19%**	**0.95%**		**3.63%**

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Statement of Revenue and Expense
SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
TWELVE MONTHS ENDING JUNE 30, 2020

		DISTRICT ONLY Actual 06/30/20	YEAR-TO-DATE Actual 06/30/20	Budget 06/30/20	Positive (Negative) Variance	Percentage Variance	Prior Year 06/30/19
Gross Patient Revenue							
[1]	Inpatient Revenue	$0	$85,172,736	$96,194,253	($11,021,517)	-11.46%	$92,014,593
[2]	Inpatient Psych/Rehab Revenue	0	0	0	0	0.00%	0
[3]	Outpatient Revenue	0	183,815,111	209,123,631	(25,308,521)	-12.10%	201,184,376
[4]	Long Term Care Revenue	0	0	0	0	0.00%	0
[5]	Home Health Revenue	0	0	0	0	0.00%	0
[6]	Total Gross Patient Revenue	0	268,987,846	305,317,884	(36,330,038)	-11.90%	293,198,969
Deductions From Revenue							
[7]	Discounts and Allowances	0	(214,191,735)	(242,882,756)	28,691,021	11.81%	(233,989,417)
[8]	Bad Debt Expense	0	(7,839,364)	(12,232,768)	4,393,404	35.92%	(10,296,276)
[9]	Prior Year Settlements	0	0	(700,000)	700,000	100.00%	0
[10]	Charity Care	0	(1,038,200)	(600,338)	(437,862)	-72.94%	(674,019)
[11]	Total Deductions From Revenue	0	(223,069,298)	(256,415,862)	33,346,564	13.00%	(244,959,712)
[12]			82.9%	84.0%	-1.1%		83.5%
[13]	Net Patient Revenue	0	45,918,548	48,902,022	(2,983,474)	-6.10%	48,239,257
Non Patient Operating Revenues							
[14]	IGT/DSH Revenues	0	17,832,408	15,916,426	1,915,982	12.04%	17,499,929
[15]	Tax Subsidies Measure D	2,393,627	2,393,627	2,462,730	(69,103)	-2.81%	2,265,438
[16]	Tax Subsidies Prop 13	1,368,731	1,368,731	1,479,858	(111,127)	-7.51%	1,362,839
[17]	Tax Subsidies County Supplemental Funds	108,763	108,763	195,000	(86,237)	-44.22%	193,913
[18]	Other Operating Revenue	17,883	9,445,364	3,035,367	6,409,997	211.18%	2,891,419
[19]	Clinic Net Revenues	182,486	182,486	333,034	(150,548)	-45.20%	268,589
	Non- Patient Revenue	4,071,489	31,331,378	23,422,415	7,908,963	33.77%	24,482,128
	Total Operating Revenue	**4,071,489**	**77,249,927**	**72,324,437**	**4,925,489**	**6.81%**	**72,721,385**
Operating Expenses							
[20]	Salaries and Wages	0	37,348,282	37,319,083	(29,199)	-0.08%	35,205,378
[21]	Fringe Benefits	0	8,852,902	9,024,130	171,228	1.90%	8,421,584
[22]	Contract Labor	0	730,364	666,943	(63,420)	-9.51%	1,279,534
[23]	Physicians Fees	8,800	4,040,662	2,345,796	(1,694,866)	-72.25%	2,959,573
[24]	Purchased Services	495,842	8,421,212	8,121,721	(299,491)	-3.69%	5,056,088
[25]	Supply Expense	554	8,851,044	8,657,846	(193,198)	-2.23%	8,226,210
[26]	Utilities	3,000	963,984	856,631	(107,352)	-12.53%	905,646
[27]	Repairs and Maintenance	16,757	713,392	540,459	(172,932)	-32.00%	699,894
[28]	Insurance Expense	0	1,239,322	1,217,425	(21,897)	-1.80%	1,040,876
[29]	All Other Operating Expenses	91,098	1,917,822	0	(1,917,822)	0.00%	1,781,297
[30]	IGT Expense	0	1,313,802	1,204,404	(109,398)	-9.08%	704,910
[31]	Leases and Rentals	0	907,965	817,661	(90,305)	-11.04%	1,567,270
[32]	Clinic Expense	806,164	1,135,530	864,771	(270,759)	-31.31%	1,185,518
[33]	**Total Operating Expenses**	**1,422,215**	**76,436,282**	**71,636,871**	**(4,799,411)**	**-6.70%**	**69,033,778**
[34]	**EBIDA**	**2,649,274**	**813,645**	**687,566**	**126,078**	**18.34%**	**3,687,607**
Interest Expense and Depreciation							
[35]	Depreciation	6,077,964	6,077,964	6,000,000	(77,964)	-1.30%	6,007,230
[36]	Interest Expense and Amortization	4,675,287	5,167,115	4,793,339	(373,776)	-7.80%	4,986,401
[37]	**Total Interest & depreciation**	10,753,251	11,245,080	10,793,339	(451,741)	-4.19%	10,993,631
Non-Operating Revenue:							
[38]	Contributions & Other	331,846	331,846	200,000	131,846	65.92%	82,964
[39]	Tax Subsidies for GO Bonds - M-A	7,666,352	7,666,352	8,000,000	(333,648)	-4.17%	8,165,810
[40]	**Total Non Oper**	**7,998,198**	**7,998,198**	**8,200,000**	**(201,802)**	**-2.46%**	**8,248,774**
[41]	**Total Net Surplus/(Loss)**	**($105,779)**	**($2,433,237)**	**($1,905,773)**	**($527,464)**	**27.68%**	**$942,750**
[42]	Extra-ordinary loss on FInancing						
[43]	**Increase/(Decrease in Unrestricted Net Assets**	**($105,779)**	**($2,433,237)**	**($1,905,773)**	**($527,464)**	**27.68%**	**$942,750**
[44]	**Total Profit Margin**	**-2.60%**	**-3.15%**	**-2.64%**			**1.30%**
[45]	**EBIDA %**	**65.07%**	**1.05%**	**0.95%**			**5.07%**

Balance Sheet - Assets

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
TWELVE MONTHS ENDING JUNE 30, 2020

		DISTRICT ONLY Current Month 06/30/2020	Current Month 06/30/2020	Prior Month 05/31/2020	ASSETS Curr vs Prior Mo. Positive/ (Negative) Variance	Prior Year End 06/30/2019
Current Assets						
[1]	Cash and Cash Equivalents	$3,500,626	$12,264,322	$5,336,629	$6,927,693	$4,175,227
[2]	Gross Patient Accounts Receivable	0	43,985,931	41,077,227	2,908,704	49,210,703
[3]	Less: Bad Debt and Allowance Reserves	0	(36,588,966)	(33,567,774)	(3,021,192)	(40,680,940)
[4]	Net Patient Accounts Receivable	0	7,396,965	7,509,452	(112,488)	8,529,763
[5]	Taxes Receivable	1,154,437	1,154,437	3,933,244	(2,778,807)	566,680
[6]	Other Receivables	0	(48,230)	4,776,563	(4,824,793)	436,869
[7]	Inventories	0	1,789,074	1,786,147	2,928	1,632,865
[8]	Prepaid Expenses	72,875	288,638	253,404	35,234	1,326,928
[9]	Due From Third Party Payers	0	690,273	1,336,151	(645,878)	554,344
[10]	Malpractice Receivable	0	0	0	0	0
[11]	IGT Receivables	0	12,640,253	13,050,001	(409,747)	10,058,792
	Total Current Assets	**4,727,938**	**36,175,733**	**37,981,591**	**(1,805,858)**	**27,281,468**
Assets Whose Use is Limited						
[12]	Cash	0	0	0	0	0
[13]	Investments	0	0	0	0	0
[14]	Bond Reserve/Debt Retirement Fund	9,387,717	9,394,161	7,464,159	1,930,002	8,867,208
[15]	Trustee Held Funds	0	0	0	0	0
[16]	Funded Depreciation	0	0	0	0	0
[17]	Board Designated Funds	0	0	0	0	0
[18]	Other Limited Use Assets	0	0	0	0	0
	Total Limited Use Assets	**9,387,717**	**9,394,161**	**7,464,159**	**1,930,002**	**8,867,208**
Property, Plant, and Equipment						
[19]	Land and Land Improvements	6,686,845	6,686,845	6,686,845	0	4,820,671
[20]	Building and Building Improvements	127,399,218	127,399,218	127,399,218	0	129,283,884
[21]	Equipment	26,360,626	26,360,626	26,154,679	205,947	25,586,875
[22]	Construction In Progress	8,391,329	8,391,329	8,391,329	0	8,390,249
[23]	Capitalized Interest	0	0	0	0	0
[24]	Gross Property, Plant, and Equipment	168,838,018	168,838,018	168,632,071	205,947	168,081,679
[25]	Less: Accumulated Depreciation	(77,159,178)	(77,159,178)	(76,600,268)	(558,911)	(71,114,751)
[26]	**Net Property, Plant, and Equipment**	**91,678,839**	**91,678,839**	**92,031,803**	**(352,964)**	**96,966,928**
Other Assets						
[27]	Unamortized Loan Costs	1,449,675	1,449,675	1,451,335	(1,660)	1,522,444
[28]	Assets Held for Future Use	0	0	0	0	0
[29]	Investments in Subsidiary/Affiliated Org.	12,849,427	0	0	0	0
[30]	Other	0	0	0	0	0
[31]	**Total Other Assets**	**14,299,102**	**1,449,675**	**1,451,335**	**(1,660)**	**1,522,444**
[32]	**TOTAL UNRESTRICTED ASSETS**	**120,093,596**	**138,698,408**	**$138,928,888**	**($230,480)**	**134,638,048**
Restricted Assets		0	0	0	0	0
[33]	**TOTAL ASSETS**	**$120,093,596**	**$138,698,408**	**$138,928,888**	**($230,480)**	**$134,638,048**

Ave Exp /Day>	$208,762
Days of Cash On Hand	58.75

Balance Sheet - Liabilities and Net Assets

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
TWELVE MONTHS ENDING JUNE 30, 2020

		District Only Current Month 06/30/2020	Current Month 06/30/2020	LIABILITIES AND FUND BALANCE Prior Month 05/31/2020	Positive/ (Negative) Variance	Prior Year End 06/30/2019
Current Liabilities						
[1]	Accounts Payable	$332,738	$4,875,880	$3,917,957	$957,922	$4,436,438
[2]	Notes and Loans Payable (Line of Credit)	0	6,000,000	$6,000,000	0	$0
[3]	Accounts Payable- Construction	0	0	$0	0	$0
[4]	Accrued Payroll Taxes	0	4,146,098	$3,610,726	535,373	$3,844,094
[5]	Accrued Benefits	0	81,148	$87,059	(5,912)	$76,513
[6]	Accrued Benefits Current Portion	0	0	$0	0	$0
[7]	Other Accrued Expenses	0	0	$0	0	$0
[8]	Accrued GO Bond Interest Payable	2,020,229	2,020,229	$1,616,183	404,046	$2,049,304
[9]	Stimulus Advance	0	2,577,690	$2,577,690	0	$0
[10]	Due to Third Party Payers (Settlements)	0	0	$0	0	$0
[11]	Advances From Third Party Payers	0	0	$0	0	$0
[12]	Current Portion of LTD (Bonds/Mortgages)	2,335,000	2,335,000	$2,335,000	0	$0
[13]	Current Portion of LTD (Leases)	0	0	$0	0	$0
[14]	Other Current Liabilities	0	37,380	36,103	1,276	15,758
	Total Current Liabilities	**4,687,967**	**22,073,425**	**20,180,719**	**1,892,705**	**10,422,106**
Long Term Debt						
[15]	Bonds/Mortgages Payable (net of Cur Portion)	108,213,822	108,213,822	108,229,575	(15,753)	112,856,547
[16]	Leases Payable (net of current portion)	0	0	0	0	0
[17]	**Total Long Term Debt (Net of Current)**	**108,213,822**	**108,213,822**	**108,229,575**	**(15,753)**	**112,856,547**
Other Long Term Liabilities						
[18]	Deferred Revenue	0	0	0	0	0
[19]	Accrued Pension Expense (Net of Current)	0	0	0	0	0
[20]	Other	0	0	0	0	0
[21]	**Total Other Long Term Liabilities**	**0**	**0**	**0**	**0**	**0**
	TOTAL LIABILITIES	**112,901,790**	**130,287,247**	**128,410,295**	**1,876,952**	**123,278,653**
Net Assets:						
[22]	Unrestricted Fund Balance	7,297,586	10,844,398	$10,844,398	0	10,416,645
[23]	Temporarily Restricted Fund Balance	0	0	0	0	0
[24]	Restricted Fund Balance	0	0	0	0	0
[25]	Net Revenue/(Expenses)	(105,779)	(2,433,237)	(325,805)	(2,107,432)	942,750
[26]	**TOTAL NET ASSETS**	**7,191,807**	**8,411,161**	**10,518,594**	**(2,107,432)**	**11,359,394**
[27]	**TOTAL LIABILITIES AND NET ASSETS**	**$120,093,596**	**$138,698,408**	**$138,928,888**	**($230,480)**	**$134,638,048**

Statement of Cash Flows
SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
TWELVE MONTHS ENDING JUNE 30, 2020

		CASH FLOW	
	HEALTHCARE SYSTEM CASH FLOW	**Current Month 06/30/2020**	**Year-To-Date 06/30/2020**
	BEGINNING CASH BALANCES		
[1]	Cash: Beginning Balances- HOSPITAL	$3,636,544	1,049,179
[2]	Cash: Beginning Balances- DISTRICT	1,700,085	3,126,083
[3]	Cash: Beginning Balances TOTALS	$5,336,629	$4,175,262
	Receipts		
[4]	Pt Collections	3,412,886	45,996,976
[5]	Tax Subsidies Measure D	950,918	3,844,054
[6]	Tax Subsidies Prop 13	0	873,878
[7]	Tax Subsidies County Supplemental Fur	101,336	210,075
[8]	IGT & other Supplemental (see detail be	2,579,143	19,912,483
[9]	Draws/(Paydown) of LOC Balances	0	6,000,000
[10]	Other Misc Receipts/Transfers	5,308,422	7,937,109
	TOTAL RECEIPTS	**12,352,705**	**84,774,576**
	Disbursements		
[11]	Payroll/ Benefits	2,897,320	45,147,190
[12]	Other Operating Costs	3,944,977	29,962,280
[13]	Capital Spending	0	426,844
[14]	Debt serv payments (Hosp onlyw/ LOC i	29,528	343,323
[15]	Other (increase) in AP /other bal sheet	(1,588,492)	(5,792,796)
[16]	**TOTAL DISBURSEMENTS**	**5,283,333**	**70,086,839**
[17]	**TOTAL CHANGE in CASH**	**7,069,372**	**14,687,736**
	ENDING CASH BALANCES		
[18]	Ending Balances- HOSPITAL	$8,760,974	$8,760,974
[19]	Ending Balances- DISTRICT	3,645,027	3,645,027
[20]	Ending Balances- TOTALS	$12,406,001	$12,406,001
	ADDITIONAL INFO		
[21]	LOC CURRENT BALANCES	$6,000,000	$6,000,000
[22]	LOC Interest Expense Incurred	$29,528	$343,323

	GROSS DAYS IN AR BY PAYOR	FY 20 Year-To Date	FY 19 06/30/2019	TARGET 10/31/2016	FY 20 MAR	FY 20 APR	FY 20 MAY	FY 20 JUNE
24	Blue Shield	29.0	30.7	60.4	40.6	43.8	29.0	29.0
25	Blue Cross	62.6	55.6	44.6	49.2	53.7	62.6	62.6
26	MediCal	87.4	57.0	66.3	72.0	68.0	87.4	87.4
27	IEHP /Other MediCal HMO	39.3	27.3	27.5	27.9	29.1	39.3	39.3
28	Champus /Other Govt	109.6	147.6	132.2	107.1	98.6	109.6	109.6
29	HMO/PPO/Commercial	95.1	96.0	86.4	99.1	94.0	95.1	95.1
30	Medicare	43.3	58.0	36.3	47.3	38.2	43.3	43.3
31	Self Pay/Credit Bals	125.7	82.5	80.5	105.3	120.9	125.7	125.7
32	Senior HMO	76.0	64.5	59.5	73.1	71.0	76.0	76.0
33	Workers Comp	144.8	111.6	136.2	85.8	152.7	144.8	144.8
34	TOT GROSS DAYS IN AR	67.93	59.00	53.9	62.14	61.21	67.93	67.93

TAB E

SAN GORGONIO MEMORIAL HOSPITAL
Medical Staff Services Department

M E M O R A N D U M

DATE: July 15, 2020

TO: Susan DiBiasi, Chair
Governing Board

FROM: Sherif Khalil, M.D., Acting Chairman
Medical Executive Committee

SUBJECT: MEDICAL EXECUTIVE COMMITTEE REPORT

At the Medical Executive Committee held this date, the following items were recommended for approval by the Governing Board:

Approval Item(s):

Policies & Procedures

Clostridium difficile Prevention and Control
This policy was established to treat prevent and control the transmission of Clostridium difficile infections among hospitalized patients at SGMH (See attached).

Controlled Air Purifying Respirator (CAPR)
The purpose of this policy is to protect staff, unable to wear N95, from airborne pathogens during routine care for patients where protection from airborne contaminants are is warranted and during high-hazard procedures on a patients with a suspected or confirmed Aerosol Transmissible Disease (See attached).

Coronavirus Disease 2019 (COVID-19) Risk Assessment & Management Plan
The purpose of this policy is to provide guidance for the management of Coronavirus Disease (See attached).

OR – Duties of a Scrub Nurse/Technician
The Scrub Nurse is a member of the operating room team; duties are outlined (See attached).

QuickVue Dipstick Strep A Test
The QuickVue Dipstick Strep A is intended for the rapid, qualitative detection of Group A Streptococcal antigen from throat swabs or confirmation of presumptive Group A Streptococcal colonies recovered from culture. The test is to be used to aid in the diagnosis of Group A Streptococcal infection (See attached).

Sepsis Identification and Management
This policy was established to emergently identify and manage septic patients (See attached).

Sterile Supplies
Sterile Processing Department is responsible for sterilizing all sterile supplies used by the Emergency Department (See attached).

Types of Containers Used for Specimen Collection
This policy describes the types of containers used for 24 hour specimen collection (See attached).

Legionella Investigation Report
On February 11, 2020, A-Tech Consulting, Inc., conducted Limited Water Legionella Sampling in various areas of SGMH. Based on the sampling conducted, no immediate health hazard or occupational exposure risk was detected (See attached).

List of Policies & Procedures
The attached list of policies and procedures must be approved annually (no revisions), except:

Prone Positioning in Non-Intubated Patients with Hypoxemic Respiratory Failure (New Policy)

Dietary Manual
Every five (5) years SGMH purchases a diet manual from Food and Nutrition Management Services. Attached is the revised diet manual of 2019 (See attached).

SAN GORGONIO MEMORIAL HOSPITAL

Origination: *07/2016*
Approved: *N/A*
Last Revised: *05/2020*
Policy Area: *Infection Control*
References:

Clostridium difficile Prevention and Control

Policy:

Diagnosis of C *difficile* is based on clinical symptoms in combination with testing by the lab. Clinical severity of disease should strongly be taken into consideration prior to choosing drug therapy.

C *difficile* is a bacterial enteric pathogen that causes a broad range of clinical disease from asymptomatic colonization or mild diarrhea to pseudomembranous colitis. C *difficile* produces disease by toxin production in the colon via two toxins, toxin A and Toxin B. The usual presentation is watery diarrhea and cramps associated with antibiotic use. According to the Center for Disease Control (CDC) the major risk factors for C *difficile are* antibiotic exposure, long term care, hospital stays, GI surgeries, advanced age, immunocompromising conditions and proton pump inhibitors.

Protocol:

Within the first 3 days of admission time, if a patient has a diarrhea stool, defined as watery, unformed stool, conforms to shape of container, (Bristol 7 only) obtain a physician order for C. *difficile* testing and send the specimen to lab for testing for C. *difficile*. This will define if this is community acquired C. *difficile*.

After the patient has been admitted for over 3 days, wait for three diarrhea (Bristol 7 only) stools then send the third one to lab for C. *difficile* testing. This will help to define if this is hospital acquired C. *difficile*.

Other causes of diarrhea should be considered and ruled out. Some common causes include tube feeds, drugs, exacerbations of medical conditions. Check to see if patient is on a laxative and ask physician to consider discontinuing if it is not ordered for specific diagnosis i.e. lactulose.

Documentation of specimen sent to lab will be done on the electronic medical record (Clinical Care Station).

A. Laboratory Diagnosis
   a. The lab will perform testing per their protocol.
   b. It is unnecessary to send multiple specimens for C *difficile* testing.
   c. Do not repeat a negative test for at least 7 days.
   d. All positive C. *difficile* results are to be reported as a STAT critical lab to attending physician by nursing staff.
   e. Do not repeat a positive test for at least 21 days.

Infection Control

A. Contact Plus Isolation is used for *C. difficile* positive patients.

B. See "Transportation of the Isolation Patient" for transport to another department.

C. Refer to San Gorgonio Memorial Hospital (SGMH) Standard and Isolation Precautions Policy & Procedure.

Treatment

A. Consider stopping all non-essential antibiotics

B. Discontinue all stool softeners and laxatives.

C. Do not use drug therapy as prophylactic treatment

D. Duration of therapy should be at least 10-14 days

References:

Clinical Practice Guidelines for C. *difficile Infections* in Adults 2010 SHEA-IDSA Infection Control and Hospital Epidemiology May 2010, vol. 31, no. 5

https://www.cdc.gov/hai/organisms/cdiff/cdiff_clinicians.html

Attachments

Bristol Stool Chart

Approval Signatures

Step Description	Approver	Date
	Susan Sommers: Director of Infection Control and Risk Management	pending

SAN GORGONIO MEMORIAL HOSPITAL

Origination: *N/A*
Approved: *N/A*
Last Revised: *N/A*
Policy Area: *Infection Control*
References:

Controlled Air Purifying Respirator (CAPR)

PURPOSE:

Usage of a CAPR is to protect staff , unable to wear N95 respirators, from airborne pathogens during routine care for patients where protection from airborne contaminants is warranted, and/or during high-hazard procedures on a patient with a suspected or confirmed Aerosol Transmissible Disease (ATD).

POLICY:

MAXAIR CAPR Systems are to be used by all staff entering negative airflow, Airborne Infection Isolation Rooms (AIIR), who are unable to wear N95 respirators, during hospitalization of patients requiring Airborne Precautions and/or by those individuals performing high-hazard procedures on a patient with a suspected or confirmed Aerosol Transmissible Disease (ATD).

All staff who will have need to enter an airborne isolation room will receive initial and annual respiratory protection training, including proper use, procedures for assembly/disassembly, donning/doffing, cleaning/ disinfection, and storage of respirators. CAPR wearers still need full annual respiratory protection training. Additional training will be provided to the Health Care Worker as needed by the hospital, by employee health services and/or the clinical educator.

The following departments will be included, but not limited to using the CAPR systems for medical use:

- RT, ED, Isolation rooms, Med/Surge, Obstetrics
- Anesthesia, Lab, Radiology, OR, Peri-natal, Pari-operative
- Diagnostic Imaging/X-ray, Engineering, Clinical lab/Phlebotomists
- Cardio-pulmonary, Patient Transport, ICU/DOU
- GI/Pulmonary, L & D, PACU and Environmental Services

PROCESS:

The following personnel/departments will or may be involved with initial inspection, assembly, storage and/or distribution:

1. **Respiratory Therapy**- will maintain CAPR cart in the Respiratory Therapy Department and will co-sign with EVS personnel, on a sign out form located on the CAPR cart, each time a CAPR helmet and supplies are removed or returned to the CAPR cart.
2. **Patient's Nurse**- will contact EVS when order is received to place patient on Airborne Isolation

3. **EVS Personnel**– will set up Isolation cart outside of the patient room and will contact Respiratory Therapy personnel (or the House Supervisor if Respiratory Therapy unable to assist) and go the Respiratory Department to obtain a CAPR helmet with supplies (CAPR helmet, comfort strips, one box Disposable Lens-Cuff (DLC) Lens-Cuff Med/Lg and one box DLC Lens- Cuff SM/Med, battery, charger, waist belt and box of surgical caps).
4. **EVS personnel** - will place CAPR helmet, battery, charger and waist belt in a bag which they will place in the anteroom of the Airborne Isolation room or on a hook on the cart if no anteroom available.
5. **EVS personnel** – will place box of comfort strips, one box DLC Lens-Cuff Med/Lg and one box DLC Lens- Cuff SM/Med on isolation cart.
6. **House Supervisor** – will sign out the CAPR helmet and supplies to EVS if Respiratory Therapy personnel are not available to assist.

Quick Instructions for MAXAIR CAPR Use:

1. Gather equipment from isolation cart prior to entering isolation room: Comfort strip, DLC – S/M or M/L, and surgical cap.
2. Enter anteroom with above supplies. (When patient's isolation room does not have an anteroom the following steps should be conducted just outside the patient room prior to entering).
3. Remove the following from the designated CAPR bag in the anteroom/ or on cart just outside the patient room:
    a. CAPR Helmet
    b. Lithium-Ion Battery – powers the CAPR system
    c. Battery/helmet cord
4. Connect and gently twist the helmet power cord into the battery
5. Check indicator lights in front of helmet: 5 LED lights will illuminate for 3-5 seconds, one Amber, one Red and three Green, and then only the Green battery charge status lights will remain illuminated.
    a. Battery holds charge for approximately 8 - 10 hours
        i. Yellow = airflow low
        ii. 3 Green lights
            1. 3 Green lit = approximately 75-100% charge remaining
            2. 2 Green lit = approximately 50-75% charge remaining
            3. 1 Green lit = approximately 25-50% charge remaining
        iii. Red = approximately 0-25% charge remaining
            1. Change out battery within 15 - 20 minutes
6. Visually inspect to ensure CAPR is in good working order and free of defects. For any defects, place a red tag on equipment and send work order to Engineering.
    a. Inspect for any cracks, tears or broken parts.
7. Place battery in right side pocket or clip on user's right side pants/belt/waist belt.
8. Don surgical cap.
9. Attach new comfort strip to inside front of helmet

10. Pull tab to remove outer lens protective film on the DLC
11. Attach the DLC to helmet by snapping into all three (3) attachment holes. (A clicking noise will be heard).
12. Turn ratchet knob (on back of helmet) counter clockwise to loosen the headband prior to donning.
13. Hold helmet by ratchet knob with one hand and top center of cuff with the other. Pull the cuff toward your chin, place chin into cup between lens-cuff and pull the helmet over and down on the head.
    a. The cuff is a thin flexible plastic cuff that faces to inside of helmet behind the lens. Headband should rest ½ inch above eyebrow
    b. Insure that the DLC is fit to the face all around the chin and up to the temples on each side, and that the DLC Flappers are away from the lens and within ¼ inch of the temples on each side of the head
14. Tighten ratchet band by turning ratchet knob "clockwise" for most secure and comfortable fit.

Doffing and Storage of CAPR:

1. When the nurse/user is preparing to egress the patient's room, the nurse/user removes soiled gloves and washes her/his hands in the patient's room, or washes her/his hands in the anteroom.
2. The nurse/user dons a new pair of gloves, removes the helmet from her/his head, doffs the surgical cap, removes and disposes of the Disposable Lens Cuff (DLC) and the comfort strip, wipes the inside of the helmet then the outside of the helmet, then the helmet power cord and battery with disinfectant wipes (Sani-cloth) and places them in a single bag.
3. The nurse/user places the bag on a hook in the anteroom or outside the patient's room on the cart signifying that the CARP and supplies are clean/disinfected.
4. If the patient involved is a c-diff precaution patient, the nurse/user uses a Clorox or bleach based wipe on the inside of the helmet, and a quaternary ammonium or alcohol based wipe on the outside of the helmet, i.e., Sani-cloth

CAPR Disinfection (Terminal Cleaning/ Charging of the Battery/ Storage):

The following procedures will be utilized by but not limited to the personnel below:

1. The nurse/user on the unit wearing the CAPR will remove the Disposable Lens Cuff (DLC) and the front sweatband, and dispose of according to hospital protocol, then follow instructions in the **MAXAIR CAPR Disinfection Procedures** listed below in Section #5. **MAXAIR CAPR Disinfection Procedures**
    a. Remove gloves and gown in patient room
    b. DO NOT REMOVE THE CAPR UNIT
    c. Perform hand hygiene by cleaning hands with soap and water or alcohol based hand sanitizer.
    d. Don a new pair of gloves
    e. Remove the CAPR helmet by grasping the ratchet knob and pulling forward to remove the helmet.
    f. Doff the surgical cap
    g. Use Sani-Cloth wipe to disinfect CAPR unit
    h. Clean the inside of the CAPR
    i. Wipe down the entire outer surface of the CAPR, which includes the battery cable and battery pack
    j. Allow CAPR to dry before reuse
        i. Super Sani-Cloth (purple top) = 2 minute dry time

ii. Sani-Cloth Plus (red top) = 5 minute dry time

2. The nurse on the unit using the CAPR disinfects the unit and places the battery on the charger after each shift. The CAPR is stored in a plastic tote bag which includes the CAPR, the battery and helmet cable..
3. EVS is responsible for picking up the used CAPRs when Airborne isolation has been terminated, providing terminal disinfection, and returning the disinfected CAPR helmet with battery, charger and helmet battery cord, to the Respiratory Therapy department.
4. On a monthly basis, a designated individual in the Respiratory Therapy department will perform preventive maintenance of the CAPRs- clean ALL units, regardless of frequency of use, and conduct preventive maintenance (PM) on all helmets via a visual inspections of the helmet, filter cover cap, HE filter cartridge, inside of helmet, battery and battery charger for any obvious signs of damage or abuse of the system. They also replace each filter cartridge as needed and at least once a year.

Procedures Required for Use OF CAPR for Patients on Airborne Isolation Precaution:

Practitioners determination that use of CAPR would compromise performance/result of procedure is rational for use of alternative respiratory protection i.e. N95 respirator.

The following procedures are included but not limited to the use of the CAPR System:

- Autopsy
- Bronchoscopy
- CPR
- Intubation
- Medication Administration By Aerosol Spray or Nebulizer (e.g. Pentamidine Treatment)
- Nasal/Endotracheal Suctioning
- Pulmonary Function Testing
- Sputum Induction
- TP Lymph Node Lancing

Traffic Control:

1. Hospital Employees not directly involved in the direct care of the patient requiring Airborne Precautions will not be allowed in the rooms.
2. The doors to the rooms will remain closed at all times to maintain negative pressure and avoid disruption of air flow.
3. Nursing has the authority and responsibility to limit visitors and guests as needed for patient, visitors and employee safety.
4. All visitors entering the airborne infection isolation rooms will be required to wear a surgical mask or an N95 mask respirator as minimum.
5. Only Health Care Workers are permitted to don a CAPR. CAPRs are not for visitor or patient use.

Workplace Safety

1. Be sure CAPR is turned off and disconnected from power before cleaning with wipes or any liquid material.
2. Do not immerse helmet in water or any liquid as it may damage the fan module.
3. Do not use alcohol (Isoprophyl alcohol may be used) or solvents to clean the helmet as it may deface the

CAPR material.

4. CAPRs are not intended for use in atmospheres deemed immediately dangerous to life or health (IDLH).
5. CAPRs do not produce oxygen; therefore, do not use CAPRs in atmospheres containing less than 19% oxygen.
6. Pay attention to the status lights of the CAPR. Damaged and worn filters cartridges must be replaced immediately to ensure adequate protection for the user

WARNING: Inspect each system component before use to insure against defects, damage, or residue from cleaning. DISCLAIMER: This recommendation is based on best efforts of understanding disinfection procedures currently in place for similar items and is not based on laboratory data or specific experimental findings.

Storage of MAXAIR Systems beyond routine use should only be done in environments that are comparable to normal working environments for health care professionals in terms of temperature, pressure, relative humidity, and the presence of any toxic and corrosive elements.

ITEM	ESTIMATED SHELF LIFE*
Helmets, helmet liners, power cords, filter covers, filter cover caps, DLCs, hooks	Relatively indefinite; 7-10 years
Filters, hoods, filter cartridges	2-5 years
Li-Ion Batteries	3-5 years
Cuffs, shrouds, chin straps	5-10 years
Comfort strips	5-10 years
Chargers	Relatively indefinite; 7-10 years

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Infection Control Committee	Susan Sommers: Director of Infection Control and Risk Management	pending
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	03/2020
	Susan Sommers: Director of Infection Control and Risk Management	03/2020

SAN GORGONIO MEMORIAL HOSPITAL

Origination: *N/A*
Approved: *N/A*
Last Revised: *N/A*
Policy Area: *Infection Control*
References:

Coronavirus Disease 2019 (COVID-19) Risk Assessment & Management Decision Making

Purpose:

The purpose of the policy is to provide guidance for the management of Coronavirus Disease 2019 (COVID-19). San Gorgonio Memorial Hospital (SGMH) may need to respond to a surge in patients requiring care. Note that public health guidance will shift as the COVID-19 outbreak evolves. SGMH will be notified of any updates from local and state public health recommendations and will notify associates as information becomes available. Our facility goal is to:

A. Reduce morbidity and mortality
B. Minimize disease transmission
C. Protect healthcare personnel
D. Preserve healthcare system functioning

Hospital Preparation:

The hospital follows the Centers for Disease Control and Prevention (CDC) recommendations:

1) Minimize chance of exposure: Measures are implemented before patient arrival, upon arrival, and throughout the duration of the Person Under Investigation (PUI) presence in the hospital.

A. Prior to arrival: If patient is arriving via transport by emergency medical services (EMS) or phones in before arrival, staff will take appropriate preventative actions (e.g. place a facemask on PUI prior to entry into the hospital). Staff will prepare an isolation cart outside of the negative pressure room.
B. Upon arrival and during the visit: Steps will be taken to ensure all persons with symptoms of suspected COVID-19 or any other respiratory infection adhere to respiratory hygiene and cough etiquette, hand hygiene, and triage procedures throughout the duration of the visit. Visual alerts are posted at the entrance of the Emergency Department lobby to provide patients with instructions about hand hygiene, respiratory hygiene, and cough etiquette. Patients with fever, respiratory symptoms, and recent travel and/or contact with a laboratory-confirmed case of COVID-19 will be isolated and rapidly triaged in a negative pressure room or a well-ventilated space that allows people to be separated six or more feet (e.g. disaster tent).
C. The hospital has developed an algorithm for Risk Assessment & Management Decision Making for anyone that presents to the Emergency Department (ED) waiting room with fever, respiratory

symptoms, and recent travel and/or exposure with a laboratory-confirmed case of COVID-19. Please see attached.

2) Adherence to standard, contact, and airborne precautions, including the use of eye protection.

A. A patient with known or suspected COVID-19 will be placed in a negative pressure room.

B. Transport and movement outside the negative pressure room will be limited. If out of the negative pressure room the patient must wear a mask.

C. Associates entering the room will use Personal Protective Equipment (PPE), including N95 and eye protection. Only essential personnel should enter the room to minimize exposure. The hospital will keep a log of all personnel who come into contact with the PUI.

D. Hand hygiene should be performed before and after all contact with PUI.

E. All respiratory specimens should be double-bagged in a hazardous specimen collection bag.

F. If the patient has a confirmed diagnosis of COVID-19, the room will be cleaned using standard practice for airborne precautions.

Plan for COVID-19 Pandemic:

A. Implement the Hospital Incident Command System (HICS).

B. Handle surge capacity and business continuity. This is done by implementing Code Purple and HICS if necessary. The Respiratory Hygiene Cough Etiquette Program should be instituted. A plan will be in place to optimize SGMH's supply of PPE in the event of shortages. SGMH will identify flexible mechanisms to procure additional supplies when needed.

C. Work with The California Department of Public Health (CDPH) and the County of Riverside Public Health Department (CRPHD) to understand the impact and spread of the outbreak in our area. SGMH will fulfill proposed disease reporting requirements to these organizations.

D. Monitor healthcare workers and ensure maintenance of essential healthcare facility staff and operations:

1. Ensure staff is encouraged to stay home if they are ill with respiratory symptoms.
2. Make contingency plans for increased absenteeism caused by employee illness or illness in employees' family members that would require them to stay home. Planning for absenteeism could include extending hours, cross-training current employees, or hiring temporary employees.

E. Reschedule elective surgeries as necessary.

F. Limit visitors to COVID-19 patients. If visitors are with COVID-19 patients, they will be educated on standard, contact, and airborne precautions and PPE.

G. Plan for a surge of critically ill patients and identify additional space to care for these patients.

H. Promoting the increased use of telehealth.

Reference(s):

The Center for Disease Control and Prevention https://www.cdc.gov/coronavirus/2019-ncov/index.html

California Department of Public Health https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx

Attachments

Coronavirus (COVID-19) Disease Algorithm 3.30.2020.docx

Approval Signatures

Step Description	Approver	Date
Infection Control Committee	Susan Sommers: Director of Infection Control and Risk Management	pending
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	03/2020
	Susan Sommers: Director of Infection Control and Risk Management	03/2020

SAN GORGONIO MEMORIAL HOSPITAL

Origination:	*12/1986*
Approved:	*N/A*
Last Revised:	*05/2020*
Policy Area:	*Surgical Services*
References:	*AORN (2020) Guidlinesfor Sharps Safety AORN*

OR - Duties of a Scrub Nurse / Technician

Policy:

The Scrub Nurse/technician is the member of the operating room team who manages the sterile field and works closely with the surgeon.

Purpose:

To describe the duties of the Scrub Nurse /Technician in the OR.

Procedure:

Characteristics and Qualities:

1. Organization of work
2. Strict Sterile/Aseptic technique
3. Functions at a quick pace without breaks in technique
4. Ability to act promptly and efficiently under any circumstances
5. Quiet and pleasing manner

In Advance:

- Arrange sterile and non-sterile supplies according to surgeon's preference card.
- Help open sterile packs and instruments and sutures.
- Scrub hands and arms by OR routine.
- Don sterile gown and gloves per ***OR - Gown and Glove*** policy.
- Arrange instruments, drapes and supplies on sterile supply \ table in convenient manner.
- Check chemical indicator parameters.
- Be sure all instruments with working parts move easily.
- Prepare ligatures and sutures as surgeon ordinarily uses them.
- Count sharps and sponges with Circulator. Needle counters must be used on all cases to secure needles and blades.See policy: ***OR - Sponge, Needle and Instrument Counts***.
- Assist in gowning and gloving the surgical team.
- Assist in draping the patient and field, as needed.
- Move sterile tables convenient to draped field.

- Place all sterile cords and tubing (suction, bovie) convenient to Surgeon and secure to drapes.
- Place radiopaque sponges or lap sponges on field as desired by Surgeon.
- Participate in the Time out Procedure See policy: ***Surgical Services - Universal Protocol***.

During Operation:

- Watch progress of operation; anticipate and furnish needs of Surgeon.
- Hand instruments, sponges, sutures, etc. when and as needed in an efficient manner.
- Keep operative field and Mayo stand organized during case.
- Keep instruments free of blood and tissue by wiping frequently with sterile, damp sponge.
- Handle "sharps" minimally and with caution to prevent injury and to protect edges of device.
- Run sterile solution through suction tip as needed to prevent clogging.
- Keep accurate count of irrigation solution used.
- If necessary to hold a retractor, watch tip location in wound to avoid pressure on blood vessels or nerves.
- Retain on back table of the sterile field any organs, skin bone or cartilage removed. Tissue may be replaced in wound or processed for banking/pathology per physician's orders. Keep moist with saline solution.
- Tissue specimens to be sent to Pathology may be handed to circulating nurse on a towel or in a basin.
- Keep track of needles, instruments and sponges so that none will be misplaced or lost in the wound. Keep accurate needle/instrument count.
- Keep accurate sponge, needle and instrument counts. Count sponges carefully prior to closure with circulating nurse. (See policy: ***OR - Sponge, Needle and Instrument Counts***)
- Supply sterile dressing materials only after wound closesure.

Responsibilities:

- To maintain a sterile field.
- To anticipate, insofar as possible, the needs of the surgical team and to supply such needs
- To assist efficiently within the sterile field as requested by Surgeon.
- To use supplies conservatively and economically.
- To perform all duties in a manner consistent with good operative/sterile technique.

After Operation:

- After patient leaves, the room and all equipment are prepared for decontamination or cleaning.
- Use Cleansing solutions and disinfectants for washing down tables and equipment.
- The policy: ***Surgical Services - Cleaning of Surgical Procedure Rooms*** should be followed.
- At the end of the case, the scrub person takes all instruments to the decontamination area in a covered, leak-proof, puncture-proof container. See policies related to the Sterile Processing Department for details: ***Cleaning and Decontamination of Surgical Instruments***.
- Drapes should be checked for instruments before removal, then discard soiled drapes or linen into appropriate containers. Unused linen is also bagged and sent to the laundry. Waste and trash are removed and discarded. All unused supplies are either discarded or returned to sterile storage. When everything has been returned to its proper place, the scrub nurse/tech may then turn attention toward preparing for the next case.
- The separate activities of the Scrub and Circulating Nurse must be closely coordinated throughout the case if it is to proceed smoothly. Duties of these two positions are listed separately, but it must be understood that their performance be in a spirit of mutual cooperation that will best serve the patient's needs.

Guidelines and Precautions to be Observed in Accordance with Aseptic Technique and Good Patient Care:

1. Prompt action is extremely important, do not minimize this fact. However, never sacrifice aseptic technique for promptness. Organized work facilitates accuracy and promptness, which then operates hand in hand, with sterile/aseptic technique. When work is organized, movements are definite and orderly.
2. Every person working in surgical services must develop a "sterile conscience", alert to contamination, no matter how slight.
3. Use appropriate protective barriers such as sterile gowns, gloves,masks and drapes to prevent transfer of microorganisms to health care personnel or patients.
4. Sterile areas of one scrubbed person should only touch sterile areas of another. The same is true of non-sterile areas.
5. Leave margin for safety between sterile and non-sterile areas. Direct line of traffic away from sterile areas.
6. Keep wrapped, sterile supplies in an area where they will remain clean and dry.
7. Do not transport or store sterile and non-sterile instruments on the same shelf.
8. Sterile and direct patient care items should not come in contact or be stored on the floor.
9. Be sure, when transferring medications or supplies of any kind, that no loose particles or non-sterile items fall on sterile field.
10. Use appropriate environmental controls, to prevent the spread of microorganisms, such as keeping doors closed, minimizing traffic movement and excluding unnecessary personnel during procedures.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Infection Control Committee	Susan Sommers: Director of Infection Control and Risk Management	pending
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	05/2020
	Jayme Goodner: Director Surgical Services	05/2020

SAN GORGONIO MEMORIAL HOSPITAL

Origination:	*04/2019*
Approved:	*N/A*
Last Revised:	*03/2020*
Policy Area:	*Clinical Laboratory*
References:	

QuickVue Dipstick Strep A test

Policy:

Intended Use

The QuickVue Dipstick Strep A test is intended for the rapid, qualitative detection of Group A Streptococcal antigen from throat swabs or confirmation of presumptive Group A Streptococcal colonies recovered from culture. The test is to be used to aid in the diagnosis of Group A Streptococcal infection. For use by healthcare professionals.

Summary and Explanation

Group A *Streptococcus* is one of the most important causes of acute upper respiratory tract infection. Early diagnosis and treatment of Group A Streptococcal pharyngitis has been shown to reduce the severity of symptoms and serious complications such as rheumatic fever and glomerulonephritis.1 Conventional identification procedures for Group A *Streptococcus* from throat swabs involve the isolation and subsequent identification of viable pathogen techniques that require 24 to 48 hours or longer for results.2

Principle of the Test

The QuickVue Dipstick Strep A test is a lateral-flow immunoassay utilizing Quidel's patented antibody-labeled particles. The test detects either viable or nonviable organisms directly from throat swabs or culture colonies within 5 minutes.

To perform the test, a throat swab specimen is collected. Antigen is extracted from the swab specimen with Reagents A and B. The Dipstick is then added to the extracted sample.

If the sample contains Strep A antigen, a pink-to-purple Test Line along with a blue procedural Control Line will appear on the Dipstick, indicating a positive result. If Strep A antigen is not present, or present at very low levels, only a blue procedural Control Line will appear.

Procedure:

Reagents and Materials Supplied

Each kit contains:

? Individually packaged Dipsticks (25 or 50): Dipsticks coated with rabbit polyclonal anti-Group A *Streptococcus*

? Extraction Reagent A (1): Contains 4 M sodium nitrite

? Extraction Reagent B (1): Contains 0.2 M acetic acid

? Sterile Throat Swabs (25 or 50)

? Tubes (25 or 50)

? Positive Control (1): Heat-inactivated Group A *Streptococcus* with 0.02% sodium azide

? Negative Control (1): Heat-inactivated Group C *Streptococcus* with 0.02% sodium azide

? Package Insert (1)

? Procedure Card (1)

Warnings and Precautions

? For *in vitro* diagnostic use.

? Do not use beyond the expiration date printed on the outside of the box.

? Dispose of containers and used contents in accordance with Federal, State and Local requirements.

? The Dipstick must remain sealed in the protective foil pouch until just prior to use.

? Reagent B contains an acidic solution. If the solution contacts the skin or eye, flush with large volumes of water.

? Use of nitrile or latex gloves is recommended when handling the extraction reagents within this kit.3,4

? Do not interchange reagent bottle caps.

? If Reagent B is green prior to mixing with Reagent A in the Tube, do not use and contact Technical Support.

? To obtain accurate results, you must follow the package insert instructions.

Storage and Stability

Store the kit at room temperature 59–86°F (15–30°C), out of direct sunlight. Kit contents are stable until the expiration date printed on the outer box. Do not freeze.

Specimen Collection and Storage

Collect throat swab specimens by standard clinical methods. Consult standard reference procedures such as the collection method described by Miller and Holmes.5 Depress the tongue with a tongue blade or spoon. When swabbing the throat, be careful not to touch the tongue, sides or top of the mouth with the swab. Rub the swab on the back of the throat, on the tonsils and in any other area where there is redness, inflammation or pus.

Use rayon tipped swabs to collect throat specimens. Do not use calcium alginate, cotton tipped or wooden shaft swabs.

It is recommended that swab specimens be processed as soon as possible after collection. Swabs can be held in any clean, dry plastic tube or sleeve up to 72 hours at room temperature (15–30°C), or refrigerated (2–8°C) before processing. The use of charcoal or agar medium is not recommended.

If a culture is desired, lightly streak the swab on a 5% sheep blood agar plate before using the swab in the QuickVue Dipstick Strep A test. Do not perform the QuickVue Dipstick Strep A test before streaking the swab,

as the Extraction Solution will destroy the bacteria on the swab, thereby rendering the organism incapable of successful culturing. Alternatively, throat swab specimens can be obtained by dual swabs or by two sequential swabs for the culture procedure.

Culture Confirmation

The QuickVue test can be used to confirm the identification of Group A Streptococcus on blood agar plates. Lightly touch a colony using a sterile swab. Do not sweep the plate. Follow the instructions in the TEST PROCEDURE section to test the swabs.

Quality Control

Built-in Control FeaturesThe QuickVue Dipstick Strep A test provides three levels of internal procedural controls with each test run. For daily quality control, Quidel recommends documenting that these internal controls were checked for the first sample tested each day.

? The color of the Extraction Reagent changes from clear to green as the reagents are mixed together. The color change is an internal extraction reagent control and is an indication that the reagents were mixed and functioning properly.

? The appearance of a blue Control Line is an internal control. The Dipstick must absorb the proper amount of sample and the Dipstick must be working properly for the blue Control Line to appear. Additionally, the appearance of the Control Line indicates that capillary flow occurred.

? A clear background is an internal background negative control. If no interfering substances are in the sample and the Dipstick is working properly, the background in the Result area should be white to light pink within 5 minutes and not interfere with the reading of the test result.

External Quality Control TestingExternal controls may also be used to demonstrate that the reagents and assay procedure perform properly.

Quidel recommends that positive and negative controls be run once for each untrained operator, once for each new shipment of kits — provided that each different lot received in the shipment is tested — and as deemed additionally necessary by your internal quality control procedures, and in accordance with local, state, and federal regulations or accreditation requirements.

If the controls do not perform as expected, repeat the test or contact Quidel Technical Support before testing patient specimens.

Assay Procedure

? Do not remove Dipsticks from the foil pouch until ready to perform the assay.

? To avoid cross contamination, do not allow the tip of the reagent bottles to come in contact with sample swabs.

Test Procedure

Important:

? *Gloves should be worn when handling samples.*

? *Do not use Reagent B if the solution is green prior to mixing with Reagent A in the Tube. If this occurs, contact Technical Support.*

1 Just before testing, add **three (3) DROPS** of Reagent A and **three (3) DROPS** of Reagent B into a clean

tube. This solution should turn **green.**

When adding drops, hold bottle vertically so that a complete drop forms.

2 Immediately add the patient swab sample to the tube. **Squeeze** the bottom of the tube so the swab head is compressed. Rotate the swab a **minimum of five (5) times.**

Keep swab in tube for one (1) minute.

3 Express **all** liquid from the swab against the inside of the tube. **Squeeze** the swab firmly as it is removed from the tube. Discard the swab.

4 Remove the Dipstick from the foil pouch. Place the Dipstick into the tube with the arrows of the Dipstick pointing down. Do not handle or move the Dipstick until the test is complete and ready for reading.

5 Read result at five (5) minutes. Some positive results may appear sooner.

Interpretation of Results

POSITIVE RESULT: Any pink to purple Test Line along with any shade of a blue procedural Control Line is a positive result for the detection of Group A *Streptococcus* antigen.

NEGATIVE RESULT: A blue procedural Control Line and no pink Test Line is a presumptive negative result.

INVALID RESULT: The test result is invalid if a blue Control Line is not visible at 5 minutes. If this occurs, retest using a new sample and a new Dipstick or contact Technical Support.

QC Testing Procedure

? Follow the instruction procedures in the TEST PROCEDURE to dispense the Extraction Reagents into the tube (step 1).

? Vigorously mix the Control Bottles. Add one (1) drop of the Negative or Positive Control into the tube.

? Place a clean swab into the tube and follow the instructions for testing the patient swab.CONTROL REGION (C)TEST REGION (T)**POSITIVE(+) NEGATIVE(–) INVALID( )**

Limitations

The contents of this kit are for use in the **qualitative** detection of Group A Streptococcal antigen from throat swab specimens and culture colonies only. Failure to follow the test procedure and interpretation of test results may adversely affect performance and/or produce invalid results.

The test detects both viable and nonviable Group A *Streptococci* and may yield a positive result in the absence of living organisms.

Respiratory infections, including pharyngitis, can be caused by *Streptococcus* from serogroups other than Group A as well as other pathogens. The QuickVue Dipstick Strep A test will not differentiate asymptomatic carriers of Group A *Streptococcus* from those exhibiting Streptococcal infection.6

Some commercial controls may contain interfering additives and are not recommended for use in the QuickVue test.

Test results must always be evaluated with other data available to the physician. A negative test result might occur if the level of extracted antigen in a sample is below the sensitivity of the test or if a poor quality specimen is obtained. Additional follow-up testing using the culture method is recommended if the QuickVue test result is negative.

Expected Results

It is believed that approximately 19% of all upper respiratory tract infections are caused by Group A *Streptococci.*7 Infection is most prevalent in winter and early spring, with most cases arising in patients living in highly populated areas.

Performance Characteristics

Field Study In a multi-center field evaluation, a total of 329 throat swab specimens were collected from patients presenting with pharyngitis. Each swab was inoculated onto a sheep blood agar plate, then tested by the QuickVue Dipstick Strep A test. Plates were incubated for 24–48 hours at 37°C with a Bacitracin disk. Presumptive GAS colonies were confirmed with commercially available Strep A testing kits.

Of the 329 total specimens, 192 were negative and 137 were positive by culture. The QuickVue test identified 188 of the culture negative and 126 of the culture positive for a specificity of 98% and a sensitivity of 92%. The 95% confidence intervals were calculated to be 95%–99% for specificity and 86%–96% for sensitivity. Overall agreement between culture and the QuickVue Dipstick Strep A test was 95%. These study results demonstrate that no statistical differences were observed between the QuickVue test and standard culture techniques.

In addition, the QuickVue test was used to confirm the identification of Group A *Streptococcus* on blood agar plates. As a culture confirmation, the test was 100% sensitive.**Sensitivity:** 126/137 = 92%**Specificity:** 188/192 = 98%**Agreement:** 314/329 = 95%**Culture+Culture–TotalQuickVue –QuickVue +**126411137188192**Culture Classification QuickVue Results** Total Negative**Specificity**188/192 (98%)1+ (≤ 10 colonies)16/20 (80%) Rare1/3 (33%)2+ (11–50 colonies)46/49 (94%) 3+ (> 50 colonies)28/30 (93%) 4+ (predominant growth)35/35 (100%) Total Positive**Sensitivity**126/137 (92%) Total **Agreement**314/329 (95

QuickVue Dipstick Strep A test FOR INFORMATIONAL USE ONLY ? FOR INFORMATIONAL USE ONLY Not to be used for performing assay. Refer to most current package insert accompanying your test kit.

Cross-ReactivityThe following organisms tested at levels of approximately 1x107 organisms/test and greater were all found to be negative when tested in the QuickVue test.

Streptococcus Group B*Streptococcus* Group C*Streptococcus* Group F*Streptococcus* Group G *Streptococcus pneumoniae Streptococcus mutans Streptococcus sanguis Streptococcus* ungrouped *Branhamella catarrhalis Bordetella pertussis Candida albicans Corynebacterium diptheria Enterococcus faecalis E. coli Hemophilus influenza Klebsiella pneumoniae Neisseria gonorrhoea Neisseria meningitidis Neisseria sicca Neisseria subflava Pseudomonas aeruginosa Staphylococcus aureus Staphylococcus epidermidis Serratia marcescens*

POL Studies An evaluation of the QuickVue test was conducted at three Physicians' Offices using a panel of coded specimens. Testing was performed by physician office personnel with diverse educational backgrounds and work experiences at three different locations. The proficiency panel contained negative, low positive and moderate positive specimens. Each specimen level was tested at each site in replicates of at least five over a period of three days. No significant differences were observed within run, between runs or between sites.

Assistance

If you have any questions regarding the use of this product, please call Quidel's Technical Support number, (800) 874-1517 (toll-free in the U.S.A.) or (858) 552-1100, Monday through Friday, between 7:00 a.m. and 5:00 p.m. Pacific Time, U.S.A. If outside the United States, contact your local distributor or technicalsupport@quidel.com.

References

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Infection Control Committee	Susan Sommers: Director of Infection Control and Risk Management	pending
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	03/2020
	Mark Beck: Medical Director Clinical Lab	03/2020
	Byron Hazley: Director Laboratory	03/2020

SAN GORGONIO MEMORIAL HOSPITAL

Origination:	*06/2018*
Approved:	*N/A*
Last Revised:	*02/2020*
Policy Area:	*Nursing*
References:	*CMS Core Measure*

Sepsis Identification & Management

Purpose:

Emergent Identification of Septic Patients

Policy: Surviving Sepsis Guidelines

GUIDELINES: Surviving Sepsis Campaign (SSC) is widely recognized as the industry standard source of best practice recommendations related to the identification and treatment of sepsis patients, including the 3 and 6 hour bundles of care. With this Standard we want to fully implement the recommendations of the SSC.

Sepsis can present in any acute care environment. Our primary focus will be in the Emergency Department (ED) and Intensive Care Unit (ICU) both common starting points for sepsis initiatives. We will also provide timely screening and interventions at the point of first presentation in any inpatient unit upon any patient status changes during the course of their inpatient stay.

BACKGROUND: It is estimated that one sepsis or septic shock patient presents to a United States (US) Emergency Department (ED) every minute. Sepsis represents approximately 20% of all Intensive Care Unit (ICU) admissions. Mortality for sepsis with or without hypo-profusion and septic shock ranges from 28 to 50%. An estimated 215,000 deaths from sepsis occur in the US each year and the costs associated with the disease are in excess of $16 billion. Sepsis is the leading cause of death in non-cardiac ICUs and the 10th leading cause of death overall in the US. Patients may present for treatment anywhere along the sepsis continuum from sepsis to hypo-perfusion to septic shock. Time is of the essence in treating this deadly disease regardless of the stage at which it presents. Early recognition and timely treatment are shown to reduce progression of this disease. Estimates of death from septic shock increases more than 7% for every hour proper treatment is delayed.

Procedure: Sepsis Screening

Standard Criteria/Elements for Sepsis Screens - The screening of patients for sepsis should include the following elements:

A. Suspected of Confirmed Infection (aka "Question 1" from Screening tool) from any potential source including but not limited to pulmonary, urinary tract, abdominal, central nervous system (CNS), meningitis, skin/soft tissue, bone/joint, wound (surgical or traumatic), blood stream, catheter/device. Particular attention should be paid to those patients with predisposing risk factors for infection such as immune suppression (whether as result of certain disease states or from immune suppressing medications such

as corticosteroids, anti-inflammatory biologics or cancer chemotherapeutic agents), recent surgical procedure, or chronic illnesses such as chronic renal or hepatic failure.

B. Signs and symptoms of Systemic Inflammatory Response Syndrome (SIRS) (aka "Question 2" from screening tool):
    1. Temperature greater than 38.2 C0(100.9 F0) or less than 36 C0 (96.8 F0)
    2. Heart rate greater than 90 bpm
    3. Respiratory rate greater than 20 bpm or PaCO2 less than 32 mmHg
    4. Normal WBC count with (immature forms) Bands greater than 10%
    5. WBC count greater than 12,000 or less than 4,000
    6. Plasma glucose greater than 140 mg/dL or 7.7 mmo/L in the absence of diabetes

C. Signs of Organ Dysfunction (aka "Question 3"):
    1. Systolic blood pressure less than 90 mmHg or mean arterial pressure (MAP) less than 65 mmHg
    2. Systolic blood pressure decrease of greater than 40 mmHg from baseline
    3. Acute mental status changes
    4. Creatinine greater than 2.0 mg/dL (34.2 mmol/L) OR creatinine increase from baseline greater than 0.5 mg/dL OR urine output less than 0.5 ml/kg/hour for 2 hours or more
    5. Bilirubin greater than 2 mg/dL (34.2 mmol/L)
    6. Platelet count less than 100,000
    7. Lactate greater than 2 mmol/L (18.0 mg/dL)
    8. INR greater than 1.5 OR aPTT greater than 60 seconds
    9. Acute lung injury with PaO2/Fi02 less than 250 in the absence of pneumonia as infection source
    10. Acute lung injury with Pa02/Fi02 less than 200 in the presence of pneumonia as infection source

D. Screening Results - based upon the screening criteria above patients can be placed into one of the following categories:
    1. No Sepsis - absence of suspected or documented infection or infection with fewer than 2 SIRS criteria once screening is complete, including lab results
    2. Sepsis - Suspicion or documentation of infection PLUS two or more SIRS criteria met OR
    3. Sepsis - Sepsis as defined above PLUS one or more organ dysfunctions OR
    4. Sepsis with hypo-perfusion - Sepsis as defined above in the presence of hypotension (SBP less than 90, MAP less than 65, or SBP decrease of greater than 40) AND/OR lactate greater than or equal to 4 (four)
    5. Septic Shock - Sepsis with hypo-perfusion as defined above requiring vasopressors after initial fluid resuscitation of at least 30 ml/kg in order to maintain BP and signs of improved perfusion

E. Process for Conducting Sepsis Screening in Emergency Department:
    1. In Triage - Triage RN should complete sepsis screening form with all available elements on ALL ADULT PATIENTS. A nurse-driven protocol is in place to obtain a Point of Care (POC) or STAT lactate if the initial screen is positive for sepsis (i.e., suspected/confirmed infection plus at least two SIRS criteria). Provider should be notified right away of all positive sepsis screens. Patients meeting

criteria for sepsis, sepsis with hypo-perfusion, or septic shock should be bedded immediately and resuscitation/3-hour treatment bundle initiated (see description below).

2. Once Initial Laboratory Values are Available - All patients for whom "Question 1" with a suspected or confirmed infection is positive will need to have at a minimum a white blood cell count, band count, and glucose drawn to complete the SIRS criteria portion of the sepsis, sepsis with hypo-perfusion or septic shock, the 3-hour bundle should be initiated immediately.

F. Intensive Care Units:

1. On Admission - The bedside nurse should complete electronic sepsis screening in Clinical Care Station or the downtime form upon admission to ICU for all patients
2. As needed Change of Condition - The bedside nurse should complete another electronic sepsis screening in Clinical Care Station or the downtime form as needed in patient condition.

G. Other Inpatient/Observation Unit (e.g., Med/Surg, DOU):

1. On Admission - The bedside RN should complete the electronic sepsis screening in Clinical Care Station or the downtime form upon admission to the unit for all patients
2. At Change of Shift during Nursing Assessment - The bedside nurse should repeat the electronic sepsis screening in Clinical Care Station or the downtime form at the start of each shift.
3. PRN Change of Condition - The bedside RN should repeat the electronic sepsis screening in Clinical Care Station or the downtime form as needed with any concerning change in patient condition (e.g., change in mentation, change in vital signs, new or worsening lab values suggesting infection or organ dysfunction).

H. Use of Lactate Level:

1. When - Upon determination of a positive sepsis screen, a POC or STAT lactate should be completed, ideally via RN driven protocol or Code Sepsis process.
2. Turnaround Time - Lactate should be resulted within 60 minutes maximum to ensure initial treatment bundle can be completed within 3 hours. POC/STAT lactate is recommended when possible.
3. Repeat Lactate Level - If initial lactate greater than 2, a lactate level will be repeated every 3 hours until lactate normalizes (less than 2) per reflex order.
    a. Definition of Time Zero - "Time Zero" is the time at which the clock starts for purposes of tracking the 3 and 6 hour intervention bundles described below:

I. Emergency Department - Time Zero for all ED patients is defined as arrival time in the ED, NOT Triage Time.

II. Other Locations - In other locations (e.g., ICU, DOU, Med/Surg and OB) Time Zero is defined as the time of the first positive screen for either sepsis with hypo-perfusion or septic shock.

Interventions:

A. "Simple" Sepsis Patients - Management of the simple sepsis patient is at the discretion of the patient care team. Antibiotic therapy should be initiated if the suspected or confirmed infection source is likely bacterial in nature. Necessity of admission to an inpatient unit for treatment is dependent upon patient condition. In all cases the patient should have close follow up to monitor for progression of sepsis. Simple sepsis alone does not necessitate implementation of the full 3-hour bundle described below.

B. Sepsis Patients with or without hypo-perfusion initiated in the 3 HOUR BUNDLE - These items are to be

completed within 3 hours of "Time Zero" for patients with sepsis with or without hypo-perfusion.

1. Standard Labs - The following labs should be drawn as soon as possible after "Time Zero" to ensure all subsequent elements of the bundle can be completed during the 3 HOUR window:
    a. Lactate STAT
    b. Comprehensive Metabolic Panel
    c. Prothrombin time (PT)
    d. Partial thromboplastin time (PTT)
    e. CBC with differential
    f. Blood cultures X 2 - not to be drawn via indwelling vascular catheter and must be drawn from two different sites. **Blood Cultures** should be obtained before the first dose of antibiotics administered.
2. Additional Symptom-specific Labs/Imaging - The following labs/imaging studies should be added if relevant based on clinical signs/symptoms: urinalysis with micro, urine culture, sputum culture, wound culture, chest x-ray, computerized tomography (CT) scanned abdomen, arterial blood gas, and other cultures/imaging based upon presentation.
3. Antibiotics - Broad spectrum IV antibiotics should be initiated pending source identification and sensitivities. First dose to be given within 3 HOUR window from Time Zero in the ED setting and within one hour from Time Zero for inpatients.
4. STAT 30 ml/kg Fluid Bolus for sepsis patients with hypo-perfusion - Administer STAT minimum 30 ml/kg bolus of Normal Saline or Lactated Ringers if any of the following apply: SBP less than 90, MAP less than 65, SBP decrease from baseline greater than 40 mm/Gh, Lactate greater or equal to "4". The infusion rate is dependent on the patient's severity of illness but a bolus can typically be administered at 500 ml per 15 minutes via two lines. To meet the 3 HOUR bundle compliance, the bolus must be completed during this time frame.
5. Disposition - Any patient meeting criteria for sepsis, sepsis with hypo-perfusion or septic shock will require inpatient admission. If patient remains hypotensive or continues to have lactate greater than or equal to "4" after minimum 30 ml/kg fluid resuscitation, the 6 HOUR bundle should be initiated and the patient should be admitted/transferred to the ICU.

C. Septic Shock Patients - Addition of the 6 HOUR Bundle in addition to completing all elements of the 3 HOUR Bundle above the following items are to be completed within 6 HOURS of Time Zero for patients determined to have septic shock:

1. Fluid Resuscitation - Continue additional fluid resuscitation as appropriate. Additional modalities for assessment of intravascular volume and adequacy of resuscitation may be valuable.
2. Vascular Access - Place central line if central access not already available.
3. Vasopressors - If hypotensive following initial minimum 30 ml/kg fluid bolus described above in the 3 HOUR Bundle, begin treatment with vasopressors via central line.
    a. First Line - Begin vasopressor treatment with norepinephrine unless contraindicated. Titrate to systolic blood pressure greater than 90 mmHG and/or MAP greater than 65 mmHg
    b. Second Line - Consider additional vasopressors as needed.
4. Ongoing Monitoring - Ongoing and regular assessments of volume status and perfusion should be conducted and documented either by bedside physical assessment or by other available means.

5. Disposition - Patients with ongoing evidence of organ dysfunction, hypo-perfusion or shock should optimally have treatment continued in an ICU setting until their condition has stabilized.

SPECIAL INDICATIONS/NEEDS/CONSIDERATIONS

A. ID Consultation - Early consultation with an Infectious Disease consultant is recommended for all patients with sepsis, sepsis with hypo-perfusion, or septic shock to assist with source identification and antibiotic selection.

B. DNR, Comfort Care, Hospice, or Palliative Care Patients - It is recommended that patients with sepsis be screened for the appropriateness of Palliative Care consultation and asked about existing advanced directives as soon as possible upon diagnosis , even in the ED if presenting there. Should palliative care consultation be available and recommended the consultation should occur within the first three days of the hospital stay to ensure patient wishes are clearly understood and optimal care is delivered. DNR/ Comfort Care patients may be treated with only those elements of the 3 and 6 HOUR Bundles that are appropriate for their status and consistent with their values and wishes. Designated hospice patients and others who are clearly at the end of life (e.g., persistent vegetative state) may be removed from the sepsis pathway if agreement exists with patient or proxy and these wishes are appropriately documented.

ADDITIONAL ELEMENTS OF SEPSIS MANAGEMENT PROGRAM

A. Code Sepsis/Rapid Response Team - It is a strongly recommended that inpatient acute care, non ICU areas have a Rapid Response Team and or specific Code Sepsis process that is triggered immediately as soon as any patient screens positive for sepsis, sepsis with hypo-perfusion, or septic shock. This ensures patients receive timely assessment and intervention and is an important step in monitoring for progression of the disease and possible need for escalation in care.

B. Order set Use - Use of a consistent, standard, protocol based order set for 3 and 6 HOUR Bundles is highly recommended as it ensures that all elements are provided.

C. Metric Tracking and Data Reporting - It is recommended that regular review of key sepsis metrics be incorporated into existing process improvement and quality management avenues (e.g. sepsis team, daily huddle, Lean Daily Management). Concurrent case review is also recommended with timely feedback to the care team by the Sepsis Lead or his/her designee. Bundle fall outs and process gaps should also be reviewed at least once a month by the multi-disciplinary sepsis team described below to assess the need to revise or continue with the current sepsis performance improvement plan.

PROGRAM OVERSIGHT AND MONITORING

A. Sepsis Lead - Our hospital and/or ED will designate a Sepsis Lead (RRT-RN/ICU Charge RN/ED Charge RN) for sepsis patients.

   1. Qualifications - Clinical background is preferred, an RN or someone with significant experience in a quality oversight/clinical change management role may be qualified as well. Past ED or ICU experience is recommended. The role may not need to be a full time employee (FTE), but sufficient time must be allotted in order to complete the described duties below.

   2. Expectations - The site Sepsis Lead is the primary person responsible for oversight and monitoring of the facility's sepsis program although they may call upon other individuals for completion of and/or assistance with specific duties as needed. This includes:

      a. Chairing the multi-disciplinary sepsis team (see below), with the assistance of a physician co-chair if applicable.

      b. Monitoring screening and bundle compliance data and outcomes. Conducting periodic gap

analysis to ensure compliance with elements of the sepsis clinical standard and optimally concurrent chart review.

c. Determining with the assistance of other members of the sepsis team, the relevant course of action when any gaps are determined.

d. Ensuring implementation of identified performance improvement initiatives.

e. Communicating progress and results to facility leadership/team and the appropriate Medical Executive committee on a timely and consistent basis.

f. Providing formal and informal education at various levels throughout the facility.

g. Supporting clinical documentation specialists and facility leadership in ensuring proper documentation in sepsis cases.

B. Multi-disciplinary Sepsis Team - The hospital including the ICU, ED, Med/Surg, Physician(s) should assemble a multidisciplinary team that is charged with implementation of the clinical standard review of site-specific data, assessment and action plan development on any fall outs and provision of individual provider/staff feedback.

1. Team composition (required) - A hospital-based team should include at at minimum the following individuals as well as a dedicated ED team including as many of these individuals as possible and should also engage their primary inpatient referral destinations in regular performance discussions:

a. Designated Sepsis Lead

b. ICU RN

c. Intensivist (Preferred) or other physician who frequently admits to ICU

d. Emergency Department RN

e. Emergency Department Physician

f. RN from Med/Surg or other inpatient floor

g. Hospitalist (Preferred) or other physician who frequently admits to non-ICU inpatient units

h. Clinical Pharmacist

i. Laboratory Director or designee

j. Director of Performance Improvement

k. Director of Infection Control

l. Respiratory Therapist

C. Rapid Response/Code Sepsis Team member (if not already represented among the individuals listed above) and/or House Supervisor

D. Team Composition (optional) - Other team members may be added at the facility's discretion and may include representatives from other departments (e.g., infectious disease, infection preventionists) or specialty areas (e.g., Cardiology, Neurology) as appropriate.

D. Education - An educational plan should be developed at each facility to address the educational needs of providers, nurses, allied health professionals, and non-licensed patient care staff.

1. At a minimum initial education designed to enhance the ability to identify early patient at risk for sepsis, sepsis with hypo-perfusion and septic shock and the steps needed to prevent the progression of sepsis should be delivered to all staff along with non-licensed staff members as assigned. The hospital may seek

to utilize simulation training with return demonstration of the screening tool in addition to the content provided via the appropriate on-line learning system. Ongoing educational strategies recommended include:

a. Unfolding interactive case study scenarios following case review
b. RN review of information available in orientation in the Sepsis resource folder including sepsis screening tool tips, lecture outlines, basic hemodynamic monitoring guides, drug titration and precaution tip sheet and other tools available.

Reference(s):

Levy, M.M., Evans, L.E. & Rhodes, A. Intensive Care Med (2018). https://doi.org/10.1007/s00134-018-5085-0 DOI https://doi.org/10.1007/s00134-018-5085-0

Dellinger RP, Levy MM, Rhodes A, et al. (2012). Surviving sepsis campaign: International guidelines for management of sever sepsis and septic shock. Critical Care Medicine, 41(2), 580-637.

Levy, M., Dellinger, P., Townsend, S., Walter, T., Marshal, J., Bion, J., et al. (2010). The surviving sepsis campaign; Results of an international guideline-based performance improvement program targeting severe sepsis. Critical Care Medicine, 38(2), 1-8.

The ProCESS Investigators. (2014). A Randomized trial of protocol-based care for early septic shock. New England Journal of Medicine, 370, 1683-1693. DOI:1056/NEJMoa1401602

Tromp, M., Hulscher, M., Bleeker-Rovers, C., Peters, L., Van den Berg, D., Borm, G., et al. (2010). The role of nurses in the recognition and treatment of patients with sepsis in the emergency department: A prospective before-and-after intervention study. International Journal of Nursing Studies, 47, 1464-1473

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Infection Control Committee	Susan Sommers: Director of Infection Control and Risk Management	pending
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	03/2020
	Gayle Freude: Nursing Director Med/Surg	03/2020

SAN GORGONIO MEMORIAL HOSPITAL

Origination:	*05/1991*
Approved:	*N/A*
Last Revised:	*08/2018*
Policy Area:	*Emergency Department*
References:	

Sterile Supplies

Policy:

Sterile supplies may be obtained from the Sterile Processing Department (SPD) at any time. If an item is taken from SPD. and the Surgery department is closed, then a note should be left on the desk in Surgery listing what has been removed.

Sterile Processing Department is responsible for sterilizing all sterile supplies used by the Emergency Department. The Emergency Department is responsible for placing all used equipment into a sealed blue plastic bag, with the proper amount of water, and then into the red biohazard box. The red biohazard box is to be placed into the transporting cart and returned to SPD. for autoclaving. SPD will rewrap and repackage sterile trays and instruments.

No sterile instruments are to be stored in the ED clean utility room. All sterile trays and instruments will be checked for packaging and expiration dates. Sterile trays and instruments needing to be re-packaged will be thoroughly cleaned and taken to SPD.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Infection Control Committee	Susan Sommers: Director of Infection Control and Risk Management	pending
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	03/2020
	Angela Brady: ED Director	02/2020

SAN GORGONIO MEMORIAL HOSPITAL

Origination:	*05/1991*
Approved:	*N/A*
Last Revised:	*06/1996*
Policy Area:	*Clinical Laboratory*
References:	

Types of Containers Used For Speciman Collection

1. **URINE**
   a. 24-hour collection bottle obtained from Laboratory. Request correct type of bottle for test to be performed.
   b. Urine bottle, non-sterile, for random urine specimens.
   c. Sterile bottle for Clean Catch for Culture and Sensitivity (C&S).
2. **STOOL**
   a. Disposable container, with cover, for liquid or formed stools.
3. **SPUTUM**
   a. Single Specimen - have patient cough up material deep from lungs or bronchi and expectorate into disposable, sterile, covered sputum cup. Early a.m. specimen is preferred, and is required for AFB (Acid-Fast Bacillus) culture smears.
   b. 24-hour Specimen - have patient cough up materials from lungs or bronchi and expectorate material coughed over a 24-hour period into disposable, sterile, covered sputum cup(s).
   c. Induced sputum by Respiratory Therapy requires a physician's order. This method is utilized when the patient cannot readily cough up a specimen.
   d. If Sputum is white & frosty, it is probably only mucous. Discard. Get new specimen container and repeat procedure.
   e. If you cannot obtain a specimen by the end of the shift following the one in which it was ordered, the physician is to be notified and an order for a nebulized specimen obtained.
4. **GASTRIC CONTENTS**
   a. Collect sample of vomitus into a disposable cup.
   b. Collect aspirated contents into test tubes.
5. **BODY FLUIDS**
   a. Spinal. Collect into a sterile test tube.
   b. Thoracic. Collect into a sterile test tube.
   c. Abdominal. Collect into a sterile container.

d. Wound Culture. Collect into a sterile container, using a sterile swab.

6. **NOSE AND THROAT CULTURES**

   a. Nose: Insert sterile swab into nostril, roll and withdraw. Insert swab into appropriate sterile transport media/container.

   b. Throat: Hold down tongue with tongue depressor, rub sterile swab across the posterior pharynx, including any areas of purulence. The swab must not touch any other part of the oral cavity. Insert swab into appropriate sterile transport/media container.

7. **BLOOD SPECIMENS**

   a. Collected by phlebotomist, doctors, technicians, or nurses per test requirements. Withhold breakfast on all patients having fasting blood work ordered.

   b. Blood culture specimens require a thorough cleaning of skin and blood tube with Provoiodine on Chlorhexadine. Allow skin and tube to dry before inserting needle.

8. **BLOOD CULTURES**

   See Nursing & Laboratory Policies

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Infection Control Committee	Susan Sommers: Director of Infection Control and Risk Management	pending
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	03/2020
	Mark Beck: Medical Director Clinical Lab	02/2020
	Byron Hazley: Director Laboratory	02/2020

A-Tech Consulting, Inc.

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www.atechinc.net

LIMITED WATER (LEGIONELLA) SAMPLING INVESTIGATION REPORT

San Gorgonio Hospital
600 North Highland Springs Avenue, Various Areas

City of Banning
County of Riverside
State of California

Project Number: Atch-200099

March 2, 2020

PREPARED FOR:

San Gorgonio Hospital

PRIVILEGED & CONFIDENTIAL

Cover

WATER

Table of Contents

Atch-200099
Water Sampling
600 North Highland Springs Avenue
Banning, California 92220

March 2, 2020

San Gorgonio Hospital
600 North Highland Springs Avenue
Banning, California 92220

Attn: Mr. Dan Mares

Re: San Gorgonio Hospital
600 North Highland Springs Avenue, Various Areas
Banning, California 92220

Pursuant to your request, A-Tech Consulting, Inc. has completed Domestic Water (Legionella) Sampling of various areas of San Gorgonio Hospital located at 600 North Highland Springs Avenue in Banning, California. The following report summarizes the findings of this assessment.

1.0 BACKGROUND INFORMATION

On February 11, 2020, A-Tech Consulting, Inc. conducted Limited Water Legionella Sampling in various areas of San Gorgonio Hospital located at 600 North Highland Springs Avenue in Banning, California.

2.0 OBSERVED/SAMPLED AREAS

The areas inspected were:

Sample Location	Constituents
Building E, Cooling Tower 1, 2 and 3	Legionella
Basement, Old Boiler Room	Legionella
1st Floor, Hot Water Storage 1	Legionella
1st Floor, Hot Water Storage 2	Legionella
1st Floor, Domestic Water Line	Legionella
1st Floor, Patient Room 112	Legionella
1st Floor, Staff Kitchen (Nutrition)	Legionella
1st Floor, Nurse Station H-174 (Emergency)	Legionella
1st Floor, Exam Room 4 H-158 (Emergency)	Legionella
2nd Floor, Patient Room H-208 (ICU)	Legionella

Note: For detailed sampling information refer to Attachment (A) Water Sample Record for Legionella included within this report.

During our visual inspection, it was noted that very good housekeeping is maintained in the subject areas.

3.0 SAMPLING & ANALYTICAL METHODOLOGY

Water samples were collected for Legionella. Specific results are listed on the water sample records in this report. Additional information concerning the specific sampling and analytical methods appears below.

Six (6) potable and four (4) non-potable water samples were collected for Legionella non-pneumophila, L. pneumophila serotype 1, L. pneumophila serotype 2-14 and other Legionella species analysis, collecting 250, 500 or 1,000 milliliters for potable water samples and 250 milliliters of non-potable water. A Sodium Thiosulfate preservative was added to the poly containers prior to sample collection. Most samples were collected as 1st Draw or 2nd Draw samples leaving a 1-inch air space in bottle. Specific information and analytical results are listed on the water sampling records in this report. All samples were submitted the same day as sample collection, in a cooler containing ice, using strict chain-of-custody procedures to Aerobiology Laboratory Associates, Inc. of Huntington Beach for analysis. Aerobiology Laboratory Associates, Inc. of Huntington Beach is a CDC Elite Certified Laboratory for Legionella analysis. The laboratory results are presented in colony forming units per milliliter of water (CFU/mL).

4.0 ANALYTICAL RESULTS & DISCUSSION

Six (6) potable and four (4) non-potable water samples collected were below the detection factor of 1 CFU/ml. Currently, there are no regulatory requirements, guidelines or established maximum contaminant levels for Legionella. Trace amounts of Legionella bacteria in water samples is common and do not in itself pose a health hazard. Guidelines are available from ASHRAE Standard 188-2015 for Legionella management and response treatment if concentrated growth or infection related to Legionella exposure is determined.

5.0 CONCLUSION.

Based on the sampling conducted, it is A-Tech Consulting, Inc.'s professional opinion that no immediate health hazard or occupational exposure risk was detected for San Gorgonio Hospital.

6.0 RECOMMENDATIONS

All recommendations are based strictly on the limited assessment information and analytical data that were available to A-Tech Consulting, Inc. at the time this report was prepared.

1.) Continue scheduled bacterial monitoring of the facilities water. It is recommended to repeat monitoring every three months. Ensure all lines and points of entry are flushed, at a minimum, bi-weekly.

2.) It is recommended that continued housekeeping, water treatment and engineering controls be maintained. If there are changes in equipment or maintenance practices, additional monitoring and sampling may be warranted.

7.0 LIMITATIONS

The conclusions presented in this document are professional opinions based solely upon our observations at the site and laboratory analysis. They are intended exclusively for the purpose outlined herein and for the site location and project indicated.

Services performed by A-Tech were conducted in a manner above the care and skill ordinarily and currently exercised by members of the same profession that even the most comprehensive scope of services might fail to detect environmental liabilities at a particular site. A-Tech makes no representation or warranty that no environmental hazards exist at this site. Additionally, Legionella is ubiquitous and bacterial activity and contamination can change.

No expressed or implied representation or warranty is included or intended in our reports, except that our services were performed, within the limits prescribed by the scope of services, with the customary thoroughness and competence of our profession. The conclusions presented in this report are professional opinions based solely upon visual observations at the site and laboratory analysis of the tested samples. They are intended exclusively for the purposes outlined herein, and for the site location and project indicated. We do not diagnose, correct or warranty against the cause of contributing environmental contaminant issues.

Recognizing that even the most comprehensive inspection may fail to detect Legionella at a particular site, this study was not intended to identify all potential Legionella present in the building or at the site for such reasons as (1) the possible existence of buried, covered and inaccessible areas and features; and (2) the limited number of samples collected.

Information and opinions presented herein apply to the existing and reasonable foreseeable site conditions at the time of our investigation. They cannot necessarily apply to site changes of which we are unaware, and/or which we have not had the opportunity to review. Changes in the conditions of this property may occur with time due to natural processes or works of man on the subject property or on adjacent properties.

Changes in applicable standards may also occur as a result of legislation or the broadening of knowledge. Accordingly, the findings of this report may be invalidated, wholly or in part by changes beyond our control. A-Tech does not warrant that the site inspection would satisfy the dictates of, or provide a legal defense in connection with environmental laws or regulations. This report is not for the purpose of determining potential health risks associated with any environmental contaminants. Any individuals with health concerns should consult their physician.

This report is intended for the sole use of the contracted client. The exchange of information was unique between A-Tech and the client regarding its scope of service. Unless explicitly authorized in this report, no third party is beneficiary to the contract or findings of this report. The unauthorized use or reliance of this document or the findings, conclusion or recommendations presented herein, by any other party or parties is at the sole risk of any such third party. For the same reasons, no warranties or representations, expressed or implied in this report, are provided to any such third party.

A-Tech assumes no responsibility for the protection of any and all employees, tenants, visitors, or project contract workers from environmental contaminant exposure.

A-Tech bears no responsibility for the actual condition of the structure or safety of a site pertaining to Indoor Environmental contamination regardless of the actions taken by the client.

A-Tech trusts that the information presented herein provides you with the information and supporting data you require. Should you have any questions or comments, please do not hesitate to contact the undersigned professional at A-Tech (800) 434-1025.

Respectfully submitted,
A-Tech Consulting, Inc.

Casandra N. Williams

Casandra N. Williams, CEICC, CIEC
CEICC #1404017 CIEC #1306023

A-Tech Consulting, Inc.

Water Sample Record-Legionella

Client Name: San Gorgonio Hospital

A-Tech Project Number: 200099

Location: San Gorgonio Hospital, 600 North Highland Springs Avenue, Various Areas

Sample Number	Sample Location	Potable/Non-Potable	Hot Water Temperature	Cold Water Temperature	Sampled From	Sample Time	Date	Sample Volume	Sample Draw	Source	Analytical Results (cfu/ml)
200099-LG-0001	Building E, Cooling Tower 1, 2 and 3	Non-Potable	-	59.3 °F	Water Line	10:01 AM	02/11/2020	250 mL	1st Draw	Bleed Line, Cooling Tower	No Legionella Isolated
200099-LG-0002	Basement, Old Boiler Room	Non-Potable	93.2 °F	-	Water Line	10:12 AM	02/11/2020	250 mL	1st Draw	Bleed Line, Cooling Tower	No Legionella Isolated
200099-LG-0003	1st Floor, Hot Water Storage 1	Non-Potable	123.4 °F	-	Water Line	10:17 AM	02/11/2020	250 mL	2nd Draw	Bleed Line, Cooling Tower	No Legionella Isolated
200099-LG-0004	1st Floor, Hot Water Storage 2	Non-Potable	128.4 °F	37.4 °F	Water Line	10:18 AM	02/11/2020	250 ml	2nd Draw	Bleed Line, Cooling Tower	No Legionella Isolated
200099-LG-0005	1st Floor, Domestic Water Line	Potable	-	77.3 °F	Mixed	10:20 AM	02/11/2020	250 ml	1st Draw	Sink	No Legionella Isolated
200099-LG-0006	1st Floor, Patient Room 112	Potable	111.3 °F	-	Hot	10:25 AM	02/11/2020	1,000 ml	2nd Draw	Sink	No Legionella Isolated

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A-Tech Consulting, Inc.

Sample Number	Sample Location	Potable/Non-Potable	Hot Water Temperature	Cold Water Temperature	Sampled From	Sample Time	Date	Sample Volume	Sample Draw	Source	Analytical Results (cfu/ml)
200099-LG-0007	1st Floor, Staff Kitchen (Nutrition)	Potable	-	37.4 °F	Cold	10:27 AM	02/11/2020	500 ml	1st Draw	Ice Machine Supply Line	No Legionella Isolated
200099-LG-0008	1st Floor, Nurse Station H-174 (Emergency)	Potable	92.4 °F	-	Mixed	10:29 AM	02/11/2020	1,000 ml	2nd Draw	Sink	No Legionella Isolated
200099-LG-0009	1st Floor, Exam Room 4 H-158 (Emergency)	Potable	-	67.8 °F	Mixed	10:31 AM	02/11/2020	1,000 ml	1st Draw	Sink	<1
200099-LG-0010	2nd Floor, Patient Room H-208 (ICU)	Potable	81.6 °F	-	Mixed	10:35 AM	02/11/2020	1,000 ml	2nd Draw	Sink	<1

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Aerobiology Laboratory Associates, Incorporated
Expertise Since 1997

Certificate of Analysis
AIHA-LAP EMLAP# 218951

15061 Springdale St
Suite 111
Huntington Beach, California 92649
(714) 895-8401
www.aerobiology.net

A-Tech Consulting, Inc.
1640 N. Batavia Street
Orange, California 92867
Attn: Robert Williams
Project: **San Gorgonio Hospital Atch 200099**
Condition of Sample(s) Upon Receipt: Acceptable

Date Collected: 02/11/2020
Date Received: 02/11/2020
Date Analyzed: 02/21/2020
Date Reported: 02/21/2020
Project ID: 20005934

Client Sample #: LG-01
Lab Sample #: 20005934-001
Sample Location: Building E, Cooling Tower 1,2,3
Test: 1015, WATER, Legionella Analysis, CDC Method: NON-POTABLE SOP 2.35/SOP 2.22
Results: **No Legionella isolated**
Liquid Volume: **1 (mL)**
MRL: **10 CFU/mL**

Client Sample #: LG-02
Lab Sample #: 20005934-002
Sample Location: Basement, Boiler Room
Test: 1015, WATER, Legionella Analysis, CDC Method: NON-POTABLE SOP 2.35/SOP 2.22
Results: **No Legionella isolated**
Liquid Volume: **250 (mL)**
MRL: **0.8 CFU/mL**

Client Sample #: LG-03
Lab Sample #: 20005934-003
Sample Location: CUP Hot Water Storage 1
Test: 1015, WATER, Legionella Analysis, CDC Method: NON-POTABLE SOP 2.35/SOP 2.22
Results: **No Legionella isolated**
Liquid Volume: **250 (mL)**
MRL: **0.8 CFU/mL**

Client Sample #: LG-04
Lab Sample #: 20005934-004
Sample Location: CUP Hot Water Storage 2
Test: 1015, WATER, Legionella Analysis, CDC Method: NON-POTABLE SOP 2.35/SOP 2.22
Results: **No Legionella isolated**
Liquid Volume: **250 (mL)**
MRL: **0.8 CFU/mL**

Client Sample #: LG-05
Lab Sample #: 20005934-005
Sample Location: CUP Domestic Water Line
Test: 1015, WATER, Legionella Analysis, CDC Method: POTABLE SOP 2.35/SOP 2.22
Results: **No Legionella isolated**
Liquid Volume: **250 (mL)**
MRL: **0.8 CFU/mL**

Client Sample #: LG-06
Lab Sample #: 20005934-006
Sample Location: 1st Floor, Patient Room 112
Test: 1015.7, Water, Legionella Analysis, CDC Method 1 liter
Results: **No Legionella isolated**
Liquid Volume: **1000 (mL)**
MRL: **0.1 CFU/mL**

Aerobiology Laboratory Associates, Incorporated
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A-Tech Consulting, Inc.
1640 N. Batavia Street
Orange, California 92867
Attn: Robert Williams
Project: **San Gorgonio Hospital Atch 200099**
Condition of Sample(s) Upon Receipt: Acceptable

Date Collected: 02/11/2020
Date Received: 02/11/2020
Date Analyzed: 02/21/2020
Date Reported: 02/21/2020
Project ID: 20005934

Client Sample #: LG-07
Lab Sample #: 20005934-007
Sample Location: 1st Floor, Staff Kitchen
Test: 1015.7, Water, Legionella Analysis, CDC Method 1 liter
Results: **No Legionella isolated**
Liquid Volume: **500 (mL)**
MRL: **0.2 CFU/mL**

Client Sample #: LG-08
Lab Sample #: 20005934-008
Sample Location: 1st Floor, Nurse Station 1
Test: 1015.7, Water, Legionella Analysis, CDC Method 1 liter
Results: **No Legionella isolated**
Liquid Volume: **1000 (mL)**
MRL: **0.1 CFU/mL**

Client Sample #: LG-09
Lab Sample #: 20005934-009
Sample Location: 1st Floor, Patient Room 158
Test: 1015.7, Water, Legionella Analysis, CDC Method 1 liter
Results: **<1 CFU/mL**
Liquid Volume: **1000 (mL)**

Organism(s) Isolated:	Raw Count	CFU/mL	% Total	MRL
Legionella pneumophila Serogroup 2-15	1	<1	100	0.1 CFU/mL
	1	<1	~100%	

Client Sample #: LG-10
Lab Sample #: 20005934-010
Sample Location: 2nd Floor, Patient Room 208
Test: 1015.7, Water, Legionella Analysis, CDC Method 1 liter
Results: **<1 CFU/mL**
Liquid Volume: **1000 (mL)**

Organism(s) Isolated:	Raw Count	CFU/mL	% Total	MRL
Legionella pneumophila Serogroup 1	3	<1	99	0.1 CFU/mL
	3	<1	~100%	

Aerobiology Laboratory Associates, Incorporated
Expertise Since 1997

Lab Use: 20005934

Page 1 of 1

ELITE Program
AZ, CA, CO, GA, NJ, VA

AIHA LAP, LLC Accredited Laboratory
192683 (CO) 102977 (GA)
163063 (VA) 210229 (AZ)
102747 (NJ)

Aerobiology Client	A-Tech Consulting, Inc.
Field Contact	A-Tech Consulting, Inc.
Address	1640 N Batavia St, Orange, CA 92867
Address	Orange, CA 92867
Phone/Fax	714-434-6360
Email	labs@atechinc.net
10-14 Day Turn Around Time	

Collected By/Date: 2/11/20
Relinquished By/Date: 2/11/20
Relinquished By/Date:
Received By/Date: [illegible] 2-11-20 1:20 pm

Samples Must Be Submitted Within 24 Hours of Collection

PO#/Job#/Project Name: San Gorgonio Hospital Atch 200099

Notes/CC Info:

	Sample No.	Test Code	Sample Location	Swab	Non Potable	Potable	Volume
1	LG-01	1015	Building E, Cooling Tower 1,2,3	☐	☑	☐	250mL
2	LG-02	1015	Basement, Boiler Room	☐	☑	☐	250mL
3	LG-03	1015	CUP Hot Water Storage 1	☐	☑	☐	250mL
4	LG-04	1015	CUP Hot Water Storage 2	☐	☑	☐	250mL
5	LG-05	1015	CUP Domestic Water Line	☐	☑	☐	250mL
6	LG-06	1015	1st Floor, Patient Room 112	☐	☐	☑	1000mL
7	LG-07	1015	1st Floor, Staff Kitchen	☐	☐	☑	~~1000mL~~ 500
8	LG-08	1015	1st Floor, Nurse Station 1	☐	☐	☑	1000mL
9	LG-09	1015	1st Floor, Patient Room 158	☐	☐	☑	1000mL
10	LG-10	1015	2nd Floor, Patient Room 208	☐	☐	☑	1000mL
11		1015		☐	☐	☐	
12		1015		☐	☐	☐	
13		1015		☐	☐	☐	
14		1015		☐	☐	☐	
15		1015		☐	☐	☐	
16		1015		☐	☐	☐	
17		1015		☐	☐	☐	
18		1015		☐	☐	☐	
19		1015		☐	☐	☐	
20		1015		☐	☐	☐	

1015	Culture - WATER Legionella - CDC Analysis Method	1016	Culture - AIR Legionella - CDC Analysis Method
1017	Culture - SWAB Legionella - CDC Analysis Method	1063	Culture - BULK Legionella - CDC Analysis Method
2056	WATER - Heterotrophic Plate Count (HPC)	1010	WATER - Potable - E. coli/total coliforms

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SAN GORGONIO MEMORIAL HOSPITAL

APPROVAL OF POLICIES AND PROCEDURES

Title	Owner	Expiration	Revised
Abruptio Placenta	Echols, Carrie: Nursing OB Director	12/05/2020	Revised
Admission Of High Risk Neonate	Echols, Carrie: Nursing OB Director	12/07/2020	Revised
Adoption Planning	Echols, Carrie: Nursing OB Director	12/07/2020	Revised
Bed Making	Freude, Gayle: Nursing Director Med/Surg	12/05/2020	Revised
Code Carts – Adult and Pediatric	Brown, Pat: Chief Nursing Officer	03/04/2023	Revised
Controlled Substance Administration	Lopez, Jose: Director Pharmacy	09/14/2019	Revised
CT Chest For Evaluation of Pulmonary Embolism	Chamberlin, Krystal: Director Diagnostic Imaging	10/30/2019	Revised
Dead on Arrival	Brady, Angela: ED Director	02/06/2021	Revised
Elopement from Emergency Department	Brady, Angela: ED Director	02/06/2021	Revised
Gastric Decompression: Insertion, Maintenance, and Removal of a Nasogastric Tube	Freude, Gayle: Nursing Director Med/Surg	12/05/2020	Revised
Intake and Output	Freude, Gayle: Nursing Director Med/Surg	12/05/2020	Revised
Interdepartmental Transfer of Patients	Freude, Gayle: Nursing Director Med/Surg	03/06/2021	Revised
Ordering of Outpatient Services	Brown, Pat: Chief Nursing Officer	05/11/2019	Revised
Pre-operative - Surgical Screening Requirements	Goodner, Jayme: Director Surgical Services	03/13/2021	Revised
Prone Positioning in Non-Intubated Patients with Hypoxemic Respiratory Failure	Freude, Gayle: Nursing Director Med/Surg	N/A	New
Surgical Services - Fire Prevention & Response Plan	Goodner, Jayme: Director Surgical Services	02/06/2021	Revised
Temperature, Measuring Body	Freude, Gayle: Nursing Director Med/Surg	12/05/2020	Revised

SAN GORGONIO MEMORIAL HOSPITAL

Origination:	*N/A*
Approved:	*N/A*
Last Revised:	*N/A*
Policy Area:	*Nursing*
References:	

Prone Positioning in Non-Intubated Patients with Hypoxemic Respiratory Failure

Purpose:

Acute respiratory distress syndrome (ARDS) has a high mortality rate of 25-40%. Previous studies showed an improvement in oxygenation and reduced mortality in moderate to severe ARDS with early prone positioning (PP) on mechanically ventilated patients.

There are some studies that show improvement in oxygenation and possible reduction in rate of intubation in hypoxemic respiratory failure patients (on nasal cannula and high-flow oxygen) who undergo awake prone positioning.

We will do a trial of prone positioning in our non-intubated patients with hypoxemic respiratory failure to evaluate for improvement in oxygenation and possibly a reduction in the rate of intubations.

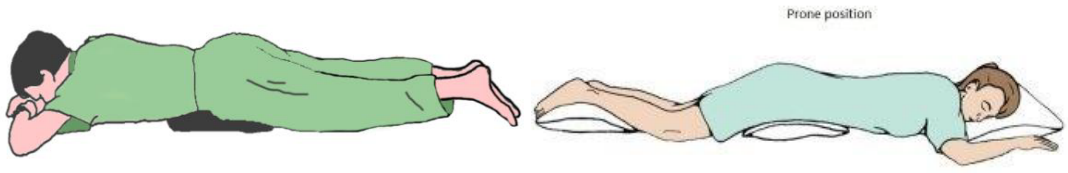
Policy:

Patient population:

- Age greater than 18
- Non-cardiogenic hypoxemic respiratory failure on supplemental oxygen of great than or equal to 2L/min that meet SpO2/FiO2 ratio of less than 350.
- Able to follow instructions and self-prone (aka lie on their stomach) with some minimal assist with devices/bed/positioning.

Contraindications:

- Hemodynamic instability – vasopressors, arrhythmias
- Evidence of acutely/rapidly worsening respiratory distress or fatigue, anticipated need for urgent mechanical ventilation
- SpO2/FiO2 ratio of <100, RR > 35
- Any mechanical contraindications to prone positioning (facial/chest trauma, fractures)
- Altered mental status, delirium
- Refusal/inability to comply/collaborate with prone positioning
- Patients that require maximum assist



Nursing	Physician
Initial evaluation: • Assess for contraindications • If saturating < 95% on ≥2L/min O_2, then obtain the 4 **ROSE** criteria:	**Initial evaluation:** • Look at the **ROSE** criteria reported to you by RN • Calculate SpO2/FiO2 ratio on 2L • 2L O2 = FiO2 of 0.27

Nursing	Physician
◦ **R**R ◦ **O**2 L/Min ◦ **S**pO2 ◦ **E**ffort: labored breathing: yes/no • Next, call Provider to discuss initiating prone positioning • Note: If patient is requiring 3L O2 or greater, they automatically meet criteria for prone positioning still call the physician • Titrate O2 to keep SpO2>92% **Once prone positioning ordered by MD:** • Tell patient to lie on stomach for: ◦ 3 hours TWICE a day – or as close to 3 hours as possible depending on patient tolerability ◦ Ok to use pillows/towels to support head, legs, pelvis ◦ OK to lie on side or stand for a few minutes PRN - but majority of the 3 hours should be on stomach • Record ROSE criteria at **TWO** intervals: ◦ Right before initiating prone session ◦ At end of prone session (when patient stops proning) • Please document the right time - this helps us know how long each prone session lasted • **Document in Flowsheets** ◦ **Pick PRONE in the position row** • If patient has worsening oxygen requirements or appears unstable, sit patient upright and call Provider ASAP	• If SpO2/FiO2 <350, commence prone positioning as noted below • **Note**: If patient is requiring 3L O2, then they automatically qualify for prone position. • Use high flow nasal cannula beyond 6L O2 • Remember to assess for contraindications **Once you decide to prone patient:** • Write order for self proning • Prone for 3 hours TWICE a day – or as close to 3 hours as possible depending on patient tolerability • Continue until patient is off supplemental O2 or if respiratory failure rapidly worsens requiring mechanical ventilation • Monitor closely

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	pending
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	06/2020
	Gayle Freude: Nursing Director Med/Surg	05/2020

DIET MANUAL UPDATE

Every 5 years San Gorgonio purchases a diet manual from Food and Nutrition Management Services. The manual needs to be reviewed to insure in meets our needs.

The revised diet manual of 2019 is essentially the same as the current one we have been using (2015). The following items need to be brought to your attention:

1) We will be adopting the International Dysphasia Diet Standards (IDDS), see attached sheet. These changes are considered best practices in preventing aspiration. These standards bring about clear guidelines to thickened liquids and texture definitions. We will start using this terminology with the implementation of the new computer system.
2) The new computer system lists several diets slightly different then what the diet manual refers to them as, therefore the following definitions will be added to the manual
   A) Carbohydrate Controlled = No Concentrated sweets,
   B) Consistent Carbohydrate Diet=NCS, Low fat with 4 servings of carbs/meal, 2 servings of carbs at night snack, and provides ~1800-2000 calorie
   C) Mechanical Soft—we are moving away from this terminology under IDDS. If this diet is ordered the patient will receive minced/moist texture
3) Our renal diet is defined as 2 grm sodium, 2 grm K and 1 grm Phos. Not every ESRD patient needs exactly the same restriction. I would like to add this statement to the description of the renal diet:
   "The restrictions of the renal diet are meant as a guideline. Individualization of diet needs to be considered depending on the degree of renal failure, intake and the serum blood levels. The dietitian may individualize the restrictions with the advisement of the nephrologists."
4) Items that were adapted in the 2015 manual that we will continue using in the 2019
   a) The low sodium diet (AKA 2 grm Na) will be defined as 1900-2300 mg na/day)
   b) Our Full Liquid diet will not include blendarized foods so that it can still be used by the Speech Therapist for patients with swallow fatigue.
   c) Continue with the liberal diet of No Concentrated Sweets diet
   d) Continue with the Surgical Soft diet – which is low fat, low fiber and no spicy foods.

Respectfully submitted,

Jean Kielhold, RD

IDDSI

International Dysphagia Diet Standardisation Initiative

www.iddsi.org

TAB F

Title	Policy Area	Owner	Workflow Approval
Abruptio Placenta	Obstetrics	Carrie Echols, Director OB/GYN	Ariel Whitley for Hospital Board of Directors
Admission of High Risk Neonate	Obstetrics	Carrie Echols, Director OB/GYN	Ariel Whitley for Hospital Board of Directors
Adoption Planning	Obstetrics	Carrie Echols, Director OB/GYN	Ariel Whitley for Hospital Board of Directors
Bed Making	Nursing	Gayle Freude, Director Med/Surg	Ariel Whitley for Hospital Board of Directors
Code Carts - Adult and Pediatric	Administration	Pat Brown, CNO/COO Administration/Nursing	Ariel Whitley for Hospital Board of Directors
Controlled Air Purifying Respirator (CAPR)	Infection Control	Susan Sommers, Director Infection Control	Ariel Whitley for Hospital Board of Directors
Controlled Substance Administration	Pharmacy	Jose Lopez, Director Pharmacy	Ariel Whitley for Hospital Board of Directors
Coronavirus Disease 2019 (COVID-19) Risk Assessment & Management Decision Making	Infection Control	Susan Sommers, Director Infection Control	Ariel Whitley for Hospital Board of Directors
CT Chest For Evaluation of Pulmonary Embolism	Diagnostic Imaging	Krystal Chamberlin, Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
Dead on Arrival	Emergency Dept.	Angela Brady, Director Emergency Dept.	Ariel Whitley for Hospital Board of Directors
Elopement from Emergency Department	Emergency Dept.	Angela Brady, Director Emergency Dept.	Ariel Whitley for Hospital Board of Directors
Gastric Decompression: Insertion, Maintenance, and Removal of a Nasogastric Tube	Nursing	Gayle Freude, Director Med/Surg	Ariel Whitley for Hospital Board of Directors
Intake and Output	Nursing	Gayle Freude, Director Med/Surg	Ariel Whitley for Hospital Board of Directors
Interdepartmental Transfer of Patients	Nursing	Gayle Freude, Director Med/Surg	Ariel Whitley for Hospital Board of Directors

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board meeting of August 4, 2020

Title	Policy Area	Owner	Workflow Approval
OR - Duties of a Scrub Nurse / Technician	Surgical Services	Jayme Goodner, Director Surgery	Ariel Whitley for Hospital Board of Directors
Ordering of Outpatient Services	Administration	Pat Brown, CNO/COO Administration/Nursing	Ariel Whitley for Hospital Board of Directors
Pre-operative - Surgical Screening Requirements	Surgical Services	Jayme Goodner, Director Surgery	Ariel Whitley for Hospital Board of Directors
Prone Positioning in Non-Intubated Patients with Hypoxemic Respiratory Failure	Nursing	Gayle Freude, Director Med/Surg	Ariel Whitley for Hospital Board of Directors
QuickVue Dipstick Strep A test	Clinical Laboratory	Byron Hazley, Director Laboratory	Ariel Whitley for Hospital Board of Directors
Sterile Supplies	Emergency Dept.	Angela Brady, Director Emergency Dept.	Ariel Whitley for Hospital Board of Directors
Surgical Services - Fire Prevention & Response Plan	Surgical Services	Jayme Goodner, Director Surgery	Ariel Whitley for Hospital Board of Directors
Temperature, Measuring Body	Nursing	Gayle Freude, Director Med/Surg	Ariel Whitley for Hospital Board of Directors
Types of Containers Used For Specimen Collection	Clinical Laboratory	Byron Hazley, Director Laboratory	Ariel Whitley for Hospital Board of Directors

TAB G

Hospital receives several additional ventilators

BY DAVID JAMES HEISS
Record Gazette

San Gorgonio Memorial Hospital has acquired six ventilators in the past few weeks, courtesy of a donation through the nonprofit San Gorgonio Memorial Hospital Foundation.

An announcement was made during the San Gorgonio Memorial Healthcare District's July 7 meeting that the foundation had donated $168,652.04 to cover the cost of the equipment, as the hospital readies itself to meet the demand of a potential influx of coronavirus patients.

Ventilators delivers breaths of oxygen to patients that cannot breathe on their own.

The six Bellavista 1000 ventilators can be used on more than one patient at a time, according to Chief Information Officer Holly Yonemoto.

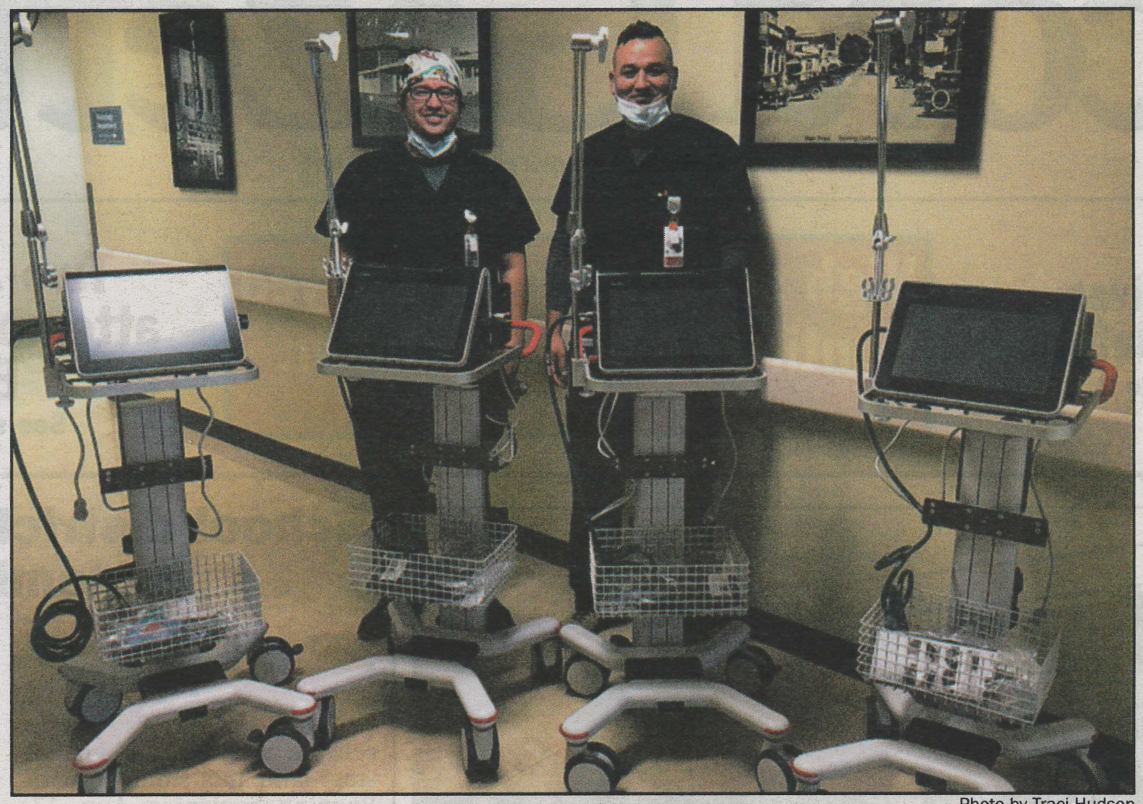


Photo by Traci Hudson
Hospital respiratory therapists Chris Garcia (left) and Rudy Gutierrez with the new ventilators.

"The foundation was excited to purchases these new, much-needed ventilators," says foundation President George Moyer. "During this time of uncertainty, it's comforting to know that equipment that the foundation purchased is being used immediately to help with patient care."

While the hospital refers questions regarding coronavirus cases to the county, spokeswoman Holly Yonemoto noted in a message to the Record Gazette that "We, as all local hospitals, have a surge that has gotten us all to capacity" and giving medical workers a chance to respond accordingly as cases come in, "as many are working overtime to care for our community here at San Gorgonio Memorial Hospital."

Chief Nursing Officer Pat Brown was happy to add them to the hospital's inventory of 15, which includes some that are leased.

"Like other hospitals in the area, we have been experiencing periodic surges in the number of hospitalized patients, some with COVID-19," Brown says. "These patients require stringent isolation procedures and a lot of specialized care."

She credited the dedication of her hospital's staff for "being able to meet the needs of all our patients during these trying times."

Staff Writer David James Heiss may be reached at dheiss@recordgazette.net, or by calling (951) 849-4586 x114.