SIERRA VIEW MEDICAL CENTER

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

OCTOBER 27, 2026

OPEN SESSION (5:00 PM)

The Board of Directors will call the meeting to order at 5:00 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 5:05 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. **The public meeting will reconvene in person at 5:30 P.M.** In person attendance by the public during the open session(s) of this meeting is allowed in accordance with the Ralph M. Brown Act, Government Code Sections 54950 et seq. Per California Government Code § 54953, the public may use the following link for remote participation during open session: https://svmc.zoom.us/j/81270565991

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

1. **General Update;**
2. **Report on Peer Review/Credentials**

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

C. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation; Anticipated Litigation: **Conference with Legal Counsel**. BETA Claim Number: 26-002061

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): **Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning**. Estimated date of disclosure December 1, 2027

E. Pursuant to Gov. Code Section 54957(b) and Gov. Code Section 54957.6: **Discussion Regarding Confidential Personnel Matter with CEO Donna Hefner the Board's Designated Representative** – One (1) Item. Estimated Date of Disclosure October 1, 2028, for materials that are not part of an individual's private personnel file.

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

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

A. Chief of Staff Report:

1. **General Report**
   Recommended Action: Information only; no action taken

2. **Report on Peer Review/Credentials**
   Recommended Action: Approve/Disapprove Report on Peer Review and Credentials as Given

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

C. Conference with Legal Counsel/BETA Claim No 26-002061
Recommended Action: Reject Claim as Untimely Under Cal. Gov. Code §§ 915 and 911.2.

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

E. Discussion Regarding Personnel Matter
Recommended Action: Approve the Offer of CFO Employment Contract

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

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

VI. Public Comments

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

will be distributed to the Board at this time but will not be read by the Board secretary during the public comment period.

VII. Consent Agenda

Recommended Action: Approve/Disapprove Consent Agenda Policies and Accept Reports therein as presented

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

VIII. Approval of Minutes

A. September 22, 2026 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove September 22, 2026, Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

A. FY 2026 Financial Audit
Recommended Action: Approve/Disapprove Report at Given

B. September 2026 Financials
Recommended Action: Approve/Disapprove September Financial Report as Presented

C. Capital Budget Report Quarter 1
Recommended Action: Approve/Disapprove Capital Budget Report Q1

D. Investment Report Quarter 1
Recommended Action: Approve/Disapprove Investment Report Q1

E. Bylaws Review
Recommended Action: Approve/Disapprove Changes as Presented

F. **Declaration of Surplus Land Under Cal. Gov. Code, § 54221(b)(1). Property: APNs 215-330-060 and 215-330-064, Strathmore, CA 93267.**
Recommended Action: Approve/Disapprove Motion to Find APNs 215-330-060 and 215-330-064, Strathmore, CA 93267 are surplus property, appoint Ron Wheaton as negotiator for SVLHCD and direct District leadership to commence the steps for sale of the Subject Property.

X. **SVLHCD Board Chair Report**

XI. **SVMC CEO Report**

XII. **Announcements:**

- Regular Board of Directors Meeting – November 24, 2026, at 5:00 p.m.

XIII. **Adjournment**

PUBLIC NOTICE

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

PUBLIC NOTICE ABOUT COPIES

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SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	10/07/2026
BOARD OF DIRECTORS APPROVAL	
	10/27/2026
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
October 27, 2026 BOARD APPROVAL

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

		Pages	Action
I.	**Policies**:		**APPROVE**
	• 24 Hour Urine Collection	1-2	
	• Admission of a Newborn Born Outside of Hospital	3-6	
	• American Heart Association Internal Dispute Resolution	7-8	
	• American Heart Association Program Quality Assurance Plan	9-11	
	• Amnisure Rupture of Fetal Membranes (ROM) Test	12-22	
	• Blood Culture Collection	23-25	
	• Blood Patch	26-29	
	• Breast Milk Collection and Storage	30-33	
	• CIWA-Ar: Assessment and Treatment of Acute Alcohol Withdrawal	34-41	
	• Clean Catch Urine Collection for Urinalysis	42	
	• Clinical Decision Unit Admission Criteria	43-45	
	• Communication with the Patient/Family After a Harm Event	46-52	
	• Competency Assessment Process	53-57	
	• Compounded Sterile Preparation: Quality Assurance Program	58-62	
	• Criteria for Collection of Stool for Ova and Parasites	63-64	
	• Criteria for Collection of Stool for PCR	65-66	
	• Criteria for Rejection of Lab Specimens	67-71	
	• Delinquent Medical Records	72	
	• Education Needs Assessment	73-74	
	• Emergency Blood Release	75-78	
	• Fetal Fibronectin Specimen Collection for Enzyme Immunoassay	79-82	
	• Guidelines for the Initial Assessment and Triage of Obstetric Patients	83-94	
	• Hiring Clinical Lab Scientist Trainees	95-100	
	• IV Preparation and Dispensing	101-116	
	• Interpretive Services: Language Assistance Program	117-121	
	• Intrauterine Growth Restriction (IUGR)	122-124	
	• MCH – Admission Criteria	125-126	
	• Massive Transfusion	127	
	• Nasogastric/Nasointestinal Tube Insertion and Placement Verification Utilizing the Kangaroo Feeding Tube with Iris Technology in the Adult Patient	128-132	
	• Newborn Screening Tests	133-134	
	• NICU Documentation	135-137	
	• No Prenatal Care (Drop In)	138-141	
	• Obstetrical Hemorrhage	142-150	
	• Oxygen Administration: Newborn	151-154	

• Placement of Fetal Scalp Electrode (FSE) • Preceptorship Program • Prenatal Record – Antepartum • Pre-Term Labor • Rapid Response Team Adult & Pediatric • Sign-Out Protocol for Blood Components • Simulation Lab Program • Transfusion Reaction Procedure • Trauma in Pregnancy • Treatment of Adult Patient with Suspected Sepsis • Umbilical (Arterial Line) Catheterization: Neonate • Umbilical Cord Blood Sampling for Blood Gases • Use of Externally Supplied Medications in Clinic Settings • Venous Blood Collection	155-157 158-161 162-163 164-167 168-173 174-175 176-183 184-188 189-193 194-200 201-207 208-210 211-212 213-214	**APPROVE**

SUBJECT: **24 HOUR URINE COLLECTION**	SECTION: **Page 1 of 2**

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

POLICY:

A complete and accurate urine collection will be done to ensure proper evaluation of tests on a 24 hour urine sample.

AFFECTED AREAS/PERSONNEL: *LABORATORY STAFF, NURSING, PHYSICIANS*

PROCEDURE:

- Have patient empty bladder first thing in the morning and discard this specimen, note time and date.
- After the first morning specimen is discarded, collect all urine passed during the next 24 hour period in a clean container.
- The final collection is when the patient empties his or her bladder the next morning at the same hour. Note time and date.
- Keep the collected urine refrigerated, or on ice, and send to the laboratory as soon as possible after the 24 hour collection is complete.

NOTES:

- Twenty four hour urine tests should be ordered in the computer.
- Urine containers for the collection of 24 hours specimens may be obtained from the laboratory.
- If 24 hour urine collections are to be made, they should be made before administration of dyes for intravenous pyelograms (IVPs) and other X-ray contrasts.

24 HOUR URINE COLLECTION GUIDE #11008

TEST **FOOTNOTE**	**COLLECTION INSTRUCTIONS START**	**AFTER**
1. Calcium	None	None
2. Catecholamines, Frac.	None	Freeze
3. Citric Acid	None	Freeze 5 ml aliquot
4. Creatinine	None	None
5. Hydroxycorticosteroids,17	None	Freeze
6. Hydroxyindoleacetic Acid,5 (5-HIAA)	None	Freeze
7. Ketosteroids,17	None	Freeze
8. Magnesium	None	Freeze

9. Metanephrines	None	Freeze
10. Oxalate	None	Freeze
11. Phosphorus	None	Freeze
12. Potassium	None	None
13. Protein	None	None
14. Sodium	None	None
15. Uric Acid	None	None
16. Vanillylmandelic Acid (VMA)	None	Freeze

REFERENCES:

- Siemens CA document number 11110115_01_CA_ACH_EN
- Quest Diagnostics.com, Test Menu, 2021
- Siemens CREA document number 11110159_08_Crea_2_ACH_EN
- Siemens MG document number 11110175_01_Mg_ACH_EN
- Siemens PHOS document number 11110174_02_IP_ACH_EN
- Siemens A-Lyte Integrated Multisensor document number 11109447_01_IMT_NaKCl_ACH_EN
- Siemens UCFP document number 11111705_01_UCFP_ACH_EN
- Siemens URCA document number 11110187_01_URCA_ACH_EN

SUBJECT: **ADMISSION OF A NEWBORN BORN OUTSIDE OF HOSPITAL**	SECTION: **Page 1 of 4**

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

PURPOSE:

To establish guidelines for the admission and initial care of newborn infant born outside of Labor & Delivery area (born outside of hospital).

POLICY:

- Infants delivered outside of hospital will be admitted to MCH.
- Isolation precautions will be implemented based on identified maternal or neonatal infectious risk factors in accordance with Infection Prevention and Control policies and practice.
- Upon admission, the infant will be placed under a radiant warmer for assessment, observation, and stabilization with the mother in postpartum.
- If the physician has deemed the infant medically stable, the infant will be cared for as a normal newborn admit. See policy and procedure, "Neonatal Intensive Care Unit (NICU): Admission, Discharge and Transfer Criteria."
- If the infant is unstable and requires further observation, see policy and procedure, "Neonatal Intensive Care Unit (NICU): Admission, Discharge and Transfer Criteria."

AFFECTED AREAS/ PERSONNEL: *MCH DEPARTMENT/REGISTERED NURSES (RNs)*

EQUIPMENT:

- Radiant warmer
- Infant identification bands
- Measuring tape
- Newborn chart forms
- Thermometer
- Blood glucose monitor
- Newborn medications
- Newborn supplies (diapers, formula etc.)
- Stethoscope
- Bulb syringe

- Alcohol wipes

PROCEDURE:

1. Secure necessary articles. Place individual supplies into lower cabinet for isolette.
2. Follow routine Admission procedures:
   a. Notify Admitting of infant's birth
   b. Notify pediatrician of infant's birth
   c. Complete admission assessment
   d. Administer newborn medications
3. Rooming-in with the mother is encouraged when the infant is clinically stable. Standard newborn care practices will be followed unless infection control precautions are indicated
4. Obtain CBC with manual differential and blood culture at 3 hours of age based on provider assessment of neonatal sepsis risk factors and current neonatal sepsis evaluation guidelines.
5. Notify physician of CBC results.
6. Observe for early signs of infection, including temperature instability, poor feeding or refusal to feed, lack of weight gain, gastric residual, vomiting, diarrhea, abdominal distention, hypoactivity/lethargy, tachypnea, jaundice, rash, petechiae, lesions, cyanosis and/or pallor and notify pediatrician if any of these are evident.
7. Follow routine procedures for the disposal of linens and trash.
8. Follow routine procedures for care of the normal newborn.
9. Obtain Social Services Referral.
10. Obtain Tulare County High Risk Referral.
11. Toxicology testing will be obtained in accordance with hospital policy, state regulations, and identified maternal or neonatal risk factors.
12. Follow HBIG Administration (Hepatitis B Immunoglobulin) policy if mother's hepatitis status is unknown or unavailable.
13. If cord blood was not obtained, order blood type, Rh, and any order per pediatrician.

DOCUMENTATION:

Document in Electronic Medical Record (EMR):

- Vital Signs
- Newborn System Assessment
- Newborn and mother's ID bands checked and match
- Physician notified
- Newborn birth weight
- Newborn Measurements
- Any information obtained from the mother/EMT/paramedic about the delivery and pregnancy history

Document medication administration in PCS on the Electronic Medication Administration Record (EMAR).

REFERENCES:

American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2021). *Guidelines for perinatal care* (9th ed.). Elk Grove Village, IL: Authors.

American Academy of Pediatrics. (2021). *Textbook of neonatal resuscitation* (8th ed.). Elk Grove Village, IL: American Academy of Pediatrics.

AWHONN. (2023). *Standards and guidelines for professional nursing practice in the care of women and newborns* (9th ed.). Washington, D.C.: AWHONN.

California Code of Regulations. (2020). *Title 22, § 70547(b)(22)(c)(k)*. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1

Gardner, S. L., Carter, B. S., Hines, M. E., & Hernandez, J. A. (2021). *Merenstein & Gardner's handbook of neonatal intensive care* (9th ed.). St. Louis, MO: Elsevier.

Joint Commission. (2022). *Hospital accreditation standards*. Joint Commission Resources.

Verklan, M. T., & Walden, M. (2021). *Core curriculum for neonatal intensive care nursing* (6th ed.). St. Louis, MO: Elsevier Saunders.

CROSS REFERENCES:

- Neonatal Intensive Care Unit (NICU): Admission, Discharge and Transfer Criteria Policy Link

SUBJECT: AMERICAN HEART ASSOCIATION INTERNAL DISPUTE RESOLUTION	SECTION: Page 1 of 2

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

PURPOSE:

To ensure that the Sierra View Medical Center (SVMC) American Heart Association (AHA) Training Center (TC) maintains consistency with AHA quality standards.

DEFINITIONS:

1. Conflict: A conflict is anything in a course which a participant believes to be unjust, wrong or unfair, and contradicts AHA policy as noted in the AHA Program Administration Manual (PAM).

POLICY:

The policy of the SVMC TC is to provide an opportunity to resolve problems or misunderstandings arising from a course offered by an Instructor employed by or aligned with the TC or from other TCs' activities or business.

Any participant who has a conflict about the application of a policy is encouraged to use the resolution procedure cited in this policy. SVMC AHA TC Instructors, Coordinator and/or Education Director will actively listen to every participant and respond in a timely manner to any issues which may be cause for participant concern.

AFFECTED AREAS/PERSONNEL:

REGIONAL FACULTY, TRAINING CENTER COORDINATOR AND INSTRUCTORS, EDUCATION DEPARTMENT DIRECTOR, COURSE PARTICIPANTS

PROCEDURE:

A. Participants should express their concerns directly with the instructor or with the Training Center Coordinator. At each step, responses will be communicated to the participant within 24 hours.

B. If the issue is not resolved to the participant's satisfaction at step one, the problem will be appealed in writing to the Regional Faculty or Director of Education.

C. If the Training Center is unable to resolve the issue within 30 days of notification; the Training Center must then forward the dispute/complaint to the Regional ECC Office by providing the required information as stated in the online AHA Program Administration Manual.

D. The SVMC AHA Training Center will comply with the most current version of the American Heart Association Program Administration Manual and related Training Center guidance.

REFERENCES:

American Heart Association. (2022). *Emergency cardiovascular care program administration manual: Guidelines for program administration and training (International version).* https://www.heart.org/-/media/BDD5142CCDEE4490A577770FC7EBE670.ashx

American Heart Association. (2026). *AHA instructor resources and program administration manual.* American Heart Association CPR & First Aid. https://cpr.heart.org/en/resources/aha-instructors

American Heart Association. (2026). *ATLAS: Training center and instructor resources.* https://atlas.heart.org

SUBJECT: AMERICAN HEART ASSOCIATION PROGRAM QUALITY ASSURANCE PLAN	SECTION: American Heart Association Training Center Page 1 of 3

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

PURPOSE:

To meet the requirements of the American Heart Association (AHA), as a Training Center (TC) teaching resuscitation classes, distributing provider cards and renewing skills of staff.

POLICY:

Sierra View Medical Center (SVMC), as an American Heart Association (AHA) Training Center, will administer and oversee all AHA courses in accordance with the current American Heart Association Program Administration Manual (PAM), AHA course standards, and applicable regulatory requirements. The Training Center is committed to providing high-quality, evidence-based resuscitation education, maintaining instructor competency, supporting continuous quality improvement, and ensuring participants achieve proficiency in lifesaving skills and high-quality CPR

AFFECTED AREAS/PERSONNEL: *REGIONAL FACULTY (RF), TRAINING CENTER COORDINATOR (TCC), INSTRUCTORS, AND COURSE PARTICIPANTS*

EQUIPMENT:

AHA pocket books/pocket guides as applicable
AHA testing materials/paper tests/answer sheets
AHA textbooks made available for use
Ambu bags (adult, pediatric)
Audit sheets
Automatic Electrical Defibrillators (AEDs)
Cleaning supplies
Course Evaluations
DVD player
Face masks (adult, pediatric, infant)
Instructor materials for each instructor
Mouth pieces for each participant (disposable)
Resuscitation mannequins for each participant pair (adult, child, infant)

PROCEDURE:

A. Quality Assurance

1. The Training Center (TC) is solely responsible for:
   a. Quality of the courses provided
   b. Compliance with AHA policies and guidelines

B. Quality Assurance Plan

1. Current AHA exams are used in all courses that require testing for issuance of course completion cards.

2. TC ensures that each student has a current, appropriate textbook readily available for use before, during, and after the course. For more information, refer to *Use of AHA Materials* AHA Program Administration Manual (PAM).

3. The TC follows the AHA PAM manual for developing, monitoring, and updating instructors and renewing instructor status.

4. Every AHA course conducted by the TC uses the AHA core content and AHA developed materials.

5. Written exams are stored securely in a locked location.

6. TC has adequate resources to complete contracted program requirements, including instructors, space, method for ensuring infection prevention, and resuscitation simulation equipment and training supplies.

7. The appropriate course completion card is issued to every student only upon successful completion of the course.

8. TC has written internal dispute resolution policies and procedures that each instructor receives.

9. Each instructor has instructions on how to access the most current version of the AHA PAM at the AHA website.

10. Instructors and TC monitor equipment used in all AHA courses to ensure cleanliness and working condition. All equipment is cleaned after each course taught, following manufacturer's guidelines.

11. TC records shall be maintained in a secure electronic and/or paper format consistent with AHA requirements and SVMC record retention practices. Access to participant, instructor, and course records shall be restricted to authorized personnel.

12. TC follows AHA PAM on how Training Center Faculty (TCF) and instructors receive training for their roles and are actively involved in the Quality Assurance /Performance Improvement process to ensure providers are able to perform quality CPR.

13. TC follows AHA PAM for how courses that are taught and skills sessions conducted by instructors will be monitored.

14. TC follows AHA PAM to evaluate its courses, instructors, and program administration:

    a. Courses shall be evaluated using the class instructor sheet completed by the class participants, and periodically by the TCC and/or RF

b. Training and updates will be conveyed to all instructors via e-mail, meetings, classes, or written / personal notice

c. Suggestions for course improvement are encouraged and may be made known to the Department Director and RF/TCC

15. All instructors shall maintain current instructor status and demonstrate ongoing competency through:
    a. Teaching required course minimums
    b. Participation in instructor updates
    c. Adherence to current AHA Guidelines
    d. Successful monitoring as required by the AHA
    e. Compliance with Training Center policies and procedures

16. Resuscitation training equipment shall be cleaned and disinfected according to manufacturer recommendations and SVMC Infection Prevention standards after each use. Appropriate personal protective equipment shall be available when indicated.

REFERENCES:

American Heart Association. (2026). Atlas: Training center resources and program administration information. https://atlas.heart.org/PAM

American Heart Association. (2026). Program administration manual: Guidelines for program administration and training (International version, effective February 1, 2026). https://www.heart.org/-/media/04191BA05B574F49941485ADAF2AF631.ashx

American Heart Association. (2026). AHA instructor resources. https://cpr.heart.org/en/resources/aha-instructors

Joint Commission. (2026). Competency assessment vs orientation. https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000001037

Joint Commission. (2026). Standards. https://www.jointcommission.org/en-us/standards

SUBJECT: **AMNISURE RUPTURE OF FETAL MEMBRANES (ROM) TEST**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 11**

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

PURPOSE:

To establish the procedure for the use of the AmniSure ROM test.

POLICY:

Laboratory and Maternal Child Health (MCH) staff will follow the appropriate procedure for the AmniSure ROM test.

AFFECTED AREAS/PERSONNEL: *ALL LABORATORY AND MCH STAFF*

PROCEDURE:

1. **Principle:**



The AmniSure ROM test is a rapid, non-instrumented, qualitative test for the detection of amniotic fluid in vaginal discharge of pregnant patients who report signs, symptoms or complaints suggestive of rupture of membranes. Rupture of membranes (pPROM) prior to 37 weeks' gestation complicates up to 12% of all pregnancies.[1] It uses the principle of immunochromatography to detect human PAMG-1 (placental α-1 microglobulin) protein present in amniotic fluid of pregnant women. Placental Microglobulin was selected as a marker of fetal membrane rupture due to its unique characteristics, i.e. its high level in the amniotic fluid, low level in blood, and extremely low background level in cervico-vaginal discharge when the fetal membranes are intact.

The test does not require a speculum exam. A sample of amniotic fluid (taken by vaginal swab) is placed into a vial with solvent. The solvent extracts the sample from the swab for one minute, after which the swab is disposed. The AmniSure test strip, a lateral flow device, is then placed into the vial. The solvent containing the PAMG-1 flows from the pad region of the strip to the Test Region. If PAMG-1 is present in the patient sample it will bind with antibodies in the test region producing a second line. The test result is indicated visually and can be read immediately or within 10 minutes. One line (Control) indicates no membranes are ruptured. Two lines indicate there is a rupture.

This method is classified by the Clinical Laboratory Improvement Amendments of 1988 (CLIA'88) as a "moderately complex" test procedure (per FDA update 7/19/04). FDA cleared the use of this test by Nurses and Midwives, as well as physicians. This test is used for definitive purposes.

2. **Responsible Persons:**

Only authorized operators may perform AmniSure testing. Authorized operators are those individuals who have attended a training session and successfully demonstrated the skills required for testing.

3. **Hazards:**

   a. Kit contents are for *in vitro* diagnostic use.

   b. Do not use kit contents after the expiration date printed on the outside of the kit.

   c. Do not use test strips if bent or damaged.

   d. Use appropriate precautions in the collection, handling, storage and disposal of the patient samples and used kit contents. Discard used materials in proper biohazard container.

   e. The test strip should remain sealed in foil pouch until just prior to use (must use within 6 hours).

   f. Proper testing protocol must be followed to obtain accurate results.

4. **Specimen Requirements:**

   a. Patient Preparation:

   If the patient gives a history of possible ruptured membranes and the nurse does not see visible amniotic fluid, yet suspects that the membranes have ruptured, an AmniSure test can be performed. Prepare patient for vaginal exam.

   b. Type:

   - Collect sample of vaginal discharge using sterile vaginal swab provided in kit.
   - Remove swab from packaging using care not to touch anything prior to insertion into vagina.
   - Collect sample from surface of vagina, holding swab in the middle of the stick while patient is lying flat on back.
   - Carefully insert the polyester tip of the swab into the vagina until fingers contact the skin no more than 2-3 inches (5-7 cm) deep.
   - Withdraw the swab after 1 minute.
   - Rinse swab after collection in solvent vial for 1 minute, and dispose of as indicated in test procedure.

- Test the patient sample as soon as possible after collection.

- If patient sample is not tested within 4 hours and sample storage is necessary, tightly close the sample vial and place in refrigerator for no more than 6 hours.

5. Materials:

a. AmniSure ROM Kit in foil pouch with desiccant (FMRT-1-25 for 25 test kit; FMRT-1-10 for 10 test kit)

b. Sterile polyester swab (supplied in kit)

c. Plastic vial with solvent (supplied in kit; contains 0.9% sodium chloride, 0.01% triton x 100, 0.01 NaN3)

d. Timer and Sample Rack

e. Storage Requirements:

- Store kits in dry location at room temperature 4-24 °C (40-75°F)
- Kits may be used until printed expiration date.
- Once AmniSure Test Strip is removed from foil pouch, it must be used **within 6 hours.**

6. Quality Control:

a. Internal Controls

- Each AmniSure test strip has built in reagent and procedural controls with an internal quality control line to ensure that adequate sample volume was present and adequate capillary migration of the sample has occurred.
- Patient tests where the internal quality control line is not visible must not be interpreted as the AmniSure test strip may be defective or the sample volume may be inadequate. Testing must be repeated with a new AmniSure test strip.
- External Quality Control fluids containing PAMG-1 and not containing PAMG1 are tested on each new lot number and shipment of AmniSure test strips to ensure accurate test strip performance.
- The appearance of one or two lines in the test area verifies the integrity of the test procedure. The appearance of the control line assures that adequate sample volume

was present and that adequate capillary migration (lateral flow) of the sample has occurred.

- It also verifies proper assembly of the test strip by manufacturer.

b. External Controls

- Prior to patient testing, external positive and negative controls must be run with random kits selected from each new shipment of AmniSure ROM kits to verify performance (i.e. validation or acceptability testing).
- External controls will also be run whenever there is suspicion that product performance is compromised or whenever kits have not been stored according to its labeling instructions.
- The External Controls will be provided by Point of Care Testing, SVMC Lab.

c. Quality Control Procedure

- External Positive Control: Protein positive control (available from the manufacturer).
- External Negative Control: AmniSure Solvent solution.
- After reconstituting positive protein control with the provided AmniSure Solvent solution, the obtained solution can be stored under refrigeration at 4-8°C for up to 24 hours. It is preferred, however, to run the QC procedure immediately after preparing a sample of positive protein control.

d. External Positive Control – Procedure:

- Take the vial containing 10 ng of freeze-dried Human PAMG-1 protein and add the provided 1 ml of AmniSure Solvent Solution. Mix solution well to ensure full reconsitution (e.g. vortex or shake vigorously).
- This solution from step #1 may be aliquoted out into 5 separate vials (similar to the original vial), each containing 0.2 ml of the solution. This optional method allows 5 positive controls to be run from 1 vial of PAMG-1 protein.
- Use the solution from step #1 for positive quality control of the AmniSure® ROM Test by following the two steps below:
  - Dip the white end of the test strip into the vial with solvent **for exactly 10 minutes**.
  - Remove the test strip after exactly 10 minutes. Read results by placing

the test strip on a clean, dry, flat surface. Do not interpret results **after 15 minutes have passed** since dipping test strip into vial.

e. Negative External Control - Procedure:

- Using AmniSure Solvent for the external negative control, follow steps 6.1.2 to 6.1.3 of the above procedure. Document external QC on QC log.

To interpret the AmniSure quality control results follow the chart below		
If the negative control (saline) is…	**Then…**	**And then…**
Negative	Quality control has passed	Proceed to positive control interpretation
Positive or invalid	Quality control has not passed	Repeat procedure NOTE: Do not release strips to nursing for patient testing
If the positive control (PAMG-1 protein) is…	**Then…**	**And then…**
Positive	Quality control has passed	Quality control has passed AmniSure test kits can be released to the nursing floors for patient testing
Negative or invalid	Quality control has not passed	Repeat procedure NOTE: Do not release test strips to nursing for patient testing
NOTE: Both levels of positive and negative controls need to pass for each new lot number or new shipment of test strips for the performance of the test strips to be acceptable. If the test strips do not pass quality control with an acceptable performance, sequester the kits and contact the manufacturer.		

Results reporting	**1.**	Locate the AmniSure Test kit Quality Control Log sheet
	2.	Fill out the positive and negative control results and the lot number of test strips

f. Expected Results:

- 1 Line Present (Control) in Test Area: Negative for Ruptured Membranes
- 2 Lines Present (Control and Patient) in Test Area: Positive for Ruptured Membranes
- 0 Lines Present in Test Area: Invalid Test

7. Procedure – Patient Testing (Refer to Section 3.0 – Specimen Requirements)

a. Open the AmniSure test kit and remove the contents

b. Shake the solvent vial to make sure that all of the liquid in the vial settles to the bottom

c. Open the solvent vial and place it in a vertical position

d. Insert the sterile polyester swab from the AmniSure test kit into the vagina for 2-3 inches.

e. Withdraw the swab after one minute has elapsed

f. Place the polyester swab into the vial

g. Rise the swab by rotating for one minute

h. Remove and dispose of the swab after one minute

i. Tear open the foil pouch at the test notches and remove the AmniSure test strip.

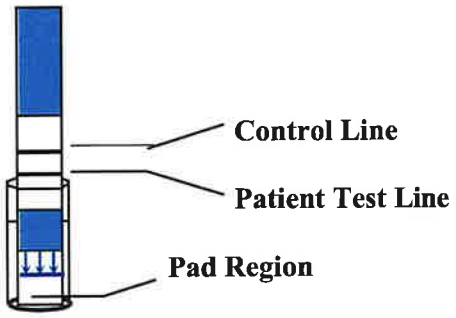
j. Dip the white end of the test strip (marked with arrows) into the solvent

k. Allow strip to remain in vial for 10 minutes, unless 2 lines are clearly visible.

NOTE: Strong leakage of amniotic fluid will make results visible within minutes, while a small leak may take up to 10 minutes.

l. Read the results by placing the strip on a clean, dry flat surface.

m. Do not read or interpret results after 15 minutes have passed since placing test strip into vial.



Results interpretation	If the result area on the test stick has…	Then the test result is…	And then…
	One line	Negative	The amniotic membranes have not ruptured
	Two lines	Positive	The amniotic membranes have ruptured

	No lines	Invalid	The test is invalid and must be repeated with a new swab, test vial and stick.
	Chart the results.		

8. Procedure Notes:

a. Properly identify the patient and solvent vial used in testing.

b. Test strip must remain sealed in foil pouch until just prior to use. Once open, the test strip must be used within 6 hours.

c. When there is a **significant presence of blood** on the swab, the test can malfunction and is not recommended. In cases of only trace amounts of blood on the swab, the test still functions properly.

d. Do not interpret results after 15 minutes have passed since placing test strip into vial.

e. Positive test results from a strong leakage of amniotic fluid may be visible right away.

f. A very small leak of amniotic fluid may take the full 10 minutes to become positive and a negative result must not be interpreted until the full 10 minutes have elapsed.

g. False negative results may occur when the sample is taken more than 12 hours after the fetal membrane rupture has occurred.

h. The AmniSure test should not be performed within 6 hours after the removal of any disinfectant solutions or medicines from the vagina

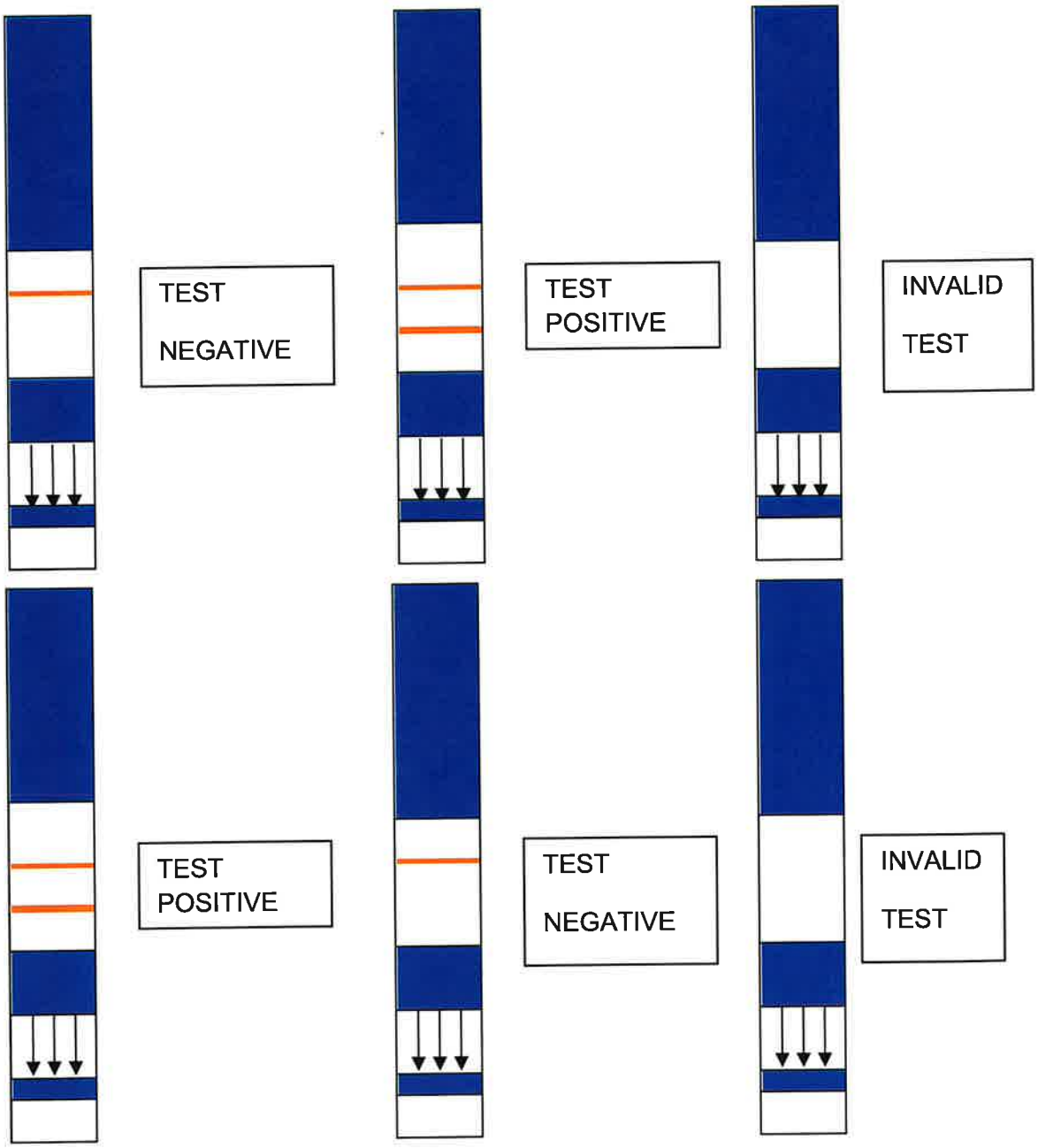
i. If AmniSure is performed as a lab test, L&D will collect the sample and send it to the lab that will run the test and record/interpret the results. In such a scenario, follow the following procedure:

- After step #5 of the procedure (i.e. after "Remove and dispose of the swab" step), place the cap on the vial.
- Complete the collection worksheet and bring the sample vial and paperwork directly to the Laboratory within 30 minutes of collection. Sample collection time must be recorded on the collection sheet and attested to by a CLS in the laboratory.
- If absolutely necessary, the sample may be held in the refrigerator (+4°C) by the lab for up to six (6) hours.

9. Reporting Results:

There are 3 possible result interpretations:

Only Control Line Present in Test Area:	**Control Line and Test Line Present in Test Area:**	**Control Line Not Present in Test Area: TEST**
INVALID, NO MEMBRANE RUPTURE	**THERE IS A RUPTURE**	**repeat specimen collection and testing**



- The darkness of the lines may vary.
- The test is valid even if the lines are faint or uneven.
- Do not try to interpret the test result based on the darkness of the line.

10. Reporting Format:

a. Document the internal control QC for one patient each day of patient testing.

b. All AmniSure patient results must be documented on the patient chart and must be accompanied by the internal QC, date and time of testing and operator's initials.

11. Expected Values and Clinical Significance:

Leakage of amniotic fluid is indicative of the fetal membrane rupture in all women. Studies of placental a-1-microglobulin protein (PAMG-1) have established it as a marker of amniotic fluid. Concentration of PAMG-1 in cervical and vaginal discharge of pregnant women without complications in pregnancy was measured and is ranged from 0.05 to 0.22ng/ml. When vaginitis or non-significant admixture of blood is present, the background level of PAMG-1 can reach the maximum level of 3ng/ml. PAMG-1 concentrations in the amniotic fluid fall into the 2,000-25,000 ng/ml range. Clinically significant leakage of amniotic fluid increases PAMG-1 concentration in cervico-vaginal discharge by a factor of thousands. The sensitivity threshold of the AmniSure Test is set by a factor of 20 above the background level of PAMG-1 (AmniSure detects ~5 ng/ml of PAMG-1).

12. Procedural Limitations

a. AmniSure test kit is for the in vitro detection of human amniotic fluid PAMG-1 protein in vaginal secretion of pregnant women. The test should be used to evaluate patients with clinical signs/symptoms suggestive of fetal membranes rupture.

b. Until the diagnosis of membrane rupture is excluded, avoid digital cervical examination to prevent infection and shorten the latency period.

c. Exclusion criteria include active vaginal bleeding from any source and placenta previa.

d. Interrupted leakage with minimal residual fluid can lead to false negative result.

e. Operators must follow all directions carefully to get an accurate reading of the results.

f. Each test is a single use disposable unit and cannot be reused.

g. The results obtained are qualitative and no quantitative interpretation should be made based on the results.

h. When there is a significant presence of blood on the swab, the test can malfunction and is not recommended. In cases of only trace amounts of blood on the swab, the test still functions properly.

i. In very rare cases when a sample is taken 12 hours or later after a rupture, a false negative result may occur due to the obstruction of fetus or resealing of the amniotic sac.

j. AmniSure should not be used earlier than 6 hours after the removal of any disinfectant solutions or medicines from the vagina.

k. Test performance in patients without signs or symptoms of ROM is unknown.

l. Results should always be used in conjunction with other clinical information.

m. Placenta previa and performing digital exams prior to sample collection can lead to inaccurate test results.

n. Women may labor spontaneously despite a negative test result.

13. Interfering Substances

a. Vaginal infections or urine do not interfere with the results of the AmniSure test.

b. The performance of AmniSure has not been established in the presence of the following contaminants: meconium, anti-fungal creams or suppositories, K-Y Jelly, Baby Powder (Starch and Talc), Replens, and Baby Oil.

c. Studies have shown that there is no interference of sperm factor in results.

d. The performance of the Amnisure ROM test has not been established in the presence of meconium in the amniotic fluid.

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SUBJECT: **BLOOD CULTURE COLLECTION**	SECTION: ***Provision of Care, Treatment & Services (PC)*** 3 **Page 1 of 2**

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

POLICY:

Blood culture is a widely-used tool for the detection of bacteremia or fungemia. The collection of blood cultures is a crucial step in determining the etiology of blood stream infections. This can also be critical for patients with sepsis and/or septic shock.

A positive blood culture establishes an infectious etiology for a patient's illness. The ability to perform susceptibility testing on a positive blood culture enables optimization of antimicrobial therapy. Contaminated blood cultures lead to a delay in diagnosis and care.

"A blood culture is a Laboratory test in which blood, taken from the patient, is inoculated into bottles containing culture media to determine if infection-causing organisms (bacteria or fungi) are present in the patient's blood stream" (BioMerieux, 2023).

There are 3 main aims of blood cultures:

1. Confirm infectious etiology
2. Identify the etiological agent
3. Guide antimicrobial therapy

EQUIPMENT:

- Sterile syringe of appropriate volume
- Chlorhexidine prep
- 21 or 22 gauge needle
- 2 blood culture bottles (one aerobic and one anaerobic) for each culture ordered or one aerobic pediatric bottle
- Additional venipuncture supplies (tourniquet, alcohol prep, cotton, etc.).

AFFECTED AREAS/PERSONNEL: *LABORATORY AND NURSING STAFF*

SUBJECT: **BLOOD CULTURE COLLECTION**	SECTION: ***Provision of Care, Treatment & Services (PC)***

PROCEDURE:

NOTE: Blood culture collection is a CRUCIAL step in the blood culture process. Standard precautions should be used, and STRICT ASEPTIC conditions in place throughout the collection of blood. A contaminated blood culture can directly affect our ability to treat the patient.

Step	Reason
1. At least 2 blood culture sets should be collected from 2 separate venipuncture sites.	For suspected bacteremia
2. Examine the bottles	Look for evidence of damage, deterioration, or contamination.
3. Check the expiration date	DO NOT use expired bottles
4. Label the bottles – clearly and correctly	Unlabeled bottles cannot be processed
5. Keep the bottles upright	
6. Ensure each set has BOTH an aerobic and anaerobic bottle	This is a proper "set"
7. Blood should be venous, not arterial	Lower contamination rate
8. If possible, avoid drawing blood from venous or arterial catheters	These devices often exhibit higher contamination rates
9. Immediately prior to venipuncture, the rubber septum on the blood culture bottle(s) should be disinfected with an alcohol prep by rubbing the rubber septum with friction, then allowing it to completely dry.	

10. Disinfect the skin THOROUGHLY:
• Choose the collection site, palpate the vein and visualize landmarks.
  ○ If you need to touch the site once it is disinfected, use a sterile glove
• Cleanse the venipuncture site with friction for 30 sec, using an alcohol prep
• Allow site to air dry
• Apply disinfectant (Chloraprep) in a cross-hatch pattern
• Allow site to dry per manufacturer's recommendations
• If patient is allergic to chlorhexidine, use only alcohol to prep the site.
11. Skin disinfection in Pediatric Patients:
• Less than 2 months old:
  ○ Povidone-iodine and alcohol
• Greater than 2 month old
  ○ Chlorhexadine or 2% iodine tincture
DO NOT touch site once disinfected, unless wearing sterile gloves.
	To minimize the risk of contamination of blood specimens with skin flora, the venipuncture site requires a minimum 30 second friction scrub with an appropriate disinfectant

SUBJECT: **BLOOD CULTURE COLLECTION**	SECTION: ***Provision of Care, Treatment & Services (PC)*** 3 **Page 3 of 2**
For additional information regarding pediatric blood culture collection, see Exhibit A: Biomeieux Pediatric Blood Culture Collection	
12. Collect Blood cultures Follow hand hygiene and don gloves	
13. Fill each bottle with 10 mL of venous blood (for adults). Always fill the blood culture bottles first, starting with the aerobic bottle, if blood is drawn for multiple tests. For pediatric patients, the volume used is based on the manufacturer's recommendations.	Ideal blood volume in each bottle optimizes the detection of pathogenic bacteria or fungi. The aerobic bottle is first. If you are not able to obtain enough blood for 2 culture bottles, fill the aerobic bottle.
14. Blood culture bottles should be inverted gently several times after filled with blood	To prevent clotting
15. Transport filled bottles to lab in less than 30 MINUTES	Changes in the bottle may happen after 30 min. When the bottle is placed in the incubator after 30 min, the machine may not recognize the change and may yield a false negative result, missing a positive culture.
16. Document as appropriate for your role	

References:

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- Emergency Nurses Association (ENA). Clinical practice guideline: Prevention of blood culture contamination https://www.guidelinecentral.com/guideline/308349/#section-320058
- Bednarek, R.S.; Nassereddin, A. & Ramsey, Michael L.(2023) Skin antiseptics. Stat Pearls, National Library of Medicine. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK507853/#:~:text=Healthcare%20Team%20Outcomes-,Antiseptic%20agents%20in%20dermatologic%20surgery%20commonly%20include%20chlorhexidine%2C%20povidone%2Diodine,as%20essential%20to%20preventing%20SSIs.
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- UpToDate (2024) Detection of bacteremia: Blood cultures and other diagnostic tests. Retrieved from

https://www.uptodate.com/contents/detection-of-bacteremia-blood-cultures-and-other-diagnostic-tests?search=blood%20culture%20collection&sectionRank=1&usage_type=default&anchor=H835114581&source=machineLearning&selectedTitle=1%7E150&display_rank=1#H835114581

SUBJECT: **BLOOD PATCH**	SECTION: **Page 1 of 4**

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PURPOSE:

To establish evidence-based guidelines for nursing care of patients undergoing an epidural blood patch (EBP) for the treatment of post-dural puncture headache (PDPH). The procedure involves injection of autologous blood into the epidural space to seal cerebrospinal fluid leakage and relieve symptoms associated with PDPH. An epidural blood patch should be considered for patients with PDPH whose symptoms significantly impair activities of daily living or fail to improve with conservative management. Conservative therapies may include hydration, oral analgesics, caffeine, and rest.

POLICY:

1. The blood patch is performed aseptically by anesthesiologist or certified registered nurse anesthetist (CRNA).

2. The Anesthesia provider will obtain informed consent.

3. If ineffective the blood patch may be repeated after 24 hours.

4. Blood patch is contraindicated:

   - ☐ Coagulopathy or bleeding disorders
   - ☐ Therapeutic anticoagulation not appropriately managed
   - ☐ Local infection at the injection site
   - ☐ Systemic infection or fever
   - ☐ Patient refusal or inability to provide informed consent

AFFECTED PERSONNEL/AREA: *MATERNAL CHILD HEALTH (MCH) DEPARTMENT; REGISTERED NURSES (RN)s*

EQUIPMENT NEEDED:

1. Peripheral IV lock with NS flush

2. Tape

3. Epidural or spinal tray or individual contents (MD/CRNA choice)

   a. Betadine solution or gel

   b. Benzoin spray

   c. 20 ml syringe with needle or needleless adaptor

   d. Lidocaine 1%

4. Sterile gown and gloves for MD/CRNA and for the assisting nurse

PROCEDURE:

1. Verify order.
2. Obtain Vital Signs (temperature, pulse, respirations and blood pressure).
3. Start peripheral IV and place lock or be prepared to start an IV after the site is prepared by the MD/CRNA and withdraw the blood directly from the IV catheter.
4. Position patient in sitting or lateral position with neck flexed toward chest (if patient is in lateral position, bring knees up toward chest as well).
5. Perform a Pre-procedural Time out and document in the electronic medical record.
6. Assist MD/CRNA as needed in setting up and maintaining the sterile field.
7. MD/CRNA will prep the site and insert the catheter.
8. The nurse will prep the IV site or IV lock with Betadine and withdraw blood from the patient. If withdrawing from an IV lock, discard 3 ml to 5 ml before obtaining 20 ml of venous blood from the site and hand it to the MD or CRNA who will inject it into the epidural/lumbar space via the spinal needle.
9. The MD/CRNA will withdraw the needle while holding pressure on the site. Patients may experience partial or complete symptom relief following the procedure; ongoing assessment is necessary as symptom improvement may be immediate or delayed.
10. Apply a band-aid or sterile dressing to the site.
11. Following the procedure, position the patient according to anesthesia provider orders and monitor for symptom improvement, neurological changes, or adverse effects. Duration of post-procedure positioning may vary based on provider preference and patient condition.
12. Perform a post procedural Time out and document in the electronic medical record.
13. Repeat vital signs after the procedure, if stable then return to previous orders.

DOCUMENTATION:

1. Assess and document patient symptoms such as:

- Headache severity using a pain scale
- Presence of neck stiffness
- Visual disturbances
- Auditory symptoms
- Neurological status before and after the procedure

2. Nursing measures given to relieve any symptoms (for example, warm blanket, dimmed lights, bed rest, hydration, oral analgesics, etc.)

3. Consent for procedure and an informed consent obtained.

4. Vital signs

5. Patient response to treatment such as relief of pain

6. Document patient education such as:

- Expected post-procedure
- Signs of infection
- Worsening headache
- New neurological symptoms
- When to notify the provider or seek emergency care

Patients should receive follow-up evaluation by the anesthesia team if symptoms persist, worsen, or recur following the epidural blood patch.

REFERENCES:

American Society of Anesthesiologists. (2021). *Statement on post-dural puncture headache management.* https://www.asahq.org/standards-and-practice-parameters/statement-on-post-dural-puncture-headache-management

Tubben, R. E., Jain, S., & Murphy, P. B. (2023). *Epidural blood patch.* In *StatPearls*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK482336/

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SUBJECT: **BREAST MILK COLLECTION AND STORAGE**	SECTION: **Page 1 of 4**

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PURPOSE:

To provide a safe and standard method for the collection, storage, and administration of breast milk.

POLICY:

- Infants will be fed their mother's breast milk when ordered by the physician under the following provisions:

  - The mother must not be taking drugs that are contraindicated in nursing
  - Most maternal infections are not contraindications to breastfeeding. True contraindications are rare and should be evaluated in accordance with current AAP and CDC guidance.
  - Milk has been collected observing clean technique that protects from contamination

- Mothers will be instructed on procedures for milk expression:

  - General instructions
  - Hand expression
  - Manual/electric pump
  - Freezing and storage of breast milk

AFFECTED AREAS/ PERSONNEL: *MCH DEPT./RN'S, IBCLCs,*

EQUIPMENT:

- Breast pump (electric or manual)
- Breast pump collection kit
- Milk storage containers (clean plastic bottles for milk storage)
- Wash Basin (for cleaning pump kit)
- Warm wash cloth
- Infant ID Label (which includes bar code) for in patient NICU babies; moms label for babies transferred.

PROCEDURE:

1. Mothers will be instructed to wash hands and scrub finger nails prior to breast milk collection.

2. Mothers will be instructed to massage their breast in a circular motion towards the nipple prior to each pumping.

3. Mothers will be provided with clean milk storage containers.

4. Provide the mother with new milk storage containers and Infant ID labels to take home each time she brings in full containers.

5. Mothers will be encouraged/assisted to express their milk at least eight times in 24 hours.

6. Freshly expressed breast milk may be stored in a refrigerator at 40°F (4°C) or lower for up to 4 days. If the milk will not be used within 4 days, it should be frozen as soon as possible.

   a. The breast milk refrigerator will have an electronic temperature control check which will be documented in the pharmacy.

   b. If at any time the refrigerator is not in compliance with temperature greater than 40 degrees F., all breast milk will be discarded and the refrigerator will be cleaned.

7. Use infant label for in patient NICU babies and mom's label for babies transferred.

8. Before feeding the infant, the nurse will verify that the infant's ID band matches the breastmilk label.

9. General Guidelines for Breast Milk Expression:

   a. Educate mother that applying a warm, wet wash cloth to the breast for a few minutes or taking a warm shower, especially prior to hand expression, may help to relax her and aid in the milk "let down".

   b. Sitting in a quiet room in a comfortable chair and/or listening to relaxing music may also aid the mother in relaxing and cause her milk to "let down".

   c. Looking at a picture of her baby while expressing milk may encourage a "let down" response.

   d. Adequate rest and increased fluid intake will improve milk production.

10. Hand Expression of Breast Milk:

    a. Instruct the mother to massage the breast from perimeter to nipple, moving hands clockwise. .Move fingers around the breast in a clockwise or counter-clockwise direction so milk begins to flow.

    b. Instruct the mother to grasp the outer margin of the areolar area with her thumb and forefinger, supporting the breast with the other three fingers. Gently compress this area using pressure toward the chest wall. Milk will flow more freely.

    c. The mother should switch sides after 5-10 minutes and alternate between sides at least twice, expressing 5-10 minutes on each side. This may facilitate another "let down" reflex. The mother should continue to express until the milk no longer flows.

11. Manual/Electric Pump:

    a. The mother should follow user instructions for the specific pump she is using.

    b. The milk expressed should then be placed into a milk storage container and an Infant ID Label with the date and time documented.

    c. Instruct the mother to pour 1-2 ounces of milk into each container or approximately enough for her infant's feeding. Instruct the mother to leave enough room at the top of the container to allow room for expansion if she is planning to freeze the milk. Cap the milk storage container tightly.

    d. The mother should then label the containers with the infant ID label and include the date and time the milk was expressed. Place the expressed milk in the refrigerator; do not place in the refrigerator door compartment.

    e. If milk is collected at home, the milk must be transported to the hospital on ice. Once the milk has been thawed, it cannot be refrozen. Frozen milk is not to be transported to the hospital unless it is to be used within 24 hours.

12. Thawing Breast Milk:

    a. Frozen breast milk should be thawed using the waterless breastmilk warmer located in the NICU.

    b. Breast milk should NEVER be thawed in the microwave oven, because heating is uneven and may destroy many beneficial properties of the breast milk and microwaved breast milk may have hot spots. Never allow breast milk to sit out at room temperature to thaw.

    c. Take out enough breast milk for the feeding and place the remainder in clean milk storage container labeled with the Infant ID label and the date and time the milk was thawed. Place the container into the refrigerator for the next feeding. Thawed breast milk can be kept for 24 hours.

CARE OF EQUIPMENT:

- Electric breast pumps are cleaned according to manufacturer's recommendations.
- The disposable collection kits are for single patient use.
- Personal collection kits will be washed in a basin with hot, soapy water after each use and allowed to air dry on a paper towel.

DOCUMENTATION:

- Document instructions
- Patient's understanding
- Return demonstration

SPECIAL PRECAUTIONS:

1. Freshly expressed breast milk can be kept at the bedside for up to 5 hours. After 5 hours at room temperature, expressed breast milk must be discarded.

2. Containers of milk should be labeled with infant ID label and date and time of collection.

3. Breast milk from each pumping should be stored separately. Do not mix warm milk with cold milk.

4. Breast milk should be frozen within 4 days if not used. Frozen breast milk is best used within 6 months, although storage for up to 12 months is acceptable.

5. Milk should be fed to infant so that the oldest milk is used first.

6. Any breast milk remaining after a feeding should be used within 2 hours after the feeding has ended and then discarded.

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SUBJECT: **CIWA-Ar: ASSESSMENT AND TREATMENT OF ACUTE ALCOHOL WITHDRAWAL**	SECTION: **Page 1 of 8**

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

PURPOSE:

The purpose of this policy is to ensure a standard approach to the treatment of patients suffering from an acute alcohol withdrawal syndrome (AWS).

DEFINITIONS:

1. AUDIT: Alcohol-use disorders identification test
2. CIWA-Ar: Clinical Institute Withdrawal Assessment Revised
3. CPOE: Computerized Physician Order Entry
4. AWS: Alcohol Withdrawal Syndrome
5. RASS: Richmond Agitation Sedation Scale
6. Delirium Tremens (DTs): A rapid onset of confusion, auditory, and/or visual hallucinations usually caused by AWS. Occasionally, a very high body temperature or seizures may result in death.

POLICY:

A. Any clinical history/assessment of alcohol abuse/withdrawal/dependence or anything else that elicits suspicion of potential AWS should initiate the AUDIT questions (See addendum 2 below). An AUDIT score of ≥8 should prompt notification to the physician to assess patient for possible alcohol withdrawal syndrome.

B. Upon provider's diagnosis of acute alcohol withdrawal syndrome, they are encouraged to consider the use of a tool to assess patient's risk of severe or complicated withdrawal. A scale such as the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) is recommended. A score of ≥4 represents a high risk for complicated AWS. Prophylaxis and/or treatment may be indicated. Providers should utilize the CIWA order set if indicated.

C. Staff will utilize the CIWA-Ar ASSESSMENT QUESTIONAIRE (see addendum 1 below) to approximate the patient's current level of alcohol withdrawal. Depending on the outcome of the patient's score, they will be stratified into either Mild, Moderate or Severe as described below. For admitted patients, determination of the appropriate unit for admission should take into consideration the multidisciplinary clinical assessment of both the RN and Physician, taking into consideration the assessment frequency and patient likelihood of complicated AWS. CIWA assessment frequency will be a driver in determination of appropriate unit.

CIWA score & units consideration.

1. CIWA Score < 8 = **Mild** AWS
   a. Assess and document **q4hrs.**
   b. No restriction on unit
2. CIWA Score ≥ 8 to ≤ 15 = **Mild/Moderate** AWS = recommended department is minimally **Med-Surg**, but if deemed unmanageable by Med-Surg RN and Physician judgment, then transfer to **Telemetry.**

a. ~~Assess and document **q4hrs** on **Med-Surg.**~~
b. Asses and document **q2hrs** on **Telemetry.**

3. CIWA Score ≥ 16 ≤ 25 = **Moderate/Severe** AWS = recommended department is minimally **Telemetry,** but if deemed unmanageable by Telemetry, RN and Physician judgment, then transfer to the **ICU.**

a. Assess and document **q2hrs** on **Telemetry**
b. Assess and document **q1hr in the ICU.**

4. CIWA Score CIWA > 25, RASS 4-5= **Very Severe/Delirium Tremens** AWS = patient must be in **ICU with physician at bedside.**

a. Assess and document **q15min in the ICU.**

5. Based on the final determination of providers, assessment frequency will be ordered. The following stratification is policy for which units the assessment frequency is appropriate.
a. CIWA assessment order for Q4hrs- all units acceptable
b. CIWA assessment order for Q2hrs- Telemetry or ICU acceptable
c. CIWA assessment order for ≤Q1hrs- ICU only

AFFECTED PERSONNEL/AREAS: *PHYSICIANS, REGISTERED NURSES AND PHARMACISTS IN THE ED, ICU, TELEMETRY, AND MED-SURG DEPARTMENTS.*

PROCEDURE:

A. Ordering Provider

1. Upon initial patient assessment, or during stay if delayed onset, determine if patient is suffering from AWS. If signs/symptoms of alcohol withdrawal are present, then place appropriate orders via CPOE.

a. Consider contraindications to protocol

2. If patient is not currently in the appropriate acuity level, then consider transferring to a more suitable department according to clinical judgment or per policy; use their CIWA score as a guide.

3. Be available to respond to any nursing concerns bedside, especially if CIWA score is > 25 or if RASS is 4-5.

B. PHARMACIST

1. Ensure the appropriate medications, routes and dosing intervals are being prescribed and administered in the appropriate departments.

2. Upon escalation or de-escalation between order sets, discontinue previous order set's medication orders. Ensure there is no ambiguity surrounding the active CIWA orders.

3. Assist RNs with protocol decisions whenever consulted.

C. REGISTERED NURSE

1. Upon receiving orders for the initiation of the CIWA-Ar AWS Protocol, utilize the 10 question CIWA-Ar (CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED) ASSESSMENT QUESTIONAIRE (see addendum 1 below) to calculate the patient's current CIWA Score.

2. Assess and document the patient's CIWA score and vital signs at the appropriate time intervals per received orders.

Addendum 1: CIWA-AR Questions

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?"
Observation:
0 no nausea and no vomiting
1 mild nausea with no vomiting
2-3
4 intermittent nausea with dry heaves
5-6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?"
Observation:
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart.
Observation:
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2-3
4 moderate, with patient's arms extended
5-6
7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?"

Observation:
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS –
Observation:
0 no sweat visible
1 barely perceptible sweating, palms moist

2-3
4 beads of sweat obvious on forehead
5-6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?"
Observation:
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?"
Observation:
0 no anxiety, at ease
1 mild anxious
2-3
4 moderately anxious, or guarded, so anxiety is inferred
5-6
7 equivalent to acute panic states as seen in severe delirium or
acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
Observation:
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

AGITATION –
Observation:
0 normal activity
1 somewhat more than normal activity
2-3
4 moderately fidgety and restless
5-6
7 paces back and forth during most of the interview, or constantly
thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you?

Who am I?"
Observation:
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total **CIWA-Ar** Score _____
Maximum Possible Score 67

Addendum 2: AUDIT QUESTIONS

1. How often do you have a drink containing alcohol?

0 – Never
1 – Monthly or less
2 – 2-4 times a month
3 – 2-3 times a week
4 – 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

0 – 1 or 2
1 – 3 or 4
2 – 5 or 6
3 – 7 to 9
4 – 10 or more

3. How often do you have six or more drinks on one occasion?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of your drinking?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily

9. Have you or someone else been injured because of your drinking?

0 – No
2 – Yes, but not in the last year
4 – Yes, during the last year

10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?

0 – No
2 – Yes, but not in the last year
4 – Yes, during the last year

Notes
Low risk (0 to 7 points)
Medium risk (8 to 15 points)
High risk (16 to 19 points)
Addiction likely (20+ points)

REFERENCES:

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- Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357.

- Hoffman, R.S. Management of moderate and severe alcohol withdrawal syndromes. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on May 7, 2026).

SUBJECT:	SECTION:
CLEAN CATCH URINE COLLECTION FOR URINALYSIS	**Page 1 of 1**

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

POLICY:

All patients will be instructed how to correctly cleanse and collect a urine specimen for urinalysis.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. ***Collection of Clean-Catch Midstream Urine - Male***

   a. Wash hands thoroughly with soap and water and wipe dry with a paper towel.

   b. Pull back the foreskin (if uncircumcised) and thoroughly cleanse the glans penis with the provided antiseptic towelette.

   c. Begin to urinate. Allow the first stream of urine to flow into the toilet, then place the container under the stream and fill the container 1/4 full.

   d. Do not touch the rim or the inside of the specimen container.

2. ***Collection - Females***

   a. Wash hands thoroughly with soap and water, wipe dry with a paper towel.

   b. Cleanse each side of the urinary meatus, then cleanse meatus with the provided antiseptic towelette, wiping from front to back.

   c. Begin to urinate. Allow the first stream of urine to flow into the toilet, then place the container under the stream and fill the container 1/4 full.

   d. Do not touch the rim or inside of the specimen container.

REFERENCE:

- Turgeon, Mary Louise, Linne & Ringstrud's Clinical Laboratory Science, 8th Edition, 2020.

SUBJECT: **CLINICAL DECISION UNIT ADMISSION CRITERIA**	SECTION: **PROVISION OF CARE, TREATMENTS & SERVICES** **Page 1 of 3**

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

PURPOSE:

To define the criteria for admission on the clinical decision unit.

POLICY:

Admissions will be processed efficiently and in an expedient manner. Every effort is made to facilitate the optimum care and placement of these patients.

AFFECTED PERSONNEL/AREAS: *CLINICAL STAFF*

PROCEDURE:

1. Clinical Decision Unit will be defined as Medical/Surgical beds 310-328

2. All members of the medical staff with admitting privileges may admit to the clinical decision unit.

3. Before admitting to the Clinical Decision Unit patient will be screened through Meghan's Law when mixing the pediatric population with the adult population. If patient appears in the Meghan's law search the patient will not be accepted to this area but place in the same level of care in a different area.

4. Patients may be admitted to Clinical Decision Unit in any of the following ways:

    a. **Direct Admissions** are admitted directly from their doctor's offices or their homes, with arrangements made by phone though the Utilization Review Department or the House Supervisor after hours. These patients may transport themselves to the hospital, and register at the Admitting Department after which they will be transported to the Unit. Orders should arrive with the patient. If no orders are received, the attending physician will be contacted to obtain orders.

    b. **Emergency Admissions** are admitted from the emergency room. Prior to transferring patients to the Clinical Decision Unit, emergency department personnel must confirm that transfer meets all criteria and orders for admission have been entered/written.

    c. **Transfer Patients** are admitted to Clinical Decision Unit from other units such as operating room (i.e. Surgical Day Care patients). Prior to transferring patients to the Clinical Decision Unit, the transferring department personnel must confirm that transfer meets all criteria and orders for admission have been entered/written.

CIRCUMSTANCES OF ADMISSION:

1. Patients admitted to the Clinical Decision Unit will have orders that specify:
   a. Admitting diagnosis and orders to admit as Surgical Day Care (SDC), Observation(OBS), or Inpatient status;
   b. Code status;
   c. Diet;
   d. Laboratory tests and procedures that need to be performed;
   e. Routine medications.
2. The RN assigned to the patient will notify the attending physician of the patient's arrival on the unit and of the patient's status.
3. Doctors will visit patients on the unit daily and provide appropriate medical documentation on their conditions.
4. The nursing staff will consider a patient's diagnosis, sex, age, and acuity level in placing him/her in a room.
5. Nursing responsibilities with regard to the newly admitted patient include:
   a. Compiling an admission database by the RN/LVN utilizing admission interventions and guidelines.
   b. The RN is responsible for completing and documenting the initial admission assessment and the general admission information.
   c. Developing a care plan initiated at the time of hospital admission.

INCLUSION CRITERIA:

- Hemodynamically stable
- Absences of ECG changes
- Initial cardiac biomarkers negative and continued serial monitoring
- Resolving pain
- Overflow

LIMITATIONS:

The unit is staffed and designed for patients who are hemodynamically stable. Patients who require remote telemetry monitoring must not have a new onset of cardiac problems or require acute intervention for cardiac arrhythmias. Patients who are NOT candidates for admission as Clinical Decision Unit include, but are not limited to:

- Pediatrics (those requiring remote telemetry monitoring will be transferred to a higher level facility)
- Registered Sex Offenders
- Patients with new onset of cardiac problems; requiring a cardiac drip (unless overflow from telemetry)
- Patients with elevated biomarkers and acute chest pain (unless overflow from telemetry)

NOTE: *Overflow in this area maybe from all other acute care areas including medical surgical, telemetry, and post-partum. Overflow patients will be assigned to a nurse competent in the level of care the patient is requiring*

REFERENCE:

The Joint Commission. (2026). *Comprehensive accreditation manual for hospitals*. Joint Commission Resources.

SUBJECT: **COMMUNICATION WITH THE PATIENT/FAMILY AFTER A HARM EVENT**	SECTION: **Page 1 of 7**

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

PURPOSE:

The purpose of this policy is to provide structure and guidelines for communication with patients and families after harm, unanticipated or adverse medical outcomes. The goal is to provide a coordinated process for promoting timely, transparent, empathetic communication with patients and families. It is recognized that communicating with patients and families is a process rather than one conversation in time, with additional information shared as it is learned and understood.

DEFINITIONS:

1. Harm Event: Any measurable amount of physical, psychological, or financial injury.

2. Patient Communication Request: A request to have a member of the SVMC team, communicate with a family who is upset or has experienced an adverse event.

3. Communication: The process of conveying information verbally or in writing to a patient/family member or other designee after a healthcare related event. Types of communication in the context of this policy include:

    a. Empathic Communication: One that expresses a concern and curiosity about the impact of a harm event on a patient and their loved ones.

    b. Apology: An empathic communication that includes the expression of sorrow to the patient or family for inappropriate care that caused harm. This is done with an eye toward potential early financial or other forms of resolution such as promise for process improvement.

    c. Disclosure of Medical Error: Telling the patient or family the facts of what happened and the way in which mistakes or errors caused the healthcare related harm (Disclosure is not an isolated conversation; rather it is a series of conversations).

4. Empathy: The ability to share in another's emotions, thoughts or feelings.

5. Leadership: Members of the Board of Directors, Hospital Administration and Medical Staff.

6. Timely: Initial communication to the patient/family is to occur, whenever possible, within 60 minutes of actual knowledge of the harm event.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to ensure all patients and/or their family members receive timely, empathic communication from the patient's healthcare team or other designated organization representatives about all relevant aspects of their care including information about patient related harm events and/or unanticipated or adverse medical outcomes of their diagnostic tests, medical treatment and surgical intervention. When harm is related to care or treatment, the hospital personnel and

medical staff will strive to follow the procedure below in communicating to patients/families. Patients/families should be fully informed about unanticipated or adverse medical outcomes, which include events, related to medical error as well as other complications of care or patient care issues which resulted in a negative and/or adverse patient and family outcome or experience.

Adverse events, medical errors and complications can cause emotional stress and fear with providers, patients and families. This fear may prohibit communication and transparency which may cause mistrust; all of which may interfere with communication. Therefore, it is essential that the patient/family receive consistent, cogent and accurate information about the event, complication or issues with patient care process in a timely fashion.

It is the responsibility of the direct care providers to notify the Patient Safety Officer and the Administrator on Call. The Patient Safety Officer and Senior Quality Leader will work to assure communication of the harm event with the patient/family occurs in a timely, coordinated, consistent and accurate manner. Every effort will be made to begin the communication process with the patient/family within 60 minutes of the harm event. The Patient Safety Officer and Senior Quality Leader will determine who will be part of the communication.

At the time of the initial communication about a harm event, the patient/family should be informed about when they can expect follow-up communication about the event. This is not a disclosure communication but acknowledging the harm event and offering an apology.

Communication Procedure

1. Communication huddles prior to speaking with the patient/family, to include the Patient Safety Officer, Senior Quality Leader, Chief Nursing Officer, and appropriate clinical leadership.

   The initial communication huddle should include the following:

   a. Identification of who shall participate in the pre-communication discussion and when and where the communication discussion should occur.

      i. Who should participate in the discussion with family; who has the most trusted relationship with the family and can they be present for the conversation?

   b. Review the message which shall take place during the planned communication and, if possible, rehearse with participants at least once prior to patient/family meeting.

      i. What emotion should be anticipated and how will you validate and respond to them?

   c. Identify clinical support staff which may be needed, social services, interpreter services, chaplain, patient family advisory council member, other.

   d. Determine family's concrete needs, e.g. cultural services, food and parking assistance, family accommodations, travel, other.

e. Review the goals of this specific interaction.

f. When you should reach out with further information to the patient/family (set a date/time) and who the contact person is for the patient/family.

g. How will you open the conversation and what will you say.

h. What information is known and can be shared and discussed.

i. What questions can you anticipate from the patient/family.

j. Who takes the lead in responding to the patient/family as more information becomes available

k. How do you respond to and support caregivers.

l. Notify attending physician of communication plans if he/she is not the individual carrying out the initial communication.

m. An interpreter shall be used if the preferred language is other than English or the patient and family do not speak or understand English.

n. The cultural aspects of the patients/family are to be considered as well.

Initial Communication Guidelines

a. All efforts will be taken to initiate communication with the patient and family within 60 minutes of actual knowledge of the harm event.

b. The initial patient/family communication packet, housed with the Patient Safety Officer and Senior Quality Leader, should be filled out completely, starting with the initial communication checklist.

c. The harm event will be acknowledged to the patient/family. This is not an admission of guilt; rather it acknowledges that a harm event occurred while the patient was under SVMC's care.

d. First priority is to take care of the patient and meet their healthcare, social, emotional and spiritual needs.

e. Patients and families should be reassured that the harm event will be investigated with the goal of learning what contributed to the event so that the organization can takes steps to prevent recurrence. Patient and family should also be reassured that they will be given more information as it becomes available.

f. The initial communication should include the nature of the harm event, what is known about the potential impact of the event on the patients' health and what is being done to mitigate any effects on the patient's health.

g. Avoid speculation and conjecture. Communicate facts known at the time. If the facts are not known then state at this time we do not know, but will look into it and get back to you within a specific agreed upon timeframe of the next communication.

h. Avoid expressions of blame or fault.

i. The communication should not include information on errors or so called "near-misses" which at the time of the event did not appear to have affected the patient's medical condition or outcome.

j. Ask the patient and family if there are any immediate needs that have not been addressed. Offer support services such as the social worker, chaplain, patient advocate, interpreter etc. as needed.

k. Patients and families should be reassured SVMC staff and physicians will continue to provide ongoing care including the management of the harm event.

l. It is always appropriate to express empathetic regret for an adverse event or medical error and apologize to the patient and/or family affected by the event.

How to Communicate and Empathize:

a. Be honest and truthful while acknowledging the event

b. Explain what happened slowly and show empathy such as "this must be very difficult." "I can't even imagine how difficult this must be right now for your family." "Is there anything you need right now?"

c. Apologize – To express empathy.

d. Avoid use of technical language.

e. Pause and allow ample time for questions to ensure the patient/family understand the communication.

f. Inform the patient/family that an investigation and analysis will be completed to understand what occurred and that results will be shared.

g. Designate an organizational contact person who will reach out to the patient/family within an agreed upon time period and that the patient/family can contact with questions.

h. Ensure the patient/family has written contact information of the organizational contact person such as a business card.

Activation of the communication team once a harm event is identified

a. Activation of the communication team (to include one of the following; Patient Safety Officer, Senior Quality Leader) at minimum, should be considered for:

i. Events that fall under California Health and Safety Code Section 1271.1 (reportable adverse events to the California Department of Public Health),
ii. Any instance of serious bodily harm or death, or
iii. Any instance where a patient or family is extremely upset or angry regarding the care received or an adverse event.

b. Once a harm event is identified the employee will notify a communication team member for guidance via contact with the Patient Safety Officer (4706) or Senior Quality leader (6047). For after hours, contact PBX who will reach out via after hours numbers.

c. If a communication team member is present on campus they will come to the area of the organization where the clinicians are present and guide the clinicians in the conversation.

d. If there are no communications team members physically on campus the on-call communication team member will guide the clinicians on the phone until they can arrive on-site.

Who shall communicate the harm event to patients/families:

a. It is the responsibility of the attending physician or designee and the organizational leaders to assure communication of the harm event with the patient/family occurs in a timely, coordinated, accurate and consistent manner.

b. Upon knowledge of a harm event the communication team shall be notified and the lead on the team or designee will guide the clinicians in the communication of the harm event. A communication team member will also be present, if possible, for the actual communication with the providers communicating with the patient.

Documentation of the conversation:

a. The communication lead shall document the conversation in the medical record. The record note must be factual only and not state conjecture or opinions but rather the facts of the conversation.

b. The note shall include the date, time and place of the discussion and the names, titles and relationships of those present. Information provided and plan of care going forward will be noted. Offers of assistance to the patient/family as well as the patients/families

response shall be documented. The documentation shall also include any referrals/consults initiated as a result of the harm event.

Follow-up communication:

a. As more facts become known throughout the continual investigation the contact person will inform the patient/family.

b. The organizational contact person will ensure the patient/family has written contact information such as their business card for further communication and any questions the patient or family may have.

c. The contact person will arrange specific dates and times for follow-up at regular intervals.

Debriefing the effectiveness of the communication:

a. There will be a debriefing of the communication team members after the meeting to discuss what went well and to identify any opportunities for improvement. The results of the team debrief will be communicated to leadership as well.

AFFECTED PERSONNEL/AREAS: *ALL AREAS*

REFERENCES:

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- California Legislature. (2008, January 1). California Health and Safety Code Section 1279.1. Retrieved April 24, 2026, from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1279.1.&lawCode=HSC
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- The Joint Commission. (2026.). Sentinel Events and Communication. Retrieved from https://www.jointcommission.org/en-us/knowledge-library/sentinel-events

CROSS REFERENCES:

- **Serious Clinical Adverse Event policy**

SUBJECT: **COMPETENCY ASSESSMENT PROCESS**	SECTION: **Page 1 of 5**

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

PURPOSE:

SVMC maintains a comprehensive competency assessment and validation program to ensure that all employees possess and demonstrate the knowledge, skills, abilities, and behaviors necessary to perform their assigned responsibilities safely, effectively, and in accordance with regulatory, accreditation, professional, and organizational standards. Competency assessment is an ongoing process that supports patient safety, quality outcomes, employee development, and continuous performance improvement.

DEFINITION:

Competency: ability to meet the performance standards in the application of knowledge, skills and behaviors that are required to meet organizational and departmental requirements under the varied and unpredictable circumstances of the healthcare setting.

POLICY:

Methods utilized for competency assessment will be based on job title.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

The following assessment methods will be utilized for all job titles in the organization:

1. Pre-Employment Assessment: Competence begins with the evaluation of the individual's qualification for the particular position based on the position's scope and requirements. Pre-employment competency assessment will include, but is not limited to, validation of the following:

    a. Licensure, registration, cards of completion and certification (where applicable)

    b. Previous experience and current skills and abilities through the interview process, reference checking, résumés and applications

2. Performance Appraisals: During the initial and annual performance appraisal process, competency is evaluated to determine ability to meet job requirements and to identify opportunities for improvement. In response to the appraisal, the manager/director may develop an action plan to improve performance. Some factors that may be considered during the appraisal process are the individual's:

    a. Ability to exercise independent judgment as appropriate

    b. Ability to competently carry out specific components of patient care or support services

c. Understanding of their role in the organization

d. Success in meeting customer needs

Additional methods of competency assessment are required for specific job titles within the organization as listed in Appendix A. This process is outlined below:

1. Initial Competency Assessment: Within the first 90 days of employment, an initial competency assessment will be completed. This assessment may include validation of the following:

   a. Core job functions

   b. Frequently used functions and accountabilities

   c. High-risk, low-volume job functions and accountabilities

2. Annual Competency Assessment: Competency assessment will continue on an ongoing, annual basis. Annual competency assessment may include validation of the following:

   a. New policies, procedures, equipment, technologies, service lines and initiatives

   b. Changing policies, procedures, workflows, technologies and initiatives

   c. High-risk, low-volume functions and accountabilities

   d. Problematic job aspects identified through performance improvement data, incident reports, customer surveys, review of aggregate competency data, quality performances indicators etc.

   e. Changes in scope of practice or professional standards

3. Competencies will reflect the employee's job description, focuses on performance standards and behaviors necessary to perform core job functions.

4. Each department is responsible for identifying competencies to meet the job performance standards and behaviors, and for determining the appropriate methods for validating those competencies.

5. Methods of validating competencies include direct observation of work, return demonstration /teach back, simulation, written testing, exemplars, presentations, case studies and performance improvement monitors.

6. Competency validation is documented and kept accessible in staff competency folders in each department and/or in the facility electronic Learning Management System (LMS). A standardized hospital-wide format will be utilized for documenting competency validation.

7. Employees will function under the supervision of a preceptor/resource person until designated competencies have been validated.

   a. The preceptor/resource person will have documented competency validation in the specific knowledge, skills and technologies necessary to orient and validate competency in others.

   b. The employee and assigned preceptor/resource person share responsibility for completing competency assessment and submitting documentation within the established time frames.

PROCEDURE:

Competency Accountability - The accountability for competency assessment will occur at three levels:

1. Organizational – collaborative oversight will be provided by the Human Resources, Education and Quality departments

2. Designated director for each department - The Director in each department is responsible for:

   a. Conducting a needs assessment to identify both unit specific and house-wide competencies based on low volume, high risk, new workflow/process/equipment, problem prone areas

   b. Receiving and distributing information from Human Resources, Education and Quality departments

   c. Establishing a mechanism to identify unit-specific competencies with staff involvement

   d. Creating an environment that promotes timely competency assessment and ongoing growth and development

   e. Providing education to employees on the competency process

   f. Monitoring employees progress

   g. Participating in evaluation of the competency process

3. The employee is responsible for:

   a. Completing competencies as indicated

   b. Participating in competency development

4. Agency, registry, temporary, contracted, and traveler personnel providing patient care or patient support services shall demonstrate and document competency consistent with organizational requirements prior to independently performing assigned duties.
5. Additional competency assessment may be required at any time based on patient safety concerns, adverse events, quality indicators, changes in job responsibilities, introduction of new technology, prolonged absence from practice, or identified performance concerns.

Validation of Individual Competencies

1. The employee will be deemed "competent" when the competency assessment method has been completed and documented.

2. If successful completion is not achieved, the employee will be remediated and an action plan to complete the required competencies will be created in collaboration with the department manager/director, Human Resources, and Education Departments as applicable.

3. At the end of the action plan, if the employee has not completed their competencies as indicated, they will be removed from the work schedule and placed on a two (2) week Administrative Leave without pay, to seek another position for which they may be qualified and competent. Paid Time Off may not be utilized during the Administrative Leave.

4. At the end of the two (2) week Administrative Leave, if no other position has been sought or accepted, the employee will be separated from employment with the District.

REFERENCES:

Association for Nursing Professional Development. (2022). *Nursing professional development: Scope and standards of practice* (4th ed.). Association for Nursing Professional Development.

Harper, M. G., & Maloney, P. (Eds.). (2022). *Nursing professional development: Scope and standards of practice* (4th ed.). Association for Nursing Professional Development.

The Joint Commission. (2025). *Standards.* https://www.jointcommission.org/en-us/standards/

The Joint Commission. (2025). *Competency (v2025B).* https://manual.jointcommission.org/releases/HCSS2025B/DataElem0179.html

U.S. Department of Health and Human Services, Office of Minority Health. (2025). *National standards for culturally and linguistically appropriate services (CLAS) in health and health care.* Think Cultural Health. https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards_Revised_June2025.pdf

- OMH CLAS Standards – Standards 2 and 6
- California Code of Regulations (2026). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCES:

- Human Resources Management Plan
- Performance Review Process

SUBJECT:	SECTION:
COMPOUNDED STERILE PREPARATION: QUALITY ASSURANCE PROGRAM	***Medication Management (MM)*** **Page 1 of 5**

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

PURPOSE:

To provide guidelines for the pharmacy quality assurance practices related to the preparation of compounded sterile drug products.

DEFINITION:

Quality Assurance – For purposes of these guidelines, quality assurance is the set of activities used to ensure that the processes used in the preparation of sterile drug products lead to products that meet predetermined standards of quality.

BSC - Biological Safety Cabinet, Class II – A ventilated cabinet with an open front and inward and downward unidirectional HEPA-filtered airflow and HEPA-filtered exhaust. A BSC used to prepare a CSP must be capable of providing an ISO Class 5 or better environment for preparation of the CSPs.

CAI - Compounding aseptic isolator – A type of RABS that uses HEPA filtration to provide an ISO Class 5 unidirectional air environment designed for compounding of sterile non-HDs.

CACI - Compounding Aseptic Containment Isolator - is a unidirectional HEPA-filtered airflow isolator designed to provide worker protection from exposure to undesirable levels of airborne drug and to provide an aseptic environment for compounding sterile preparations, also known as sterile intravenous preparation hood.

CSP - Compounded Sterile Preparation

PEC - Primary engineering control - A device or zone that provides an ISO Class 5 or better environment through the use on non-turbulent air, unidirectional HEPA-filtered first air for compounding sterile preparations.

RABS - Restricted-access barrier system – An enclosure that provides HEPA-filtered ISO Class 5 unidirectional air that allows for the ingress and/ or egress of materials through defined openings that have been designed and validated to preclude the transfer of contamination, and that generally are not to be opened during operations. Examples include CAIs and CACIs

POLICY STATEMENT:

It is the policy of Sierra View Medical Center (SVMC) that all pharmacy preparations of compounded sterile products will follow accepted standards of practice by conducting regular quality assurance activities and testing.

PROCEDURE:

A. Quality Assurance will be implemented to evaluate the following:

1) Personnel Qualifications
   - See Sterile Products: Education and Competency

2) Personnel performance. The total number of errors will be reported in the following categories:

- Wrong Drug or solution
- Wrong Strength
- Wrong Label
- Wrong Expiration Date

3) Equipment and facilities

- Record of daily anteroom countertop sanitizations
- Record of daily cleanings and sanitizations of cleanroom floors
- Record of daily cleanings for PEC
- Record of weekly anteroom cleaning
- Record of weekly wall and ceiling cleaning
- Record of weekly shelf cleaning environment
- Record of daily CAI/BSC pressures and room pressures
- Record of monthly sporicidal cleaning

4) Environment

- Daily record of room temperature and humidity
- Daily record of refrigerator/temperature controlled cabinet temperature
- Record airflow pressure differentials daily, where they are available, when open for patient care. During non-operational days, continuous monitoring will alarm for an out of range result and Engineering will alert the pharmacist on-call or the Pharmacist-in-Charge (PIC).
- In the event of a parameter excursion, personnel will follow the procedure outlined in: MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL

4) Pharmacy personnel will be trained annually on:

- Proper garbing (donning and doffing of personal protective equipment (PPE) while in the compounding areas)
- Proper cleaning/disinfecting/decontamination of compounding areas
- USP 797 Appendix V, "Sample Form for Assessing Cleaning and Disinfection Procedures" will be used as an education and competency training tool.

Competency will be validated by written and visual observation and training records shall be retained.

5) Sterility Testing

- End product sampling will be performed at least quarterly.
- In the event of a positive culture, the following shall occur:
    - The pharmacy member that compounded the product will not be allowed to compound sterile IV products until a duplicate CSP is prepared and analyzed for sterility. If the CSP yields a final result of no growth, the pharmacy member may resume sterile compounding.

6) Compounded sterile preparation analysis

- Randomly-selected compounded sterile preparations will be subjected to qualitative and quantitative analysis at least on a quarterly basis. Testing shall include:
    - Potency Testing
    - Endotoxin Testing
    - Particulate Matter Testing
    - Any products failing to meet minimum standards will be reviewed by the Pharmacist-in-Charge and the following corrective actions will be taken:
        - Failed Potency and/or Concentration Test:
            - Review procedure with personnel
            - Review master formula
            - Repeat procedure under Pharmacist-in-Charge's supervision
            - Resubmit for analysis
        - Failed Endotoxin or Particulate Matter Test:

- The pharmacy member that compounded the product will not be allowed to compound sterile IV products until a duplicate CSP is prepared and analyzed for endotoxins and/or particulate matter. If the CSP yields a final result of no growth, the pharmacy member may resume sterile compounding.

7) Recall procedures

- Recalls will be handled as per SVMC policy DRUG RECALL PROCEDURE.
- Per B&P 4127.1, Pharmacy will provide any recall notice for sterile drug products it has compounded to the Board within 12 hours of the notice.

8) Adverse Events and Complaints

- Adverse events related to CSPs will be reported into the hospital's incident reporting software for review.
    - Adverse events with CSPs will be reported to the Food and Drug Administration (FDA) through the MedWatch program for human drugs.
- The PIC will review all complaints related to CSPs and determine if the complaint indicates a quality problem with CSP. Such reviews must occur within 72 hours of receipt of the complaint or occurrence and shall be annotated and dated as such.
    - If a quality problem is discovered:
        - A corrective action plan will be initiated immediately, which may include:
            - A recall of all CSPs that may have been affected
            - A suspension of compounding
    - A written record of the complaint must be kept and contain:
        - The name of the complainant
        - Date received
        - Nature of complaint
        - Response to the complaint
        - Name and strength of the CSP, prescription number
        - Findings of investigation
        - Record of complaint must be kept so it is readily retrievable
        - A CSP returned with a complaint must be quarantined until it is destroyed AFTER the investigation.
    - Per B&P 4127.1, adverse effects reported or potentially attributable to a pharmacy's sterile drug product shall be reported to the Board of Pharmacy within 12 hours.

9) Validation of beyond-use-dates

- Beyond-use-dates will be reviewed periodically with a complete update of current manufacturers and/or peer-reviewed literature.

- Any changes identified in the interim time period will result in the immediate updating of the table found in GUIDELINES FOR PRODUCT DATING or STERILE PRODUCTS_EDUCATION AND COMPETENCY.

DOCUMENTATION:

A. Training record retention shall be maintained in employee files. Re-training will be performed per USP Chapter 797.

B. All compounding logs and chart records shall be retained for three years and shall be filed alphabetically by generic name.

C. Classified areas additionally must be recertified if there are changes to the area such as redesign, construction, replacement or relocation of any PEC, or alteration in the configuration of the room that could affect airflow or air quality. Specific tests are used to certify airflow velocity and HEPA filter integrity. Records of certification shall be retained for three years.

EDUCATION:

SVMC Staff: All pharmacists and pharmacy technicians will receive education regarding the indicators used to track quality assurance of pharmacy prepared sterile drug products. All pharmacy staff will sign an acknowledgement form indicating that they understand and will comply with the policy.

REFERENCES:

- The Joint Commission (2025). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Pharmacy Law: California Edition. (2025) San Clemente, California: Law Tech Publishing Group.
- USP 797. (n.d.). Retrieved March 20 6, 2023 from http://www.usp.org/compounding/general-chapter-797.

CROSS REFERENCES:

- Drug Recall Procedure – SVMC Policy and Procedures
- Medication Procurement, Storage, Distribution and Control – SVMC Policy and Procedures
- Guidelines for Product Dating – SVMC Policy and Procedures

SUBJECT: **CRITERIA FOR COLLECTION OF STOOL FOR OVA AND PARASITES #1020**	SECTION: **Page 1 of 2**

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

PRINCIPLE:

One of the most important steps in the diagnosis of intestinal parasites is the proper collection of specimens. Improperly collected specimens can result in inaccurate results.

SPECIMEN CONTAINER:

Total-Fix transport system

AFFECTED AREAS/PERSONNEL: *NURSING, LABORATORY STAFF*

PROCEDURE:

- Collect all fecal specimens prior to the administration of antibiotics or antidiarrheal agents. Avoid the use of mineral oil, bismuth, and barium prior to fecal collection, since all of these substances may interfere with the detection or classification of intestinal parasites.
- A bedpan is an ideal initial collection container provided it has been thoroughly cleaned and the patient is cautioned against contaminating the specimen with urine. A clean, wide mouthed container or a plastic bag or plastic wrap placed over the toilet seat is also acceptable.
- An appropriate (i.e. bloody, slimy, watery) area of stool should be selected and sampled with the collection spoon provided in the cap of the transport container. Add sufficient specimen to bring the liquid level up to the "Add Specimen to this Line" mark. This will result in approximately 5 ml of sample. Repeat for the other transport container.
- Agitate each specimen with the spoon along the sides of the vial, tighten the cap and shake firmly to insure that the specimen is adequately mixed. The specimen should appear homogenous.
- Label each specimen, return the containers to the ziplock bag and transport specimens to the laboratory.

PROCEDURE NOTES:

- To ensure the recovery of parasitic organisms that are passed intermittently and in fluctuating numbers, the examination of a minimum of three specimens collected over a 7- to 10-day period is recommended. Infections with Entamoeba histolytica/E. dispar or Giardia lamblia may require the examination of up to six specimens before the organism is detected.
- Stools from inpatients who have been in the hospital for >3 days are of limited value. Patients may become symptomatic with diarrhea after they have been inpatients for a few days; however symptoms are usually attributed not to parasitic infections but generally to other causes.

CRITERIA FOR SPECIMEN REJECTION:

When a specimen is rejected for any of the reasons listed below, the nursing unit will be notified by phone, giving the reason for the rejection and a new specimen will be requested.

- Specimen received in improper transport container, or appears to be dry on the surface or edges. Protozoan trophozoites will not survive if the stool specimen begins to dry out.
- Specimen contaminated with urine or water from the toilet.
- Specimens contaminated with the materials listed in the table below.

Materials and/or Drugs Used	Required Interval After Use
Iron Bismuth (in some ulcer medications) Oil (castor or mineral) Particulate substances (Metamucil or others)	One Week
Barium Gallbladder dye Antibiotics Iodine preparations Antiamebic drugs Antimalarial drugs (certain)	Three Weeks

REFERENCE:

- Patricia M. Tille, PhD, MLS(ASCP), AHI(AMT), FACSc, (2022), Bailey and Scott's Diagnostic Microbiology, C.V. Mosby Co., St. Louis, Missouri, 15th edition.
- Isenberg, Henry D., Clinical Microbiology Procedures Handbook, American Society for Microbiology, 1994
- Murray, Patrick R., Manual of Clinical Microbiology, American Society for Microbiology, 1995
- Medical Chemical Corporation, Total-Fix package insert, Rev. 05/15

SUBJECT: CRITERIA FOR COLLECTION OF STOOL FOR PCR	SECTION:

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

POLICY:

SPECIMEN CONTAINER:

Collected liquid or soft stool specimens, either unpreserved, preserved in Cary-Blair transport media (Preferred) or in FecalSwab™, should be kept between 2 °C and 25 °C during transport.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

NOTE: Avoid contamination with water or urine and avoid mixing toilet paper or soap with the specimen.

In order to obtain an adequate specimen, the procedure for specimen collection must be followed closely. Using a dry, clean container, liquid or soft stool specimens are collected according to the following procedure:

- A bedpan is an ideal initial collection container provided it has been thoroughly cleaned, and the patient is cautioned against contaminating the specimen with urine. A clean, wide mouthed container or a plastic bag or plastic wrap placed over the toilet seat is also acceptable.

- Unpreserved specimens:
  a) Transfer the liquid or soft stool specimen to a dry, clean container (Specimen Cup.)

- Cary-Blair preserved specimens:
  a) Transfer the liquid or soft stool specimen to a 15 mL transport device according to the manufacturer's instructions.

- FecalSwab™ preserved stool specimen (Cary-Blair):
  a) Transfer the liquid or soft stool specimen to the 2 mL FecalSwab™ transport device according to the manufacturer's instructions.

PROCEDURE NOTES:

- Specimens collected after antibiotic therapy has been initiated may be contraindicated for successful recovery of organisms.

- Erroneous results may occur from improper specimen collection, handling, storage, technical error, sample mix-up, or because the number of organisms in the specimen is below the analytical sensitivity of the test.

- Fecal PCR should not be performed for patients being treated with broad-spectrum antimicrobial agents, because it is likely that the antimicrobial therapy is responsible for the diarrhea.

- Stools from inpatients who have been in the hospital for >3 days are of limited value unless the patient is known to be human immunodeficiency virus positive or in cases of a cluster epidemic within the hospital. Consider *C. difficile* testing as an alternative to routine microbiologic studies.

CRITERIA FOR SPECIMEN REJECTION:

When a specimen is rejected for any of the reasons listed below, the nursing unit will be notified by phone, giving the reason for the rejection, and a new specimen will be requested.

- Specimens in transport medium received >24 hours after collection if at room temperature (2-25C.)

- Specimens in transport medium received >5 days after collection if refrigerated (2-8C.)

- This product is intended for use only with unpreserved and Cary-Blair preserved human stool specimens. Stool specimens **from rectal swabs or fixed stools** have not been validated with the BD MAX™ Enteric Bacterial Panel.

- Hard, solid stools that cannot be sampled for inoculation.

- Specimens contaminated with urine or water from the toilet.

REFERENCES:

- Tille, Patricia M., Bailey and Scott's Diagnostic Microbiology, C.V. Mosby Co., St. Louis, Missouri, 15th edition, 2021.

- BD maxTM enteric bacterial panel and extended enteric. (n.d.). https://bdmaxclub.com/wp-content/uploads/2023/03/BD-MAX%E2%84%A2-Enteric-Bacterial-Panel-and-Extended-Enteric.pdf

- 510(k) SUBSTANTIAL EQUIVALENCE DETERMINATION DECISION SUMMARY A. 510(k) Number: K140111 B. Purpose for Submission: To obtain a Substantial Equivalence Determination for the BD MAX Enteric Bacterial Panel on the BD MAXTM System. (n.d.). Retrieved July 8, 2026, from https://www.accessdata.fda.gov/cdrh_docs/reviews/K140111.pdf

- Remel, Inc. Cary Blair Transport Medium package insert, IFU 21610, Revision 10/25/12.

SUBJECT: **CRITERIA FOR REJECTION OF LAB SPECIMENS**	SECTION: 5 **Page 1 of 4**

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

PURPOSE:

To ensure the integrity of patient specimens and the achievement of accurate results.

POLICY:

A. The lab will reject a specimen for any of the reasons below.

B. When the physician, nurse, or patient is responsible for the collection and the specimen is rejected, the nursing unit or physician's office will be notified by phone and a new specimen will be requested.

C. In the event a physician insists a procedure be run on a specimen where results might be compromised, the condition of the specimen must be noted on the patient's lab report.

AFFECTED PERSONNEL/AREAS: *LABORATORY STAFF, NURSING STAFF, PHYSICIANS*

SPECIMEN CRITERIA:

A. All specimens must be properly labeled and submitted in conjunction with a suitable electronic or paper request.

1. Outpatient Referrals:

   a. Patient name and date of birth
   b. Date of collection
   c. Time of collection (if applicable)
   d. Source (if applicable)

2. Inpatients:

   a. Patient name and date of birth
   b. Patient account number or other suitable identifier
   c. BBK# and collector's and witnesses mnemonics (for blood bank specimens)
   d. Date and time of collection
   e. Meditech mnemonic of collecting person
   f. Patient location (if applicable)
   g. Pertinent clinical data (if applicable)

B. Within the hospital institution, all specimens not collected by lab personnel shall be transported to the laboratory in sealed plastic biohazard bags.

C. All specimens must be adequate for the testing requested.

Rejection Criteria for Blood Bank Specimens: (Antibody Screen, ABO typing, Crossmatch, Rh)

- Hemolyzed specimen
- Specimen > 48 hours old
- Improper labeling such as missing BBK#, lacking two sets of mnemonics and/or time of collection
- Any sample suspected of contamination with IV fluid

Rejection Criteria for Serology Specimens:

- HIV – whole blood >5 days old
- Mono – contaminated serum or plasma
- RA – contaminated serum or plasma; gross hemolysis; lipemia
- Any sample suspected of contamination with IV fluid

Rejection Criteria for Chemistry Specimens:

- ABG – clotted specimen; inhomogeneous specimen; venous blood
- Amylase – gross hemolysis
- Alcohol – specimen drawn using alcohol prep; received in Lab >20 minutes
- Alkaline Phosphatase – gross hemolysis; serum or plasma in contact with cells >3 hours
- ALT – gross hemolysis; serum or plasma in contact with cells >2 hours
- Ammonia – specimen received in Lab >20 min
- AST – gross hemolysis; serum or plasma in contact with cells >2 hours
- Bilirubin – gross hemolysis; specimens exposed to light >2 hours
- CPK (CK) – gross hemolysis; lipemia; serum in contact with cells >2 hours
- CRP – contaminated serum or plasma; specimen >8 hours old
- Glucose – serum or plasma in contact with cells >2 hours
- HCG – contaminated specimen; specimen >48 hours old
- Iron – hemolysis; serum or plasma >2 hours old
- Lactate – specimen >20 minutes old
- LDH – hemolysis; serum or plasma in contact with cells >2 hours
- Sodium and Potassium – hemolysis, serum or plasma in contact with cells >2 hours; specimen drawn in sodium heparin or EDTA
- Any sample suspected of contamination with IV fluid

Rejection Criteria for Hematology/Coagulation Specimens:

- Blood Counts – clotted specimens; specimens >24 hours old; specimens drawn in other than EDTA
- Smears – no ridges, lines, or holes; leukocytes not evenly distributed; cells broken; too small or too long

- Platelet Count – drawn in other than EDTA; clotted specimen; specimen not mixed; specimen >24 hours old
- Reticulocyte Count – specimen >24 hours old
- PT or PTT – tube not filled to the line; clotted specimen
- Semen – specimen >2 hours old
- Body fluids for cell counts – clotted specimen
- Any sample suspected of being contaminated with IV fluid

Rejection Criteria for Microbiology Specimens:

- Any dry swab
- Labeling on specimen and requisition label do not correlate
- Specimen in improper collection device, container, or transport media
- Specimen not in sterile container
- Collection device outdated
- Insufficient quantity and/or dried specimen
- Specimens exhibiting gross external contamination of the container (spillage)
- Sputum – saliva, mouthwash, or food contamination; specimen doesn't meet gram stain criteria for number of epithelial cells
- Stool – not fresh or not transferred into Cary Blair medium; collected on swab
- Urine – unpreserved specimen >20 minutes after void; specimen in preservative tube >48 hours old

Rejection Criteria for Molecular Diagnostics Specimens:

- Abbott ID NOW COVID-19 RNA – NP swab held at room temperature greater than 1 hour
- Abbott ID NOW Influenza A/B 2 – NP swab held at room temperature greater than 2 hours
- Abbott ID NOW RSV – NP swab held at room temperature greater than 2 hours
- Abbott ID NOW Strep A 2 Rapid Test – Throat swab held at room temperature greater than 3 days
- Abbott COVID-19 Antigen – Nasal swabs held at room temperature greater than 1 hour
- BD Max SARS-CoV-2 PCR – NP swab not put into UTM (universal transport media) and/or held unrefrigerated (2-8 degrees C); specimens greater than 3 days old
- BD Max Enteric Bacterial Panel – collected specimen not maintained at 2-25 degrees C; specimen not tested within 24 hours when stored at 2-25 degrees C or within 5 days stored at 2-8 degrees C
- BD Max *Cdiff* – formed stool specimen and/or specimens held at room temperature greater than 48 hours, only loose or liquid stools are acceptable
- BD Max CT/GC/TV Panel – unpreserved urine (not transferred into UVE special collector) >4 hours at room temperature or >24 hours at 2-8 degrees C; endocervical swab
- BD Max Vaginitis Panel – specimen not in UVE special collection kit within 2 hours of colletion

Rejection Criteria for Urinalysis:

- >2 hours without preservative

REFERENCES:

- Garcia, Lynne S (2016). Clinical Microbiology Procedures Handbook, Fourth Edition, Washington, D.C.: American Society for Microbiology.

- Turgeon, Mary Louise (2020). Clinical Laboratory Science, Eighth Edition, Maryland Heights, MO: Elsevier Mosby.
- BD C&S urine collection tube package insert (2016)
- Abbott ID NOW package inserts (2020)
- BD Max package inserts (2021)

CROSS REFERENCE:

- The Joint Commission (2023). Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing. QSA. 02.12.01, EP4 NPSG 01.01.01, DC 01.01.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **DELINQUENT MEDICAL RECORDS**	SECTION: 1 **Page 1 of 2**

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

POLICY:

Medical record delinquency rates shall be measured every three (3) months.

The Health Information Management Department (HIM) shall notify a provider of suspension when he/she has delinquent medical records.

PROCEDURE:

- Notification of incomplete records are populated on the provider's workload within the Meditech system.
- Providers are sent a listing of incomplete medical records displayed on their system workload of deficiencies as a courtesy on the second Tuesday of each month.
- Providers identified as "on vacation" or "out of the office", must notify Medical Staff or HIM of the date range that they will be out. This is entered into the Meditech system to prevent incomplete days from counting against the provider.
- Should the medical record(s) remain incomplete on the 15th day after patient discharge, the HIM Department will notify the provider, via certified mail, that his/her admitting, consultative and surgical privileges have been suspended until his/her medical records have been completed.
- A copy of all suspension letters mailed are placed in the provider's peer review file housed in the Medical Staff Office.
- The nursing units, all clinical outpatient departments, medical staff, and Senior Leadership are notified by the HIM Department of the suspension. When the suspension of privileges has been lifted, a notice will be submitted, and the admitting privileges will be restored in the electronic system.
- If a provider is on suspension for a total of 30 cumulative days in the fiscal year, his/her name shall be submitted to the Medical Executive Committee. The Committee shall then submit his/her name to the State Medical Board.
- The medical record delinquency rate shall be averaged from the last four (4) quarterly measurements and shall be 50% or less of the average monthly discharge (AMD) rate.
- Each individual quarterly measurement shall be no greater than 50% of the AMD rate.

REFERENCE:

- The Joint Commission (2025). Hospital accreditation standards. RC.01.03.01. Joint Commission Resources. Oak Brook, IL.
- California Code of Regulations (2023). Title 22. § 70751(g),

SUBJECT: **EDUCATIONAL NEEDS ASSESSMENT**	SECTION:

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

PURPOSE:

To define the mechanisms used to identify the educational needs for staff in all roles across Sierra View Medical Center.

POLICY:

Educational needs of the organization are assessed on an ongoing basis.

AFFECTED AREAS/PERSONNEL: *ALL DEPARTMENTS*

PROCEDURE:

A. Educational needs are identified through organizational and departmental assessments including quality and patient safety data, competency assessments, employee performance evaluations, regulatory and accreditation requirements, leadership rounding, patient and employee feedback, strategic initiatives, service line expansion, new technology implementation, and performance improvement findings.

B. Additionally, department leadership will encourage staff to complete a self-assessment tool as part of the electronic annual performance review, asking input on individual educational needs.

C. Housewide educational programs and courses are coordinated through the Human Resources and Education Departments

D. Department specific educational programs are coordinated by department leadership.

E. Training methods may include competency-based education, instructor-led classroom education, skills validation, simulation-based learning, e-learning modules, learning management system assignments, webinars, virtual education, independent study, evidence-based practice resources, hospital intranet resources, department huddles, written communications, competency assessments, and other educational activities designed to address identified learning needs, regulatory requirements, and practice gaps.

F. Training provided at Sierra View Medical Center will be tracked in the learning management system and with department leadership.

G. The effectiveness of educational activities will be evaluated using applicable measures, including competency validation, participant feedback, quality indicators, regulatory compliance findings, patient safety outcomes, and performance improvement metrics. Educational plans will be revised based on identified opportunities for improvement.

H. Educational activities should be designed to address identified practice gaps and support the development and validation of employee competencies required for safe and effective job performance.

REFERENCE:

Association for Nursing Professional Development. (2022). *Nursing professional development: Scope and standards of practice* (4th ed.). Association for Nursing Professional Development. https://learn.anpd.org/products/scope-standards-of-practice-4th-ed-2022

California Code of Regulations, Title 22, § 70719, *Personnel policies*. (Current through Register 2025). https://www.law.cornell.edu/regulations/california/22-CCR-70719

California Department of Public Health. (2026). *Licensing and certification program regulations*. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Regulations.aspx

Joint Commission Resources. (2021). *Comprehensive accreditation manual for hospitals (CAMH): Standards, elements of performance, accreditation policies and procedures*. Joint Commission Resources.https://digitalassets.jointcommission.org/api/public/content/assets/1/14/cah21_samplepages.pdf

The Joint Commission. (2026). *Competency assessment vs. education and training*. https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000001044

The Joint Commission. (2026). *Competency assessment vs. orientation*. https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000001037

SUBJECT: **EMERGENCY BLOOD RELEASE**	SECTION: **Page 1 of 2**

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

PURPOSE

To define the process for releasing blood components for transfusion in a time-sensitive emergency situation.

No blood components will be issued for transfusion before completion of processing or crossmatching. In the event of an emergency, the attending physician may request blood components from the blood bank department of the clinical laboratory and assume responsibility for the outcome of the use of those products by signing the emergency release form. This form must be returned to the blood bank department and attached to the original request for blood products. All physician requests for emergency blood products must be done so on patients who have been registered in the SVMC hospital information system, whether their identity is known or not. All requests for blood components must be accompanied with a *Request For Blood Component* form.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. ABO/Rh Requirements:

   a. If time permits, a properly-labeled sample shall be obtained and the patient's ABO and Rh shall be determined. Type-specific blood shall then be issued when possible, or type-compatible blood issued if type-specific is not available.

   b. If there is insufficient time to obtain a specimen, or to perform tests to determine the ABO/Rh, Group O (PRBCs) is the only ABO group that can be administered to patients of unknown ABO. Do not rely on past records to determine the patient's ABO/Rh.

   c. Pull segments from units if the blood is issued before testing has begun.

   d. Issue blood.

   e. Units are issued in the laboratory information system (LIS) under the Emergency Issue Protocol. This will generate the Emergency Issue Card, which needs to be signed by the attending physician. If the patient has not yet been admitted into the hospital information system, the "computer down time" emergency issue card should be used.

2. Unexpected Antibodies:

   a. In the event the patient has a history of an unexpected antibody, the Medical Director will be notified, but the decision to transfuse will be at the discretion of the attending physician with as minimal a delay as possible.

3. Compatibility Testing:

   a. A properly collected and labeled patient sample must be collected and the routine compatibility testing procedure must begin. If the physician requires the blood for transfusion before the crossmatch is complete, it may be released if the "UNCROSSMATCHED BLOOD Emergency Unit Issue Card" has been signed, but the crossmatch must be completed in any event.

Massive Bleed Protocol:

- An elevated emergency level of response for patients that are in immediate jeopardy beyond the usual Emergency Release.
- Requires immediate communication to the Lab, "Emergency release of uncrossmatched blood for a massive bleed in_____(location)."

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

- Lab Blood Bank will tag and issue 2-4 units of PRBC and 1 unit of FFP if requested, per specific situation, and will work closely with Nursing Services to release continued blood products as needed. Crossmatched blood will be utilized upon availability.
- The other processes of Emergency Release, such as the use of the Emergency Release forms and follow up crossmatching, will still apply.

REFERENCES:

- Association for the Advancement of Blood & Biotherapies, Standards for Blood Banks and Transfusion Services, 35th Edition, 5.27, 2026.
- The Joint Commission (2026). Laboratory accreditation standards. QSA.05.11.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **EMERGENCY BLOOD RELEASE**	SECTION: **Page 1 of 2**

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

PURPOSE

To define the process for releasing blood components for transfusion in a time-sensitive emergency situation.

No blood components will be issued for transfusion before completion of processing or crossmatching. In the event of an emergency, the attending physician may request blood components from the blood bank department of the clinical laboratory and assume responsibility for the outcome of the use of those products by signing the emergency release form. This form must be returned to the blood bank department and attached to the original request for blood products. All physician requests for emergency blood products must be done so on patients who have been registered in the SVMC hospital information system, whether their identity is known or not. All requests for blood components must be accompanied with a *Request For Blood Component* form.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. ABO/Rh Requirements:

    a. If time permits, a properly-labeled sample shall be obtained and the patient's ABO and Rh shall be determined. Type-specific blood shall then be issued when possible, or type-compatible blood issued if type-specific is not available.

    b. If there is insufficient time to obtain a specimen, or to perform tests to determine the ABO/Rh, Group O (PRBCs) is the only ABO group that can be administered to patients of unknown ABO. Do not rely on past records to determine the patient's ABO/Rh.

    c. Pull segments from units if the blood is issued before testing has begun.

    d. Issue blood.

    e. Units are issued in the laboratory information system (LIS) under the Emergency Issue Protocol. This will generate the Emergency Issue Card, which needs to be signed by the attending physician. If the patient has not yet been admitted into the hospital information system, the "computer down time" emergency issue card should be used.

2. Unexpected Antibodies:

    a. In the event the patient has a history of an unexpected antibody, the Medical Director will be notified, but the decision to transfuse will be at the discretion of the attending physician with as minimal a delay as possible.

3. Compatibility Testing:

    a. A properly collected and labeled patient sample must be collected and the routine compatibility testing procedure must begin. If the physician requires the blood for transfusion before the crossmatch is complete, it may be released if the "UNCROSSMATCHED BLOOD Emergency Unit Issue Card" has been signed, but the crossmatch must be completed in any event.

Massive Bleed Protocol:

- An elevated emergency level of response for patients that are in immediate jeopardy beyond the usual Emergency Release.
- Requires immediate communication to the Lab, "Emergency release of uncrossmatched blood for a massive bleed in_____(location)."

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- Lab Blood Bank will tag and issue 2-4 units of PRBC and 1 unit of FFP if requested, per specific situation, and will work closely with Nursing Services to release continued blood products as needed. Crossmatched blood will be utilized upon availability.
- The other processes of Emergency Release, such as the use of the Emergency Release forms and follow up crossmatching, will still apply.

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- Association for the Advancement of Blood & Biotherapies, Standards for Blood Banks and Transfusion Services, 35th Edition, 5.27, 2026.
- The Joint Commission (2026). Laboratory accreditation standards. QSA.05.11.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT:	SECTION:
FETAL FIBRONECTIN SPECIMEN COLLECTION FOR ENZYME IMMUNOASSAY	4 **Page 1 of 5**

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

PURPOSE:

1. To provide guidelines for the nurse to obtain a vaginal swab for fetal fibronectin enzyme immunoassay (FFN) via sterile speculum examination to assist in assessing the patient's risk for preterm delivery.

2. To establish the criteria by which Registered Nurses (RNs) are deemed competent to collect specimens for FFN.

POLICY:

1. Labor & Delivery RNs who have demonstrated competency in obtaining an FFN specimen may do so upon the order of a physician.

2. All patients with risk factors for preterm labor will have a FFN swab collected before a vaginal exam is performed if ordered by the physician.

A specimen collected for FFN may, according to the physician order, be transported to the laboratory for immediate processing or may be held in the laboratory specimen refrigerator for up to 72 hours.

3. An RN must meet the following requirements to be deemed competent to obtain a vaginal swab for FFN without supervision:

   a. Successful completion of orientation to Labor & Delivery which includes completion of Labor & Delivery Orientation Competency Checklist.

   b. Demonstration and completion of sterile speculum exam.

   c. Demonstrate competence in the collection of a specimen for FFN concurrently under supervision of a designated evaluator using competency checklist.

   d. Successful completion of an educational activity on obtaining a vaginal swab for FFN, including indications, contraindications, patient screening, benefits, sampling technique and interpretation of results.

   e. In order to continue collecting FFN specimens an RN must demonstrate continuing competency by presenting evidence of at least one successful specimen collection with an appropriately identified patient annually..

AFFECTED PERSONNEL/AREA: *MCH STAFF, RNs*

CRITERIA FOR ELIGIBILITY:

1. Gestational age between 24 and 34 6/7 weeks

2. Signs and symptoms of preterm labor:

   a. Uterine contractions

   b. Backache, abdominal discomfort, pelvic pressure and cramping
   c. Vaginal bleeding
   d. Change of vaginal discharge

3. Intact amniotic membranes

PATIENTS NOT ELIGIBLE:

1. Patients with ruptured membranes

2. Patients known to be dilated > 3 cm

3. Patients with moderate or heavy vaginal bleeding

4. Cancer of the reproductive tract

5. Placenta previa or abruptio placenta

6. Patients who have engaged in sexual intercourse within the past 24 hours

7. Patients who, within the past 24 hours, have experienced: manipulation of the cervix such as digital cervical exam, a vaginal probe ultrasound, a Pap smear and/or collection of vaginal specimens for culture

8. Patients who, within the past 24 hours, douched or used other vaginal solutions, lubricants, creams or medications

EQUIPMENT / SUPPLIES:

- Gloves
- Sterile speculum
- Saline or water for lubricant
- Fetal fibronectin collection kit
- Biohazard specimen bag

PROCEDURE:

1. Obtain physician order to obtain specimen for eligible patients. NOTE: Specimen must be obtained PRIOR to performing vaginal examinations.

2. Explain the procedure to the patient. Provide for privacy.

3. Assemble equipment.

4. Position patient in dorsal lithotomy position. Drape patient to ensure privacy.

5. Open the fFN collection kit, which contains a sterile Dacron swab for specimen collection and a transport tube containing extraction buffer. Don sterile gloves and lubricate with sterile saline or sterile water if indicated. NOTE: sterile saline and sterile water are the ONLY lubricants which may be used for specimen collection for fFN.

6. If there is leakage of amniotic fluid from the cervical os and/or the cervix is obviously visually dilated > 3 cm with speculum exam, the patient is not a candidate for fFN: do not collect the specimen.

7. During a speculum examination, prior to any examination or manipulation of the cervix or the vaginal tract, lightly rotate the sterile swab across the posterior fornix of the vagina for approximately 10 seconds to absorb cervicovaginal secretions. Subsequent attempts to saturate the swab may invalidate the test.

8. The Dacron swab will then be placed in the extraction buffer/medium that is contained in the collection kit. Break the shaft of the Dacron swab even with the top of the specimen tube at the pre-scored location (a guide mark indicates the correct place to break the shaft). Align the end of the swab shaft with the hole inside the specimen tube cap and push the cap down tightly to seal the tube.

9. Label the specimen tube properly with the patient and collector identification and date and time of collection.

10. Once the swab is collected, the routine evaluation of the patient can continue, including digital vaginal exam if appropriate. If the membranes are ruptured or the patient's cervix is > 3cm, do not send the fFN specimen to lab discard the FFN specimen and notify the physician.

11. After the nursing evaluation consult with the physician as appropriate regarding management of the patient, notifying him/her of any abnormalities or changes in the condition of the patient or fetus.

12. After notifying the physician, the fFN sample may be sent to lab for testing or to be held in the specimen refrigerator for 72 hours according to physician order. If indicated the test will be ordered through Meditech Expanse.

13. Results will be available in Meditech Expanse after lab receives order to run the test.

a. The absence of fetal fibronectin in the cervical and vaginal secretions suggests a very low probability that the patient will deliver within two weeks, even if there are contractions and other symptoms suggestive of preterm labor.

b. To be reliable, the specimen must be collected before digital exam has been performed.

c. The presence of fetal fibronectin does not guarantee preterm delivery, but suggests the increased risk of preterm delivery.

d. The test is good at predicting who will NOT experience preterm labor rather than those who will.

e. Positive results mean that a patient is at high risk for a spontaneous preterm delivery (within the following 2 weeks) and the physician may choose to treat the patient with hydration, tocolysis or increased surveillance. (A positive result is not a good predictive that true labor will occur).

f. Negative results can be interpreted as the patient is not at risk for delivery within 14 days of the test and can be managed on an outpatient basis.

DOCUMENTATION:

1. The fFN may be collected by use of a speculum if collecting other vaginal cultures requiring the use of a speculum. Remember to obtain the fFN culture first since the other specimens may result in manipulation of the cervix.

2. Document in the Electronic Medical Record (EMR):

   a. Patient's response and any difficulty encountered or unsuccessful attempts at time of specimen collection.

   b. Education provided to patient.

REFERENCES:

- American College of Obstetricians and Gynecologist. (2016). Practice Bulletin No. 171: Management of preterm labor. *Obstetrics & Gynecology, 128*, e155-e164. Reaffirmed 2020.
- Rapid fFN® for the TLiIQ® System_Information for Healthcare Providers. (2024). Retrieved September 11, 2026 from https://www.hologic.com/package-inserts/diagnostic-products/rapid-ffn
- Simpson, K. R., & Creehan, P. A., O'Brien-Abel, N., Roth, C.K., Rohan, Annie J. (2021). Perinatal nursing (5th ed.). Philadelphia: Wolters Kluwer.

SUBJECT: **GUIDELINES FOR THE INITIAL ASSESSMENT AND TRIAGE OF OBSTETRIC PATIENTS**	SECTION: **Page 1 of 12**

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

PURPOSE:

To set nursing guidelines for conducting a Medical Screening Examination (MSE) for labor evaluation/fetal assessment to facilitate appropriate clinical management of obstetric patients who present to the hospital for care.

POLICY:

- Registered Nurses performing Medical Screening Examinations under standardized procedures shall maintain documented initial competency, annual competency validation, and ongoing compliance with hospital-approved standardized procedures consistent with California Board of Registered Nursing regulations.
- A Registered Nurse who has completed initial and annual Standardized Procedure: Medical Screening Exam Competency may perform the Medical Screening Examination (MSE).
- Refer to "Standardized Procedure: Medical Screening Examination Policy for limits of MSE.
- The MSE is an on-going process and will continue until the patient is stable for discharge, admitted or transferred to a higher level of care or transferred to the Emergency Room for appropriate care.
- The Registered Nurse performing the MSE will report results of MSE to the MD/CNM.
- Provider orders for discharge will be obtained and documented in the Electronic Medical Record (EMR).
- The MSE may take place in either the Maternal Child Health or the Emergency Department.
- Pregnant patients with pregnancy-related complaints at ≥20 weeks gestation, or per hospital capability and EMTALA-approved obstetric screening criteria, will be triaged to Labor & Delivery/Maternal Child Health for Medical Screening Examination. Patients with non-obstetric emergencies will receive stabilization and appropriate emergency evaluation in collaboration with the Emergency Department
- A Rapid Response will be called for patients who present for obstetric triage and the results of the MSE turn into an emergency medical condition.
- A Registered Nurse will take all calls from MD's requesting to send patients for evaluation and treatment of non-obstetric illness and take measures to ensure the patient is appropriately placed.
- The Maternal Fetal Triage Index (MFTI) shall be utilized to prioritize obstetric patients according to acuity and facilitate timely evaluation, treatment, and resource allocation.

AFFECTED AREAS/ PERSONNEL: *MATERNAL CHILD HEALTH (MCH) DEPT., REGISTERED NURSES (RNs) & EMERGENCY DEPARTMENT PERSONNEL*

PROCEDURE:

1. General Guidelines – Assessment of all patients arriving in Maternal Child Health will include:

   a. Maternal physical status:

   - Patient's chief complaint or description of symptoms
   - Date and time of arrival
   - Gravida and parity (gravida, term, preterm, abortions, living)
   - Vital signs
   - Estimated date of delivery (EDD) determined by dates, ultrasound
   - Estimated gestational age
   - Vaginal bleeding, including date, time, duration, associated events
   - Pregnancy risk factors
   - Current medications
   - Allergies
   - Vaginal exam, if not contraindicated (bleeding, gestational age < 32 weeks, or history of placenta previa)

   b. Fetal status:

   - Fetal movement (as applicable)
   - Fetal heart rate obtained by Doppler or electronic fetal monitor (as applicable)

   c. Labor status:

   - Uterine contractions, including date and time of onset, frequency, and strength
   - Membrane status, including date and time of rupture, color of amniotic fluid

   d. Psychosocial needs – assessment may include, but is not limited to:

   - Significant stress
   - Relationship problems/abuse

- Educational level and needs
- Economic problems
- Support systems
- Cultural and religious needs
- Substance abuse
- Home care needs (Can patient care for self at home if discharged? Does she have transportation to return to the hospital when necessary?)

e. Review of prenatal records/Attempt to obtain Prenatal Record from MD office or other facility if patient is from out of town. If there has been no prenatal care, refer to and follow policy "No Prenatal Care."

f. Patient interview – Further assessment parameters will be directed from patient's chief complaint and information gathered during the data collection.

g. All obstetric patients shall be assessed for signs and symptoms of maternal infection and sepsis. Patients meeting sepsis screening criteria shall receive immediate physician notification and escalation of care according to hospital sepsis protocols.

2. Guidelines for the Evaluation of Labor:

a. Fetal status:

- Electronic Fetal Monitoring (EFM) or intermittent auscultation as clinically indicated. Fetal heart rate assessment shall be interpreted using NICHD/AHWONN terminology and Category I, II, or III fetal heart rate classification when applicable.
- Assess fetal presentation.

b. Labor status:

- Review prenatal record for information regarding last cervical exam.
- Palpate abdomen for tenderness, uterine contractions, and resting tone.
- If no history of prematurity, rupture of membranes, vaginal bleeding, or placenta previa, proceed with digital cervical examination to include dilation, effacement, and position.
- Encourage patient to ambulate following Category 1 monitor strip, if appropriate.

- Repeat cervical exam (e.g., in approximately 1 hour) to assess for change.

c. Patient/family teaching:

- Signs/symptoms of labor or complications
- Fetal movement awareness-Instruct on fetal kick counts
- Follow-up appointment with care provider

3. Guidelines for the Evaluation of Preterm Labor:

a. Maternal physical status:

- Increase in vaginal discharge or bloody show
- Low back pain
- Menstrual-like cramps
- Pelvic pressure
- Symptoms of urinary tract infection
- Precipitating events
- Symptoms of dehydration
- Obtain a fetal fibronectin and/or cervical length assessment when clinically indicated per provider orders

b. Fetal status:

- If gestational age is < 24 weeks, use Doppler to obtain fetal heart rate (FHR).

  If gestational age is ≥ 24 weeks gestational, obtain 20-minute fetal monitor strip to evaluate FHR and variability or Category if appropriate.

- Assess fetal presentation.

c. Labor status:

- Review prenatal history for information regarding previous cervical exams and prescribing measures for preterm labor.
- Palpate abdomen for tenderness, uterine resting tone and uterine contractions.

- Obtain monitor strip for uterine contraction assessment.

d. Patient/family teaching:

- Signs and symptoms of preterm labor
- Precipitating events
- Bedrest in the lateral position
- Maintain adequate hydration
- Fetal movement awareness
- Follow-up appointment with care provider

4. Guidelines for the Evaluation of Vaginal Bleeding:

a. Patients presenting with vaginal bleeding shall be assessed for risk of obstetric hemorrhage. Emergency response procedures shall be initiated for suspected maternal hemorrhage, placental abruption, placenta previa with active bleeding, or hemodynamic instability.

b. Maternal physical status:

- Obtain information regarding bleeding such as amount, color, onset, and precipitating events.
- Review prenatal record to obtain information regarding most recent ultrasound report (location of placenta) and previous cervical exam.

c. Fetal status:

- If gestation age is < 24 weeks, use Doppler to obtain fetal heart rate.
- If gestational age is ≥ 24 weeks, obtain 20-minute monitor strip to evaluate FHR and variability or Category if appropriate.

d. Labor status:

- Palpate abdomen for tenderness, uterine contractions and resting tone.

e. Patient/family teaching (may include but not limited to):

- Signs and symptoms of preterm/term labor

- Fetal movement awareness (kick counts).

5. Guidelines for the Evaluation of Ruptured Membranes:

   a. Maternal physical status interview:

      - Time of suspected ruptured membranes
      - Description of fluid (color, odor)
      - Estimated amount of fluid

   b. Fetal status:

      - Obtain 20-minute fetal monitor strip to evaluate FHR and variability or Category, if appropriate

   c. Labor status:

      - Palpate abdomen for tenderness, uterine contractions, and resting tone.
      - Assessment of rupture of membranes per hospital's evaluation kit.

   d. Patient/family teaching:

      - Signs/symptoms of preterm/term labor
      - Fetal movement awareness (kick counts)
      - Signs of ruptured membranes
      - Follow-up appointment with care provider

6. Guidelines for the Evaluation of Decreased Fetal Movement:

   a. Fetal status:

      - If gestational age < 24 weeks, use Doppler to obtain fetal heart rate.
      - If gestational age ≥ 24 weeks, obtain 20-minute fetal monitor strip to evaluate FHR and variability or Category if appropriate.

   b. Patient family teaching:

      - Fetal movement awareness (kick counts)

- Follow-up appointment with care provider

7. Guidelines for the Evaluation of Preeclampsia:

   a. Maternal status:

   - Interview patient:
     - History of elevated blood pressure
     - Sign and symptoms of preeclampsia (headache, vision changes, right upper quadrant pain, nausea, heartburn).
   - Review medical record:
     - Initial blood pressure (first trimester)
     - Previous interventions to manage blood pressure
   - Assess for signs and symptoms of severe features of preeclampsia including persistent headache, visual disturbances, right upper quadrant or epigastric pain, pulmonary symptoms, severe hypertension, laboratory abnormalities, and other evidence of end-organ involvement.
   - Assess Deep Tendon Reflexes (DTR's).
   - Obtain laboratory studies and urine protein assessment per provider orders.

   b. Fetal status:

   - If gestational age < 24 weeks, use Doppler to obtain fetal heart rate.
   - If gestational age ≥ 24 weeks, obtain 20 minute monitor strip to evaluate FHR and variability or Category if appropriate.

   c. Patient/family teaching:

   - Signs/symptoms of labor
   - Fetal movement awareness (kick counts).
   - Signs/symptoms of preeclampsia
   - Interventions

- Follow-up appointment with care provider

8. Guidelines for the Evaluation of Urinary Tract Infections:

   a. Maternal physical status:

   - Interview patient regarding:
     - Onset of symptoms
     - Type of symptoms (pain with urination, urgency, and frequency)
   - Review prenatal record for:
     - History of UTIs
   - Assess for suprapubic discomfort, abdominal tenderness, and flank pain.
   - Obtain urine for urine analysis (UA), and Culture & Sensitivity (CS) if UA positive, as ordered per MD.

   b. Patient/family teaching:

   - Medications
   - Fetal movement awareness (kick counts).
   - Follow-up appointment with care provider

9. Guidelines for the Evaluation of Nausea, Vomiting, Diarrhea:

   a. Maternal status:

   - Interview patient:
     - Onset of symptoms
     - Type of symptoms
     - Nutritional intake
     - Precipitating events
     - Characteristics of stools if complaint is diarrhea
   - Assess for sign/symptoms of dehydration including:

- Dry mucous membranes
- Urine volume, color, and clarity
- Maternal temperature

- If unable to tolerate clear liquid diet, consider antiemetic and/or antidiarrheal agent

b. Fetal status:

- If gestational age < 24 weeks, use Doppler to obtain fetal heart rate.
- If gestational age ≥ 24 weeks, obtain 20-minute fetal monitor strip to evaluate FHR and variability or Category if appropriate. Fetal tachycardia may be related to maternal dehydration.

c. Labor status:

- Obtain 20-minute monitor strip to assess for uterine contractions.

d. Patient/family teaching:

- Symptoms of dehydration
- Clear liquid diet, advancing as tolerated
- Medications
- Fetal movement awareness (kick counts)

10. Report the following findings to the physician/CNM:

a. Patient name

b. Gravida and para

c. EDC by prenatal data or by ultrasound report

d. Gestational age

e. Uterine frequency and duration on monitor, by patient report and by palpation

f. Fetal monitoring to include interpretation of baseline, variability, and the presence of accelerations or decelerations as appropriate.

g. Patient vital signs

Presenting complaint or symptoms

h. A review of prenatal records, identification of risk factors, medical history, allergies, and current medical history

i. Assessment of fetal position (Leopold's)

j. Assessment of vaginal bleeding or bloody show

k. Determination of status of membranes:

- Intact or ruptured
- Presence of odor
- Color of fluid

l. Vaginal exam to include:

- Dilation
- Effacement
- Station
- Cervical position
- Fetal presentation

11. Disposition of the patient:

a. Be prepared to admit patient or to continue evaluation per order.

b. Transfer to Emergency Room if it is determined that patient's condition is not pregnancy related after discussion with the physician or midwife.

c. If the patient condition warrants tertiary care, the patient may be transferred to a higher level of care. The RN will proceed with the transfer process after the MD has discussed the risks, benefits, and alternatives with the patient.

d. If maternal and fetal status is stable and true labor and/or medical emergency can be excluded, based on examination by the RN, the MD may elect to discharge the patient via telephone order to the RN.

12. Prior to discharge:

    a. Maternal condition is stable

    b. Fetal status reassuring appropriate to gestational age

    c. No evidence of active labor requiring admission

    d. No unresolved emergency medical condition

    e. Discharge instructions reviewed and understood

    f. Return precautions provided

    g. Follow-up plan established

DOCUMENTATION

1. Document on the appropriate form or electronic medical record.

    a. MFTI acuity level

    b. Time of arrival and time of MSE initiation

    c. Nursing assessment, interventions, and findings

    d. Plan of care

    e. All provider communication and orders

    f. Communication and disposition decisions

2. If the patient is transferred to a higher level of care facility, the appropriate transfer forms and copies of selected documentation records are sent with the patient.

REFERENCES:

Association of Women's Health, Obstetric and Neonatal Nurses. (2024). *Basic, high-risk, and critical care intrapartum nursing: Clinical competencies and education guide* (7th ed.). Washington, DC: Author.

Association of Women's Health, Obstetric and Neonatal Nurses. (2024). *Fetal heart monitoring. Journal of Obstetric, Gynecologic & Neonatal Nursing, 53*(3), e5-e9. https://doi.org/10.1016/j.jogn.2024.03.001

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Lyndon, A., & O'Brien-Abel, N. (2021). *Fetal heart monitoring principles and practices* (6th ed.). Association of Women's Health, Obstetric and Neonatal Nurses.

CROSS REFERENCES:

- No Prenatal Care (Drop In)

SUBJECT:	SECTION:
HIRING CLINICAL LAB SCIENTIST TRAINEES	***HUMAN RESOURCES***
	Page 1 of 6

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

PURPOSE:

- To define the hiring requirements and steps in the training process for a Clinical Lab Scientist (CLS) Trainee.
- To delineate timelines and requirements of trainees.

POLICY:

Testing of human specimen in clinical laboratories plays a crucial role in the detection, diagnosis, and treatment of human diseases. California licensed clinical laboratory scientists (CLS) and specialists perform most laboratory tests. Those licensed personnel require a high level of interpersonal skills, the ability to work independently and interdependently, the ability to prioritize and manage multiple tasks simultaneously, and must possess communication skills and leadership qualities. The CLS and CLS trainee work in many different areas of the clinical laboratory, which include:

1. **Clinical Chemistry and Body Fluids**
   The CLS performs analysis on blood and other body fluids, utilizing some of the most sophisticated diagnostic techniques and instrumentation to analyze human body chemistry, such as glucose, cardiac and liver markers, electrolytes, kidney function tests, drugs of abuse and many more.

2. **Clinical Microbiology**
   The CLS performs analysis on various body specimens to identify pathogenic Microorganisms, including bacteria, mycobacteria, fungi, viruses, and parasites utilizing the latest isolation and identification techniques.

3. **Hematology**
   The CLS performs analysis on blood, bone marrow specimens and other body fluids, utilizing some of the most advanced diagnostic instruments and techniques to detect hematopoietic diseases such as anemia, leukemia, hemoglobinopathies and coagulation syndromes.

4. **Immunohematology (Blood Banking and Transfusion Services)**
   The CLS performs various tests on patient blood utilizing the latest diagnostic instruments and techniques to ensure safe transfusion and component therapy.

5. **Immunology**
   The CLS performs various tests employing the latest methodologies and instrumentations in use for the detection and identification of immune complex diseases.

6. **Molecular Biology**
   The CLS performs various tests employing the use of DNA and RNA methodologies for detection of disease-causing organisms.

All laboratory tests performed require a high level of accuracy, judgment, and knowledge of test principles, procedure, and interpretation. The laboratory results reported to the treating physician have direct influence on the medical treatment a patient receives.

Sierra View Medical Center (SVMC) believes in and supports the hiring of CLS Trainees to attract potential new recruits to the facility. Starting the trainee as soon as possible provides a greater opportunity in the growth and development of the laboratory professional.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS*

PROCEDURE:

HIRING CLS TRAINEE

Academic Requirements of the Program

Candidates seeking admission into the CLS training program must possess a minimum of a baccalaureate degree or higher from a regionally accredited college or university. All candidates must complete the program's required courses within **5 years** prior to applying for the CLS trainee program, with a preferred minimum cumulative GPA of 3.0. The academic requirements are based on the requirements established by the California Department of Public Health/ Laboratory Field Services. The training curriculum of all six training programs is challenging and requires individuals to be dedicated, self-motivated, and disciplined to achieve success.

Eligibility Requirements

1. Coursework and degree requirements as listed above.

2. Courses in molecular biology, immunohematology, parasitology and genetics are highly desirable.

3. Laboratory experience, lab/research techniques is preferred, but not mandatory.

4. Completed application packet.

5. Valid Clinical Laboratory Specialist Trainee License issued by California Department of Public Health/Laboratory Field Services.

6. Graduates of foreign colleges or universities must have their academic credentials evaluated by the American Association of Collegiate Registrars and Admissions Officers (AACRAO). Contact AACRAO at (202) 293-9161 or at www.aacrao.org

7. Foreign degrees must be equivalent to a baccalaureate or higher degree from a regionally accredited college or university in the United States.

Objectives of the Training Program

The duration of the clinical laboratory specialty training is one year. Training is 40 hours per week and takes place during the day shift. The training program provides students with the opportunity to develop, demonstrate, apply, and evaluate scientific knowledge and competencies necessary to achieve skills through integration of the program objectives as listed below:

1. Be given a description of the full role of the clinical laboratory in the delivery of health care.
2. Understand the importance of quality control (QC) and quality assurance (QA) in the clinical laboratory.
3. Learn, through information provided by the clinical laboratory staff and independent studies, how to correlate test results with disease states.
4. Understand and interpret laboratory test procedures, principles of reactions, specimen type, normal/critical values, and sources of errors and clinical interpretation of results.
5. Understand, operate, and troubleshoot a variety of automated and manual tests.
6. Assume responsibility for reading assignments, running parallel testing, timely completion of unknown specimen, quizzes/exams, practical evaluation, and discussions with the instructors of all modules.
7. Describe the functions of laboratory management principles.
8. Emphasize the need for continued education.

Trainee Responsibilities

During the 52 weeks of training, each student will be expected to:

1. Observe and adhere to all of SVMC's policies and procedures.
2. Develop a disciplined and balanced schedule of independent study, attendance, and other required assignments.
3. Take initiative to perform and reflect on applied learning skills at the bench.
4. Seek assistance, when appropriate from section supervisors, instructors, or other resource personnel.
5. Complete examinations and assignments.
6. Use sound judgment in making maximum effective use of time at the bench.

7. Successfully complete all competency checklists. Competency checklists are guides used to maintain a record of a student's progress while providing a listing of the laboratory tests to be performed during each training module. Competency checklists give the student and the instructor a clear expectation of what is to be accomplished in order to satisfy the completion of the terminal objectives of each module. Upon completion of each module, the student and the instructor will sign off the checklists acknowledging that pertinent training is completed successfully. Student competency is assessed during and upon completion of each training module. Ways to evaluate competency include:

   - Direct observation of test performance; including pre-analytical, analytical, and post analytical variables.
   - Correct recording and reporting of test results.
   - Assessment of quality control, instrument function checks and preventive maintenance.
   - Assessment of problem solving, troubleshooting, behavioral and cognitive skills.

8. Maintain a satisfactory performance level as measured by:

   - The attainment of a minimum score of 75% in each of the modules written quizzes/ examinations, 90% score on practical examinations and unknown specimen assignments of manual procedures. These minimum score of 75% must also be achieved on the final examination. Failure to successfully complete any two measured levels of performance as defined above (practical and/or theoretical) of the training program can and may result in dismissal from the CLS training program at the discretion of the CLS Program Coordinator. In addition, the Laboratory Manager will work directly with the Human Resources Department to evaluate and assess a trainee's job performance, lack of competency, progress in the program, and failed scores on examinations prior to a trainee being dismissed from the CLS Trainee program. Prior to formal removal from the CLS Trainee Program, the VP of HR and Respective VP of Laboratory Services will be notified of intent to send dismissal letter to the Clinical Laboratory Services.
   - Adherence to established policies and procedures.
   - Willingness to do additional work or accept additional assignments to improve practical skills.
   - Showing courtesy and respect to colleagues, supervisors, and patients.

Trainees who fail to meet the standards of performance as outlined above or who violate any of SVMC's policies or procedures will be subject to the disciplinary action policies of SVMC.

CLS Trainee Evaluations

CLS Trainees will receive a performance evaluation after 90 days, at the completion of each module, and at 12 months as indicated by institutional policies.

Review

Time will be allotted at the end of the training program for review. This period will be defined on the trainees schedule.

Completion of Training

A certificate of completion will be awarded to successful trainees at the end of the one-year training program. Notification of anticipated completion for each student will be submitted to Laboratory Field Services approximately one month prior to completion of training.

*** CLS trainees who have completed the one year training program and are waiting for a date to take the exam to obtain their CLS license will have two options:

1. If the trainee has enough Vacation/Holiday leave to carry them through until the exam can be taken (no longer than two months), the trainee will be allowed to remain employed with SVMC during the interim. This will allow the employee to apply and interview for a Clinical Lab Scientist position (should one be available and posted on the SVMC website) without a break in employment. If the trainee obtains his/her CLS license during this time period and applies and interviews for a CLS position and is not offered the position, he/she will be placed on a 2-week Administrative Leave of Absence to allow them to apply for another position within the District for which they are qualified. If after two weeks they are unable to find such a position, they will be terminated from employment.

2. If the employee does not have enough Vacation/Holiday leave to carry them through until the exam can be taken and results returned or the employee does not wish to use his/her Vacation/Holiday leave, he/she will have the option of going on an Administrative Leave of Absence for a period no longer than two months. During the time the employee is on the Administrative Leave, he/she will be required to pay the full cost of their medical/dental/vision insurance. This will allow the employee time to apply and interview for a Clinical Lab Scientist position (should one be available and posted on the SVMC website) without a break in employment. If the employee is not offered a CLS position or does not apply for another position within the District for which they are qualified during the specific time period, they will be terminated from employment.

Licensing

Successful students of the specialty training program will be eligible to take a California-approved certification exam. Six weeks prior to completion of the training program, trainees must apply to this site http://secure.cps.ca.gov/cltreg to allow sufficient time to process the application.

At the same time, trainees must also apply to: http://www.ascp.org/services/SelectCertification.aspx to arrange a testing date, time and location.

For further assistance, visit the Laboratory Field Services website at: http://www.cdph.ca.gov/programs/lfs/Pages/default.aspx Laboratory Field Services will issue a license to students who complete the entire application process and pass the CLS examination. Licensed individuals can engage in performance of high complexity laboratory testing as well as moderate and or waived laboratory testing in all sections of the clinical laboratory after documentation of competency by the medical director of the clinical laboratory.

REFERENCES

- American Society for Clinical Pathology (ASCP) Board of certification (BOC) (2019). Retrieved from ascp.org/content/board-of-certification.

- California Department of Public Health (CDPH) (2019). Retrieved from https://cdph.ca.gov/Programs/OSPHLD/LFS/pages/ClinicalLaboratoryPersonnel.aspx.

PURPOSE:

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

DEFINITION:

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

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

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

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

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

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

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

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

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

CSP- Compounded sterile preparation

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

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

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

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

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

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

POLICY STATEMENT:

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

PROCEDURE:

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

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

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

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

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

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

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

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

c. Category 1 or 2 CSP's may be prepared at SVMC's Cancer Treatment Center's Suite B nonhazardous sterile product IV room.

B. Master Formulation Records must be present before the pharmacy can compound any sterile preparations. They must contain the following elements:

a. Name, strength, dosage form

b. Quantity prepared

c. Active ingredients and amounts

d. Inactive ingredients and amounts

e. Equipment to be used

f. The maximum allowable beyond use date for the preparation and the rationale or reference source justifying its determination.

g. Sierra View Medical Center's main pharmacy has a maximum BUD per USP 797's Category 1 specifications.

h. Sierra View's Cancer Treatment Suite B is a nonhazardous product room is a Category 2 facility. The maximum BUD will not exceed 10 days for refrigerated items.

i. Specific and essential compounding steps used to prepare the drug.

j. Quality reviews required at each step in the preparation of the drug.

k. Post-compounding process and any required post-compounding process and procedures, qualitative checks, including visual check and pharmacist initials that signify final product check.

l. Instructions for storage and handling of the compounded drug preparation.

m. Physical description of final preparation and final container to be used.

n. Where the pharmacy does not routinely compound a preparation, then the record may be documented on the prescription itself.

o. Any other information that may be needed to describe the operation and ensure its reproducibility.

p. Professional reference to cite where the compounding information can be found.

C. The methodology for determining the formulation of the sterile product shall be:

a. Consulting appropriate professional references

i. USP 797
ii. American Society of Health System Pharmacist
iii. Trissel's Drug Compatibility
iv. Lexi Comp Drug Information
v. Drug manufacturer package insert

D. A Compounding Record will be present and contain all of the following elements:

a. Name, strength, and dosage form of the compounded sterile preparation

b. Date and time that the preparation was compounded

c. Identity of pharmacy technician and pharmacist who performed the PRE check and POST compounding check.

d. Name and amount of each component

e. Manufacturer, expiration date, and lot number of each component

f. A pharmacy assigned unique reference or lot number

g. BUD: SVMC main pharmacy (Category 1) and CTC Suite B (Category 2)

h. The final quantity or amount of drug preparation compounded for dispensing

i. Visual check of final product. Review for particulates, discoloration, or other loss of integrity.

j. Master formula recorded as reference.

k. The log will be separated alphabetically by active ingredient. All logs will be kept for three years and will be filed alphabetically by the active ingredient's generic name. The last year's compounded drugs will be kept in the pharmacy. Any previous years will be kept at a designated pharmacy storage site as per approved Board of Pharmacy waiver to store records off site.

E. The most common source of contamination of sterile products is from personnel. The two most common causes of these contaminations are via particle shedding from personnel and improper manipulation of equipment.

a. Contamination from personnel due to shedding can be reduced by proper hand hygiene, gowning and gloving.

i. Personnel who are experiencing rashes, sunburn, weeping sores, conjunctivitis, or active respiratory infections shall not compound sterile products.

b. Another common source of contamination is from products as they move into SEC/PEC/SCA areas.

i. Introducing Items into the SEC

Before any item is introduced into the clean side of anteroom(s), placed into pass-through chamber(s), or brought into the SCA, providing that packaging integrity will not be compromised, it must be wiped with a sporicidal disinfectant, EPA-registered disinfectant, or sterile 70%IPA using low-lint wipers by personnel wearing gloves. If an EPA-registered disinfectant or sporicidal disinfectant is used, the agent must be allowed to dwell for the minimum contact time specified by the manufacturer. If sterile 70%IPA is used, it must be allowed to dry. The wiping procedure should not compromise the packaging integrity or render the product label unreadable.

ii. Introducing Items into the PEC

Just before any item is introduced into the PEC, it must be wiped with sterile 70%IPAusing sterile low-lint wipers and allowed to dry before use. When sterile items are received in sealed containers designed to keep them sterile until opening, the sterile items may be removed from the covering as the supplies are introduced into the ISO Class 5PEC without the need to wipe the individual sterile supply items with sterile 70% IPA. The wiping procedure must not render the product label unreadable.

iii. Use of Sterile 70% IPA on Critical Sites within the PEC
Critical sites (e.g., vial stoppers, ampule necks, and intravenous bag septum's) must be wiped with sterile 70% IPA in the PEC to provide both chemical and mechanical actions to remove contaminants.

F. Compounding personnel shall not wear cosmetics, hand, wrist, or other visible jewelry, artificial nails, or extenders. Natural nails shall be kept neat and trimmed. Do not wear earbuds or headphones. Do not bring unnecessary electronic devices into the compounding area. Wipe eyeglasses, if worn.

G. Hand hygiene and donning of personal protective equipment (PPE) will take place in the anteroom:

a. Shoe covers.

b. Hair/beard cover should contain all hair.

c. Mask should be worn to cover from bridge of nose to chin.

d. Hands and forearms will be vigorously washed with soap (and water for at least 30 seconds.

- Remove debris from under fingernails, if present, using a nail cleaner (pick) under warm water.
- Hands and forearms shall be washed vigorously with soap and water for at least 30 seconds.
- Dry hands and forearms up to the elbows with low-lint disposable towels.
- Gown is to be donned next.
    - For a Category 1 & 2: Low-lint (non-shedding) garment with sleeves that fit snugly around the wrists and an enclosed neck (e.g., gown or coverall)

- Visibly soiled gowns must be changed immediately. Gowns and garbing items must be segregated and stored before use in an enclosure to prevent contamination (away from sinks to avoid splashing).

- If compounding Category 1 and Category 2 CSPs, gowns may be reused within the same shift by the same person if the gown is maintained in a classified area or adjacent to, or within, the SCA in a manner that prevents contamination.

- Prior to donning sterile gloves, use Sterillium© and allow hands to dry thoroughly.

- Put on appropriate sized sterile gloves and apply sterile 70% alcohol and allow to dry.

e. Gloves should be disinfected immediately before compounding begins, before inserting hands into CAI, and before entering or re-entering the PEC and after contact with non-sterile objects.

f. Gloves that become contaminated by contact with non-sterile surfaces should be disinfected with sterile 70% isopropyl.

g. Gloves should be changed whenever contaminated (spills, etc.), torn or every 30 minutes.

h. The CAI fixed glove assembly shall don sterile gloves OVER the CAI isolator gloves immediately before non-hazardous compounding. These sterile gloves must be changed by each individual whenever continuous compounding is ceased and before compounding starts again or when a rip or tear is visible.

H. Personnel will not prepare compounded sterile products until training is complete and competency validated as per SVMC policy STERILE PRODUCTS:EDUCATION AND COMPETENCY.

a. Personnel will be validated every 6 months for garbing competency (including GFT) and media fill with post-GFT and surface sampling. Furthermore, they will be validated every 12 months for training and competency in sterile compounding principles and practices. There will be dates and signatures reflecting all annual reviews of the policies and procedures by the pharmacist-in-charge.

b. Periodic quality checks will be performed per policy. Failure of any quality test will result in the employee being unable to compound sterile products until retrained and competency validated.

I. Proper conduct in the sterile processing area also protects from contamination.

a. Food and drink are prohibited in all areas of the SCA or cleanroom.

b. Actions such as talking and coughing should be directed away from the work area.

c. Any unnecessary motion within the hood should be avoided to minimize the turbulence of air flow.

d. Activities in the sterile products room should only be related to the procedures for parenteral preparations.

e. No cardboard boxes may be in the ante-room or segregated compounding area. Supplies shall be wiped down with sterile alcohol before placing them in the anteroom and buffer room.

J. Proper technique in the ISO Class 5 environment is required to prevent contamination.

a. The critical principle in using laminar airflow hoods is that nothing should interrupt the flow of air between the HEPA filter and the critical site.

b. To maintain sterility, nothing should pass behind a sterile object in a vertical flow hood. Materials placed within the laminar flow hood disturb the patterned flow of air blowing from the HEPA filter. When laminar air flow is moving on all sides of an object, the zone of turbulence is created that may extend six times the diameter of the object. For these reasons, it is advisable to work with objects at least six inches from the sides and front of the hood without blocking air vents, so that unobstructed airflow is maintained between the HEPA filter and sterile objects.

c. Overcrowding of the critical work area may interfere with airflow and increase the potential for compounding errors. Only one individual may work in a hood at one time.

d. Items introduced into the CAI/Hood and their critical sites (vial stopper, IV bag septum) or hood shall be disinfected with 70% sterile alcohol and allowed to dry before aseptic manipulations begin.

K. Although the laminar air flow hood provides an aseptic environment that is safe for the manipulation of sterile products, it is essential that strict aseptic technique be used in conjunction with proper hood preparation.

L. All equipment (syringes, needles, bags, devices) will be used according to standard references to ensure quality, stability and compatibility. Up-to-date references are available in the pharmacy.

M. Ampule Use

a. Before an ampule is opened, any solution visible in the top portion (head) should be moved to the bottom (body) by swirling the ampule in an upright position.

b. To make an ampule break properly, the ampule neck is cleansed with an alcohol swab and the swab should be left in place. Pressure should be exerted on both thumbs, pushing away from oneself in a quick motion to snap open the ampule.

c. Ampules should not be opened toward the HEPA filter of the laminar flow hood or toward other sterile products within the hood.

d. To withdraw medication from an ampule, the ampule should be tilted and the bevel of the needle placed in the corner space (or shoulder) near the opening. As fluid is withdrawn, increase the angle of tilt so that more of the ampule contents flows into the shoulder.

e. Use a filter needle or filter straw to withdraw the ampule contents, and then switch to a regular needle before expelling the solution from the syringe. Alternatively, a regular needle may be used to draw the solution from the ampule, but a filter needle must be used when expelling the solution from the syringe.

f. All ampules are to be immediately discarded and are not to be stored for any length of time.

N. Vial Use

a. Vials with drugs in solution can be multi dose or single dose.

b. Multi dose vials contain a small amount of preservative agent. The presence of these substances does not make the solution self-sterilizing and the use of strict aseptic technique is still required. Common substances used as preservatives include benzyl alcohol, parabens, phenol and benzalkonium chloride. Due to their toxicity, solutions with preservatives should not be used in preparations for pediatric or neonatal patients or for epidural or intrathecal dosage forms.

c. Unless otherwise specified by the manufacturer, a multi-dose container stored according to the manufacturer's specifications is used in its entirety or its remaining contents are labeled with a BUD and discarded within 28 days from initial opening or puncture. Any multidose container not stored properly or not labeled with a BUD or if BUD is incorrect, the container and drug must be immediately discarded.

d. Single-dose vials do not contain preservative.

i. Most protective covers do not guarantee sterility of the rubber stopper. Before the stopper is penetrated, it must be swabbed with 70% isopropyl alcohol and allowed to dry.

ii. Needle entry into vials with rubber stoppers should be done cautiously to avoid the creation of rubber core particles.

d. Single-dose containers of a compounded sterile drug preparation, other than an ampule, such as a bag, bottle, syringe, or vial, are used in their entirety or their remaining contents are to be labeled with a BUD and discarded within the following time limit, depending on the environment:

i. When needle-punctured in an environment with air quality worse than ISO Class 5,will be discarded immediately.
ii. When needle-punctured in an environment with ISO Class 5 or better air quality, within twelve hours, unless otherwise specified by the manufacturer.

O. The Role of the Pharmacist

a. As physician's orders are received, the pharmacist will enter the order into the computer, preferably selecting premixed preparations.

b. Medications not available in premixed form will be entered in the computer as part of a multiple item compound that includes the appropriate volume of a compatible base solution.

c. A label will be generated from the computer system.

d. The pharmacist will check ALL ingredients (and calculations) prior to a pharmacy technician commencing any compounding. This PRE check will be documented on the compounding log.

e. Upon completion of the compounding, the pharmacist will visually inspect the product for visible turbidity, cloudiness, i.e., qualitative inspection of the final product and document this on the compounding log, a POST Check.

P. The Role of the Pharmacy Technician

a. Disposal of Supplies Upon Completion of Sterile Compounding

i. Needles will be discarded in puncture-resistant, sealable containers, often called "sharp" containers.
ii. Do NOT recap needles before discarding them into the "sharps" container.
iii. Syringes and containers that do not have medication in them that is not considered to be Resource Conservation and Recovery Act (RCRA) waste shall be disposed of in appropriate pharmaceutical waste bins.
iv. Nonhazardous, empty vials may be discarded in the regular trash.

b. Intravenous Piggyback Set-Up Procedures

i. An intravenous admixture ward list will be printed once a day by pharmacy technicians. This list will create intravenous admixture labels that will need to be affixed to either premixed (from the manufacturer) admixtures. If there are no premixed solutions available, then the admixture will be compounded in the compounding aseptic isolator.
ii. Any frozen solutions shall be thawed from the Pharmacy service freezer.
iii. Using the oldest frozen preparation that will not expire within the 24-hour dispensing period, the technician will label each solution specifically for the patient, drug, and dose.
iv. Expiration dates on the frozen solutions will be checked to assure the oldest acceptable date.
v. Docking of proprietary bag to vial systems for future activation must be done in accordance with USP 797.

c. Pediatric Syringe Preparation Procedure

i. The intravenous admixture ward list will be printed once a day.
ii. Patients with doses due before the next list is printed will have those labels segregated from the worklist.
iii. The amount of drug needed for compounding based on total patient requirements shall be determined.
iv. Materials required for aseptic medication transfer should be gathered and placed in the CAI antechamber and wiped with sterile alcohol.
v. The supplies and drug shall be transferred into the CAI mixing chamber and allowed to sit undisturbed for at least three minutes to allow for the CAI to purge any airborne particles.
vi. The technician will call the pharmacist into the IV room for a PRE check on the materials and calculations for the preparation to be compounded. The identity and quantity of each component will be validated by the pharmacist BEFORE the addition is performed.
vii. After the pharmacist signs off on the PRE check on the compounding log, the appropriate amount of medication for syringe preparation shall be diluted (in the CAI) by the technician.
viii. The calculated amount of drug shall be drawn into the syringe.
ix. Aseptically, the technician will inject the syringe contents into the predetermined base solution and affix the patient-specific label.
x. The patient-specific label is immediately applied and the product is removed from the CAI and made available for the pharmacist to do a final quality check.
xi. The remaining drug in the source container shall be discarded.

d. Large volume parenteral preparation procedure:

i. Solution fill list and labels are obtained as described in the pediatric syringe preparation.
ii. Labels are assembled according to additive type.
iii. The outer wraps of solutions are removed upon reintroduction into the PEC. The large volume bags are wiped with sterile alcohol in the CAI antechamber.
iv. The materials for compounding (drugs and syringes, etc.) are placed in the mixing chamber in the CAI and allowed to sit for a minimum of three (3) minutes to allow for the particulate to return to an ISO class 5 state.
v. The pharmacist is called into the IV room, and the identity, quantity, and calculations are reviewed with the technician prior to the pharmacist signing the compounding log and prior to the technician compounding the sterile product.
vi. The patient specific label is immediately applied and the product is removed from the CAI and made available for the pharmacist to do a final quality check.

Q. Sterile product preparation and verification PRE procedure to be done by the technician BEFORE and during the pharmacist's PRE compounding check:

a. Drugs and equipment and patient specific label (needles/syringes/alcohol wipes/etc.) necessary to prepare and mixture will be assembled for the pharmacist to review with the technician.

b. Ingredients will be carefully checked for accuracy using the master formulation record and label. All products selected for use in compounding shall be verified by the pharmacist prior to any compounding activity. In addition, calculations will be verified with the pharmacist during the PRE CHECK phase of compounding.

c. The pharmacist will then sign and date the compounding log acknowledging the technician has assembled all proper materials, drugs, equipment and has reviewed any and all pertinent calculations.

R. Procedure for transferring necessary ingredients and equipment into the PEC. All items will be carefully wiped down with sterile alcohol and allowed to dry before being placed in the PEC.

a. Only ingredients to make one admixture should be in the PEC.

b. Items will be arranged in a manner that does not block or disrupt airflow.

c. After the compounding materials are in the PEC, a purge time of three (3) minutes will pass before beginning any compounding activities.

d. Gloves will be disinfected with sterile alcohol and allowed to dry.

e. A pharmacist will check ingredients and calculations prior to compounding.

f. Admixture will be prepared using aseptic technique.

g. Trash will be managed in a way that does not obstruct airflow.

h. Admixture will be removed from the PEC and labeled.

i. Label will be signed by the employee and the beyond use date will be written on the label.

j. Employee preparing and pharmacist checking the IV will inspect the IV for leakage, foreign matter, precipitate, or cloudiness.

k. All ingredients and supplies will be removed from PEC and kept together for verification by a pharmacist.

S. Sterile product labels must contain the following elements:

a. The generic names of the drugs

b. The quantity or volume and strength of the active ingredient(s)

c. The name of the patient

d. The direction for use

e. The date of dispensing

f. The name and address of the compounding pharmacy and dispensing pharmacy if different.

g. An order number to identify the prescription, e.g., lot number or pharmacy reference number (prescription number).

h. The name of the prescriber

i. Beyond Use Date (BUD)

j. Date compounded

k. Route of administration

l. Rate of administration for IV admixtures

m. Instructions for storage & handling or warning labels if needed

n. All hazardous drugs shall bear a label which states, "Chemotherapy-Dispose of Properly" or "Hazardous-Dispose of Properly"

T. Statement the "Drug was compounded in pharmacy" if preparation was not outsourced.

U. Beyond Use Dating (BUD) will be assigned to all drug products based on manufacturer's chemical stability recommendations or in accordance with the standards for sterility testing found in USP 797, whichever is shorter.

a. SVMC's main pharmacy exclusively prepares sterile-to-sterile transfers in an ISO class 5 PEC that is located in a segregated compounding area, i.e., Category 1 classification.

b. The Cancer Treatment Center (CTC) suite B prepares hazardous and non-hazardous compounded sterile products by using sterile to sterile transfers in a negative pressure hood and room and a positive pressure room and hood, respectively. The products produced at this location will qualify for Category 2 and MAY have a BUD of not greater than 4 days at room temperature and 10 days refrigerated.

U. Single-dose and multi-dose container dating

a. A single-dose container (not an ampule) must be used entirely or discarded:

i. Within twelve hours, if needle-punctured or opened in an ISO Class 5 environment. If a puncture time is not noted on the container, the container must be immediately discarded.

ii. Immediately, if needle-punctured or opened in a worse than ISO Class 5 environment.

b. An ampule is a single-dose container that must be used immediately and not stored for any timeframe.

c. A multi-dose container must be used or discarded within 28 days (or shorter if specified by manufacturer).

V. Documentation Retention

a. All records of compounding and materials used to compound sterile preparations shall

be maintained in a readily retrievable form for three (3) years from the date the record was last in effect. They will be maintained in a manner to provide an audit trail for revisions and updates of each record document.

b. The pharmacy will maintain records of the acquisition, storage, and destruction of any component used in compounding.

W. Whenever a change in a policy or procedure occurs, the pharmacist in charge will notify the staff via a meeting or email. Staff shall sign off on changes acknowledging changes and intent to comply. Any material failure to follow the pharmacy's written policies and procedures shall constitute a basis for disciplinary action by the Board of Pharmacy.

X. This policy and all policies related to sterile compounding will be reviewed annually by the pharmacist-in-charge, and recordation of the annual review shall be present on each policy and be readily retrievable upon request by the Board of Pharmacy.

Y. All pharmacy staff who compound sterile products or who are responsible for training staff who work in the sterile product environment shall review all policies related to sterile products annually. Documentation of the annual staff review shall be readily retrievable for the State Board of Pharmacy.

Z. In the event of a drug recall, the written plan found in DRUG RECALL PROCEDURE shall be followed.

AA. The Department of Pharmacy will not handle or compound any infectious materials in the sterile compounding area.

BB. Pharmacy will run a report for all IV compounds needed to compound within the next 24hrs once daily in the morning. Dispensing of the IV's are done in a manner to ensure the BUD date is not before their due time.

CC. All medications that are retrievable from Pyxis are immediately available for "dispense" after pharmacy verification. Any medication that does not require compounding and not dispensed via Pyxis will be dispensed prior to first dose upon pharmacy notification. A supply of medications are sent for medications not in Pyxis and are to be delivered as soon as possible and before the next due time.

EDUCATION:

SVMC Staff: All pharmacist and pharmacy technicians will receive education regarding sterile product preparation and aseptic technique.

REFERENCES:

- The Joint Commission (2025). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
  - MM.05.01.07
    - EP1
    - EP2
    - EP3
    - EP4
    - EP5
  - MM.05.01.11
    - EP3
- Pharmacy Law: California Edition (2025) San Clemente, California: Law Tech Publishing Group.
- USP 797. (n.d.). Retrieved March 4th 2024 from http://www.usp.org/compounding/general-chapter-797.

SUBJECT:	SECTION:
INTERPRETIVE SERVICES: LANGUAGE ASSISTANCE PROGRAM	***Ethics, Rights & Responsibilities (RI)*** 5 **Page 1 of 6**

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

PURPOSE:

To define methods used by Sierra View Medical Center (SVMC) to accommodate the interpretive needs of patients and family members/significant others, and to delineate the mechanisms used to ensure that potential barriers to effective communication with patients are minimized or eliminated.

POLICY:

Interpreter Services shall be provided to any patient requesting or requiring it without charge to the patient. No patient shall be denied the use of an interpreter once the needs of an interpreter are known.

Language assistance will be provided for patients who do not speak or understand English in order to ensure effective communication set forth in the Policy Guidance Document provided by the Office of Civil Rights of the Department of Health and Human Services, referring to Title VI of the Civil Rights Act of 1964.

DEFINITIONS

Interpret – Converting oral communication from one language to another.

Translate – Converting written communication from one language to another.

Interpreter – One who converts oral communication from one language to another. These services may be provided by qualified bilingual employees.

Translator – One who converts the written documentation from one language to another.

Bilingual Employee – A hospital employee who has the ability to speak English and another language.

Healthcare Professional or Hospital Staff – A physician or hospital employee who provides medical or ancillary care for patients.

Bilingual Family Member – A family member of the patient who has the ability to speak English and the patient's language.

Telephonic Interpretation – Interpretation that occurs over the telephone.

Video/Telephonic Interpretation - Interpretation that occurs through video and telephone.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL EMPLOYEES*

PROCEDURE:

A. Signage communicating the right to and availability of free interpreter services is posted in conspicuous physical areas within the hospital where patient/customer interaction takes place. The signage includes the primary language of the top 15 non-English languages in California.

B. The preferred language of all patients are identified on admission.

C. Accessing Interpreter Services

1. If a Spanish interpreter is needed, refer to the list of in-house certified interpreters posted on the hospital Intranet. Staff may also call the in-house interpretative services line at extension 2600 during regular business hours.

2. If an in-house Spanish interpreter is not readily available, staff may call the interpretative services line at extension 6018 to access the telephone interpreting service.

3. Telephonic Interpreter (HCIN) may be used for languages other than Spanish and when a SVMC Certified Spanish Interpreter is not available.

4. For video and telephone interpreting services, staff will use the Healthcare Interpreter Network (HCIN) equipment, located in designated patient care areas.

5. American Sign Language (ASL) is available for the deaf or Hard of Hearing. Provision of this interpreting service will be provided by one of the following resources:

   a. Utilize the HCIN video unit located in designated patient care areas.

   b. Fox Interpreting (Visalia, CA)
   Office: 559-636-3294

D. Certified Interpreters must be used for the following:

1. To obtain informed consent for surgical/invasive procedures; Do Not Resuscitate (DNR) orders; and/or organ donation requests

2. Physician communications: History & Physicals, explanation of diagnosis, and family conferences

3. Patient Education

4. Discharge instructions

5. Extensive Social Worker intervention

6. To handle a patient complaint

7. When the patient specifically requests an interpreter

E. Bilingual family members may interpret under the following circumstances:

1. The patient has the right to request that their bilingual family member serve as an interpreter unless the healthcare professional believes that a non-family member interpreter is necessary.

2. The bilingual family member must be 18 or older.

3. The healthcare professional must offer the patient the choice of using an interpreter, qualified bilingual employee, or telephonic interpreter as language assistance options before asking a bilingual family member to interpret.

4. If a patient declines a hospital interpreter, the reason for declining the service must be recorded in the patient's medical record. The name of the person who interprets for the patient and his/her relationship to the patient is also recorded.

Certified interpreters should be used for all significant clinical communications, including informed consent, patient education, treatment discussions, discharge planning, and any situation involving patient safety, patient rights, or complex medical decision-making.

F. Interpreter's Role

1. The interpreter maintains appropriate behavior and professional modeling as an interpreter – They will offer suggestions only when appropriate as relative to language or cultural issues.

2. The interpreter interprets regarding medical/health care only (as linguistic expertise permits) and does not venture into non-medical/healthcare subject matter.

G. Documentation

1. The hospital staff requesting language assistance is responsible for documenting the interpreter's name, the language used to interpret, and the nature of the communication in the medical record.

2. The individual requesting language assistance must sign the Interpreter Verification form during the registration process

3. When using telephonic interpreters, the following information must be documented in the medical record: the interpreter's identification number, the language used, and the nature of the interpretation.

H. Translation of Documents

1. Documents that need to be translated should be sent to a qualified translation company and forwarded, as needed, to the Forms Committee, the Marketing Department and the full time SVMC healthcare interpreter for approval.

2. Translation Services must be used to translate documents including, but not limited to, the following:

   a. Any document intended for patient instructions, information or education

   b. Consent forms

   c. Any information from a regulatory body

   d. Marketing material

   e. Hospital signage

   f. Visitor information

   g. Employee information

3. Bilingual employees (non-trained interpreters) may not translate any hospital documents.

I. Translation of discharge instructions

1. Bilingual discharge instructions are available for Spanish and other selected languages. Interpreters are to do a hand written translation only in the event that the approved documents are not accessible.

2. The telephonic interpreter will be utilized when discharge instructions need to be interpreted from English into a language other than Spanish.

TRAINING OF STAFF

Hospital employees are provided information regarding interpreter services, concepts and practices of culturally and linguistically appropriate health care delivery, while attending initial hospital orientation.

CERTIFIED INTERPRETER COMPETENCY

A. Potential candidates for certified interpreting are given the opportunity to apply and will be screened for skill level, plus verbal fluency, prior to acceptance.

B. Certified interpreters are tested for competency initially and annually.

C. Initially, candidates will take and must pass the standardized Interpreting Skills Exam. Annually, competency will be validated by simulation or direct observation by a certified interpreter.

D. If an employee will only interpret in their specific job role (i.e. registration), they will take and must pass the standardized Bilingual Fluency Assessment. Annually, competency will be validated by simulation or direct observation by a certified interpreter.

E. Periodic updates and in-services will be provided to certified interpreters to assist with maintaining competency.

REFERENCES:

U.S. Department of Health and Human Services, Office for Civil Rights. (2024). *Nondiscrimination in health programs and activities (Section 1557 Final Rule).* Federal Register, 89(88), 37522-37855. https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities

U.S. Department of Health and Human Services, Office for Civil Rights. (2025). *Limited English proficiency (LEP).* https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html

U.S. Department of Health and Human Services, Office for Civil Rights. (2024). *Language access provisions of the final rule implementing Section 1557 of the Affordable Care Act.* https://www.hhs.gov/sites/default/files/ocr-dcl-section-1557-language-access.pdf

U.S. Department of Health and Human Services, Office of Minority Health. (2025). *National standards for culturally and linguistically appropriate services (CLAS) in health and health care.* Think Cultural Health. https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards_Revised_June2025.pdf

U.S. Department of Health and Human Services, Office of Minority Health. (2025). *Cultural and linguistic competence.* https://minorityhealth.hhs.gov/cultural-and-linguistic-competence

- California Code of Regulations (CCR), Title XXII, § 70721
- California Health & Safety Code, §1259.

SUBJECT: **INTRAUTERINE GROWTH RESTRICTION (IUGR)**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish evidence-based nursing guidelines for the assessment, monitoring, intrapartum management, and neonatal care of patients with suspected or diagnosed fetal growth restriction (FGR) to promote optimal maternal and neonatal outcomes.

POLICY:

All pregnant patients shall be assessed for risk factors associated with fetal growth restriction (FGR).

Patients with suspected or confirmed FGR shall receive evidence-based surveillance, fetal monitoring, multidisciplinary care, and timely escalation of care in accordance with current American College of Obstetricians and Gynecologists (ACOG), Society for Maternal-Fetal Medicine (SMFM), and California perinatal care recommendations.

DEFINITION:

Fetal Growth Restriction (FGR): A fetus with an estimated fetal weight (EFW) or abdominal circumference (AC) below the 10th percentile for gestational age. Severe FGR is generally defined as EFW below the 3rd percentile.

AFFECTED AREAS/PERSONNEL: *MCH PERSONNEL AND RNs*

EQUIPMENT:

- Fetal monitor
- Intravenous (IV) fluids/pump
- Blood glucose monitor

PROCEDURE:

1. Antepartum Assessment
    - The RN shall review: gestational age confirmation, prenatal tests (ultrasound findings, fetal growth trends, NST results, BPP findings), and maternal laboratory lab results.
    - Assess for maternal risk factors including but not limited to: chronic hypertension, preeclampsia, renal disease, gestational diabetes, autoimmune disorders, cardiac disease, substance abuse, multifetal gestation, placental abnormalities, or previous pregnancy complications by FGR.

- Verify ordered fetal surveillance: i.e., Nonstress testing (NST), biophysical profile (BPP)

2. Intrapartum Management

   - Initiate continuous electronic fetal monitoring during labor
   - Maintain maternal positioning to optimize uteroplacental perfusion.
     - Left lateral position preferred
     - Avoid prolonged supine positioning
   - Monitor for:
     - Category II or III fetal heart rate tracings
     - Recurrent variable decelerations
     - Late decelerations
     - Reduced variability
   - Promptly notify the provider of:
     - Nonreassuring fetal status
     - Decreased fetal movement
     - Category III tracing
     - Significant deterioration in maternal condition
   - Anticipate potential need for:
     - Operative vaginal birth
     - Cesarean birth
     - Neonatal resuscitation support
     - Neonatal intensive care admission
   - Ensure neonatal team attendance at delivery for:
     - Severe FGR
     - Preterm FGR
     - Other high-risk fetal conditions

3. Neonatal Management
   - The RN shall monitor for complications commonly associated with FGR including but not limited to: hypoglycemia, hypothermia, feeding difficulties, respiratory distress, polycythemia, birth depression, necrotizing enterocolitis, and meconium aspiration syndrome.

4. Blood glucose monitoring: follow Neonatal Hypoglycemia protocol and provider orders

5. Thermoregulation
   - The RN shall promote skin-to-skin care when appropriate, monitor temperature per newborn care standards, maintain thermal neutrality, and escalate care for persistent hypothermia.

DOCUMENTATION:

- Documentation in the EMR shall include:
  - Maternal risk factors
  - Antepartum surveillance results
  - NST/BPP findings
  - Doppler findings
  - Fetal monitoring interpretation
  - Provider notifications
  - Interventions performed
  - Patient education
  - Referrals
  - Neonatal assessments and outcomes

REFERENCE:

American College of Obstetricians and Gynecologists. (2021). *Fetal growth restriction* (Practice Bulletin No. 227). *Obstetrics & Gynecology, 137*(2), e16-e28. https://doi.org/10.1097/AOG.0000000000004251

American College of Obstetricians and Gynecologists, & Society for Maternal-Fetal Medicine. (2021). *Fetal growth restriction: Practice Bulletin No. 227. Obstetrics & Gynecology, 137*(2), e16-e28.

Association of Women's Health, Obstetric and Neonatal Nurses. (2022). *Core curriculum for maternal-newborn nursing* (6th ed.). Elsevier.

California Department of Public Health. (2024). *California perinatal quality initiatives and maternal-child health resources*. California Department of Public Health.

Martins, J. G., Biggio, J. R., & Abuhamad, A. (2020). *Society for Maternal-Fetal Medicine Consult Series #52: Diagnosis and management of fetal growth restriction. American Journal of Obstetrics and Gynecology, 223*(4), B2-B17. https://doi.org/10.1016/j.ajog.2020.05.010

CROSS REFERENCE:

Neonatal Hypoglycemia

SUBJECT: **MCH - ADMISSION CRITERIA**	SECTION: **Page 1 of 2**

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

POLICY:

- All patients of 20 weeks gestation or greater that present to the Labor & Delivery (L&D) Department, or that enter the hospital with L&D complaints will be assessed by the L&D unit. External fetal monitors should be applied to assess the fetal heart rate and uterine activity.
- Patients presenting for the observation of labor and/or prenatal testing will be admitted as ordered by the physician.

AFFECTED AREAS/ PERSONNEL: *MATERNAL CHILD HEALTH (MCH) STAFF, REGISTERED NURSES (RN)s*

PROCEDURE:

1. Prenatal history should be available to the labor and delivery staff via the electronic medical record or faxed from the physician's office upon request to provide patient specific care.
2. The patient will be evaluated based on symptoms, complaint and reason for visit. Report to the physician will be given as soon as possible by the registered nurse.
3. An RN is to assess, admit if indicated by the physician and monitor the patient's progress as ordered per physician.
4. Admission criteria includes; but is not limited to:
    a. Active labor:
        1) Uterine contractions with cervical change
        2) 5 cm cervix primigravida
        3) 6 cm multiparous
    b. Rupture of Membranes
    c. Antepartum care and observation as ordered per physician
5. Fetal monitoring is initiated upon admission and maintained per standardized care considering the risk factors present and fetal well-being, unless otherwise ordered by the physician.
6. When a patient is examined by a RN and determined not to be in active labor, the nurse should:
    a. Follow Medical Screening Exam policy
    b. Report the assessment to the physician
    c. Request discharge status determination from the physician

If patient stable for discharge. Discharge the patient as ordered, give and discuss discharge instructions with the patient. The patient and nurse will sign the discharge document jointly.

7. Document assessments, care provided and patients understanding of education and discharge instructions.

REFERENCES:

- American College of Obstetricians and Gynecologists. (2021). *Antepartum fetal surveillance (Practice Bulletin No. 229)*. Obstetrics & Gynecology, 137(6), e116-e127. https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2021/06/antepartum-fetal-surveillance [acog.org], [pubmed.ncb...lm.nih.gov]
- Association of Women's Health, Obstetric and Neonatal Nurses. (2024). *Fetal heart monitoring: Position statement*. Journal of Obstetric, Gynecologic & Neonatal Nursing, 53(3), e5-e9. https://www.jognn.org/article/S0884-2175(24)00040-6/fulltext [jognn.org]
- Association of Women's Health, Obstetric and Neonatal Nurses. (2024). *Standards for professional nursing practice in the care of women, newborns, and people across the life span (9th ed.)*. Journal of Obstetric, Gynecologic & Neonatal Nursing, 53(1), e4-e40. https://www.jognn.org/article/S0884-2175(23)00246-0/fulltext [jognn.org]

SUBJECT: **MASSIVE TRANSFUSION**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish the criteria for activating the massive transfusion protocol.

PRINCIPLE:

Following massive transfusion, there is such a small volume of the patient's blood left that complete crossmatching has limited benefit. The pretransfusion sample no longer represents currently circulating transfused blood and sensitive AHG testing on the current specimen accomplishes virtually nothing. It is usually only necessary to confirm ABO compatibility of subsequently transfused blood.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. The crossmatch can be abbreviated in those instances in which the patient has received a volume of blood approximately equal to their own blood volume within a 24 hour period. For an average adult this can be assumed to be 10 units.

2. In cases of massive transfusions as defined above, an immediate spin major crossmatch is all that is required prior to transfusion provided that the patient has had a negative antibody screen performed within the last 3 days.

3. If the antibody screen is positive and:

    a. If the antibody has been identified, units known to be negative for the target antigen may be transfused after immediate spin crossmatch only.

    b. If the specificity of the antibody has not been determined, or if the antigen has not been tested for in the donor units, then a complete major crossmatch is required.

4. This procedure applies up to 24 hours after the occurrence of a massive transfusion.

REFERENCE:

- Association for the Advancement of Blood & Biotherapies (AABB) Technical Manual, 21st Edition, pg 609 - 611, 2023.
- Association for the Advancement of Blood & Biotherapies (AABB) Standards, 35th Edition, p66, 5.19.6, 2026

SUBJECT:	SECTION:
NASOGASTRIC/NASOINTESTIONAL TUBE INSERTION AND PLACEMENT VERIFICATION UTILIZING THE KANGAROO FEEDING TUBE WITH IRIS TECHNOLOGY IN THE ADULT PATIENT	***[Enter manual section here]***

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

PURPOSE:

1. To outline Nursing practice for insertion of the Kangaroo Feeding Tube with IRIS technology.
2. To define placement verification practices for Kangaroo Feeding Tubes placed utilizing the IRIS Technology.
3. To promote safe, evidence-based placement and verification of small-bore feeding tubes in adult patients.

DEFINITIONS:

1. **IRIS** (Integrated Real-time Imaging System) Technology- A feeding tube system incorporating a camera at the distal tip that provides real time visualization of anatomical structures during tube insertion to assist with placement.
2. **Advancement:** for the purposes of this clinical guideline, advancement refers to passing SBFT from the stomach through the pylorus into the small bowel. Advancement may involve patients position and/or the use of prescriber-ordered prokinetic agents. Gastric insufflation is considered an advancement and is an advanced nursing skill performed in the ICU requiring additional training
3. **Small Bore Feeding Tube (SBFT):** A single-lumen tube with or without a stylet inserted through either the nasal or oral route into either the stomach or small bowel. Oral insertion is restricted to Critical Care areas.

POLICY:

The Kangaroo Feeding Tube with IRIS Technology may be inserted by a Registered Nurse who has successfully completed organization-approved education and demonstrated competency validation for use of the device. Ongoing competency validation shall be maintained in accordance with organizational policy.

Contraindications include:

A. Adult patients who have had gastric, esophageal or nasopharyngeal surgery within the past 14 days.
B. Patients with known or suspected esophageal varices with active or recent bleeding.
C. Patients with esophageal obstruction or stricture.
D. Active duodenal and/or gastric ulcers;
E. Active bleeding hemangioma;
F. Acute facial, nasal or sinus injuries;
G. Patients with head and neck surgical reconstruction
H. Recent bleeding or banded esophageal and/or gastric varices (within 7 days), ulceration, hemangioma (risk of causing trauma)
I. Patients with basilar skull fracture or facial fractures.
J. Any other patient who in the nurse's judgment would have increased potential for complications from this procedure.

SUBJECT:	SECTION:
NASOGASTRIC/NASOINTESTIONAL TUBE INSERTION AND PLACEMENT VERIFICATION UTILIZING THE KANGAROO FEEDING TUBE WITH IRIS TECHNOLOGY IN THE ADULT PATIENT	***[Enter manual section here]***

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AFFECTED PERSONNEL/AREAS: *All patient care areas*

GUIDELINES:

1. A Prescriber order is required for the initial insertion of a SBFT. This order should clearly indicate the final placement (gastric vs small bowel) as SBFT is sometimes interpreted as "small bowel feeding tube.
2. SBFT can be inserted to the stomach and/or advanced to the small bowel by nursing any time of day if a x ray is ordered pot for verification
3. **ICU Only**: Gastric insufflation shall be discussed with and ordered by the Prescriber prior to commencing the procedure if contraindications are present. Contraindications to gastric insufflation include:
    a. Active gastric ulcer
    b. Esophageal, stomach or duodenal surgery
    c. Active bleeding, esophageal varices within 7 days.
    d. Active gastrointestinal bleeding
4. A maximum of two attempts to insert a SBFT into the stomach or advance SBFT to the small bowel shall be permitted per inserter. A final third attempt by a different healthcare provider with Prior Experience is permitted. If unsuccessful after third attempt, contact the Prescriber to discuss alternative insertion methods or nutrition options. Rationale for further action shall be documented in the health record by the healthcare provider.
5. Initial gastric or small bowel placement **must** be confirmed by X-ray before a SBFT can be irrigated or used for medications or enteral feeding.
6. Initial gastric or small bowel placement **shall not be** confirmed by auscultation with air bolus, characteristics of aspirates, or pH testing.
7. Ongoing placement confirmation is done by measuring the external length of the SBFT and comparing it to the documented external length at insertion.
    a. When significant discrepancies in external length exist, X-ray confirmation of placement must be repeated.
8. For gastric placement do not remove the stylet, if applicable, until the X-ray is read and final placement is confirmed by a Prescriber or Radiologist. For small bowel placement, remove the stylet prior to attempting spontaneous migration
9. The stylet wire should never be forcefully removed from a SBFT while situated in a patient. If the wire is stuck, notify Prescriber prior to removal of the SBFT.
10. A 20 mL or greater enteral syringe must be used when attempting to aspirate or flush the SBFT. Using a smaller syringe can cause excessive pressure resulting in collapse or rupture of the SBFT. Do not aspirate through a SBFT placed in the small bowel.

SUBJECT:	SECTION:
NASOGASTRIC/NASOINTESTIONAL TUBE INSERTION AND PLACEMENT VERIFICATION UTILIZING THE KANGAROO FEEDING TUBE WITH IRIS TECHNOLOGY IN THE ADULT PATIENT	***[Enter manual section here]***

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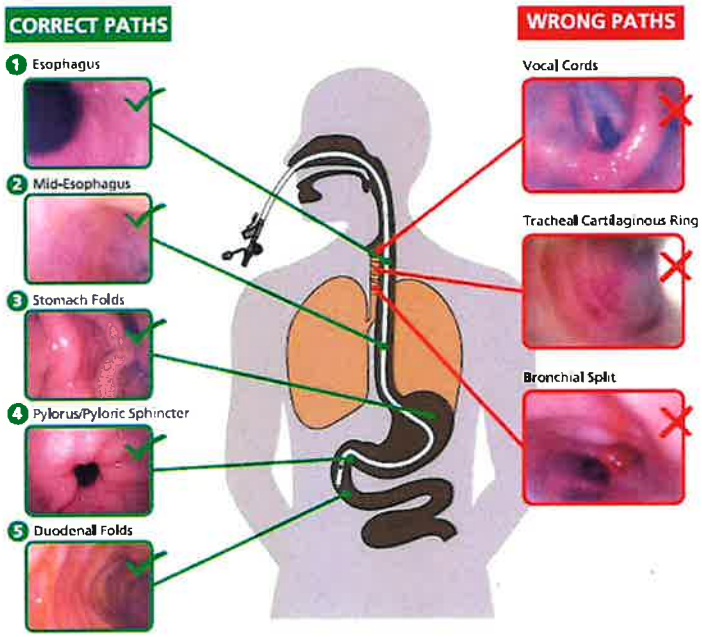
PROCEDURE:

Procedure for feeding Tube Placement

1. Power the console on.
    A. Press the power button.
    B. Verify successful start up and login screen display
2. Enter login, password and patient information.
    A. The system will request a login name and password. After typing, tap the check mark to proceed to the main menu.
    B. The main menu will appear. Tap on the procedure icon to begin the placement procedure.
    C. Follow the screen commands to enter the patient information. Patient ID is the patients MRN. All of this information needs to be entered correctly. When complete, tap the check mark to proceed.
    D. The system will ask for confirmation that the information is entered correctly. If yes, tap the check mark. If not, tap the red "x" to go back and re-enter the information.
3. Position patient and estimate feeding tube length.
    A. Position patient for feeding tube placement.
    B. To estimate insertion depth, use the tube to measure the distance from the tip of the patient's nose to the earlobe and from the earlobe to the xiphoid process for gastric placement. Add approximately 10 (ten) inches (25 cm) for intestinal placement. Spontaneous transpyloric passage of the tip often occurs within 24 to 48 hours.
        - Note: The Kangaroo feeding tube with IRIS technology tip is marked with an arrow on the tube near the feeding eyelets. The tip housing camera has optimal flexibility to bend in two directions, either towards or away from this arrow.
4. Activate Hydromer coating.
    A. Use water to activate the Hydromer coating on the Kangaroo feeding tube with IRIS technology, submerge tip for about 5 seconds to activate the Hydromer coating.
        - Note: If applying lubricant, do not put lubricant on or near the camera-side of the feeding tube. The camera vision may become blocked or blurred.
5. Connect interface cable to console.
    A. After entering patient information, the console will request a feeding tube to be attached.
    B. Connect the larger end of the interface cable to the console.
6. Connect interface cable to feeding tube.
    A. Connect the smaller end of the interface cable to the feeding tube. Once the feeding tube and interface cable are connected to the console, a live feed from the camera will display on the screen.
7. Choose the most patent nare.
    A. Choose the most patent nare and insert the feeding tube with the stylet. Direct the feeding tube posteriorly, aiming the tip parallel to the nasal septum and superior surface of the hard palate. Advance the tube to the nasopharynx, allowing the tip to seek its own passage. Once in place, do not manipulate or pull the stylet back and forth within the

feeding tube. When the tube has reached the oropharynx, encourage the patient to swallow.

8. Using console for placement.
   A. While inserting the Kangaroo feeding tube with IRIS technology, utilize the console screen to correctly identify anatomical markers during placement (see path images at below).



9. Ending procedure on the console.
   A. When the procedure is complete and the feeding tube has been placed properly, tap the green check mark.
10. Disconnect the feeding tube from the interface cable.
11. Clean and store the IRIS console according to unit practice.
12. Follow LIP orders for XRAY, if applicable, have physician confirm placement of the feeding tube via radiographic image (x-ray).
13. Once placement has been confirmed, remove the stylet, and begin using the feeding tube.

Reconnecting the console and interface cable to the Kangaroo Feeding Tube with IRIS Technology that is currently placed in a patient.

- A console used to place a feeding tube will retain the memory of which patient is associated to that tube. By re-connecting to the same feeding tube, the console will recognize it and ask for confirmation that the patient data is correct.

- Only the console used during the placement procedure will recognize the feeding tube and associated patient information. If a different console is connected to a pre-placed tube, entering the patient's information is required.

1. Power on and reconnect
   A. Power console on and enter login name and password.
   B. Connect console to interface cable.
   C. Connect interface cable to pre-placed Kangaroo feeding tube with IRIS technology.
2. Confirm patient information:
   A. A screen will pop up with the recognized patient information. Tap the check mark to confirm the information is correct.
   B. If the information is incorrect, tap the "x" to go back to the main menu screen.
3. Focus on procedure screen:
   A. The console will display the procedure screen with a live-feed from the camera on the end of the enteral feeding tube.
4. Adjust the feeding tube as needed and complete appropriate pictures.

REFERENCES:

American Association of Critical-Care Nurses. (2023). *AACN procedure manual for progressive and critical care* (8th ed.). Elsevier.

American Society for Parenteral and Enteral Nutrition. (2023). *Enteral nutrition tube placement resources*. https://nutritioncare.org/clinical-resources/enteral-nutrition/en-tube-placement

Cardinal Health. (2024). *Kangaroo™ feeding tube with IRIS technology user manual and instructions for use*. https://www.cardinalhealth.com/en/product-solutions/medical/enteral-feeding/kangaroo-feeding-tube-with-iris-technology.html

Elsevier Clinical Skills. (2025). *Feeding tube: Small-bore insertion and care*. Elsevier Clinical Skills.

SUBJECT: **NEWBORN SCREENING TESTS**	SECTION: **Page 1 of 2**

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

POLICY:

To comply with California State Department of Health Services Newborn Screening Program Regulations (CCR Title 17, sub chap 9, article 1) and to assure a high quality of collection, documentation, and transport of the newborn screening sample.

INITIAL SPECIMEN:

1. On receipt of written or electronically transmitted Lab orders for Newborn Screening (NBS) from the Maternal Child Health (MCH) Department, a nurse will obtain a whole blood sample by skin puncture from the heel as described in the current circular distributed by the State Health Department.

2. The appropriate timing for the NBS draw will be determined by the Maternal Child Health (MCH) Department.

3. The State approved NBS collection form will be used and obtained through the Maternal Child Health Department. The Maternal Child Health Department will fill out all areas of the form including **DATE, SPECIMEN COLLECTED,** and **INITIALS OF PERSON DRAWING SPECIMEN**.

4. The person drawing specimen will remove the goldenrod copy (AFTER completing the Lab portion of the NBS form) and give to MCH for placement in the newborn's medical record.

5. After collection, MCH personnel will take the NBS form (less goldenrod copy) to the Lab and allow to dry for three hours.

6. The Lab will log the NBS patient on the NEWBORN SCREENING SPECIMEN TRANSPORT LOG and retain the yellow copy of the log for documentation. The Lab should request additional NBS TRANSPORT LOGS from the State-designated Lab.

7. The Lab will then place the NBS specimens and the Transport Log in a special FedEx courier envelope pre-addressed to the State designated lab. The FedEx courier will pick up the envelope from the Sierra View Medical Center (SVMC) draw station front office Monday through Saturday. The Lab should request additional forms, as needed, from the State designated lab, and additional envelopes with address labels from FedEx.

8. A charge will be made for the initial NBS test in accordance with current regulations.

INADEQUATE SPECIMEN:

1. Upon notification from the Newborn Screening Coordinator (NSC), outpatient retesting will be done at OPL.

2. The NBS form will be obtained from the FBC by Lab personnel and labeled with a new test order number.

3. Demographic and clinical data as stated on the original form will be written on the repeat NBS form by the Lab.

4. These forms will be handled and mailed by the lab in the same way as Initial Specimens.

5. There will be no charge for this service.

RECALL SPECIMEN:

1. Upon notification from the NBSP, the outpatient lab will collect a new newborn screening specimen.

2. The lab will obtain a newborn screening form from FBC and complete all required patient information. After the blood specimen has been collected and allowed to dry, the Laboratory will notify the NBSP and provide them with the newborn screening form number.

3. The lab will send the NBS form to the State-designated laboratory by the next business day.

AFFECTED AREAS/PERSONNEL: *LABORATORY, MATERNAL CHILD HEALTH (MCH)*

REFERENCE:

- California Code of Regulations Title 17, Subchapter 9, Article 1.

SUBJECT: **NICU: DOCUMENTATION**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish standardized guidelines for complete, accurate, and timely documentation of neonatal patient care in the Neonatal Intensive Care Unit (NICU) utilizing the Electronic Medical Record (EMR). Documentation supports patient safety, continuity of care, interdisciplinary communication, quality improvement, regulatory compliance, and family-centered care.

POLICY:

All patient care provided in the NICU shall be documented in the EMR in an accurate, objective, timely, and complete manner consistent with professional standards of practice, California regulations, organizational policies, and legal requirements.

Documentation will reflect the infant's clinical condition, treatment, response to interventions, and ongoing plan of care, support communication among members of the interdisciplinary healthcare team, demonstrate application of the nursing process through assessment, planning, implementation, evaluation, and reassessment, incorporate family-centered care, including parental participation, education, and communication, and be entered as close to the time of care delivery as possible.

AFFECTED AREAS/PERSONNEL: *NURSING & MEDICAL STAFF*

PROCEDURE:

1. Charting in the NICU is done by logging in the EMR. This system allows the nurse to document all assessments and interventions. When EMR is unavailable, MediTech Downtime - Clinical Documentation procedures will be observed.

2. An initial admission assessment shall be completed for every infant. Including but not limited to: reason for admission, birth history and maternal history, gestational age and birth weight, initial physical assessment, respiratory status, nutritional plan, safety assessments, initial plan of care, and family contact information.

3. Comprehensive nursing assessments shall be documented at the beginning of each shift.

4. Reassessment is an ongoing function of the Registered Nurse (RN) caring for the infant and is documented at least every 4 hours, or more often when necessary.

    - Documentation of reassessment will include but not limited to: infant acuity, change in condition, provider orders, and unit-specific standards of care

5. Significant changes in clinical status and nursing interventions shall be documented promptly.

6. The RN shall document development, implementation, and evaluation of the individualized plan of

care. Family goals, participation, education, and discharge planning activities shall be incorporated into the plan of care whenever applicable.

7. The nurse should keep the infant's chart at the bedside. The chart includes:
   - Newborn Identification Form-which includes signature of 2 RNs who identified the baby upon birth and signature of mother upon discharge identifying her baby
   - Car seat tolerance screening documentation, when applicable
   - Immunization consent and administration records

8. All medications, including immunizations, shall be documented in the Electronic Medication Administration Record (eMAR). Documentation shall include medication name, dose, route, time of administration, required assessments, and patient response when indicated.

9. New provider orders shall be revied, acknowledged, and implemented according to Medication Administration policy.

10. Intake and output shall be documented throughout the shift and summarized according to unit standards. Documentation will include enteral intake, parenteral intake, urine output, stool occurrence, emesis, and drain output if applicable. Intake and output totals shall be calculated at least every shift and/or every 12-hours according to unit practice.

11. The infant's feedings should be recorded to include the type of feeding (breast milk, donor human milk, or formula), administration route (oral, gavage, or other ordered routes), volume administered, time of feeding, feeding duration when applicable, tolerance of feeding, and significant feeding-related events.

12. Infants receiving respiratory support shall have respiratory assessments documented according to provider orders and unit standards including: type of respiratory support, oxygen concentration (FiO2) and O2 saturation, respiratory assessment findings, ventilator or respiratory support settings, and any changes in respiratory support and patient response. Respiratory therapists shall document respiratory treatments, assessments, and interventions.

13. The RN shall assess and document all peripheral and central vascular access devices according to organizational policy including: site assessment, catheter status, infusion type, infusion rate. dressing condition, and any complications/interventions. Any signs of infiltration, extravasation, infection, or device complications shall be documented immediately, including provider notification and actions taken.

14. All procedures performed in the NICU shall be documented in the EMR including but not limited to: blood specimen collection, UAC/UVC placement, endotracheal intubation, diagnostic imagine, and other invasive or non-invasive procedures.

15. Family presence, participation in care, education provided, and significant interactions shall be documented in the medical record including but not limited to: parent/guardian communication, education provided, care conferences, discharge teaching, and informed consent discussions as applicable. Use of interpreter services shall be documented when utilized.

16. All clinically significant communications with providers shall be documented including: date and time of communication, reason for notification, provider response, orders received, interventions implemented, and patient response when applicable.

17. The RN shall document the state-required newborn screening in the EMR. Details should include the date and signature of the RN drawing the metabolic screen. A copy of the screen should be placed in the chart.

18. A discharge summary / discharge documentation shall be completed for all infants discharged or transferred from the NICU.

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American Academy of Pediatrics. (2023). *Neonatal care: A compendium of AAP clinical practice guidelines and policies* (2nd ed.). American Academy of Pediatrics. https://doi.org/10.1542/9781610024167

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CROSS REFERENCE:

Medication Administration

MediTech Downtime - Clinical Documentation

SUBJECT: **NO PRENATAL CARE (DROP IN)**	SECTION: **Page 1 of 4**

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

PURPOSE:

To establish evidence-based nursing guidelines for the assessment, management, and coordination of care for pregnant patients presenting to Labor and Delivery or Maternal Child Health (MCH) without documented prenatal care, in order to identify maternal, fetal, and neonatal risks; facilitate timely interventions; promote safe delivery outcomes; and ensure compliance with applicable California regulations and standards of care.

POLICY:

1. All pregnant patients presenting without documented prenatal care shall receive a comprehensive Medical Screening Examination (MSE) and nursing assessment in accordance with hospital policy, EMTALA requirements, and approved nursing standardized procedures.

2. Patients without prenatal care shall be considered at increased risk for:

   - Hypertensive disorders of pregnancy
   - Diabetes
   - Infectious diseases
   - Fetal growth abnormalities
   - Preterm birth
   - Substance use disorders
   - Intimate partner violence
   - Human trafficking
   - Mental health disorders
   - Social determinants of health impacting maternal or neonatal outcomes

3. A comprehensive psychosocial, medical, and obstetrical assessment shall be completed upon presentation.

4. Prenatal laboratory studies shall be obtained as ordered by the provider and may include:

   - ABO/Rh blood type and antibody screen
   - Complete blood count (CBC)
   - Hepatitis B surface antigen (HBsAg)
   - Hepatitis C screening
   - HIV screening
   - Syphilis screening
   - Rubella immunity status
   - Gonorrhea and Chlamydia testing
   - Urinalysis and urine culture as indicated

- Additional testing as clinically indicated

5. Substance use screening shall be performed utilizing an approved evidence-based screening tool and clinical assessment. Toxicology testing shall be conducted according to hospital policy, provider order, patient consent requirements, and applicable California law.

6. Consultation with Social Services, Case Management, Lactation Services, Behavioral Health, and Community Resources shall be initiated as appropriate.

7. The pediatric provider or neonatal provider shall be notified of all patients with no prenatal care prior to delivery when feasible.

8. Appropriate newborn prophylaxis, immunizations, laboratory testing, and infectious disease prevention measures shall be completed according to current pediatric and CDC recommendations.

AFFECTED AREAS/PERSONNEL: *MCH STAFF, RNs*

PROCEDURE:

1. Initial assessment, the registered nurse will:
    - Obtain maternal history including but not limited to:
        - Gravida, para, abortions, living (GTPAL), estimated gestational age, last menstrual period, previous pregnancies and outcomes, medical history, surgical history, current medications, allergies, substance use history, mental health history, immunization status, social support system.
    - Asses current pregnancy:
        - Chief complain, labor status, membrane status, vaginal bleeding, fetal movement, pregnancy complications, and prior health care encounters during pregnancy.
2. Physical assessment, the registered nurse will:
    - Assess maternal status including but not limited to:
        - Vital signs, height and weight, pain assessments, signs of infection, edema, neurological symptoms, signs of preeclampsia, signs of trauma or abuse.
    - Assess fetal status including but not limited to:

- Fetal heart rate, electronic fetal monitoring when indicated, fetal movement, and uterine activity.
- Continuous or intermittent monitoring shall be performed according to gestational age, patient condition, provider orders, and fetal surveillance standards.

3. Diagnostic testing per provider order
   - Maternal testing: CBC, blood type and Rh, antibody screen, syphilis screen, HIV screen, Hepatitis B surface antigen, Hepatitis C screening, Urinalysis, Urine culture when indicated
   - Additional testing as clinically indicated and ordered by provider: Comprehensive metabolic panel, preeclampsia laboratory studies, Group B Streptococcus screening when appropriate, toxicology testing when indicated
4. Record retrieval: if any prenatal care has been received, attempt to obtain prenatal records, contact the prenatal provider, clinic, or hospital, and document all attempts to obtain records.
5. Assess for social determinates and safety screening, and consult social services as indicated.
6. Notify Pediatrician regarding absences of prenatal care, maternal infections disease, maternal laboratory results, substance exposure concerns, and high-risk social concerns. Treat per orders.
7. Hepatitis B management: follow hospital policy HBIG Immunoglobulin-HbsAG Positive or Unknown Status and treat per provider orders.
8. Prior to discharge, maternal condition will be stable, newborn condition will be stable, follow-up appointments will be arranged, provide community resources as needed, discharge instructions will be reviewed and verified as understood, and referrals will be completed as needed.
9. Document:
   a. Admission per standards of care assessment, interventions, and findings
   b. Consultations and referrals
   c. Specimen collection and results
   d. Communication with providers and orders
   e. Patient education and disposition

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CROSS REFERENCES:

Guidelines for the Initial Assessment and Triage of Obstetric Patients

HBIG Immunoglobulin-HbsAG Positive or Unknown Status

SUBJECT: **OBSTETRICAL HEMORRHAGE**	SECTION: **Page 1 of 9**

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

PURPOSE:

The purpose of this policy is to provide nursing guidelines for identifying the risk factors, management, and treatment of maternal hemorrhage to reduce the likelihood of harm.

POLICY:

It is the hospital policy that patients admitted to labor and delivery, and will be evaluated for potential risk factors associated with postpartum hemorrhage, upon admission and during their hospital stay. The following guidelines will be followed for assessing readiness, recognize patients at risk of maternal hemorrhage, rapid response for management and treatment, continuous education to providers, staff, patients and their families, and monitoring outcome metrics for continuous quality improvement.

Definition: Obstetrical Hemorrhage

Obstetric hemorrhage is generally reported to occur in 1-3% of births and is considered the most preventable cause of maternal death. Approximately, 70% of cases are preventable. There is an increasing frequency of maternal hemorrhage in the U.S. most likely related to increased rates of cesarean birth and the increased risk of Placenta Previa and Placenta Accreta spectrum, and in some ethnicities due to disparities in quality of care. Timely recognition, availability of resources, and appropriate response are critical for preventing death and severe maternal morbidity. Provider, staff, institutional planning, and preparation are essential to ensure an appropriate response.

Cumulative blood loss greater than or equal to 1,000 mL or blood loss accompanied by signs or symptoms of hypovolemia within 24 hours after the birth process (includes intrapartum loss) regardless of route of delivery. However, a blood loss of 500 mL in a vaginal birth should be considered abnormal, particularly if heavy bleeding persists, and should prompt evaluation and close monitoring by the health care team.

- Primary postpartum hemorrhage: Occurs within the first 24 hours of birth. Common risk factors and etiologies include:
  - Prolonged first or second stage of labor
  - Induction of labor
  - Uterine Atony
  - Operative vaginal delivery
  - Trauma- lacerations, uterine rupture
  - Retained Placenta
  - Placenta Accreta spectrum, Placenta Previa, Placental abruption
  - Large for gestational age newborns
  - Hypertensive disorders of pregnancy
  - Coagulopathies (e.g. disseminated intravascular coagulation, von Willebrand disease)
  - Defects of coagulation (e.g., disseminated intravascular coagulation)
  - Uterine inversion
  - Fetal demise

- Secondary postpartum hemorrhage: Excessive bleeding that occurs more than 24 hours after delivery and up to 12 weeks postpartum. Common etiologies include:
  - Sub involution of the placental site
  - Retained products
  - Infection
  - Inherited coagulation defects (e.g., factor deficiency such as von Willebrand)

Performing ongoing risk assessments on every patient upon admission to Labor and Delivery, and Postpartum allows the healthcare team to better prepare for the eventuality of a maternal hemorrhage case.

The risk of obstetric hemorrhage is present in every pregnancy. Early identification of abnormal blood loss creates the potential to intervene and prevent major blood loss and subsequent complications of hemorrhage. Nursing action to prevent maternal morbidity should be immediate when any of the following conditions are noted:

1. Blood loss greater than 500 mL in a vaginal delivery and 1,000 mL for cesareans should be considered abnormal and should serve as an indication for the health care provider to investigate the blood deficit and for beginning the steps of active management of hemorrhage.

2. Patient complaint of light-headedness, dizziness, altered level of consciousness, nausea, visual disturbance, or shortness of breath

3. Patient is anxious, skin color is pale or ashen and skin is clammy and cool

4. Elevated heart rate, respiratory rate, decrease in blood pressure, and drop in urine output

AFFECTED AREAS/PERSONNEL: *ALL MCH STAFF, RNs, OPERATING ROOM STAFF, LABORATORY STAFF*

PROCEDURE:

All patients should undergo intrapartum obstetric hemorrhage risk assessment on admission, at the start of the second stage of labor, at transfer to postpartum care, and **any time the patient's condition changes**. Identified risk factors must be clearly communicated during hand-offs to each new clinical team caring for the patient.

Admission Assessment:

All patients are to be Type and Screened upon admission. Any patient defined as High Risk are to be Type and Cross Matched for 2 units PRBC per physician order.

Admission and Labor Risk Factors

Low Risk	Medium Risk	High Risk
Monitor for hemorrhage Routine obstetric care	Notify care team	Notify care team Mobilize resources Consider anesthesia attendance at birth
Type and screen	Type and screen	Type and Cross 2 units on hold
No previous uterine incision	Prior cesarean(s) or uterine surgery	Placenta Previa, Low-lying
Singleton pregnancy	Multiple gestation	Suspected/known Placenta Accreta spectrum
≤ 4 vaginal births	≥ 5 vaginal births	Placental abruption or active bleeding
No known bleeding disorders	Chorioamnionitis	Known coagulopathy
No history of Postpartum hemorrhage	History of Postpartum hemorrhage	History of >1 postpartum hemorrhage
	Large uterine fibroids	HEELP syndrome
	Platelets 50-100,000	Platelets <50,000
	Hematocrit <30% Hemoglobin <10 mg/dl	Hematocrit <24% Hemoglobin <8 mg/dl
	Polyhydramnios	Fetal demise
	Gestational age <37 or >41 weeks	2 or more medium risk factors
	Hypertensive disorder of pregnancy	
	Prolonged labor/ induction >24 hours	

Ongoing Assessment:
Patients are to be continuously assessed, every shift and change in condition, for development of additional obstetrical hemorrhage risk factors.

Additional Birth & Ongoing Postpartum Risk Factors

Low Risk	Medium Risk	High Risk
Routine Care	INCREASED SURVEILLANCE POSTPARTUM CARE TEAM ASSESSES RESPONSE READINESS	
	Cesarean delivery- especially if urgent/emergent/2nd stage	Active bleeding >1 pad/hour ≥ 6cm blood clot
	Operative vaginal delivery	Non-lower transverse uterine incision during cesarean
	Genital tract trauma- lacerations	Quantitative cumulative blood loss ≥ 1000 mL or treated for hemorrhage
	Quantitative cumulative blood loss 500-1000 mL in vaginal birth	General anesthesia
		Uterine rupture

Stage 0: See Appendix

- Complete Hemorrhage Risk Assessment on every patient admitted to unit.
  - Low risk: Type and Screen
  - Medium risk: Type and Screen
  - High risk: Type and Cross
  - Positive Antibody screen: Type and Cross
  - Measure QBL on every birth
- Active management of thirst stage of labor:
  - Oxytocin and fundal massage for at least 15 seconds
  - Uterine and lochia assessment

Stage 1: See Appendix

- If blood loss > 500 mL vaginal or >1000 mL cesarean or vital signs change- HR ≥110, BP ≤85/45, Map <59, O2 sat <95%. Start Stage 1 actions.
  - Immediately notify OB provider, Charge RN and Anesthesia
  - Hemorrhage cart to be taken to patient's bedside.
  - Check uterine tone, massage fundus and do digital exam to assess effect on bleeding or passage of clots. Careful inspection of perineal and pelvic anatomy for trauma.
    - Vaginal examination: evaluate for cervical and vaginal lacerations, vaginal hematomas
    - Placental examination: potential evidence of retained placental fragments
    - Uterine examination: bi-manual exam, assessment for atony, focal exploration of uterus. Consider ultrasound exam if clinically stable for retained placenta, Accreta spectrum
    - Abdominal examination: symptoms of intra-abdominal bleeding, uterine rupture, post-operative complications, concealed hemorrhage. Ultrasound or CT scan if clinically stable
    - Evaluation for coagulopathy- ascertain patient or family history, PT/PTT/INR, fibrinogen
  - Check vital signs every 5 minutes and blood loss every 15 minutes.
  - Weigh pads for Quantitative Blood Loss (QBL).
    - Make scales readily available in labor and delivery:
    - Blood-soaked materials should be placed in a precautionary container system, such as red-bagging, but kept accessible to facilitate resolution of any discrepancies in blood volume loss assessment if needed.
    - Subtract the materials dry weight from the total weight.
    - Zeroing the scale with dry material.
    - Weighing blood-soaked material and subtracting known dry weight from the total weight.
    - Use under-buttocks calibrated V-drapes with measurement marks on collection pouches- for vaginal deliveries.

- Increase IV fluid rate to bolus rate, if present, or start IV infusion with 18G IV. Place 2nd large-gauge IV.
- Start O2 @ 8-12 L/minute by mask to maintain sats at or greater than 94%. Place pulse oximeter.
- Increase rate of Oxytocin infusion: 10-30 units in 500 mL 20-60 units in 1000 mL over 10-15 minutes.
- Give utero-tonics: Methergine 0.2 mg IM (if no HTN), or Hemabate 250 mcg IM (if not asthmatic). Misoprostol only if both HTN and asthma) - 600 mcg oral or sublingual.
- Consider Tranexamic Acid (TXA) 1gm IV; within 3 hours of recognition of PPH. May give a second dose of 1 gm if bleeding continues after 30 minutes or restarts within 24 hours of completing first dose.
- Empty bladder. Consider placement of Foley catheter. Regularly measure and document intake and output.
- Type and Cross for 2 units STAT
- Consider placement of intratuterine tamponade balloon
  Convert to high risk status
- If continued bleeding with total blood los <1500mL, Start Stage 2 actions

Stage 2: See Appendix

- Call for Rapid response team
- Vital signs and QBL q 5-10 minutes
- Give next utero-tonic medications:
  - Methergine 0.2 mg IM (if no HTN), or Hemabate 250 mcg IM (if not asthmatic).
  - Consider Misoprostol *only* if both HTN and asthma; 600 mcg orally or 800 sublingually (Rectal administration is no longer recommended due to the late onset of action)
- Give TXA: no later than 3 hours post start PPH
- Send STAT labs: CBC, CMP, DIC panel
- Consider moving to OR for intervention
- Transfuse 2 units PRBC's per clinical signs. Do not wait for lab values. Consider thawing 2 FFP if transfusing >2 units PRBC's. Notify Blood bank and consider activation of MTP if bleeding continues.

- **Vaginal delivery: If moved to OR;**
  - Repair any tears
  - D&C to r/o retained products of conception
  - Place intrauterine tamponade

- **Cesarean delivery: if moved to OR;**
  - Inspect broad ligaments, posterior uterus, and retained placenta
  - B-Lynch suture
  - Place intrauterine tamponade
  - Consider IR consultation for artery embolization
  - If blood loss >1500 mL with continued bleeding, **or** >2 units PRBC's or VS unstable or suspicion of DIC: start Stage 3 actions.

Stage 3: See Appendix

- Call Rapid Response team, if not already done
- Move to OR; notify a second OB provider if available
- Initiate surgical approach.
- Activate MTP and transfuse aggressively based on VS and QBL
- Use fluid warmer, keep patient warm, and apply SCD if not already done
- Repeat STAT labs- CBC, CMP, DIC panel
- Anesthesia- consider central line, A-line, and intubation if indicated
- Provide family support. Social worker referral
- If continues with hemorrhage: definitive hysterectomy
- If hemorrhage controlled- consider higher level of care

Emergency Response Medications:

Prophylaxis	Treatment
Oxytocin infusion: • Oxytocin 10-30 units in 500 mL or 20-60 units in 1000 mL controlled infusion with a standardized rate **OR** ***Oxytocin bolus:***	*Administer first-line agent:* • Oxytocin 10-30 units in 500 mL or 20-60 units in 1000 mL, time-limited bolus infusion over 10-15 minutes, followed by maintenance infusion at a lower rate o Avoid high doses of oxytocin infusion greater than 30-40

• Oxytocin IV bolus of 1-3 units to initiate adequate uterine tone followed by an infusion to maintain adequate tone (30 units in 500 mL; running at 125 mL/hour (7.5 u/hour) **OR** ***Oxytocin IM:*** • Oxytocin 10 units IM when no IV access	units/hour o Closely monitor maternal heart rate (using pulse oximeter) and blood pressure when delivering higher-rate oxytocin infusions or boluses for active hemorrhage • Call anesthesiology backup early and consider activating OB Rapid Response if you need assistance with monitoring maternal vital signs in women post-vaginal birth with evolving hemorrhage due to severe refractory uterine atony
	Choose a standard second-line agent: • Methylergonovine (Methergine) 0.2 mg IM (not IV) every 2-4 hours ***or*** • Carboprost (Hemabate) 250 mcg IM or intramyometrial (not IV) every 15-90 minutes; maximum 3 doses **Consider Misoprostol only for patients with asthma and hypertension.** • Misoprostol 600 mcg orally or 800 mcg sublingually one time (*Rectal administration is no longer recommended due to the late onset of action)*
	Unresponsive to uterotonics: • Move quickly to non-pharmacologic methods of treatment based on etiology: e.g., uterine balloon tamponade; b-lynch suture; interventional radiology; trauma repair; dilation and curettage • Consider tranexamic acid (TXA) 1 gm IV within 3 hours of recognition of PPH, may give a second dose of 1 gm if bleeding continues after 30 minutes or if bleeding stops and then restarts within 24 hours of completing the first dose

Emergency release of PRBCs

- Immediately release within 10 minutes at least 2 units of PRBCs and brought to bedside
- Use crossmatched blood when possible
- If the patient has not been typed and crossmatched, do not delay blood transfusion to wait for crossmatched blood. Use un-crossmatched O type blood.

Massive Transfusion protocol (MTP)

- Immediately release within 10 minutes at least 2 units of PRBCs and brought to bedside
- The following blood products will be provided after the initial release of 2 units of RBC:
  - 4 units RBCs in a cooler
  - 4 units of thawed Frozen Plasma (within 45 minutes)
  - 1 unit of Platelets immediately or as soon as they can be procured.

Documentation:

- Document time of notification of physician and orders received
- Document interventions and patient response
- Document medications administered
- Document all blood loss
- Document all personnel involved

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Appendix: Obstetric Hemorrhage Care Guidelines (CMQCC)

	Assessments	Meds/Procedures	Blood Bank
Stage 0	**All births**		
• **Risk assessment** • **Active management of 3rd stage**	• **Prepare for every patient according to hemorrhage risk factors** • **Measure quantitative cumulative blood loss for every birth**	• **Active Management of 3rd Stage** • **Oxytocin IV infusion or 10u IM**	• **Medium Risk: T&S** • **High Risk: T&C 2 U** • **Positive Antibody Screen (prenatal or current, exclude low level anti-D from RhoGam): T&C 2 U**
Stage 1	**Triggers: CBL ≥ 500mL vaginal / ≥ 1000 mL cesarean with *continued bleeding* or Signs of concealed hemorrhage: VS abnormal or trending (HR ≥ 110, BP ≤ 85/45, O2 sat < 95%, shock index 0.9) or Confusion**		
• Activate hemorrhage protocol • Rule out hemorrhage causes besides atony	• Activate OB hemorrhage protocol and checklist • Notify charge nurse, OB/CNM, anesthesiologist • VS, O2 Sat q5 min • Record quantitative cumulative blood loss q5-15 min • Careful inspection with good exposure of vaginal walls, cervix, uterine cavity, placenta. If intra-op, inspect broad ligament, posterior uterus and placenta.	• **IV Access: Minimum 18 gauge** • Increase IV fluid (LR) and **oxytocin** rate • **Fundal/bimanual massage** **MOVE ON** to 2nd level uterotonic if no response (see Stage 2 meds below) • Empty bladder: Straight cath or Foley with urometer	• **Convert to High Risk and take appropriate precautions** Consider T&C 2 Units PRBCs *where clinically appropriate if not already done*
Stage 2	**Triggers: *Continued bleeding* w/ CBL < 1500 mL or VS remain abnormal**		
• **Sequentially** advance through medications and procedures • **Mobilize team** and blood bank support • **Keep ahead with** volume **and** blood products • Determine **source of** bleeding **including concealed hemorrhage**	• **OB to bedside** • **Mobilize team:** 2nd OB, OB Rapid Response, assign roles • Continue VS & record **cumulative** quantitative blood loss **q5-15 min** • **Complete evaluation** of vaginal wall, cervix, placenta, uterine cavity • Send additional labs including DIC panel • If in Postpartum: Move to L&D/OR • Evaluate for special cases: - Uterine inversion - Amniotic fluid embolism	• **2nd Level Uterotonic:** - **Methylergonovine** 0.2mg IM *(if no HTN)* or - **Carboprost** 250 mcg IM *(if no asthma)* or *Only if hypertensive and asthmatic* - **Misoprostol** 800 mcg SL • **2nd IV access (minimum 18 gauge)** • Bimanual/uterine massage • TXA 1 gram - may repeat in 30 min • **Vaginal:** (typical order) - Move to OR - Repair any tears - D&C: r/o retained placenta - Place intrauterine balloon • **Intra-op Cesarean:** (typical order) - Inspect broad ligament, posterior uterus, and placenta - Uterine sutures - Place intrauterine balloon - Uterine artery ligation	• **Notify Blood Bank of OB hemorrhage** • Bring 2 Units PRBCs to bedside, consider use of **Emergency Release products (un-crossmatched)** and transfuse per clinical signs – *do not wait for lab values* • Use blood warmer for transfusion Consider activating MTP if there is ***continued bleeding***
Stage 3	**Triggers: *Continued bleeding* with CBL > 1500mL or > 2 units PRBCs given or abnormal VS or Suspicion of DIC**		
• Initiate Massive Transfusion Protocol • Invasive surgical approaches	• **Expand team** - Advanced GYN surgeon - 2nd anesthesia provider - OR staff - Adult intensivist • **Repeat** coags & ABGs • Central line • Family support	• Selective embolization (IR) • Laparotomy - Uterine sutures - Uterine artery ligation - Hysterectomy • Patient support - Warmer for IV fluids - Upper body warming device - SCDs	• **Activate Massive Transfusion Protocol** Transfuse aggressively • Near 1:1 PRBC: FFP • 1 PLT apheresis pack per 4-6 units PRBCs

This table was adapted from the Improving Health Care Response to Obstetric Hemorrhage: A California Quality Improvement Toolkit, funded by the California Department of Public Health, 2015; supported by Title V funds.

SUBJECT: **OXYGEN ADMINISTRATION: NEWBORN**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide evidence-based guidelines for the safe initiation, administration, monitoring, and discontinuation of supplemental oxygen therapy in newborn infants experiencing hypoxemia and/or signs of respiratory distress while minimizing risks associated with hyperoxia and oxygen toxicity.

POLICY:

Supplemental oxygen shall be administered to newborn infants with documented hypoxemia, persistent central cyanosis, or clinical signs of respiratory compromise as ordered by the provider, except in emergency situations where nursing and respiratory therapy staff may initiate oxygen therapy under current NRP guidelines.

Registered Nurses (RNs) and Respiratory Therapists (RTs) trained in neonatal care are responsible for initiating, monitoring, titrating, and documenting oxygen therapy.

Oxygen therapy shall be titrated to maintain oxygen saturation within provider-prescribed parameters and avoid both hypoxemia and hyperoxia.

Continuous pulse oximetry monitoring shall be utilized during initiation, titration, and weaning of supplemental oxygen.

Utilize the lowest FiO2 necessary to achieve oxygen saturation goals and clinical improvement. For infants beyond immediate delivery-room transition, maintain oxygen saturation generally between 92% and 97%, unless otherwise prescribed by the provider.

Infants requiring the following shall be evaluated by the pediatric provider and considered for Neonatal/Perinatal consultation or transfer to a higher level of care as clinically indicated: FiO_2 >30% for more than 2 hours, escalating respiratory support, persistent respiratory distress, recurrent apnea, or oxygen therapy beyond 12 hours.

The provider shall be notified promptly following emergency initiation of oxygen therapy.

The least invasive effective method of oxygen delivery should be utilized. Methods may include: nasal cannula, CPAP (if available and ordered), positive pressure ventilation (PPV) during resuscitation per NRP guidelines.

Oxygen shall be considered a medication and administered using equipment that allows accurate delivery and monitoring of oxygen concentration.

AFFECTED AREAS/ PERSONNEL: *MCH DEPARTMENT/RNs & RESPIRATORY THERAPISTS*

EQUIPMENT:

1. Radiant warmer or isolette
2. Suction equipment:
   a. Bulb syringe
   b. Appropriate suction catheters
3. Neonatal resuscitation equipment:
   a. T-piece resuscitator or infant resuscitation bag
   b. Appropriate size neonatal mask
   c. Oxygen source with flow meter and tubing
4. Intubation equipment – Respiratory Tackle box
5. Oxygen analyzer
6. Pulse oximeter
7. Cardiorespiratory monitors
8. Feeding tube (for gastric decompression when clinically indicated)
9. Securement supplies
10. CPAP equipment (if available)

PROCEDURE:

1. Obtain and verify provider orders
2. Assess for signs of respiratory distress including:
   a. Respiratory rate less than 30 or greater than 60 breaths per minute
   b. Grunting, nasal flaring and/or retractions
   c. Color dusky or central cyanosis

d. Apnea, and or increased work of breathing

e. General behavior – lethargic, irritable, poor feeding

3. Assess and document: heart rate, respirations, temperature, oxygen saturation, breath sounds, skin color, and activity level.

4. Maintain neutral thermal environment using:

a. Skin to skin care when appropriate

b. Isolette

c. Radiant warmer

5. The provider should be notified immediately for: increasing oxygen requirements, need for FiO2 >30%, recurrent apnea, persistent grunting/retractions/tachypnea, oxygen saturation below target despite supplemental oxygen, need for CPAP/PPV/intubation, abnormal blood gas values, and any clinical deterioration.

6. Obtain blood gases as ordered and notify provider promptly of critical or abnormal results.

7. Insert nasogastric or orogastric tube when clinically indicated if infant is receiving CPAP, prolonged bag-mask ventilation, or mechanical ventilation.

8. Encourage parental participation whenever clinically appropriate, support bonding and breastfeeding when clinically feasible, and provide education regarding reason for oxygen therapy, monitoring requirements, expected course treatment, and signs of improvement or worsening condition.

9. Wean supplemental oxygen gradually according to providers order and infant response, maintain oxygen saturation within the prescribed range, and discontinue supplemental oxygenation when respiratory distress has resolved, oxygen saturation remains in target range on room air, and infant demonstrates clinical stability.

DOCUMENTATION:

- Assessment findings and signs of respiratory distress.
- Oxygen saturation values
- Route of oxygen administration, FiO2 and flow rate, all changes to oxygen therapy, and respiratory assessments
- All provider notifications and orders received

- Blood gas results
- Communications with parents and education provided.
- Response to interventions
- Record date and time that supplemental oxygen was discontinued.

REFERENCES:

American Academy of Pediatrics & American Heart Association. (2021). *Textbook of neonatal resuscitation (NRP), 8th ed.* American Academy of Pediatrics.

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SUBJECT: **PLACEMENT OF FETAL SCALP ELECTRODE (FSE)**	SECTION:

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

POLICY:

A. **Function(s):** Provides guidelines for placing a Fetal Scalp Electrode (FSE).

B. **Circumstances:**

1. **Setting:** Labor & Delivery

2. **Supervision**: Registered Nurse (RN) may perform independently.

Patient Condition/Contraindications including but not limited to:

- Known or suspected maternal HIV (depending on provider guidance)
- Active genital herpes lesions or prodromal symptoms
- Hepatitis infections as defined by organizational policy
- Placenta previa/vasa previa
- Unengaged presenting part when clinically inappropriate
- Unknown presenting part
- Intact membranes
- Gestational age considerations if preterm and risk outweighs benefit

3.

PROCEDURE:

Definition: Internal fetal monitoring using a spiral electrode attached to the fetal presenting part to provide continuous assessment of fetal heart rate when external monitoring is inadequate or inaccurate

Data Base:

1. **Subjective:** Intrauterine pregnancy in labor.

2. **Objective:** Unable to obtain a sustained and consistent fetal heart rate pattern with an external electronic fetal monitor (EFM) on patients with ruptured membranes.

Diagnosis: Inability to obtain a continuous, reliable fetal heart rate tracing using external fetal monitoring during labor

Plan:

Treatment:

1. • Verify indication and absence of contraindications.

2. • Explain procedure to patient.
3. • Perform hand hygiene and utilize appropriate PPE.
4. • Confirm ruptured membranes.
5. • Identify presenting part.
6. • Insert FSE according to manufacturer instructions.
7. • Verify fetal heart rate acquisition.
8. • Assess maternal pulse if rhythm questionable.
9. • Document placement, patient tolerance, and tracing quality.
10. • Notify provider of significant findings.
11. Patient Education: Explain procedure and purpose to patient.
12. Follow-up for: Provide information to physician, Communication of Category II/III tracings per fetal monitoring policy, Ongoing evaluation of tracing quality, Criteria for removal and replacement.

Documentation Required: Explanation of procedure and findings in the Labor Record.

STAFF AUTHORIZED TO PERFORM THE STANDARDIZED PROTOCOL: RNs

REQUIREMENTS FOR RN:

A. **Education:** California State RN License and trained in Labor & Delivery.

Training:

- Initial education
- Skills validation
- Demonstrated competency
- Annual fetal monitoring competency
- Documentation of competency in employee record
- Supervision of application x 2 by another RN approved in placement of FSE.

Experience: All RNs employed more than 90 days or previously approved in FSE placement.

Initial Evaluation: Follow-up vaginal exam to determine correct placement.

Continuing Evaluation: Annually.

DEVELOPMENT & APPROVAL of the STANDARDIZED PROCEDURE:

A. **Method:** Interdisciplinary Committee & OB/GYN Department

B. **Review Schedule:** Yearly

REFERENCES:

Association of Women's Health, Obstetric and Neonatal Nurses. (2024). *Standards for professional nursing practice in the care of women, newborns, and people across the life span* (9th ed.). *Journal of Obstetric, Gynecologic & Neonatal Nursing, 53*(1), e4-e40. https://doi.org/10.1016/j.jogn.2023.09.004

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SUBJECT: **PRECEPTORSHIP PROGRAM**	SECTION: **Page 1 of 4**

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

POLICY:

The nursing division of Sierra View Medical Center (SVMC) is committed to providing qualified preceptors for the purpose of orienting new staff to individual nursing units, mentoring students and remediation of staff as needed.

1. The Education Department with guidance for unit leadership will implement and review the preceptorship program.

2. The Education Department will be responsible for:

   a. Establishment of appropriate preceptor rewards & recognition plans

   b. Development of the preceptor workshop content

   c. Review of the preceptorship program's effectiveness

   d. Review of preceptor effectiveness

   e. Submission of secondary job code to Human Resources by leadership.

   f. Promoting ongoing evaluation by encouraging confidential feedback from preceptees.

3. Annually, Nursing Management will review & approve the process and program.

4. Each individual unit leader will recommend and select preceptor candidates to attend the preceptorship program.

5. The appropriate chain of command for issue resolution relating to this program will be followed: Preceptor – Unit leader – Education leader – Human Resources.

6. Follow the appropriate chain of command for personnel issues.

PROCEDURE:

1. All new staff will be paired with a unit preceptor for a minimum orientation period.

   a. New graduate nurses/nurses transitioning to a new department/specialty:

      i. Medical Surgical Units (MSU), Telemetry (Tele), Postpartum (PP), and District Part Skilled Nursing Facility (DPSNF) will complete a minimum of 12 weeks for unit orientation

      ii. Float Pool will complete a minimum of 12 weeks on the first unit for orientation followed by an additional orientation to all additional units worked.

1. 6 weeks if orienting on MSU/Tele/PP/DPSNF

2. 12 weeks if orienting on the Intensive Care Unit (ICU), Emergency Department (ED), or Labor and Delivery (L&D)

iii. ICU, ED, L&D, Post Anesthesia Care Unit (PACU), Flex Care, Endoscopy (ENDO), Interventional Radiology (IR), and Cath Lab will complete a 16 week unit orientation

iv. Operating Room (OR) will complete a six-month orientation

b. Experienced Nurses in that department will have a formal orientation set by management based off of competencies required and training needs.

c. The preceptor, orientee, and manager will collaborate to develop individualized orientation goals and competency milestones.

Orientation length may be extended by unit leadership based on demonstrated competency achievement, learning needs, and leadership assessment.

2. Criteria for selecting a preceptor candidate includes:

- Expresses desire to serve in the role of the preceptor
- Demonstrates clinical expertise, professional communication skills, and commitment to evidence-based practice. Specialty certification and BSN preparation are preferred but not required unless mandated by regulatory or departmental standards.
- Experience in area of preceptorship for at least 12 months, 18 months preferred or greater.
- No negative evaluative performance criteria in the past year
- All unit competencies/annual education requirements up to date

3. Preceptors will have a clear understanding of his or her duties. Preceptors serve as educators, coaches, mentors, resource persons, evaluators, and role models who support safe, patient-centered care.

- Able to apply nursing theory in the workplace
- Able to apply QSEN (Quality Safety Education for Nurses) competencies to nursing practice

4. Unit preceptors are selected by:

   - Unit Leadership

5. Preceptor candidates will:

   a. Attend the initial preceptor class
   b. Complete the eLearning preceptor modules

6. Preceptors will:

   a. Attend the annual nursing competencies

   b. Complete preceptor competencies annually

   c. Preceptor effectiveness will be evaluated through:

      - Preceptee feedback
      - Leader observations
      - Competency completion rates
      - Retention outcomes
      - Professional behavior metrics

   d. Attend 50% of the Preceptor Meetings

   e. Maintain Criteria for Preceptor Candidate

   f. Preceptors will foster a psychologically safe learning environment that promotes open communication, questioning, error reporting, and professional growth consistent with SVMC's Just Culture principles.

7. Preceptors will be responsible for completion of all preceptor program documentation and initial department competency by the end of each preceptee's orientation period.

   a. Completion of the evaluation of the orientee to be completed either at the end of each shift or the end of each week

   b. Completion of the Final Evaluation for the unit to be completed prior to the orientee coming off of orientation.

c. Departmental required training to be completed prior to coming off of orientation

Preceptors are to follow the roles and responsibilities of the preceptor as outlined in the job description. The Preceptorship Program will be evaluated annually using:

- RN retention rates
- New hire turnover
- Orientation completion rates
- Preceptee satisfaction scores
- Preceptor satisfaction scores
- Competency achievement metrics

The Nursing Division of Sierra View Medical Center is committed to providing a structured, evidence-based preceptorship program that supports safe clinical practice, professional development, competency validation, and successful transition into nursing roles. Qualified preceptors serve as educators, mentors, coaches, and role models to facilitate onboarding, specialty transition, student experiences, and remediation when indicated.

REFERENCES:

Association for Nursing Professional Development. (2023). *Summary findings from the 2023 preceptor competency consensus study*. https://www.anpd.org/Portals/0/Files/ANPD_1127571-23_PreceptorCompetencies_Report.pdf

Joint Commission Resources. (2021). *Comprehensive accreditation manual for hospitals (CAMH): Standards, elements of performance, accreditation policies and procedures*.

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SUBJECT: **PRENATAL RECORD -- ANTEPARTUM**	SECTION: **Page 1 of 2**

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

PURPOSE:

To set guidelines in the process of receiving and accessing prenatal records.

POLICY:

- Antepartum patients will have prenatal records available to Labor and Delivery prior to due date to provide information and data that will facilitate a safe labor, delivery and postpartum recovery when the patient has entered the Hospital.
- Prenatal records should be sent to Medical Records by the Provider's office and/or clinic by 28 weeks gestation.
- Prenatal records are updated as appropriate with records sent by the Provider.

AFFECTED PERSONNEL/AREA: *MCH STAFF, RNs, UNIT CLERKS & OB TECHS*

PROCEDURE:

1. Records are available for viewing in Electronic Medical Record (EMR) in Meditech.
2. If the patient is an evaluation/short stay or is discharged undelivered, all paper documentation, if any, will be sent to medical records.
3. If there are no prenatal records available, contact the provider's office to obtain them. If unable to obtain records, notify the provider.
4. All records are confidential and are to be treated as confidential material.

DOCUMENTATION:

- Document in EMR when there are no prenatal records available.
- If patient has had no care, see policy "No Prenatal Care (Drop In)".

REFERENCE:

American College of Obstetricians and Gynecologists. (2025). *Prenatal care.* https://www.acog.org/topics/prenatal-care

American College of Obstetricians and Gynecologists. (2026). *Obstetric patient record forms.* https://www.acog.org/clinical-information/obstetric-patient-record-forms

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U.S. Department of Health and Human Services, Office for Civil Rights. (2024). *The HIPAA Privacy Rule.* https://www.hhs.gov/hipaa/for-professionals/privacy/index.html

CROSS REFERENCE:

- No Prenatal Care (Drop In)

SUBJECT: **PRE-TERM LABOR**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide nursing guidelines in the diagnosis, care, and treatment of a patient in labor after 20 weeks and less than 37 weeks of gestation.

POLICY:

1. When a patient comes in experiencing regular contractions, the medical staff must first determine whether the patient is in true labor.

2. Preterm labor is defined as regular contractions that cause a change in cervical dilation, effacement of both, or initial presentation of regular contractions and dilation of at least 2 cm.

    a. The diagnosis is made when there are regular contractions with active cervical change, or regular contractions and cervical dilation of 2cm or greater. .

    b. A shortened (less than 2.5 centimeters in length), as measured by trans-vaginal ultrasound, fetal fibronectin testing or a combination of both may be useful in determining women at high risk for pre-term labor.

    c. Any patient with rule out or confirmed pre-term labor will be cared for according to established policies.

AFFECTED AREAS/PERSONNEL: *MATERNAL CHILD HEALTH (MCH) PERSONNEL, REGISTERED NURSES (RN)s*

EQUIPMENT:

- Electronic Fetal monitor
- IV pump/fluids
- Non-invasive blood pressure monitor
- Possible use of a sterile indwelling catheter.
- Possible use of sterile speculum for examination and specimen collection.
- Tocolytics if ordered

PROCEDURE:

1. Evaluate uterine activity:

    a. Apply external fetal monitor.

b. Evaluate and document variability of fetal heart rate.

c. Palpate and assess fundus to determine strength of contractions.

d. Obtain obstetrical history. Document:

- low back pain
- pelvic pressure
- vaginal discharge
- loose stools
- menstrual-like cramps/ uterine cramping
- length of time symptoms present

e. Evaluate hydration status and hydrate per physician's order).

f. Assess membrane status.

g. Notify physician of assessment.

h. Do a sterile vaginal examination to determine cervical effacement and dilation (Only after Fetal Fibronectin is obtained). Document in Electronic Medical Record (EMR)

i. Identify any other factors:

- Trauma
- Vomiting/diarrhea
- Urinary tract infection (UTI)

j. Tocolysis per physician order (See policy "Terbutaline", or " Guidelines for use of Magnesium Sulfate in the management of preterm labor") to:

- Quiet uterine activity for 48 hours in order to administer antenatal corticosteroids or,
- to provide an opportunity for transport to higher level of care

k. Consider transfer to tertiary center if under 32 weeks gestation.

l. Consider antenatal glucocorticoid administration if between 24 and 34 weeks gestation (see policy "Betamethasone – Celestone).

- Late preterm period (34-36 6/7): Antenatal corticosterioids can be considered in the late preterm period if delivery is imminent within 7 days and have not previously received steroids.

m. Treat any infections. Prophylactic antibiotics are not indicated except in the case of group B streptococcus (GBS).

n. Ultrasound (to confirm fetal age, rule out obvious anomalies). Be aware that the NST portion of a Biophysical Profile (BPP) for a fetus 24 to 32 weeks gestation may score zero making the total score 8 of 10.

o. If delivery is imminent, discontinue use of tocolytic agent.

p. Assess patient behavior and knowledge of condition:

- Keep patient and significant others informed of fetal status.
- Document information given to patient and response of understanding received.

Contraindications to Tocolysis for Preterm Labor:

- Fetal maturity
- Fetal demise
- Fetal anomaly incompatible with life
- Category II and III tracings (intrauterine resuscitation measures unsuccessful)
- Active hemorrhage
- Intra-amniotic infection
- Severe pre-eclampsia, heart disease, or significant bleeding form placenta previa or abruptio placenta
- Allergy to tocolytic
- Preterm premature rupture of membranes (PPROM): except to facilitate transport or antenatal steroid administration.
- Severe intrauterine growth restriction (IUGR)

DOCUMENTATION:

- History including gestational age

- Signs or symptoms of any illness or disease process
- Signs of trauma or abuse
- Vital signs
- Uterine and fetal monitoring
- Results of vaginal exam if done
- All orders from the MD, patient condition report and lab reports phoned or verbally given to the MD
- Interventions and patient response to any intervention
- Patient/family education

REFERENCES:

American Academy of Pediatrics, & American College of Obstetricians and Gynecologists. (2022). *Guidelines for perinatal care* (9th ed.). American Academy of Pediatrics.

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SUBJECT: **RAPID RESPONSE TEAM ADULT & PEDIATRIC**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 6**

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

PURPOSE:

The goal of the Rapid Response Team is to address the recognition of and response to an unexpected deterioration in a patient's condition. Rapid Response activation supports a culture of safety and encourages staff, patients, and families to "speak up" when concerned about a patient's condition

POLICY:

For a patient perceived to be in distress, any individual has the ability to request a Rapid Response Team evaluation without advance consultation with the patient's attending physician. Any Sierra View Medical Center (SVMC) employee may activate an RRT. *A family member/visitor may activate an RRT.*

1. The Rapid Response Team call does not replace the Code Blue/White policy or other emergency response processes.
2. Signage in patient rooms reflects family involvement and their role in initiation an RRT.
3. Patient and family concerns alone are sufficient reason to activate the RRT, regardless of vital signs or other clinical criteria
4. Patients on comfort care are excluded from this policy.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS*

PROCEDURE: (Adult Patients)

1. The Rapid Response Team will consist of the ED Charge/Lead RN and Respiratory Therapist (ER RR Team) or ICU Charge/Lead RN and a Respiratory Therapist (ICU RR Team) and House Supervisor (when available)
2. In-patients that require services, such as but not limited to Lab, Echo, MRI, CT, will follow the Rapid Response policy.
3. Patient's here for outpatient services, such as but not limited to Lab, Echo, MRI, CT, will follow the Medical Response Unit (MRU) procedures under Emergency Response to on Campus Medical Emergencies policy.
4. The following objective criteria of clinical instability are provided as a general reference guide. Numerical values do **NOT** need to be reached or exceeded before requesting a Rapid Response Team consultation. The most important activation criterion remains staff/family concern or intuition.
5. Notwithstanding the RNs overall concern for changes in the patient's condition, he/she can activate the team based on the following criteria:

Respiratory Factors to Consider:

a. Unexplained acute change in respiratory rate or rate less than 8 or greater than 36 per minute.

b. Unexplained acute change in SpO2 less than 85% for more than 5 minutes.

c. New onset of difficulty breathing

d. Difficulty Speaking

Cardiovascular Factors to Consider:

a. Unexplained acute change in heart rate- OR - heart rate less than 40 or greater than 140 beats per minute.

b. Unexplained acute change in blood pressure – OR – systolic blood pressure less than 90 or greater than 200 with symptoms.

c. Patient complaint of new onset chest pain.

Neurological Factors to Consider:

a. Unexplained acute change in level of consciousness.

b. New onset of agitation or delirium.

c. New motor/sensory function changes, seizure or sudden collapse.

d. New onset of lethargy or difficulty waking patient.

e. Difficulty speaking.

Other Factors to Consider:

a. Color change of patient or extremity (pale, dusky, gray, blue, etc.).

b. Severe uncontrolled pain.

c. Significant bleeding

d. Acute change in urine output: < 50 ml. in 4 hours.

e. Deterioration in condition despite treatments.

f. Any condition requiring immediate clinical reassessment

6. Activation of the Rapid Response Team

a. The Rapid Response Team is activated at the patient's bedside by dialing "55". The operator will then overhead page "Rapid Response Team to Room #"

b. The hospital encourages the patient and family to seek assistance when the patient's condition worsens.

c. No Employee shall discourage or delay an RRT activation when clinical concern

PROCEDURE: (Pediatric Patients)

1. The Rapid Response Team will consist of the ED Charge/Lead RN and a Respiratory Therapist (ED RR Team).

2. The following objective criteria of clinical instability are provided as a general reference guide. Numerical values do NOT need to be reached or exceeded before requesting a Rapid Response Team consultation. The most important activation criterion remains staff/family concern or intuition.

3. Notwithstanding the RNs overall concern for changes in the patient's condition, he/she can activate the team based on the following criteria: (Refer to addendum A "Criteria for Activation of RRT")

   a. Staff or patient/family member concerned about the patient.

   b. Acute changes in respiratory status or a threatened airway.

   c. Acute changes in the following:

      - Oxygen saturation
      - Heart rate
      - Systolic blood pressure
      - Level of consciousness
      - Acute significant bleeding
      - Seizures (new, repeated or prolonged)
      - Refer to Addendum A for age-based guidelines

4. Activation of the Rapid Response Team

   a. The Rapid Response Team is activated at the patient's bedside by dialing "55". The operator will then overhead page "Pediatric Rapid Response Team to Room #".

   b. The hospital encourages the patient and family to seek assistance when the patient's condition worsens.

c. No employee shall discourage or delay an RRT activation when clinical concerns exist

COMMUNICATION AND COLLABORATION

1. Bedside RN will utilize the SBAR format to RRT upon arrival
   a. Have computer for beside chart review.
   b. Contacting the primary physician.
   c. Administering medications and other interventions.
   d. Documenting the event in the EMR.
   e. Assuring that emergency equipment / supplies are available if needed, e.g. Crash Cart, suction, etc.).
2. Role of Rapid Response Team
   a. Assessing patient and applying critical thinking skills
   b. Obtaining needed tests / labs per MD order
   c. Assisting with all required interventions
   d. Stabilizing patient until transfer can occur (if required)
   e. Promoting effective communication with physician
   f. Teaching and mentoring when appropriate
   g. Calling a "Code Blue/White" if situation worsens or to obtain needed physician support
   h. Consider goals-of-care status and code status when appropriate
   i. Utilizing standardized procedures as necessary.

DOCUMENTATION:

1. All assessments, orders and interventions will be documented in the appropriate section of the medical record.
2. The RN will initiate the RRT documentation in the EMR. During downtime follow downtime procedure and give a copy of RRT documentation to ICU Monitor Tech.
3. The Adult or Pediatric Rapid Response Team Record form will be used for documentation of team processes and for tracking purposes.

4. The Rapid Response Team RN will place form in the Progress Notes of each patient's chart immediately after each Rapid Response Team call.

5. After the Rapid Response Team consult is completed, the Rapid Response Team RN and bedside nurse will have a short debriefing session.

6. The call is logged into the Rapid Response Team Log Record for tracking purposes. The log will be maintained by the ICU Monitor Tech.

7. The designated unit-nursing leader or House Supervisor will attend all RRT calls and ensure all processes are followed and completed per policy. In their absence, the Charge Nurse will attend all RRT calls and ensure all processes are followed and completed per policy.

RESCUE AND RESUSCITATION (RR) COMMITTEE

Purpose:

To ensure quality emergency medical response within Sierra View Medical Center in order to improve patient outcomes through systematic review of current SVMC processes with subsequent follow-up and actions to include competency evaluation, staff education, policy and systems review and/or changes.

Procedure:

1. In-patient RRT/Pediatric RRT calls will be evaluated based on EMR committee chosen indicators.

2. Data collected on the indicators will be used for Performance Improvement reporting.

3. Additional indicators may be added as other issues are identified through chart review. The data will be used to drive performance improvements in patient care.

4. During down time paper documentation forms will be routed to the Critical Care Monitor Technician to be reviewed by the R&R committee.

CROSS REFERENCE:

- Emergency Response to on Campus Medical Emergencies

REFERENCE:

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SUBJECT: **SIGN-OUT PROTOCOL FOR BLOOD COMPONENTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

At the time a unit is issued, Blood Bank Standards require a final check of transfusion service records, the patient's identification, and each unit of blood or component.

POLICY:

- All units of blood and blood components must be signed out by a clinical lab scientist (CLS) and another clinical care representative. The CLS and clinical care representative must be on staff at Sierra View Medical Center (SVMC).

PROCEDURE:

- The clinical care representative must present a copy of the blood bank transfusion request containing complete patient identification, using a patient's registration chart label, when coming to pick up blood or blood components.

- After successful crossmatch of the unit, the clinical lab scientist (CLS) will utilize printed unit "luggage tags" and attach them to the appropriate unit. At the time of issue, the CLS will select the patient in Meditech using the account number, examine the unit for appearance and expiration date and indicate the acceptability by documenting on the transfusion issue card. The mneumonics of the "messenger" will also be documented in Meditech. The transfusion luggage tag with the patient's name, medical record number, the donor unit number, the patient and donor unit ABO/Rh, and the expiration date of the unit will be compared with the identical information contained on the transfusion issue card, by both the CLS and the clinical care representative. All information must agree before the unit can be signed out for transfusion. ANY DISCREPANCIES MUST BE RESOLVED BEFORE ISSUE.

- After determining that the above information is in agreement and the identity of the recipient and donor are confirmed, the clinical care representative will sign the blood bank transfusion issue card (both copies).

- The clinical care representative will now be able to take the unit along with the transfusion issue card back to the nursing unit for transfusion.

- A clinical care representative will be allowed to sign-out more than one unit at a time for transfusion on the same patient if the patient is receiving dialysis or if they have two separate peripheral lines, but will not be allowed to sign-out units on different patients simultaneously.

- Units of blood issued to surgery will be placed in resealable plastic bags with the patient name, date of birth, and Blood Bank number boldly written on the resealable plastic bag.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

REFERENCES:

- Association for the Advancement of Blood & Biotherapies, "Standards for Blood Banks and Transfusion Services", 35th Edition, 5.22 through 5.25.

- The Joint Commission (2026). Laboratory accreditation standards. QSA.05.03.01. QSA.05.10.01, QSA.05.14.01, QSA.05.17.01, QSA.05.18.01, QSA.05.22.01, QSA.05.24.03. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **SIMULATION LAB PROGRAM**	SECTION: **Page 1 of 8**

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

PURPOSE:

The purpose of the Sierra View Medical Center (SVMC) Simulation Program is to enhance, support, and collaborate in the growth and development of healthcare professionals and students through evidence-based simulation, competency validation, clinical judgment development, scholarship, and continuous professional development. The Simulation Program provides a psychologically safe, learner-centered environment that promotes clinical excellence, patient safety, teamwork, communication, and quality outcomes through simulation-based education and structured debriefing. The program aligns with the Healthcare Simulation Standards of Best Practice® and the Healthcare Simulationist Code of Ethics.

SVMC's goal is to offer simulation-based education. Simulation is a best practice for fostering respect, compassion, collaboration, integrity, accountability, innovation, and patient-centered care.

DEFINITIONS:

A. **Simulator**- a device (ex: manikin) used with specific conditions and situations that are designed to replicate real life patient events.

1. Low fidelity- Often static. Used for basic skills and novice staff. Ex: Rubber IV arm

2. Medium fidelity-Produce heart sounds, rhythms, pulses. Ex: Zoll© One Step See thru CPR pads and defibrillator with manikin.

3. High fidelity- Manikin can breathe, blink, sweat, pupils change and talk.

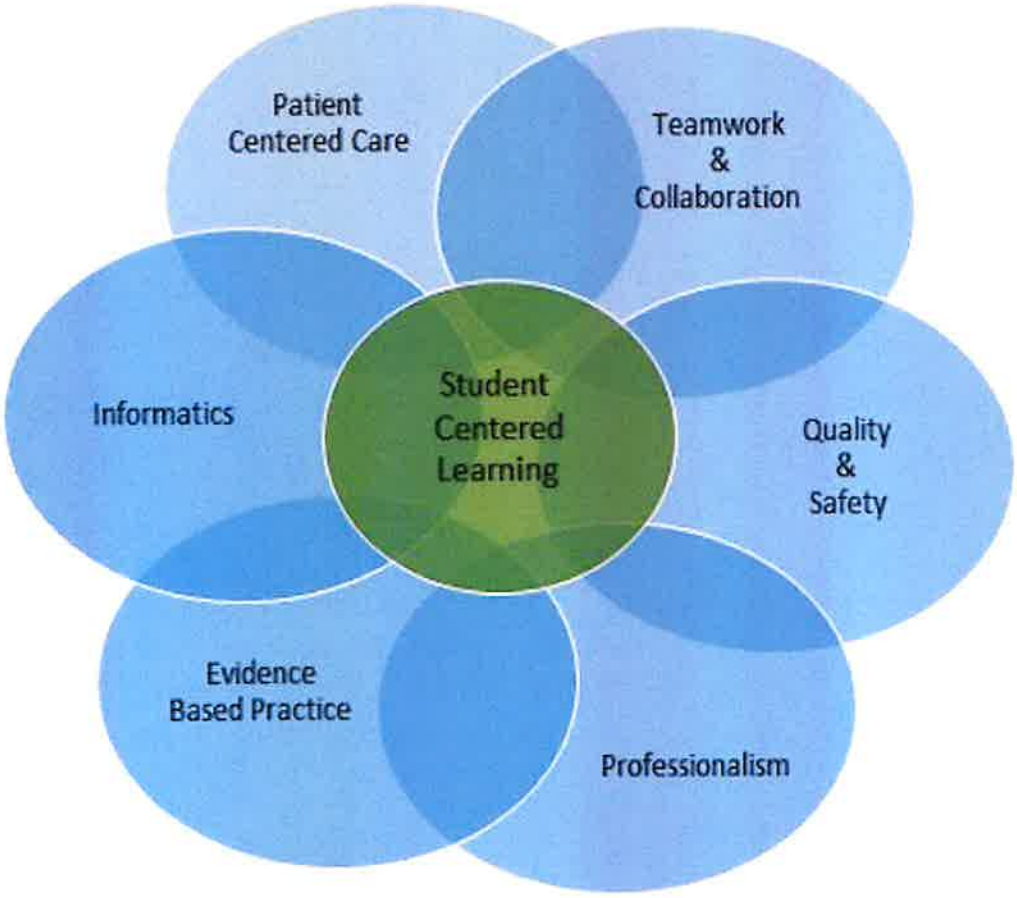
B. **Scenario**- an outline or projected sequence of events that are realistically recreated by the operator to simulate an actual patient.

C. **Debriefing**- A facilitated, structured, reflective discussion conducted during or after a simulation-based experience. Debriefing promotes critical thinking, clinical judgment, self-reflection, and transfer of learning into clinical practice. All simulation activities should include a planned debriefing process utilizing evidence-based methods and trained facilitators.

Evidence-based practice (EBP) debriefing types

Debriefing Nursing Simulations with QSEN Competencies using the G-A-S (Gather-Analyze-Summarize) Method for Healthcare Simulation

1. **QSEN: Quality And Safety Education for Nurses**



(https://www.healthysimulation.com/wp-content/uploads/formidable/10/Simulation-QSEN-Model-Nursing.png)

2. Debriefing using G-A-S (Gather-Analyze-Summarize) Method

A. The first phase is called **gather**. It encourages the team to recap the simulation event using a shared mental model.

Goal: understand participant perceptions and reactions to the simulation experience
Actions: request narrative and clarifying or supplemental information
Questions: How do you feel? How do you think it went? Tell what happened?

B. The second phase is called **analyze.** It is based on learner centered reflection, analysis of actions and critical thinking.

Goal: facilitate reflection, explore clinical reasoning, identify performance gaps, and discuss evidence-based practice
Actions: review record of events, report observations, question to assess thinking process, and stimulate reflection and redirection
Questions: What clinical cues influenced your decision-making? Tell me more about your thought process. What factors contributed to the outcome? What alternatives could have been considered?

C. The third phase is called **summary**. This final phase encompasses the important learning objectives, reviews and assesses the learning of the participant.

Goal: consolidate learning and promote future application to practice
Actions: identify positive outcomes, discuss behavioral changes and summarize
Questions: What are your key takeaways? What went well? What would you do differently in future practice? What actions will you incorporate into patient care?

ROLES AND RESPONSIBILITIES:

A. **SIMULATION member(s):**
- Actively participates
- Engaged in each learning activity
- Participates in SIM performance, skill and/or competency session(s)
- Adheres to all requirements in the Confidentiality Agreement
- Adheres to all the SIMULATION Lab "Rules"
- Actively participates and understands the importance of the debriefing process
- Takes care in the proper use and handling of all equipment and the SIM Lab room

B. **SIMULATION instructor(s):**
- Staff member in the Education department at SVMC

- Coordination, responsibility, implementation, scheduling and accountability for the Simulation Program at SVMC is done through the Education Department and Director of Education
- Prepared and timeliness of SIM session(s) is mandatory
- Facilitating the use, maintenance and care of the SIM Lab and equipment is the responsibility of each SIM instructor
- Actively participates
- Engaged in each learning activity
- Participates in SIM performance, skill and/or competency session(s)
- Adheres to all requirements in the Confidentiality Agreement
- Adheres to all the SIMULATION Lab "Rules"
- Actively participates and understands the importance of the debriefing process
- Takes care in the proper use and handling of all equipment and the SIM Lab room
- Participates in Education Department meetings and training activities related to Simulation Program at SVMC

POLICY:

Sierra View Medical Center supports the use of simulation-based education as an evidence-based strategy to enhance clinical competence, patient safety, teamwork, and professional development. All simulation activities shall be conducted in accordance with Healthcare Simulation Standards of Best Practice®, incorporate debriefing methodologies, maintain participant confidentiality and psychological safety, and be facilitated by qualified personnel to promote optimal learning and improved patient outcomes.

AFFECTED PERSONNEL/AREAS: *SIERRA VIEW MEDICAL CENTER STAFF MEMBERS AND AFFILIATED MEDICAL PROVIDERS*

PROCEDURE:

A Simulation requests should be submitted sufficiently in advance to allow planning, scheduling, and resource allocation.

A Simulation session is scheduled during normal posted SIM Lab hours.

A SVMC SIM Lab instructor must be present during every Simulation session.

A sign in sheet will be used for accurate record keeping. **If a participant is 10 minutes or more late to the sessions start time, the participant will need to reschedule the specific session.**

Agenda and objectives have been given to all participants in advance and/or prior to the session commencing.

Demonstration and/or use/location of the equipment/tools/assistive devices are reviewed prior to the session commencing.
A SVMC Simulation Lab Confidentiality Agreement has been reviewed, signed and/or is on record.

The SVMC posted SIMULATION LAB "RULES" have been reviewed by all the participants.

Any questions, issues and clarifications have been addressed in a timely manner.

Except for an emergency, participants must complete the entire session including the debriefing process to receive credit.

The Simulation Lab's Laerdal© SIM 3G Man and Noelle© are maintained and operated by trained SVMC Simulation instructors.

The Education Department will conduct an evaluation of the Simulation Program, including participant feedback, achievement of learning objectives, competency validation outcomes, quality metrics, patient safety initiatives, and organizational educational needs.

EQUIPMENT:

- Laerdal© SIM 3G Man with 2 computers and accessories/attachments
- 1 Stryker© Gurney
- Noelle© Maternal Birthing Simulator with accessories/attachments
- 1 Stryker© OB Gurney
- ***SIM Lab storage Equipment List (located in SIM Lab Redwood room)***

REFERENCES:

Association for Simulated Practice in Healthcare. (2024). ***Healthcare simulation standards of best practice™.*** **https://www.healthcaresimulationstandards.org**

Bailey, K. (2019, June 3). ***Gather-analyze-summarize: The simple GAS method for healthcare simulation debriefing.*** **HealthySimulation.com. https://www.healthsimulation.com/18874/gas-debriefing**

Healthcare Simulation Society. (2024). ***Healthcare simulationist code of ethics.*** **https://www.ssih.org/About-SSH/Code-of-Ethics**

International Nursing Association for Clinical Simulation and Learning. (2024). ***Healthcare simulation standards of best practice™: Debriefing.*** **Clinical Simulation in Nursing, 86, 1-12. https://www.nursingsimulation.org**

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The Joint Commission. (2026). *Competency assessment vs. education and training*. https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000001044

The Joint Commission. (2026). *Competency assessment vs. orientation*. https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000001037

Joint Commission Resources. (2021). *Comprehensive accreditation manual for hospitals (CAMH): Standards, elements of performance, accreditation policies and procedures*. https://digitalassets.jointcommission.org/api/public/content/assets/1/14/cah21_samplepages.pdf

Sierra View Medical Center (2020). Simulation Lab Confidentiality Agreement

Sierra View Medical Center (2020). SIMULATION LAB "RULES"

ATTACHMENTS:

SIERRA VIEW MEDICAL CENTER

SIMULATION LAB "RULES"

- Please be on time for any scheduled SIMULATION session
- SIM Instructor must be present to utilize the SIM Lab and ONLY during scheduled hours
- No food or liquids/ beverages are allowed in the SIM lab
- Cellphones and/or electronic mobile devices must be silenced during any training
- No video or audio recording by participants is allowed
- Simulation Confidentiality Agreement has been signed and is on record at SVMC
- Video/audio recordings is completed by SIM Instructor Only and used for debriefing and educational purposes only
- Using the SIMULATION Lab is a safe and confidential environment
- This is an important component of respectful, ethical and professional behavior
- Please be respectful and careful in the use of the equipment and adhere to proper team dynamics
- Breaks and/or meal times will be established before the session begins based on the agenda for the specific SIMULATION
- Use "inside voice" and be an active participant to maximize the learning experience

Simulation Lab Confidentiality Agreement

As an employee or contract provider and /or participant at Sierra View Medical Center, I will actively participate in simulations. I understand that the content of these simulations is to be kept confidential to maintain the integrity of the learning experience for myself and fellow participants. I also understand that in working and learning along-side my fellow colleagues, I will be observing their performance. It is unethical for me to share information in any format (verbal, written, electronic) regarding staff performance with persons outside the laboratory or classroom setting. Scenarios, case studies, debriefings, discussion and testing (if applicable) are included in the SIMULATION process.

I acknowledge that I fully understand any unauthorized release, inappropriate exchange, recording by any participant other than the designated Simulation Instructor(s) or mishandling of confidential information is prohibited. All HIPPA requirements will be adhered to throughout the SIMULATION process. I will practice professionally and ethically within the Simulation Lab Program Policy.

Name: _____ Date: _____

Department: _____

Simulation Instructor: _____

SUBJECT: **TRANSFUSION REACTION PROCEDURE**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 5**

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

PURPOSE:

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

POLICY:

1. In the event of a suspected transfusion reaction, the nursing personnel shall report patient symptoms to the physician. If the physician elects to stop transfusion:

   a. The Registered Nurse shall discontinue the transfusion and notify the blood bank personnel. The transfusion reaction workup will reflex order from the data entered into the Transfusion Administration Record (TAR) in Meditech. If the department is not using TAR or it is a delayed transfusion reaction, the nurse will order the transfusion reaction workup in Meditech.

   b. The Registered Nurse will call the lab to draw blood sample.

   c. Prepare the blood component bag and blood tubing and return to Blood Bank.

   d. Return the "Report of Suspected Transfusion Reaction" form 013979 (found in PDMS) with blood component bag and tubing.

   e. The Registered Nurse will verify patient identification and document as indicated on the Reaction form.

   f. The Registered Nurse will obtain physician order, and collect the urine specimen for a post transfusion urinalysis and send it to the lab.

   g. The Laboratory will collect a new, properly labeled, blood sample (avoiding hemolysis) from the patient.

2. The Laboratory will perform the following "Partial Transfusion Reaction" work-up:

   a. Urine check for Hgb. If positive, check for RBC.

   b. The label on the blood containers, pre and post patient sample tubes, requisitions and computer records will be checked to detect whether there has been a clerical error made in identifying the patient or the blood.

   c. The patient's post-reaction serum shall be inspected for evidence of hemolysis, using a pre-reaction sample for comparison if available.

d. A blood type, Rh, and DAT will be performed on the patient's post-reaction transfusion specimen.

e. The results of these above mentioned procedures shall be documented in the appropriate spaces on the "Transfusion Reaction Form" with the Clinical Laboratory Scientist (CLS) performing the work-up signing, dating and timing the form.

f. The CLS will make copies of all reports and keep one copy in Blood Bank file under Transfusion Reactions, and send original to Pathologist. Preliminary documentation of the findings will be entered into Meditech.

g. The CLS will immediately contact the Pathologist informing him / her if any of the findings are positive and then perform full workup. The CLS will order the extended transfusion reaction workup in Meditech.

h. The transfusion reaction form will be submitted to the Pathologist for his/her signature and interpretation. The Pathologist will submit a progress report. A copy of this report will be filed in Blood Bank and another submitted to the Risk Manager. The Risk Manager will forward the Progress Report to Medical Records and keep the Report to document the incident.

i. In the event a hemolytic transfusion reaction is suspected the testing protocol shall include (but not be limited to) the following procedures:

- Retesting of the patient's pre and post-transfusion specimen for ABO, Rh, and antibody screen.
- Compatibility retesting of the donor specimen in question using patient's pre and post-reaction specimen samples.
- The CLS will culture the donor blood bag if temperature rise of >4° F.
- Bilirubin determinations on the patient.
- Hemoglobin determinations will be performed on the patient.
- If reaction is suggestive of a hemolytic reaction or bacterial contamination the attending physician shall be notified immediately.
- All transfusion reactions are to be reported to the Rad/Path Committee for review.

DEFINITION OF POSSIBLE ADVERSE BLOOD TRANSFUSION REACTIONS:

1. Hemolytic Transfusion Reaction:

   a. Cause:

   Antibodies in the recipient's plasma react with antigens on donor red blood cells. This leads to donor cell agglutination and capillary occlusion, blocking blood flow and oxygen to vital organs. Eventually, the red blood cells break down and release free hemoglobin into plasma and urine. This free hemoglobin may block the renal tubules, resulting in renal failure.

   b. Signs and Symptoms:

   Chills, fever, backache, leg pain, rigors, chest pain, tachycardia, hypotension, cyanosis, hemoglobinemia, hemoglobinuria, oliguria, anuria, hematuria, jaundice, shock, vascular collapse, nausea, vomiting, restlessness, anxiety, pallor, pulmonary edema, precordial distress.

   c. Definitive Laboratory Testing:

   - Positive Direct Coombs test post-transfusion.
   - Gross hemolysis of serum post-transfusion.
   - Occult blood positive test in post-transfusion urine analysis.
   - Elevated Bilirubin post-transfusion.

2. Significant Hemolytic Transfusion Reactions:

   a. All verified hemolytic transfusion reactions are considered and reported as significant.

   b. All suspected hemolytic transfusion reactions will have a repeat ABO Type and Rh of both the recipient and the donor blood.

3. Allergic Transfusion Reaction:

   a. Cause:

      Probable mechanism of reaction due to allergens in donor blood with antibodies in recipient blood.

   b. Signs and Symptoms:

      Urticaria, pruritus, chills, nausea, vomiting, headache, nasal congestion, wheezing, bronchospasm, dyspnea, laryngeal edema, circulatory collapse, fever, diaphoresis, anxiety, restlessness, headache, pallor, erythema.

   c. Definitive Laboratory Testing:

      All suspected allergic reactions will have direct Coombs testing performed by Laboratory to determine type of reaction. If direct Coombs testing are within normal limits, the Pathologist will be notified to determine if further testing is required.

   d. Significant Allergic Reactions:

      Significant Allergic reactions are defined as: bronchospasm, laryngeal edema, severe dyspnea, circulatory collapse, pulmonary edema, skin sloughing as a result of severe pruritus and/or erythema.

4. Febrile Transfusion Reaction:

   a. Cause:

      Recipient sensitivity to donor leukocytes or platelets.

      A febrile transfusion is defined as an increase of 2° F above baseline temperature.

   b. Signs and Symptoms:

      Fever, chills, flushing, back pain, malaise, tachycardia, headache, confusion, nausea and vomiting.

   c. Definitive Laboratory Testing:

      The same procedure is followed as with allergic reactions.

d. Significant Allergic Febrile Reactions:

A significant febrile transfusion reaction is defined as: A rise in temperature greater than two (2) degrees from pre-transfusion temperature.

5. TRALI – Another possible adverse effect of transfusion is Transfusion Associated Acute Lung Injury (TRALI). This is a rare but potentially life-threating reaction to plasma containing blood components. As it is most common in donations from multiparous women, Central California Blood Center (CCBC) has instituted a policy of only collecting plasma from male donors. Platelet transfusion reactions should be monitored for fever, chills, dyspnea, cyanosis and hypotension. The Medical Director and CCBC should be notified of any suspected cases of TRALI.

6. All possible transfusion reactions are reported to the Pathology Department, Quality Improvement Committee, Transfusion Committee, Medical Executive Committee, and the Governing Body at least on a quarterly basis.

AFFECTED AREAS/PERSONNEL: *LABORATORY STAFF, NURSING, PHYSICIANS*

REFERENCES:

- Association for the Advancement of Blood and Biotherapies (AABB) Standards, 35th edition, pp 144-145, 7.3.5.1 - 7.3.5.4, 2026
- Association for the Advancement of Blood and Biotherapies (AABB) Technical Manual, 21st edition, pp 683 - 684, 2023.
- The Joint Commission (2026). Hospital accreditation standards (QSA.05.18.01, QSA.05.19.01, QSA.05.19.03, QSA.05.19.05). Joint Commission Resources. Oak Brook, IL.

SUBJECT: **TRAUMA IN PREGNANCY**	SECTION: **Page 1 of 5**

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

PURPOSE:

To establish evidence-based guidelines for the assessment, monitoring, and nursing management of pregnant patients following traumatic injury, with priority given to maternal stabilization and optimization of maternal and fetal outcomes.

POLICY:

A. All pregnant patients with history of trauma will be triaged in the Emergency Department (ED). Maternal stabilization takes precedence over fetal assessment. Activation of the obstetric provider, and neonatal services should occur based on injury severity and gestational age.

1. Pregnant patients with major trauma will be stabilized in the Emergency Department.
2. The Perinatal healthcare provider will be called to the Emergency Department for consult for pregnant patients with major trauma.
3. The ED physician will obtain consultation with the Obstetrics (OB) physician for any pregnant patient with major blunt or penetrating trauma.
4. Pregnant patients with minor trauma may be transferred to Labor & Delivery (L&D).

B. The assessment and interventions for the pregnant woman who has experienced trauma are based on the clinical situation and maternal-fetal status and may include but are not limited to the following:

1. Fetal/uterine monitoring
2. Laboratory tests
3. Vital signs monitoring
4. Physical assessment

AFFECTED PERSONNEL/AREAS: *MCH DEPARTMENT, RNs*

EQUIPMENT:

- Fetal monitor
- Non-invasive blood pressure monitor

PROCEDURE:

A. Uterine Assessment:

1. Assess uterine activity

    a. Contraction frequency, intensity, and duration

    b. Resting tone

    c. Determine type of trauma, considering blunt trauma to the abdomen may cause uterine rupture, abruption placenta, or fetal injuries.

2. Assess fundal height for approximation of gestational age with tape, measuring from the top of the symphysis pubis to the top of the fundus and record. (Fundus at level of umbilicus equals to approximately 20-week gestation)

3. Inspect perineum for presence of bleeding or leakage of amniotic fluid

4. Perform cervical exam (in the absence of vaginal bleeding or prematurity < 35 weeks)

    a. Cervical dilation, effacement, position and consistency

    b. Status of amniotic membranes

    c. Fetal station, lie, presentation

5. Assess for signs and symptoms of placental abruption:

    a. Presence of frequent uterine contractions

    b. Vaginal bleeding or increasing fundal height

    c. Evidence of fetal hypoxemia

    d. Maternal hemodynamic instability

    e. Abdominal tenderness

    f. Increased resting tone

    g. Abnormal fetal heart rate (FHR) findings

6. Screen for Domestic Violence

B. Maternal Interventions:

If mother is unstable:

1. Proceed with fluid resuscitation.

2. Type and cross 2 units PRBCs, determine Rh factor.

3. Consider labs, blood type and Rh, CBC, Clotting Analysis, Glucose, Electrolytes, and be aware pregnant patient will normally be in a hypercoagulation state.

4. Obtain as ordered: X-rays, CAT scan, and OB ultrasound. Medically necessary diagnostic imaging should not be delayed due to pregnancy when maternal injury is suspected. Imaging decisions should be based on clinical indications and provider assessment.

5. Consider inserting a Foley catheter to maintain accurate urinary output and to observe for blood in the urine.

6. Consider administration of 300 micrograms of anti-D immune globulin within 72 hours of injury for the Rh-negative pregnant patient with abdominal trauma.

7. Continuous monitoring of mother and fetus is important in order to identify change in status and prevent fetal and maternal complications or death.

8. Maintain left lateral uterine displacement or left lateral positioning when feasible to reduce aortocaval compression and improve uteroplacental perfusion.

9. Be prepared for an emergency cesarean section. In cases of maternal cardiac arrest with a potentially viable fetus, the obstetric and resuscitation team should follow current maternal cardiac arrest and perimortem cesarean delivery protocols.

If mother is stable:

1. Transfer to Labor & Delivery for continuous fetal monitoring from 6 to 24 hours following trauma based on clinical signs and symptoms.

2. Continue to reassess for changes in status. Continuous fetal monitoring and further evaluation are warranted for:

   a. Uterine contractions

   b. Fetal well being

   c. Vaginal bleeding

   d. Significant uterine tenderness or irritability

   e. Rupture of amniotic membranes

   f. Serious maternal injury

3. Proceed with ordered tests, ultrasound, etc.

4. Fetal heart rate monitoring periods of 2 – 6 hours are adequate if:

   a. No uterine contractions/tenderness

   b. Bleeding

   c. Fetal heart rate tracing is reassuring

   d. Maternal condition is stable

C. Fetal assessment and interventions:

1. Less than 20 weeks gestation: check for fetal heart rate and provide supportive care.

2. Pregnant patients with a periviable fetus (generally 20-24 weeks gestation) should receive continuous fetal heart rate and uterine activity monitoring

3. Promote uteroplacental perfusion

   a. Displace uterus laterally and avoid supine position

   b. Correct hypovolemia with fluid resuscitation

   c. Administer oxygen as indicated (mask at 10L/m)

4. MD may order ultrasound to rule out abruption, to determine viability, fetal age, amniotic fluid volume, placental location, and fetal position.

D. Psychosocial assessment and interventions

1. Identify patient's support persons. Allow for contact as soon as acute resuscitative measures are completed.

2. Inform patient and family of status of baby and mother.

3. Allow expression of fear and anxiety.

4. Provide support and reassurance.

DOCUMENTATION:

- Document all maternal and fetal assessments.
- Document type and extent of any injuries including marks, bruises and/or lacerations.

- Document all medical and nursing interventions and patient response.
- Document resuscitation measures.
- Document physician notification including indication and response.
- The Electronic Medical Record (EMR) will be used to record uterine activity and fetal heart rate, intake and output, IV, and narrative nurses' notes.

REFERENCES:

April, M. D., & Long, B. (2024). *Trauma in pregnancy: A narrative review of the current literature. American Journal of Emergency Medicine.* https://www.binasss.sa.cr/jul24/2.pdf

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Kilpatrick, S. J. (2025). *Initial evaluation and management of major trauma in pregnancy.* UpToDate. https://www.uptodate.com/contents/initial-evaluation-and-management-of-major-trauma-in-pregnancy

SUBJECT:	SECTION:
TREATMENT OF ADULT PATIENT WITH SUSPECTED SEPSIS- STANDARD OPERATING PROCEDURE	**Page 1 of 7**

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

PURPOSE:

To define the sepsis team as well as the roles and responsibilities of Sierra View Medical Center (SVMC) personnel responding to adult sepsis alert notifications, to delineate the adult sepsis alert process, and to provide guidelines for early recognition and treatment of severe sepsis and/or septic shock. This is in accordance with the guidelines from the Centers for Medicare and Medicaid Services (CMS). The scopes of this policy and program applies to non-maternal, adult patients over age 18.

DEFINITIONS:

1. **Sepsis** – A life threatening, extreme response to infection (Surviving Sepsis Campaign, 2026)

2. **Sepsis alert** – An overhead page or electronic notification announcing the presence and location of a sepsis alert patient. This alert can be activated anytime, via a defined process, for any patient that displays the sepsis alert criteria as defined in this policy.

3. **Sepsis Team** – the sepsis team includes, but is not limited to:

   a. Emergency Dept attending provider**
   b. Stroke & Sepsis Coordinator Ω
   c. ED registered nurse (RN) **
   d. ICU / RRT RN ±
   e. Intensivist §
   f. Hospitalist §
   g. Phlebotomist **, ±
   h. Nursing supervisor Ω
   i. Clinical Unit Leaders Ω
   j. Pharmacist §
   k. Respiratory therapist §

   ** denotes presence required upon sepsis alert in the ED
   ± denotes presence is required upon sepsis alert in-house
   Ω denotes presence is required, when available, for either ED or in-house sepsis alerts
   § denotes required to be available in person or by phone, but not immediately present.

4. **Systemic Inflammatory Response Syndrome (SIRS)** – a severe systemic response to a condition that provokes an acute inflammatory reaction indicated by the presence of two or more of a group of symptoms including abnormally increased or decreased body temperature (>100.9 F or < 96.8 F), a heart rate (HR) greater than 90 beats per minutes, respiratory rate (RR) greater than 20 breaths per minute, and / or a white blood cell (WBC) count of greater than 12,000, or less than 4000 (Merriam-Webster, 2019).

5. The orange form for Adult Sepsis - not part of the medical record, this is a nursing tool to guide them through bundle compliance. Forms are returned to the Sroke & Sepsis Coordinator when patient is discharged.

6. **Organ dysfunction** – a sign of tissue injury in sepsis (unless due to a chronic condition - for example, renal failure), characterized by any of the following:

   a. Lactic acid > 2
   b. Hypotension = one systolic blood pressure (BP) < 90 or mean arterial pressure (MAP < 65)
   c. Creatinine > 2
   d. Urine output < 0.5 ml/kg/hr x 2 hrs
   e. Total bilirubin > 2
   f. Platelets < 100,000
   g. International normalized ration (INR) > 1.5
   h. Partial thromboplastin time (aPTT) > 60
   i. New need for invasive or non-invasive ventilation

   j. **Surviving Sepsis Campaign** – A group formed in 2002 with a goal to decrease sepsis mortality They establish sepsis clinical practice guidelines, focusing on management in the hospital, and the pre and post – hospital settings.

7. **Severe Sepsis** – includes:
   a. Confirmed source of infection
   b. 2 or more SIRS criteria
   c. 1 sign of organ dysfunction – as defined above

8. **3 hour bundle**
   a. Initial lactic acid that will reflex to obtain a follow up value
   b. Initial Procalcitonin – optional
   c. Blood cultures
   d. antibiotic
   e. 30 ml/kg crystalloid intravenous fluid (IVF) for patient with septic shock, as evidenced by CMS criteria. This includes a lactic acid > or = 4.0, and/or initial hypotension.

9.

10. **6 hour bundle**
   a. Repeat lactic acid
   b. Vasopressors
   c. Repeat focused exam (see below)
      i. Exam – documentation of 5 of the following 8 options:
         1. Pulse ox
         2. Cap refill time

3. HR, cardiac rhythm, lung sounds
4. peripheral pulses
5. skin – condition, color, temperture
6. urine output
7. vital signs
8. shock index value
    a. Heart rate divided by Systolic blood pressure
        i. 0.5 – 0.7 = normal
        ii. Greater than 0.8 – 0.9 = concern
        iii. Greater than or equal to 1.0 = significant hemodynamic compromise

ii. Attestation – such as "I did the sepsis reassessment at _____"

iii. Bedside tests
1. CVP or Right atrial pressure
2. Central venous oxygen saturation (ScvO2)
3. Carotid flow time
4. fluid challenge or passive leg raise
5. echocardiogram
6. critical care ultrasound

11. **Septic shock** – includes:
    a. Severe sepsis
    b. Initial lactic acid ≥4 and /or initial hypotension, and/or persistent hypotension within 6 hrs of severe sepsis presentation time.

12. **Initial hypotension** – two hypotensive (SBP < 90, or MAP < 65) blood pressure readings within 3 hours of each other.

13. **Persistent hypotension** – 2 consecutive blood pressure (BP) readings with aMAP less than or equal to 65 or SBP less than or equal to 90, in the hour following the IVF bolus.

14. **Time of Presentation** – an abstracted time based upon provider documentation or clinical criteria.

AFFECTED PERSONNEL/AREAS: *EMERGENCY DEPARTMENT, NURSING, MEDICAL/SURGICAL, CLINICAL DECISION UNIT, TELEMETRY, ICU, MATERNAL CHILD HEALTH (ADULT AREAS), SURGICAL SERVICES, CATH LAB, AND LABORATORY*

PROCEDURE

A. A sepsis alert will be initiated by providers or nursing staff when a patient demonstrates a suspected infection and 2 or more SIRS criteria.

1. The Emergency Department (ED) and Intensive Care Unit (ICU) will call the alert directly by dialing #55.
2. Other units within the inpatient hospital will initiate the process by dialing #55 for the Rapid Response Team (RRT). The RRT will assess the patient and call the sepsis alert.

C. A sepsis alert is a nurse driven process that will be called for any patient that meets the criteria defined in this policy.

D. An adult with a suspected or confirmed infection and 2 or more SIRS criteria will have an electronic sepsis screening tool completed. If the screen is positive, an RRT call or sepsis alert will be initiated, based on patient location.

E. Activate a sepsis alert or the RRT by calling #55

1. Operator will page the appropriate overhead alert with a location of the patient.
2. Team, as defined above, will respond

F. If a patient meets defined sepsis alert criteria, the RN will order initial diagnostic tests consisting of an initial lactic acid, , UA C & S, and a set of blood cultures. If a pulmonary source is suspected, a portable chest x-ray (1 view) will be ordered. The RN may also draw a complete metabolic panel (CMP), complete blood count (CBC), coagulation studies (PT/INR, PTT), magnesium, troponin, and a B-type natriuretic peptide (BNP.)

1. Laboratory work to be sent as a STAT priority. Lab personnel, when present, will take the specimens directly to lab

G. Notify ED provider or attending physician that the patient met criteria for a sepsis alert and the protocol orders have been initiated, obtain any additional orders needed, such as an antibiotic and a fluid bolus volume, if indicated.

H. Ensure patient has IV access, preferably two large bore.

1. If vasopressors are required, a central line is recommended, but not required to initiate blood pressure support. Use largest bore IV established for the vasopressor.

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

J. Administer medications as ordered, to include an antibiotic, and/or an IVF bolus. Pharmacist to assist with dosage calculations as needed. .

1. Infuse theantibiotic within 3 hours from time of presentation, AFTER the blood cultures are drawn. It is preferred to administer the antibiotic within 1 hour of time of presentation.

2. If patient's lactic acid is≥4, and/or there is **initial hypotension**, CMS guidelines suggest 30 ml / kg of crystalloid IVF be initiated within 3 hours from time of presentation. The fluids must run at a rate > 125 ml/hr. It does not matter when the fluids finish, as long as they are completely infused.

3. Ideal body weight (IBW) may be used to calculate the fluid bolus amount. Weighing sepsis patients EARLY is encouraged.

4. The terms "bolus", "wide-open" or "open" are acceptable for a rate of infusion. Fluid resuscitation for this patient population is encouraged to infuse in this manner, not 999 mls/hr on the infusion pump.

5. Crystalloid fluids, or balanced crystalloid fluids, used to dilute medications – such as the antibiotic – can be ued toward the target ordered volume (30 mls/kg)

6. Crystalloid fluids to which potassium, magnesium, calcium, lactate, acetate, or gluconate have been added also count toward the target ordered volume.

7. A provider order for less than 30 mls/kg is acceptable, when:

   a. There is documentation, in a single note, of the following:
      i. The volume as either a specific volume, or a lesser weight-based volume
      ii. AND a reason for ordering a volume less than the 30 mls/kg. Reasons include and are not limited to:
         i) Concern for fluid overload
         ii) Heart failure
         iii) Renal failure
         iv) Blood pressure responded to a lesser volume
         v) A portion of the crystalloid IVF bolus was administered as colloid

8. Crystalloid IVfluids given by EmS count toward the 30 ml/kg requirement as long as:
   a. the type, volume, start time, and either a rate, duration, or end time of the infusion is documented.

9. A vasopressor should be administered for **persistent hypotension** within 6 hours of time of presentation. Noreipinephrine (Levophed) is the recommended initial vasopressor . Vasopressin is the recommended second agent, if needed to maintain SBP > 90 or MAP > 65.

K. For the septic shock patient, a repeat focused exam to evaluate perfusion must be documented after the initiation of the fluid bolus. The provider must document one of the following:

1. A statement such as "I did the sepsis reassessment" with a time

OR

2. At least 5 of the following 8 physical exam elements:

   a. Stroke volume index
   b. Capillary refill time
   c. Pulse oximetry
   d. Vital signs
   e. Cardiopulmonary exam
   f. Skin condition, assessment of perfusion
   g. Peripheral pulses / extremities
   h. Urine output

   OR

3. One of the following:
   a. Central venous pressure (CVP)
   b. Central venous oxygen saturation (ScVO2)
   c. Echocardiogram, or ultrasound assessment of inferior vena cava volume
   d. Fluid challenge
   e. Passive leg raise

L. Follow the STANDARD OPERATING PROCEDURE: SEPSIS form, whether paper or electronic (see addendum A for paper copy). This form is not part of the medical record.

M. Ensure reflex lactic acid is completed, if original lactic acid was greater than 2.0, within 6 hours of time of presentation.

N. If the patient was a sepsis alert in the previous 24 hrs, and patient continues to have symptoms and meet criteria, a call to the provider is encouraged. If it has been more than 24 hrs since the last sepsis alert, and the patient continues to meet criteria, an RRT call is recommended.

O. Treat any fever as ordered.

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SUBJECT: **UMBILICAL CATHETERIZATION: NEONATE**	SECTION: **Page 1 of 7**

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

PURPOSE:

To provide guidelines for insertion, maintenance, blood sampling and removal of umbilical catheters.

POLICY:

A. Umbilical vessel catheterization will be performed only by a qualified pediatrician or neonatologist.

B. Umbilical arterial and venous catheters should be removed as soon as clinically feasible. If ongoing central access is required, consider transitioning to PICC or other central access.

C. Sterile technique will be always used. Assistant will wear hat and mask within three feet of the sterile field.

D. The physician, will verify placement of the catheter by chest and abdomen X-ray immediately after the procedure. The physician will make any necessary adjustments in catheter placement. The RN may withdraw the catheter as directed by the physician. Line placement will be verified on all subsequent X-rays.

E. The recommended placement for umbilical catheters is:

1. Umbilical Arterial Catheter (UAC)– high line T6 –T9 (preferred).

2. Umbilical Arterial Catheter (UAC) – low line L3 – L4.

3. Umbilical Arterial Catheter (UAC)- tip locations between T10-L2 should be avoided due to increase risk of vessel injury and thrombotic complications.

4. Umbilical Venous Catheter (UVC) – Optimal UVC tip location is at the inferior vena cava/right atrial junction, just above the diaphragm and outside the cardiac silhouette.

F. Once the catheter has been advanced to the desired position and blood is easily aspirated, the catheter will be tied in place with a silk suture around the catheter and may be sutured to the umbilical stump by the physician.

G. All connections in the umbilical line will be secured with a Luer-Lock. Non-vented caps are to be used on all stopcocks. The junction of the umbilical catheter and needleless connector (except when using in line blood sampling system, Vamp Jr). must be clearly labeled as arterial or venous.

H. Attach needleless valves on all umbilical lines.

I. Fluid administration to the umbilical line will be controlled by an infusion pump properly labeled as arterial or venous infusion.

J. All infants receiving umbilical vessel IV therapy will be on strict intake/output monitoring including estimation of blood loss (lab work, accidental loss, oozing).

K. Infants with UAC will have a continuous BP monitoring. Continuous central venous pressure monitoring is not routinely required for all infants with UVCs and may be utilized only when specifically ordered by the provider and clinically indicated.

L. Standard concentration and flush volumes of heparinized solutions will be defined by the providers, pharmacy, and neonatal practice guidelines. Excessive flushing's should be avoided in extremely low birth weight infants.

M. Vital signs, pulses and tissue perfusion are assessed and any signs of decreased perfusion, especially to feet, legs, and buttocks), hypertension or sepsis is reported to the physician

N. Padded hemostat for (for each umbilical catheter) emergency blood loss situations will be always kept at the bedside.

O. An umbilical tie or gel sponge product may be used to control bleeding. Umbilical ties secured to the skin should be removed within 8 hours of placemen to prevent skin breakdown.

P. An alcohol infused cap will be attached to each un- activated needleless connector i.e., the second lumen of the double- lumen UVC, sample port of the UAC.

AFFECTED AREAS/PERSONNEL: *MCH DEPARTMENT/PHYSICIANs/RNs*

PROCEDURE:

A. Universal Protocol:

1. Documentation of the time out indicates that all team members have participated in the time out immediately prior to beginning the procedure. In addition, documentation of the time out means that the following elements have been assessed as applicable:

   a. Correct patient identity is verified by using 2 patient identifiers, (i.e., name, medical record number, billing number, or date of birth).
   b. Correct site.
   c. Agreement on the procedure to be done.
   d. Availability of special equipment or special requirements.
   e. Correct position.

2. Any discrepancy in response during the time out requires resolution before proceeding. The physician's order, History and Physical, imaging studies and other relevant, available documentation will be used to reconcile the discrepancy.

B. Insertion

1. Equipment

   a. Radiant warmer with cardiac/blood pressure monitor, oxygen, and suction set up.
   b. 4-point protective medical devices
   c. Padded hemostat at bedside
   d. Light source
   e. Mask, sterile gloves and gown, surgical cap, face protection
   f. Use antiseptic agents according to gestational age, chronological age, skin integrity, and institutional neonatal skin antisepsis guidelines. Alcohol-containing chlorhexidine may be considered when benefits outweigh risks.
   g. Umbilical catheterization tray (to include Toothed Iris forceps, Curved non-toothed forcep-2; Mosquito Hemostat)
   h. Umbilical catheter-3.5F for infants weighing less than 1500 grams;5.0F for infants weighing more than 1500 grams.
   i. 0.45% NACL (1/2 Normal Saline) Heparinized saline (Heparin 1 unit/ml)
   j. IV tubing, filter as needed, Luer Lock stopcocks, nonvented caps
   k. Transducer pressure monitoring device
   l. Heparinized IV fluid
   m. Silicone dressing (Mepiform)
   n. Infusion Pump
   o. Tegaderm
   p. Alcohol infused cap
   q. Needleless connectors
   r. Measuring tape
   s. Syringes 3 and 10 ml
   t. Sterile drapes
   u. 2x2; 4x4 sterile gauze
   v. Needle holder
   w. 3-0 silk suture;4-0 silk suture
   x. Mask, surgical cap, sterile gown, and gloves
   y. Scissors

2. Prepare the infant

   a. Place infant on radiant warmer with Servo probe attached.
   b. Connect infant to cardiac- respiratory monitor. extremities with protective medical devices.

3. Prime IV set up with prescribed solution and attach appropriate transduce monitoring device to IV setup. When possible, transduce the larger lumen of a multi-lumen catheter.

4. Set up Umbilical Catheter Tray Kit
   a. Prepare Heparinized Normal Saline.
   b. Position light source.

5. Assisting the provider

   a. Restrict traffic near the sterile field.
   b. During insertion, all personnel directly participating in the procedure shall utilize maximal sterile barrier precautions including cap, mask, sterile gown, and sterile gloves. Personnel within the sterile field shall remain appropriately attired throughout the procedure. Hand hygiene shall be performed in accordance with hospital infection prevention policy.
   c. If assistant will enter the sterile field or reach over it, they will perform hand hygiene and wear maximal barrier precautions (sterile gown, mask, hat and sterile gloves).
   d. Hold cord stump upright with clamp as needed.
   e. Monitor VS's before, during and after procedure. Assess feet, legs, and buttocks for signs of vascular compromise.
   f. Withdraw catheter as directed by Physician using clean technique.

6. Securing Umbilical Catheter

   a. Rinse Povidone-iodine or chlorhexidine gluconate with sterile water or normal saline from infant's skin once procedure is complete.
   b. Once proper catheter placement is confirmed by X-ray, secure catheter by placing soft silicone dressing (Mepiform) on abdomen. Coil catheter on top of silicone dressing and secure with Tegaderm.

7. Document procedure in the Electronic Medical Record (EMR).

8. Maintenance

   1. Calibrate transducer with the line placement every shift and PRN when BP is in question or wave is dampened for an unknown reason.

      a. Open transducer stopcock to air by turning off to the baby.
      b. Remove non-vented cap from transducer stopcock while maintaining sterility.
      c. Maintain transducer at the level of the infant's right atrium.
      d. Press zero button on monitor and "zero" reading on monitor.
      e. Replace non-vented cap on transducer stopcock.
      f. Close stopcock to air by opening stopcock to infant.
      g. Confirm the return of normal wave form.

   2. Continuously monitor pressure wave form and numbers. When wave form dampens:

      a. Check connections.
      b. Flush transducer if bubbles are present. Assure stopcock is off to the baby.
      c. Flush line gently
      d. Check selected pressure scale on monitor.
      e. Recalibrate transducer.
      f. Check cuff pressure to compare.
      g. Notify physician of dampened lines not corrected by the above.

3. Assess with diaper change for erythema or discoloration of abdominal wall. Infant's buttocks for red, discoloration, mottled skin, or signs of blanching.

4. Verify that no blood is continuing to leak around the catheter or pooling under the infant's backs or buttocks.

5. Document arterial pressure / CVP with vital signs per guidelines of care.

6. Document initial shift assessment including: insertion mark.

7. Document hourly site checks including:

   a. Site status (position the diaper well below the catheter insertion site for better viewing and to avoid potential urine contamination).
   b. Extremity color
   c. Waveform assessment

8. If UAC becomes disconnected, clamp UAC line using padded hemostat. Wipe connector with alcohol, flush line gently with syringe of 0.45% NACL (½ Normal Saline) heparinized flush (I unit/ml) while establishing sterile system.

C. Blood Sampling

1. Verify correct patient using 2 patient identifiers (neither of which will be the location of the patient).

2. Equipment

   a. Gloves
   b. Alcohol swabs
   c. Syringes
   d. Vented ABG syringe and /or lab tubes
   e. Patient labels
   f. Specimens transport bag or container
   g. 0.45% NACL (½ Normal Saline) heparinized flush (I unit/ml).

3. Wash hands and don gloves.

4. Remove alcohol infused cap.

5. Disinfect needleless connectors using vigorous friction ("scrub the hub") with alcohol or approved antiseptic for at least 15 seconds and allow to dry completely before access. Alcohol-impregnated disinfection caps may be utilized according to unit practice.

6. Place empty 3 ml syringe securely on sampling port. Turn stopcock off to IV port.
7. Withdraw 1 ½ ml of blood from the umbilical line.

8. Place vented ABG syringe (pre-Heparinized) securely on sampling port and fill to 0.2-0.3 ml mark. For labs, place empty syringe on sampling port and fill to the desired amount.

9. Place blood filled syringe SECURELY on sampling port of stopcock. GENTLY aspirate with plunger to remove any air bubbles in port or blood syringe and slowly infuse blood back into the umbilical line.

10. Remove 3 ml syringe. Place Heparinized saline syringe securely on sample port. Gently aspirate with plunger of syringe to remove any air bubbles from port of syringe. Slowly infuse 0.5 ml of flush into the line. Remove 3 ml syringe.

11. Document volume of blood removed on the electronic medical record.

12. Document lab draw note as applicable.

13. Attach patient label with date, time, and initials. Place in transport container and notify Pulmonary that specimen is ready for ABG analysis.

D. Catheter Removal

1. Equipment

a. Suture removal tray
b. Sterile water or normal saline
c. Sterile 2x2 gauze.

2. Removal of UAC

a. Obtain suture removal tray
b. Cut sutures holding catheter in place along the side, attached to the stump.
c. Check catheter placement at the beginning of procedure. Pull catheter to the 5 cm mark.
d. Turn off IV infusion.
e. Very slowly, withdraw the catheter. Apply pressure directly below and on the umbilical artery and until bleeding stops.
f. Keep infant supine for at least an hour after procedure.
g. After removal, reassess femoral pules. Check for blanching of the lower extremities and buttocks, comparing skin color and pulses to pre-removal assessment. Assess umbilicus for bleeding. Notify physician/NNP if any changes.

3. Removal of UVC

a. Removal of UVC is the same concept as UAC.
b. Remove catheter slowly.

c. Apply pressure directly above and on the umbilical vein for 3-5 minutes and until bleeding stops.

4. Documentation

a. Time of removal
b. Integrity of catheter tip. Blood loss if any.
c. Condition of umbilical site for the first 8- hours after removal with assessment.

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SUBJECT: **UMBILICAL CORD BLOOD SAMPLING FOR BLOOD GASES**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish standardized nursing guidelines for the collection, handling, transport, and documentation of umbilical cord blood gas specimens to objectively assess fetal acid-base status at birth and support neonatal clinical evaluation.

POLICY:

Umbilical cord arterial and venous blood gas analysis may be obtained following delivery to assess fetal metabolic condition at birth. Whenever possible, paired arterial and venous samples should be collected.

Cord blood gas analysis should be obtained per provider order in the presence of conditions associated with potential fetal hypoxia, acidemia, or neonatal compromise, including but not limited too:

- Cesarean birth performed for suspected fetal compromise
- Category III fetal heart rate tracing
- Persistent Category II fetal heart tracing
- Low five (5) minute Apgar score (≤ 5)
- Severe growth restriction
- Intrapartum maternal severe or suspected intra-amniotic infection
- Shoulder dystocia
- Placental abruption
- Umbilical cord prolapses
- Uterine rupture
- Multiple gestation with fetal compromise
- Neonatal resuscitation requiring positive pressure ventilation, intubation, or advanced resuscitation measures
- Any high-risk delivery where assessment of fetal acid-base status is clinically indicated
- Per provider request
- Cord gas collection should not delay neonatal stabilization or resuscitation when clinically indicated

AFFECTED PERSONNEL/AREAS: *MCH DEPARTMENT/ RNs*

EQUIPMENT:

- Gloves
- Arterial blood sampling syringe
- Cord clamps
- Specimen labels
- Biohazard bag

PROCEDURE:

1. Perform hand hygiene and don gloves.
2. Immediately following birth, double clamp a 10 to 20 cm segment of umbilical cord as soon as feasible.
3. Isolate the cord segment prior to placental delivery, when possible, to reduce alteration of blood gas values.
4. Identify the umbilical vessels
    a. One umbilical vein
    b. Two umbilical arteries
5. Using a heparinized blood gas syringe, obtain the arterial specimen first.
6. Collect approximately 0.5 to 1 mL of blood from an umbilical artery
7. Expel all visible air bubbles from the syringe immediately after collection
8. Activate the needle safety device and secure the specimen
9. Obtain a venous specimen using the same technique when ordered or according to department practice.
10. Label each specimen immediately at the bedside, clearly identifying
    a. Mother and infant identifiers
    b. Date and time of collection
    c. Arterial or venous specimen
    d. Collector initials

SPECIMEN TRANSPORT:

1. Transport specimens to the laboratory immediately after collection
2. Specimens should be analyzed as soon as possible according to laboratory standards to minimize changes in pH, pCO2, and pO2 values
3. If transport is delayed, follow laboratory policies regarding specimen preservation and handling

DOCUMENTATION:

- Indication for collection
- Date and time sample collected
- Venous and/or arterial
- Any collection difficulties
- Provider notification of critical values, if applicable

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SUBJECT: **Use of Externally Supplied Medications in Clinic Settings**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define Sierra View Medical Center's position on externally supplied medications in clinic settings.

DEFINITIONS:

Brown Bagging-
Situation where medication is procured from an external pharmacy is dispensed directly to a patient & brought by the patient to the health system or clinic for administration.

DSCSA- (Drug Supply Chain Security Act)- Federal law enacted in 2013 to enhance the U.S. Food and Drug Administration's ability to protect customers by improving detection and removal of potentially dangerous products from the pharmaceutical supply chain. The law requires hospital pharmacy chain of custody and end-to-end product traceability for medications from manufacturer to patient.

White Bagging- practice where patient-specific medication is procured from an external pharmacy (typically a specialty pharmacy owned or contracted with a patient's health insurance plan) and delivered to Sierra View Medical Center outpatient or clinic for compounding and patient administration.

POLICY:

The responsibility & accountability for purchasing, mixing, and administering injectable medications resides with Sierra View Medical Center & the providers who administer these medications. As such, their legitimacy of source and subsequent storage and handling should be assured by Sierra View Medical Center. Sierra View Medical Center will not administer any drug to a patient that Sierra View does not purchase directly from either the manufacturer or an accredited wholesaler.

Sterile medications dispensed, compounded or administered at a Sierra View Medical Center outpatient or clinic setting must be procured by Sierra View Medical Center via an approved manufacturer or wholesaler in order to meet the requirements consistent with DSCSA.

Brown bagging at Sierra View Medical Center outpatient or clinic settings is prohibited.

White bagging of injected and infused medications in the hospital outpatient or clinic setting is prohibited. If the patient's insurance requires white bagging, Sierra View may try to obtain insurance approval for Sierra View to procure, compound and dispense the medication to the patient.

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SUBJECT: **VENOUS BLOOD COLLECTION**	SECTION: **Page 1 of 2**

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

PURPOSE:

To instruct personnel of the proper procedure for collecting a specimen via venipuncture.

SYNONYMS:

Venipuncture, phlebotomy, venous blood collection.

CONTAINER:

Syringe with 20-21 gauge needles for volumes to 10 ml. Vacutainer or similar system for multiple specimens or anticoagulants.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. Verify the patient's identity using two identifiers.
2. Cleanse hands. Put on fresh pair of gloves.
    a. Apply tourniquet.
3. Select a suitable site for venipuncture. Prepare the site by scrubbing with 70% alcohol (isopropanol). Dry with sterile gauze.
4. Cleanly puncture the skin.
5. Apply gentle suction.
6. Release the tourniquet.
7. Remove the needle and fill the tubes without delay.
8. Gently invert the tubes 10 times to assure mixing of anticoagulants.
9. Aftercare:
    a. Apply pressure to the venipuncture site and elevate the arm until bleeding stops. If bleeding persists, apply a pressure dressing to the site.
10. Limitations:
    a. Venipuncture is technically difficult in obese patients, infants, children and patients with collapsed veins, such as those in shock. Hemolysis may occur as a result of excessive

suction during collection, violent mixing of specimen, or vigorous transfer of the specimen from syringe to tube.

NOTES: See individual test for specific collection requirements.

REFERENCE:

- Turgeon, Mary Louise, Linne and Ringstrud's Clinical Laboratory Science, 8th Edition, 2019.

SIERRA VIEW
MEDICAL CENTER

MEETING MINUTES

MINUTES FROM PREVIOUS MEETING SUBMITTED FOR APPROVAL

MEETING MINUTES

BOARD OF DIRECTORS MONTHLY MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly September 22, 2026, at 5:00 P.M. in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Vice Chair Reddy called the meeting to order at 5:06 p.m.

Board Attendance:

- Liberty Lomeli, Chair - Present
- Bindusagar Reddy, Vice Chair - Absent
- Areli Martinez, Secretary – Present
- Hans Kashyap, Director – Present
- Martha A. Flores, Director – Present

Others Present: Donna Hefner, President/Chief Executive Officer, Roger Larsen, Interim Chief Financial Officer, Brandy Irwin, Chief Nursing Officer, Melissa Crippen, VP of Quality & Regulatory Affairs, Ron Wheaton, VP of Professional Services & Physician Recruitment, Kim Pryor-DeShazo, Director of Marketing and Community Services, Hannah Lam, Director of Acute Care & Nursing Excellence, Sara Ledesma, Emergency Department Manager, Terry Villareal, Clerk to the Board, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

Chair LOMELI inquired if there was a motion to approve the agenda. Director FLORES moved to approve the agenda, the motion was seconded by Director KASHYAP. The motion was carried with the following vote:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
LOMELI	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:08 p.m. to discuss the following items:

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

1. General Update;
2. Report on Peer Review/Credentials

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

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

Closed Session items D, E, F and G were deferred until the conclusion of Open Session due to insufficient time for discussion before Open Session began.

III. Open Session: Chair LOMELI adjourned Closed Session at 5:34 p.m., reconvening in Open Session at 5:35 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report:

1. General Report
Recommended Action: Information only; no action taken

2. Report on Peer Review/Credentials
Following review and discussion, Director FLORES made a motion to approve the Quality of Care/Peer Review/Credentials as presented. The motion was seconded by Director KASHYAP. The motion was carried with the following vote by the Board:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
LOMELI	Yes

B. Quality Division Update

1. Following review and discussion, Director FLORES made a motion to approve the Quality Division Update as presented. The motion was seconded by Director KASHYAP. The motion was carried with the following vote by the Board:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
LOMELI	Yes

IV. Presentation

A. Proclamation by Sheriff Boudreaux

Donna Hefner presented a proclamation on behalf of Tulare County Sheriff Mike Boudreaux, who was unable to attend, recognizing SVMC staff for their collaboration, professionalism, and assistance during the tragic April 9, 2026, incident that claimed the life of Detective Randy Hoppert.

V. Public Comments
None

VI. Consent Agenda
The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans and Informational Reports were presented for approval (Consent Agenda attached to the file copy of these Minutes). Following review and discussion, it was moved by Director FLORES, seconded by Director MARTINEZ, and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
LOMELI	Yes

VII. Approval of Minutes:

A. Motion made by Director FLORES and seconded by Director KASHYAP to approve the August 25, 2026, Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Abstain
LOMELI	Yes

VIII. Business Items

A. Annual Graduate Medical Education (GME) Report
Dr. Rajinder Chahal, Designated Institutional Official, presented the Annual GME Report. This report highlighted continued accreditation, progress resolving prior citations, and corrective actions addressing resident survey concerns. Updates included proposed fellowship programs, expanded rural training, and secured Song-Brown funding. Following review and discussion, it was moved by Director KASHYAP, seconded by Director MARTINEZ and carried to approve the Annual Graduate Medical Education Report as presented. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes

LOMELI	Yes

B. August 2026 Financial Report

Roger Larsen, Interim CFO presented the August monthly financial report. Following review and discussion, it was moved by Director FLORES, seconded by Director MARTINEZ and carried to approve the August Monthly Financial Report as presented. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
LOMELI	Yes

C. Investment Policy

Following review and discussion, it was moved by Director KASHYAP seconded by Director MARTINEZ and carried to approve the updated investment policy as presented. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
LOMELI	Yes

IX. SVLHCD Board Chair Report

Chair Lomeli shared a letter of appreciation from the Porterville Academy of Health Sciences recognizing SVMC's $20,000 contribution to its scholarship program, which supported eight Class of 2026 graduates pursuing careers in health sciences.

X. CEO Report

The CEO provided an overview of September performance highlights, organizational accomplishments, community engagement, and upcoming initiatives.

- Marketing and outreach: Reviewed September performance, including approximately 31,000 website sessions, 507,000 social media views, 12,000 social media followers, and a 3.9 Google star rating.
- REACH helicopter showcase: Welcomed a new helicopter featuring additional passenger capacity, a more powerful engine, and a longer flight range.
- Employee recognition: Recognized Maternal Child Health RN Chanel Norton as the newest DAISY Award recipient for compassionate patient care.
- Organizational awards: Celebrated eight Best of Central California awards with an employee Fiesta de Oro event.

- Run for Life: Reported 417 registered participants supporting cancer programs, screenings, education, and community outreach through the Roger S. Good Cancer Treatment Center.
- Foundation fundraiser: Highlighted Midnight in Manhattan, attended by 265 guests with support from 24 sponsors. The dessert auction raised more than $15,000, with event proceeds supporting new ultrasound and echocardiogram equipment.
- Legislative update: Presented an update on AB 2311 concerning direct physician employment options for qualifying health care districts to support recruitment and retention.
- Community partnerships and upcoming activities: Reviewed five September community events and highlighted nursing pathway graduation, breast cancer awareness activities, a Pet Partners meeting, and upcoming cancer center fundraisers.

XI. Announcements:
Regular Board of Directors Meeting – October 27, 2026, at 5:00 p.m.

XII. Closed Session: Board adjourned Open Session at 6:32 p.m., reconvening in Closed Session at 6:40 p.m. to discuss the following items:

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning. Estimated date of disclosure December 1, 2027

E. Pursuant to Gov. Code Section 54957(b) and Gov. Code Section 54957.6: Discussion Regarding Confidential Personnel Matter with CEO Donna Hefner the Board's Designated Representative – One (1) Item. Estimated Date of Disclosure January 1, 2028, for materials that are not part of an individual's private personnel file.

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

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

XIII. Open Session: Chairman LOMELI adjourned Closed Session at 7:01 p.m., reconvening in Open Session at 7:02 p.m.

D. Discussion Regarding Trade Secrets Pertaining to Services
Motion made by Director KASHYAP and seconded by Director MARTINEZ to approve the recommended GME Salary increase effective January 1, 2027, as presented. The motion carried and the vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes

LOMELI Yes

E. Discussion Regarding Personnel Matter
Recommended Action: Information Only: No Action Taken

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

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

XIV. Adjournment

The meeting was adjourned at 7:05 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

SIERRA VIEW MEDICAL CENTER

BUSINESS ITEMS

Supporting materials, if any, for the business items listed on this agenda are included in this section of the agenda packet.

SIERRA VIEW
MEDICAL CENTER

FY 2026 FINANCIAL AUDIT

Communications with the Board of Directors

Sierra View Local Health Care District

June 30, 2026

FINAL DRAFT

Communications with the Board of Directors

To the Board of Directors
Sierra View Local Health Care District

We have audited the consolidated financial statements of Sierra View Local Health Care District (the District) as of and for the year ended June 30, 2026, and have issued our report thereon dated October __, 2026. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated April 10, 2026 (for fiscal year ends: 2026, 2027, and 2028), we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the consolidated financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Purpose Districts. As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Sierra View Local Health Care District's internal control over financial reporting. Accordingly, we considered Sierra View Local Health Care District's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the consolidated financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

The supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our presentation to the Audit Committee on May 26, 2026.

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Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by Sierra View Local Health Care District are described in Note 1 to the consolidated financial statements. During fiscal year 2026, the District adopted Governmental Accounting Standards Board Statement (GASB) No. 103, *Financial Reporting Model Improvements*, and Statement No. 104, *Disclosure of Certain Capital Assets*. The adoption of GASB Statement No. 103 resulted in changes to the presentation and classification of certain revenues and expenses in the consolidated financial statements, including the presentation of noncapital subsidies. Prior-year amounts were reclassified to conform to the current-year presentation. The adoption of GASB Statement No. 104 had no impact on the District's consolidated financial statements. There have been no other new accounting policies adopted and there were no changes in the application of existing policies during fiscal year 2026. We noted no transactions entered into by the District during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the consolidated financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the consolidated financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the consolidated financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the District's consolidated financial statements were:

- Management's estimate of net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.
- Allowances for contractual and uncollectible accounts receivable are based on management's estimates of collectability by payor class, considering the historical payment and collection experience from each payor class. Management records the net collectible amount as the actual accounts receivable for the consolidated financial statements. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable.
- Management recorded estimated assets and liabilities for the expected eventual settlements of claims with both Medi-Cal and Medicare, in total the "estimated third-party payor settlement." The estimated third-party settlement is based on management's estimate of each individual settlement on an issue-by-issue basis. Historical trends and other information, such as communications with fiscal intermediaries, are also considered. We have gained an understanding of management's estimation methodology and have examined the documentation supporting these methodologies and formulas. We found the resulting estimate to be reasonable.

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- Estimates of uninsured losses for professional liability have been accrued as liabilities in the accompanying consolidated financial statements. We evaluated the key factors and assumptions used to develop the estimates of uninsured losses for professional liabilities and determined that they are reasonable in relation to the consolidated financial statements taken as a whole.
- Management's estimated liability for workers' compensation claims is recognized based on management's estimate of historical claims experience and known activity subsequent to year end. We evaluated the key factors and assumptions used to develop the actuarial estimates of uninsured losses for workers' compensation as well as recent claims activity. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.
- Management's estimates of useful lives of capital assets are based on the intended use and are within accounting principles generally accepted in the United States of America. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.
- Management's estimates of the discount rate, useful lives, and lease terms related to the District's operating lease right-to-use assets, lease liabilities, lease receivable, and deferred inflows of resources - leases. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the District's consolidated financial statements taken as a whole.
- Management's estimates of the discount rate, subscription terms, and other assumptions related to the District's subscription assets and subscription liabilities. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the District's consolidated financial statements taken as a whole.

Financial Statement Disclosures

The disclosures in the consolidated financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the District are net patient service revenue, cash and cash equivalents and investments, significant concentration of net patient accounts receivable, capital assets, long-term debt, valuation of financial instruments, and commitments and contingencies in Note 2, Note 3, Note 4, Note 5, Note 6, Note 9, and Note 10 to the consolidated financial statements, respectively.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of the District's consolidated financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the District's consolidated financial statements.

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Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the District's consolidated financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with U.S. GAAS and the California Code of Regulations, Title 2 Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. There were no circumstances that affected the form and content of the auditor's report.

Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no misstatements identified by us as a result of audit procedures and uncorrected by management that are material, either individually or in the aggregate, to the consolidated financial statements as a whole.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October ___, 2026.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the District's consolidated financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Board of Directors and management of Sierra View Local Health Care District, and is not intended to be, and should not be, used by anyone other than these specified parties.

Santa Rosa, California
October ___, 2026

FINAL DRAFT

Report of Independent Auditors and
Consolidated Financial Statements with
Supplementary Information

Sierra View Local Health Care District

June 30, 2026 and 2025

FINAL DRAFT

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Management's Discussion and Analysis

FINAL DRAFT

Sierra View Local Health Care District
Management's Discussion and Analysis
Years Ended June 30, 2026, 2025, and 2024

Sierra View Local Health Care District (the District) is a public entity organized under Local Hospital District Law as set forth in the Health and Safety Code of the State of California. The District includes the following component units, which are included as blended component units of the District's consolidated financial statements: Sierra View Medical Center (the Hospital) and Sierra View District Hospital Foundation (the Foundation). The District is the sole corporate member of the Hospital and is the sole voting member of the Foundation and has certain powers, such as the appointment and removal of the boards of directors and approval of changes to the articles of incorporation and bylaws.

Our discussion and analysis of the District's financial performance provides an overview of the District's financial activities for the years ended June 30, 2026, 2025, and 2024. Please read this in conjunction with the District's consolidated financial statements and accompanying notes, which begin on page 12.

Overview of the Consolidated Financial Statements

The District's consolidated financial statements consist of the consolidated statements of net position; consolidated statements of revenues, expenses, and changes in net position; consolidated statements of cash flows; and accompanying notes. Together, these statements provide information about the District's financial position, results of operations, and cash flows as of and for the fiscal years ended June 30, 2026 and 2025.

The consolidated statements of net position report the District's assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position at fiscal year-end. The consolidated statements of revenues, expenses, and changes in net position report all revenues and expenses using the accrual basis of accounting, regardless of when cash is received or paid. The consolidated statements of cash flows explain cash receipts, cash payments, and net changes in cash from operating, noncapital financing, capital and related financing, and investing activities. The notes provide additional detail necessary to understand the amounts reported in the consolidated financial statements.

One of the most important questions asked about the District's finances is whether the District, as a whole, is better off or worse off as a result of the year's activities. Changes in net position are one indicator of financial health; however, readers should also consider nonfinancial factors such as changes in the patient base, service volumes, quality measures, and local economic conditions.

Effective for the year ended June 30, 2026, the District adopted GASB Statement No. 103, *Financial Reporting Model Improvements*. The Statement changes the presentation of the consolidated statements of revenues, expenses, and changes in net position by requiring noncapital subsidies to be reported in a separate category immediately following operating income and before other nonoperating revenues and expenses, and it revises the definitions of nonoperating revenues and expenses. The Statement also revised the required content and presentation of Management's Discussion and Analysis, including an increased focus on explaining significant changes in financial position and results of operations. As a result, certain fiscal year 2025 amounts have been reclassified to conform to the fiscal year 2026 presentation. The reclassifications did not change previously reported total net position or the previously reported increase in net position for fiscal year 2025.

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Financial Summary

Financial highlights for fiscal year 2026, include the following:

- The District's increase in net position was $12.3 million for 2026 as compared to a $10.3 million increase for 2025.
- The District reported operating income of $5.1 million in 2026 compared with an operating loss of $2.8 million in 2025.
- Total operating revenue increased $13.8 million to $191.9 million, while total operating expenses only increased $5.9 million to $186.8 million.
- In 2026, the District received net payments of $13.7 million by way of the Inter-Governmental Transfer Program. In 2025, these payments totaled $12.7 million.

Summary of Assets, Deferred Outflows, Liabilities, Deferred Inflows, and Net Position (in thousands):

	As of June 30,		
	2026	2025	pre-GASB 103* 2024
Current assets	$ 81,080	$ 77,417	$ 77,709
Capital assets	69,575	71,447	77,815
Restricted and other assets	182,898	179,683	167,530
Total assets	$ 333,553	$ 328,547	$ 323,054
Deferred outflows of resources	$ 1,007	$ 1,259	$ 1,511
Current liabilities	$ 24,592	$ 26,591	$ 25,965
Long-term liabilities	34,619	39,891	45,297
Total liabilities	$ 59,211	$ 66,482	$ 71,262
Deferred inflows of resources	$ 652	$ 946	$ 1,224
Net investment in capital assets	$ 69,370	$ 64,915	$ 64,824
Restricted - expendable	6,194	5,971	5,798
Restricted - nonexpendable	463	462	462
Unrestricted	198,670	191,030	180,995
Total net position	$ 274,697	$ 262,378	$ 252,079

**Fiscal year 2024 amounts are presented on the basis originally reported and have not been reclassified to conform to the fiscal year 2026 presentation under GASB Statement No. 103. Accordingly, certain fiscal year 2024 classifications are not directly comparable to fiscal years 2025 and 2026*

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Summary of Revenues, Expenses, and Changes in Net Position (in thousands):

	Fiscal Years Ended June 30,		
	2026	2025	pre-GASB 103* 2024
Operating revenues			
Net patient service revenues	$ 183,469	$ 169,592	$ 156,856
Other operating revenues	8,423	8,491	8,322
Total operating revenues	191,892	178,083	165,178
Operating expenses			
Salaries, wages, and benefits	100,804	94,178	93,829
Professional fees	23,377	23,398	17,714
Supplies	28,166	25,919	24,876
Depreciation and amortization	10,182	11,056	12,055
Other operating expenses	24,224	26,303	22,843
Total operating expenses	186,753	180,854	171,317
Total operating income (loss)	5,140	(2,771)	(6,138)
Noncapital subsidies			
District tax revenues	1,969	1,806	1,670
Noncapital grants and contributions	114	213	290
Total noncapital subsidies	2,083	2,019	1,960
Total income (loss) from operations and noncapital subsidies	7,223	(752)	(4,178)
Nonoperating revenues (expenses)			
Investment return	6,882	4,814	4,123
Interest expense	(863)	(961)	(1,088)
Other nonoperating items	(924)	7,198	4,867
Total nonoperating revenues	5,095	11,051	7,902
Increase in net position	$ 12,319	$ 10,299	$ 3,724

**Fiscal year 2024 amounts are presented on the basis originally reported and have not been reclassified to conform to the fiscal year 2026 presentation under GASB Statement No. 103. Accordingly, certain fiscal year 2024 classifications are not directly comparable to fiscal years 2025 and 2026*

Operating revenues increased $13.8 million, or 7.8%, in 2026, while operating expenses increased $5.9 million, or 3.3%. As a result, the District improved from an operating loss of $2.8 million in 2025 to operating income of $5.1 million in 2026. Other nonoperating revenues decreased $6.0 million. The District therefore reported a $12.3 million increase in net position in 2026 compared with $10.3 million in 2025.

FINAL DRAFT

Detailed Analyses

Analysis of Financial Position

At June 30, 2026, total assets were $333.6 million, an increase of $5.0 million, or 1.5%, from June 30, 2025. Current assets increased $3.7 million. Cash and cash equivalents decreased $9.5 million, while patient accounts receivable increased $2.8 million, other receivables increased $9.5 million primarily due to delayed supplemental funding payments, and investments and restricted funds increased $5.5 million. Capital assets decreased $1.9 million and subscription assets decreased $1.3 million.

Total liabilities decreased $7.3 million, or 10.9%, to $59.2 million. Bonds and notes payable decreased $5.7 million and estimated third-party payor settlements decreased $1.9 million. These decreases were primarily due to principal payments and bond premium amortizations and were partially offset by a $1.0 million increase in self-insurance reserves and a $0.9 million increase in accrued payroll and related costs. Deferred inflows of resources related to leases decreased $0.3 million.

Total net position increased $12.3 million to $274.7 million. Net investment in capital assets increased $4.5 million, restricted expendable net position increased $0.2 million, and unrestricted net position increased $7.6 million. From June 30, 2024 to June 30, 2025, total assets increased $5.5 million, total liabilities decreased $4.8 million, and total net position increased $10.3 million.

Results of Operations

Net Patient Service Revenue

Net patient service revenue increased $13.9 million, or 8.2%, to $183.5 million in 2026. Gross patient service revenue increased $21.8 million, or 3.1%, to $725.4 million. Outpatient service revenue increased $30.7 million, partially offset by an $8.8 million decrease in inpatient ancillary service revenue and a $0.1 million decrease in daily hospital service revenue. Contractual allowances and the provision for bad debts increased $7.9 million, partially offsetting the growth in gross revenue

The increase in net patient service revenue in 2026 is due to a robust outpatient activity. Total outpatient visits increased by 4.6% in 2026 as compared to 2025 primarily due to increased outpatient surgeries, emergency department visits, CT exams, and ultrasound procedures. Outpatient charges increased to $444 million in 2026 from $414 million in 2025 and as a percentage of total charges, outpatient charges were 61.2% as compared to 58.8%, respectively. Acute patient days decreased to 18,685 in 2026 from 19,833 in 2025 primarily due to decrease in the average length of stay from 3.74 days to 3.49 days due to improved care management and lower acuity; acute discharges increased to 5,351 from 5,306 in 2025. Inpatient charges decreased to $281 million in 2026 from $290 million in 2025.

Supplemental funding, including the Intergovernmental Transfer program, decrease to $22.5 million in 2026 from $24.9 million in 2025. Collection percentages increased to 25.3% from 24.1% in 2025 due to amended cost reports related to 2024 and 2025.

FINAL DRAFT

Other Operating Revenue

Other operating revenue decreased $0.1 million, or 0.8%, to $8.4 million and was generally consistent with the prior year.

Operating Expenses

Operating expenses increased $5.9 million, or 3.3%, to $186.8 million. The most significant changes were as follows:

- Salaries, wages, and benefits increased $6.6 million, or 7.0%, to $100.8 million. Staffing as measured by paid full-time equivalents (FTEs), was 883 in 2026 and 878 in 2025. Employee benefits totaled $19.8 million in 2026 and $18.0 million in 2025. Salaries and wages per paid FTE increased to $91,766 in 2026 from $86,717 in 2025. This increase in salaries, wages, and benefits was primarily driven by a 3% merit increase and market adjustment to salaries and wages and increased employee health insurance premium costs.

- Professional fees decreased $0.02 million, or 0.1%, to $23.4 million. This decrease was primarily driven by lower use of contracted labor (traveling nurses, therapists and other contract service costs).

- Supplies increased $2.2 million, or 8.7%, to $28.2 million. This increase was primarily driven by a $1.5 million increase in pharmaceutical costs such as chemotherapy and infusion drugs.

- Purchased services increased $0.3 million, or 2.6%, to $11.2 million. This increase was primarily driven by information technology service rate increases and medical transportation costs.

- Depreciation and amortization decreased $0.9 million, or 7.9%, to $10.2 million, reflecting changes in the depreciable, right-to-use, and subscription asset bases.

- Other operating expenses, excluding purchased services, decreased $2.4 million, or 15.4%, to $13.0 million. The decrease primarily reflected a $2.3 million reduction in the other operating expense category, partially offset by modest increases in recruiting expenses, repairs and maintenance, and utilities.

Because operating revenue growth exceeded operating expense growth, the District improved from an operating loss of $2.8 million in 2025 to operating income of $5.1 million in 2026.

Noncapital Subsidies

As required by GASB Statement No. 103, noncapital subsidies are presented separately following income from operations. District tax revenue increased $0.2 million, or 9.0%, to $2.0 million, while noncapital grants and contributions decreased $0.1 million to $0.1 million. The District property tax revenues are levied by the County on the District's behalf during the year and are intended to help finance the District's activities during the same year.

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Nonoperating Revenues and Expenses

Investment return increased $2.1 million, but the District reported a $0.8 million decrease in fair value of investments in 2026 compared with a $4.8 million increase in 2025. Combined investment return and fair value changes therefore decreased $3.6 million to $6.0 million. Interest expense decreased $0.1 million. Other nonoperating revenue, net of other nonoperating expense, decreased $2.4 million, principally because the $2.1 million gain on disposal of capital assets recognized in 2025 did not recur in 2026.

Liquidity and Cash Flows

Net cash provided by operating activities decreased $7.9 million primarily due to the $9.5 million increase in other receivables. Cash used in capital and related financing activities increased $6.0 million, reflecting $6.3 million of capital purchases, scheduled debt, lease, and subscription payments, and the absence of the prior-year proceeds from capital asset disposals.

Cash and cash equivalents decreased $9.5 million to $15.4 million. Total investments and restricted funds increased $5.5 million to $186.1 million; therefore, combined cash, investments, and restricted funds decreased approximately $4.0 million to $201.4 million. Because portions of those investments are restricted or board designated, they are not all available for general operations.

Supporting Operating Indicators

	2026	2025	2024
Census			
Adult patient days	18,685	19,833	19,849
Adult discharges	5,351	5,306	5,213
Average length of stay	3.49	3.74	3.81
Utilization			
Skilled nursing facility (SNF) patient days	178	143	477
Sub-acute patient days	12,333	11,881	11,723
Emergency room visits	42,710	41,655	41,525
Intensity of service indicator			
Case mix index (Medicare)	1.5453	1.5927	1.6368
Case mix index (Overall)	1.2947	1.3599	1.3724
Efficiency indicators			
Full-time equivalents (FTE)	882.51	878.01	862.58
Productive FTEs	760.53	752.09	736.20
FTEs per adjusted occupied bed	5.01	5.12	5.01

Fiscal Year 2025 Compared with Fiscal Year 2024

Net patient service revenue increased $12.7 million, or 8.1%, in 2025 due to robust outpatient activity. Acute patient days decreased slightly to 19,833 from 19,849, adult discharges increased to 5,306 from 5,213, total outpatient visits increased 3.7%, and inpatient and outpatient charges increased.

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Operating expenses increased $9.5 million, or 5.6%, in 2025. The largest reported changes were a $5.7 million increase in professional fees, a $1.0 million increase in supplies, and increases in purchased services and physician-related costs. The operating loss improved to $2.8 million from $6.1 million. Total nonoperating revenues increased $3.2 million, and the increase in net position improved to $10.3 million from $3.7 million.

Significant Capital Asset and Long-Term Financing Activity

Capital Asset Activity

At June 30, 2026, the District had $69.6 million invested in capital assets, net of accumulated depreciation, compared with $71.4 million at June 30, 2025. The District added $6.3 million of capital assets and recorded $8.1 million of depreciation. Construction in progress increased $1.4 million to $5.6 million after $6.3 million of additions and $4.9 million of transfers to completed assets.

The District reported approximately $2.3 million of estimated costs to complete projects under construction at June 30, 2026. The projects include various remodeling, major repair, and expansion projects funded in part from the 2019 Bond Project Fund. The District also reported approximately $33.1 million in the project fund at year-end.

Net right-to-use assets decreased $0.1 million because there were no new lease additions and amortization continued. Net subscription assets decreased $1.3 million after $0.6 million of additions, $1.9 million of amortization, and contract terminations or other reductions.

Long-Term Financing, Leases, and Subscription Arrangements

Bonds and notes payable decreased $5.7 million to $34.8 million. The decrease reflected scheduled principal payments and bond premium amortization, together with repayment of the remaining $0.9 million Banc of America note. The District did not issue new debt during 2026. The 2019 Series revenue bonds mature through 2034 and the 2020 Series revenue bonds mature through 2030.

Lease liabilities decreased $0.1 million to $0.2 million, with no new lease additions. Subscription liabilities decreased $1.2 million to $2.5 million after $0.6 million of additions and $1.9 million of payments.

The District had no changes in credit ratings, debt limitation, covenant compliance or financing plans during 2026.

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Currently Known Facts, Decisions, or Conditions

Fiscal Year 2027 Operating Budget

The District's Board of Directors approved the fiscal year 2027 budget at its June 23, 2026, meeting. For fiscal year 2027, the District is budgeted to increase its net position by $3.5 million. The increase is due to the following assumptions:

- Inpatient volumes are budgeted to increase 3.6% over 2026 volumes.
- Outpatient volumes are projected to decrease 2.4% when compared to 2026.
- Operating loss of $4.9 million.
- Total nonoperating revenue of $8.4 million.
- Overall operating revenue will decrease by 2.1% and expenses will increase by 3.3% as compared to 2026.

Compared with fiscal year 2026 actual results, the most significant expected differences are in overall operating revenue due to lower collection rates, lower outpatient volumes and higher inpatient volumes anticipated at the time the budget was developed.

Approved Capital and Financing Decisions

At June 30, 2026, the District reported approximately $2.3 million of estimated costs to complete existing projects. The District also was working with architects and structural engineers on plans for another Rural Health Clinic and an expansion of the Distinct Part Skilled Nursing, and seismic compliance plans to be submitted for approval by January 31, 2027.

Reimbursement, Regulatory, and Other Known Conditions

The District is located in southeast Tulare County, California, which is highly dependent on agriculture for employment. As of August 2025, the unemployment rate in Tulare County is approximately 180% higher than California as a whole. This situation has been the norm for several years and is not expected to improve over the next few years. The District will, therefore, continue to see a high utilization of Medi-Cal (Medicaid) and uninsured patients.

The State of California continues to experience fiscal difficulties. As a result, the District will continue to see pressure placed on its Medi-Cal reimbursement for the foreseeable future.

Workforce, Contracting, and Cost Decisions

Workforce costs are expected to increase due to a 3% merit increase in June of 2026 along with other market adjustments to compensation totaling $3.5 million increase in expense. New professional service agreements signed in 2026 are expected to increase professional fees expense in FY27 by $2.7 million. Additional contracted services and increases in contract rates are expected to increase purchased services by $1.2 million.

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Report of Independent Auditors

Placeholder

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Consolidated Financial Statements

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Sierra View Local Health Care District
Consolidated Statements of Net Position
June 30, 2026 and 2025

	2026	2025
ASSETS		
Current assets		
Cash and cash equivalents	$ 15,375,312	$ 24,837,985
Short-term investments and restricted funds	6,051,804	5,499,931
Patient accounts receivable, net of allowances for doubtful accounts of $13,382,842 and $14,220,797 in 2026 and 2025, respectively	22,208,635	19,396,341
Other receivables	29,722,616	20,268,454
Current maturities of lease receivable	314,043	301,020
Inventories	4,605,905	4,492,912
Prepaid expenses and deposits	2,801,744	2,619,918
Total current assets	81,080,059	77,416,561
Long-term investments and restricted funds	175,906,528	171,333,918
Investments in securities	4,115,745	3,738,872
Right-of-use assets, net of amortization	146,618	279,156
Subscription assets, net of amortization	2,087,195	3,374,198
Other assets	250,000	250,000
Lease receivables, net of current maturities	392,591	706,635
Capital assets		
Non-depreciable	13,945,178	12,541,445
Depreciable, net of accumulated depreciation	55,629,476	58,905,980
Total capital assets	69,574,654	71,447,425
Total assets	$ 333,553,390	$ 328,546,765
DEFERRED OUTFLOWS OF RESOURCES		
Advance refunding of bonds payable, net	$ 1,007,021	$ 1,258,777
Total deferred outflows of resources	$ 1,007,021	$ 1,258,777

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See accompanying notes.

Sierra View Local Health Care District
Consolidated Statements of Net Position
June 30, 2026 and 2025

	2026	2025
LIABILITIES		
Current liabilities		
Bond interest payable	$ 608,825	$ 693,525
Current maturities of bonds payable	4,235,000	4,235,000
Current maturities of notes payable	-	939,806
Current maturities of lease liabilities	130,972	137,820
Current maturities of subscription liabilities	1,655,578	1,482,445
Accounts payable and accrued expenses	5,344,916	5,497,946
Accrued payroll and related costs	10,100,048	9,195,437
Estimated third-party payor settlements	2,517,030	4,408,713
Total current liabilities	24,592,369	26,590,692
Self-insurance reserves	3,168,001	2,129,089
Bonds payable, less current maturities	30,572,336	35,353,576
Lease liabilities, less current maturities	33,758	164,729
Subscription liabilities, less current maturities	845,324	2,243,374
Total liabilities	$ 59,211,788	$ 66,481,460
DEFERRED INFLOWS OF RESOURCES		
Deferred inflows of resources - leases	$ 652,058	$ 946,030
Total deferred inflows of resources	$ 652,058	$ 946,030
NET POSITION		
Net investment in capital assets	$ 69,369,900	$ 64,914,933
Restricted - expendable	6,194,445	5,970,585
Restricted - nonexpendable	462,448	462,448
Unrestricted	198,669,772	191,030,086
Total net position	$ 274,696,565	$ 262,378,052

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See accompanying notes.

Sierra View Local Health Care District
Consolidated Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2026 and 2025

	2026	2025
Operating revenues		
Net patient service revenue, net of provision for bad debts of $5,263,395 and $3,183,581 in 2026 and 2025, respectively	$ 183,468,877	$ 169,592,499
Other operating revenue	8,423,273	8,491,049
Total operating revenues	191,892,150	178,083,548
Operating expenses		
Salaries and wages	81,029,456	76,137,451
Supplies	28,165,705	25,919,073
Professional fees	23,376,547	23,398,087
Employee benefits	19,774,218	18,040,796
Depreciation and amortization	10,181,735	11,055,870
Purchased services	11,200,772	10,915,328
Other operating expenses	4,633,847	6,982,048
Repairs and maintenance	3,299,653	3,257,761
Utilities	3,247,598	3,180,831
Building and equipment rent	432,925	504,446
Insurance	1,410,173	1,462,650
Total operating expenses	186,752,629	180,854,341
Income (loss) from operations	5,139,521	(2,770,793)
Noncapital subsidies		
District tax revenues	1,969,424	1,806,026
Noncapital grants and contributions	114,133	213,270
Total noncapital subsidies	2,083,557	2,019,296
Total income (loss) from operations and noncapital subsidies	7,223,078	(751,497)
Nonoperating revenues (expenses)		
Investment return	6,882,034	4,814,163
Net (decrease) increase in the fair value of investments	(849,099)	4,826,696
Interest expense	(863,016)	(961,397)
Other nonoperating expenses	(421,668)	(440,927)
Other nonoperating revenues	347,184	2,812,204
Total nonoperating revenues	5,095,435	11,050,739
Increase in net position	12,318,513	10,299,242
Net position, beginning of year	262,378,052	252,078,810
Net position, end of year	$ 274,696,565	$ 262,378,052

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See accompanying notes.

Sierra View Local Health Care District
Consolidated Statements of Cash Flows
Years Ended June 30, 2026 and 2025

	2026	2025
Cash flows from operating activities		
Cash received from patients and third-party payors	$ 178,764,900	$ 174,762,919
Cash received from other sources	8,061,354	7,967,144
Cash paid to suppliers for goods and services	(76,215,069)	(75,741,025)
Cash paid to employees for services	(108,314,313)	(96,826,432)
Net cash provided by operating activities	2,296,872	10,162,606
Cash flows from noncapital financing activities		
District tax revenues	1,969,424	1,806,026
Noncapital grants and contributions	114,133	213,270
Net cash provided by noncapital financing activities	2,083,557	2,019,296
Cash flows from capital and related financing activities		
Purchase of capital assets	(6,256,465)	(4,181,022)
Proceeds from disposals of capital assets	-	3,245,937
Payments on bonds	(4,235,000)	(4,055,000)
Proceeds from lease receivables	-	465,453
Payments on notes payable	(939,806)	(1,201,341)
Payments on lease liabilities	(137,819)	(141,812)
Payments on subscription liabilities	(1,857,875)	(1,402,140)
Interest payments on debt	(947,716)	(1,051,572)
Net cash used in capital and related financing activities	(14,374,681)	(8,321,497)
Cash flows from investing activities		
Purchase of investments	(207,088,891)	(151,008,995)
Sale of investments	200,738,436	148,288,533
Investment income	6,882,034	260,110
Net cash provided by (used in) investing activities	531,579	(2,460,352)
Net change in cash and cash equivalents	(9,462,673)	1,400,053
Cash and equivalents, beginning of year	24,837,985	23,437,932
Cash and equivalents, end of year	$ 15,375,312	$ 24,837,985

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See accompanying notes.

Sierra View Local Health Care District
Consolidated Statements of Cash Flows
Years Ended June 30, 2026 and 2025

	2026	2025
Reconciliation of income (loss) from operations to net cash provided by operating activities		
Income (loss) from operations	$ 5,139,521	$ (2,770,793)
Adjustments to reconcile income (loss) from operations to net cash provided by operating activities		
Depreciation and amortization	10,181,735	11,055,870
Amortization of bond premium	(546,240)	(623,484)
Provision for bad debts	5,263,395	3,183,581
Change in assets and liabilities		
Patient accounts receivable, net	(8,075,689)	1,235,071
Other receivables	(9,106,978)	(1,271,422)
Inventories	(112,993)	(202,260)
Prepaid expenses and deposits	(181,826)	(298,514)
Advance refunding of bonds payable, net	251,756	251,755
Lease receivables	301,021	(180,217)
Accounts payable and accrued expenses	(574,698)	(1,266,569)
Accrued payroll and related costs	904,611	635,617
Estimated third-party payor settlements	(1,891,683)	751,768
Self-insurance reserves	1,038,912	(59,911)
Deferred inflows of resources - leases	(293,972)	(277,886)
Net cash provided by operating activities	$ 2,296,872	$ 10,162,606
Supplemental disclosure of noncash investing and financing activities		
Noncash acquisition of subscription assets	$ 639,284	$ 2,823,929
Gain on disposal of capital assets	$ -	$ 2,065,350

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See accompanying notes.

Note 1 – Summary of Significant Accounting Policies

A summary of significant accounting policies applied in the preparation of the accompanying consolidated financial statements follows:

Reporting entity – Sierra View Local Health Care District (the District) is a public entity organized under Local Hospital District Law as set forth in the Health and Safety Code of the State of California. The District is a political subdivision of the State of California and is generally not subject to federal or state income taxes. The District is governed by a five-member Board of Directors, elected from within the district to specified terms of office.

The District includes the following component units, which are included as blended component units of the District's consolidated financial statements: Sierra View Medical Center (the Hospital) and Sierra View District Hospital Foundation (the Foundation). The District is the sole corporate member of the Hospital and the sole voting member of the Foundation and has certain powers, such as the appointment and removal of the boards of directors and approval of changes to the articles of incorporation and bylaws.

The District is located in Porterville, California, and operates a 132-bed acute care facility, 35-bed long-term care facility, several outpatient clinics, and provides other patient services. The District provides health care services primarily to individuals who reside in the local geographic area.

The Foundation is a California nonprofit corporation exempt from federal and state income tax. The Foundation is organized for the purpose of soliciting tax-exempt funds for the support of the Hospital. The Foundation is considered a component unit of the District.

Basis of preparation – The consolidated financial statements of the District have been prepared in accordance with accounting principles generally accepted in the United States of America, including all applicable statements of the Governmental Accounting Standards Board (GASB). The proprietary fund method of accounting is followed and uses the economic resources measurement focus and the accrual basis of accounting. In addition, these statements follow generally accepted accounting principles applicable to the health care industry, which are included in the American Institute of Certified Public Accountants' Audit and Accounting Guide, *Health Care Entities,* to the extent that these principles do not contradict GASB standards.

Accounting and audit standards – Pursuant to GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 Financial Accounting Standards Board (FASB) and American Institute of Certified Public Accountants Pronouncements*, the District's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989, and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts and the State Controller's Office prescribed reporting guidelines.

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Use of estimates – The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amount of revenues and expenses during the reporting period. Major items requiring estimates and assumptions include net patient service revenue, allowance for contractual and doubtful accounts receivable, third-party payor settlements, uninsured losses for medical malpractice liabilities, liabilities for worker's compensation claims, right-of-use lease assets and liabilities, subscription assets and liabilities, and useful lives of capital assets. Actual results could differ from those estimates.

Cash and cash equivalents and investments – The District considers cash and cash equivalents to include certain investments in highly liquid debt instruments with an original maturity of a short-term nature or subject to withdrawal upon request. Exceptions are for those investments that are intended to be continuously invested. Investments in debt securities are reported at fair value. Interest, dividends, and both unrealized and realized gains and losses on investments are reflected as nonoperating revenues (expenses) when earned.

Investments, including those held by the bond indenture trustee and restricted investments, are measured at fair value in the consolidated statements of net position. Investment income or loss (including realized gains and losses on investments, interest, and dividends) are included in the increase in unrestricted net position unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are included as the net change in the fair value of investments and reported in the accompanying consolidated statements of revenues, expenses, and changes in net position. Purchase premiums and discounts are recognized in interest income using the interest method over the terms of the securities. Gains and losses on the sale of securities are recorded on the trade date and are determined using the specific identification method.

Investments in equity securities having a readily determinable fair value and all debt securities are carried at fair value. Other investments are valued at the lower of cost (or fair value at time of donation, if acquired by contribution) or fair value. Investment return includes dividend, interest, and other investment income, realized gains and losses on investments carried at fair value, and realized gains and losses on other investments.

Restricted funds – Restricted funds include amounts designated by the Board of Directors for replacement or purchases of capital assets, and other specific purposes, and amounts held by trustees under specified agreements. Restricted funds consist primarily of deposits with local banking and investment institutions and bond trustees.

Patient accounts receivable, net – Patient accounts receivable consist of amounts owed by various governmental agencies, insurance companies, and private patients. The District manages its receivables by regularly reviewing the accounts, inquiring with respective payors as to collectability, and providing for allowances in its accounting records for estimated contractual adjustments and doubtful accounts. Significant concentrations of patient accounts receivable are discussed further in the footnotes.

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Other receivables – Other receivables are comprised of third-party payor program receivables and other miscellaneous receivables. The composition of other receivables for the years ended June 30, 2026 and 2025, were as follows:

	2026	2025
Third-party payor program receivables	26,745,877	16,573,515
Other miscellaneous receivables	2,976,739	3,694,939
Total other receivables	29,722,616	20,268,454

Inventories – Inventories are consistently reported from year to year at cost, determined by average costs and replacement values that are not in excess of market. The District does not maintain levels of inventory values such as those under a first-in, first-out or last-in, first-out method.

Lease receivables – The District's lease receivables are measured at the present value of lease payments expected to be received during the lease term. Under the lease agreements, the District may receive variable lease payments that are dependent upon the lessee's revenue. The variable payments are recorded as an inflow of resources in the period the payment is received. The deferred inflow of resources is recorded at the initiation of each lease in an amount equal to the initial recording of the lease receivable. The deferred inflows of resources are amortized on an effective interest method basis over the term of each lease.

Capital assets – Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. All purchased capital assets are valued at cost when historical records are available and at an estimated historical cost when no historical records exist. Donated capital assets are valued at their estimated fair market value on the date received. Construction in progress includes capitalized interest costs of related borrowings, net of interest earned on unspent proceeds of the related borrowings. It is the policy of the District to capitalize equipment costing more than $5,000. The costs of assets sold or retired are removed from the accounts in the year of sale or retirement, with any gain or loss included in the consolidated financial statements.

The District periodically evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset. There were no impairment losses in other operating expenses in the consolidated statements of revenues, expenses, and changes in net position as of June 30, 2026 and 2025.

Depreciation of capital assets are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 30 years for buildings and improvements, and 3 to 15 years for equipment.

Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities, or extend useful lives are capitalized.

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Right-of-use assets – The right-of-use assets are initially measured at an amount equal to the initial measurement of the related lease liability plus any lease payments made prior to the lease term, less lease incentives, and plus ancillary charges necessary to place the lease into service. The right-of-use assets are amortized on a straight-line basis over the life of the related lease.

Subscription assets – The subscription assets are initially measured at an amount equal to the initial measurement of the related subscription liability plus any contract payments made to the subscription-based information technology arrangements (SBITA) vendor at the commencement of the subscription term, capitalizable initial implementation cost, less any incentive payments received from the SBITA vendor at the commencement of the subscription term. The subscription assets are amortized on a straight-line basis over the shorter of the subscription term or the useful life of the underlying assets.

Deferred outflows and inflows – The District records deferred outflows or inflows of resources in its consolidated financial statements for consumption or acquisition of its consolidated net position that is applicable to a future reporting period. These financial statement elements are distinct from assets and liabilities.

Compensated absences – The District's employees earn paid time off (PTO) benefits at varying rates depending on years of service. Benefits can accumulate up to specified maximum levels. Employees are paid for accumulated PTO either upon termination or retirement. Accrued PTO liabilities included in accrued payroll and related costs as of June 30, 2026 and 2025, were $4,612,290 and $4,367,891, respectively.

The following is a summary of changes in compensated absences transactions for the years ended June 30:

	Balance as of July 1, 2025	Increases	Decreases	Balance as of June 30, 2026	Current Portion
Compensated absences	$ 4,367,891	$ 47,255,757	$ 47,011,358	$ 4,612,290	$ 4,612,290

	Balance as of July 1, 2024	Increases	Decreases	Balance as of June 30, 2025	Current Portion
Compensated absences	$ 4,161,071	$ 46,705,705	$ 46,498,885	$ 4,367,891	$ 4,367,891

Sick leave – The District's full-time and part-time employees are front-loaded 5 days of sick leave on date of hire and on each 12-month anniversary period and unused days are paid out the day before their annual anniversary. Per diem employees accrue up to 5 days of sick leave based on their hours worked on each 12-month anniversary period and unused days carry over to the following year, up to a maximum of 10 days. Employees are not paid for unused sick leave upon termination or retirement. Accrued sick leave is included in accrued payroll and related costs in the consolidated statements of net position.

Lease liabilities – The District recognizes lease contracts or equivalents that have a term exceeding one year and that meet the definition of an other than short-term lease. The District uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using the District's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract. Short-term lease payments are expensed when incurred.

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The following is a summary of changes in lease liabilities, net for the years ended :

	Balance as of July 1, 2025	Increases	Decreases	Balance as of June 30, 2026	Current Portion
Lease liabilities	$ 302,549	$ -	$ 137,819	$ 164,730	$ 130,972

	Balance as of July 1, 2024	Increases	Decreases	Balance as of June 30, 2025	Current Portion
Lease liabilities	$ 444,361	$ -	$ 141,812	$ 302,549	$ 137,820

Subscription liabilities – The District entered into various agreements for information technology (IT) subscriptions. These agreements range in terms up to year 2029. Total subscription payments were $1,857,875 and $1,402,140 for fiscal years 2026 and 2025, respectively. Variable payments based upon the use of the underlying IT asset are not included in the subscription liability because they are not fixed in substance; therefore, these payments are not included in subscription assets or subscription liabilities. There were no variable subscription expenses or payments in the fiscal years ended June 30, 2026 and 2025. The District did not enter into any additional subscription agreements that have yet to commence as of June 30, 2026.

The District recognizes contracts or equivalents that have a term exceeding one year and the cumulative future payments on the contract exceeding $100,000 that meet the definition of an other than short-term subscription. The District uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using the District's incremental borrowing rate at start of the subscription for a similar asset type and term length to the contract. Short-term subscription payments are expensed when incurred.

The following is a summary of changes in subscription liabilities, net for the years ended June 30:

	Balance as of July 1, 2025	Increases	Decreases	Balance as of June 30, 2026	Current Portion
Subscription liabilities	$ 3,725,819	$ 639,284	$ 1,864,201	$ 2,500,902	$ 1,655,578

	Balance as of July 1, 2024	Increases	Decreases	Balance as of June 30, 2025	Current Portion
Subscription liabilities	$ 2,896,576	$ 2,823,929	$ 1,994,686	$ 3,725,819	$ 1,482,445

Net position – The net position of the District is comprised of net investment in capital assets, restricted expendable, restricted nonexpendable, and unrestricted net positions.

Net investment in capital assets – Net investment in capital assets represents investments in all capital assets (land, construction in progress, land improvements, building and building improvements, and equipment), net of depreciation/amortization, less any debt issued to finance those capital assets.

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Restricted - expendable – The restricted expendable net position is restricted through external constraints imposed by creditors, grantors, contributors, laws or regulations of other governments, or constraints imposed by law through constitutional provisions or enabling legislation and includes assets in self-insurance trust funds, revenue bond reserve fund assets, and net position restricted to use by donors.

Restricted - nonexpendable – The restricted nonexpendable net position is equal to the principal portion of permanent endowments. The endowments remain intact, with unrestricted earnings on such funds available for use as expendable assets.

Unrestricted – Unrestricted net position consists of net position that does not meet the definition of net investment in capital assets, restricted expendable, or restricted nonexpendable.

Statements of revenues, expenses, and changes in net position – All revenues and expenses directly related to the delivery of health care services are included in operating revenues and operating expenses in the consolidated statements of revenues, expenses, and changes in net position.

Noncapital subsidies consist of resources received or provided that support ongoing operations and for which the provider does not receive goods or services of approximately equal value in return. These amounts include property tax revenues designated to support operating and community benefit activities and grants and contributions intended to support operations.

Nonoperating revenues and expenses include investment return, net increase in fair value of investments, interest expense, and other nonoperating revenues and expenses.

Net patient service revenue – Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Delinquent patient accounts are recorded as bad debts and transferred for collection. Recoveries are recorded, net of recovery costs estimated, as an increase to net patient service revenue.

Charity care – The District provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The District accepts all patients regardless of their ability to pay. Partial payments to which the District is entitled from public assistance programs on behalf of patients that meet the District's charity care criteria are reported as patient service revenue. Charity care, which is excluded from recognition as receivables or revenue in the consolidated financial statements, is measured on the basis of uncompensated cost. The cost of charity care is determined by applying the District's Medicare cost to charge ratio to the gross charges that qualify for charity care under the District's policy. Using the District's Medicare cost to charge ratio, the estimated cost of these charges was $1,506,972 and $1,037,664 for the years ended June 30, 2026 and 2025, respectively.

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District tax revenues – The District receives approximately 1.0% of its financial support from property taxes. These funds are used to support operations and meet required debt service agreements. They are classified as noncapital subsidies as the revenue is not directly linked to capital related expenditures. Property taxes are levied by the County on the District's behalf during the year and are intended to help finance the District's activities during the same year. Amounts are levied on the basis of the most current property values on record with the County. The County has established certain dates to levy, lien, mail bills, and receive payments from property owners during the year. Property taxes are considered delinquent on the day following each payment due date.

Noncapital grants and contributions – From time to time, the District receives grants from various governmental agencies and private organizations. The District also receives contributions from related foundation organizations, as well as from individuals and other private organizations. Revenues from grants and contributions are recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or capital acquisitions. These amounts, when recognized upon meeting all requirements, are reported as components of the consolidated statements of revenues, expenses, and changes in net position.

Risk management – The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters.

Income taxes – The District operates under the purview of the Internal Revenue Code, Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to state or federal taxes on income. The Foundation is a California nonprofit corporation exempt from federal and state income tax as a 501(c) (3) organization.

Reclassification – Certain reclassifications have been made to the 2025 financial statements to conform to the 2026 financial statement presentation. These reclassifications had no effect on the changes in net position.

New accounting pronouncements – During 2026, the District implemented GASB Statement No. 103, *Financial Reporting Model Improvements*. The standard establishes revised requirements for the classification of operating and nonoperating revenues and expenses and requires the separate presentation of noncapital subsidies. As a result of implementation, certain revenues and expenses, including transfers, community benefit activities, and certain subsidy-related transactions, were reclassified in the accompanying consolidated statements of revenues, expenses, and changes in net position. Prior-year amounts have been reclassified to conform to the current-year presentation. These reclassifications had no effect on previously reported increase in net position or total net position.

During 2026, the District implemented GASB Statement No. 104, *Disclosure of Certain Capital Asset*s. The standard establishes additional disclosure requirements for certain capital assets, including separate disclosure of lease assets by major class of underlying asset, subscription assets, and other intangible assets, as applicable. The standard also establishes disclosure requirements for capital assets held for sale. Implementation of the standard did not have an effect on the District's consolidated net position or increase in net position.

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Note 2 – Net Patient Service Revenue

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Payments for inpatient acute care services rendered to Medicare program beneficiaries are based on prospectively determined rates, which vary accordingly to the patient diagnostic classification system. Outpatient services are generally paid under an outpatient classification system subject to certain limitations. Certain reimbursement areas are still subject to final settlement that are determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. At June 30, 2026, cost reports through June 30, 2023, have been audited or otherwise final settled.

Medi-Cal – Prior to July 1, 2013, inpatient acute care services rendered to Medi-Cal program beneficiaries were reimbursed under a cost reimbursement methodology; however, the District is also subject to per discharge limits. The District was paid for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by Medi-Cal. Per discharge limits for the District have been determined by Medi-Cal through June 30, 2011. Beginning on July 1, 2013, inpatient acute care services were rendered to Medi-Cal program beneficiaries under a diagnostic related group (DRG) methodology. Under this methodology, similar to Medicare, services are paid at prospectively determined rates per discharge according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient skilled nursing care services rendered to Medi-Cal program beneficiaries are reimbursed at prospectively determined per diem rates. Outpatient services rendered to Medi-Cal program beneficiaries are reimbursed based on prospectively determined fee schedules. At June 30, 2026, cost reports through June 30, 2022, have been audited or otherwise final settled.

Other – Payments for services rendered to other than Medicare and Medi-Cal program beneficiaries are based on established rates or on agreements with certain commercial insurance companies, health maintenance organizations, and preferred provider organizations that provide for various discounts from established rates.

Net patient service revenue is comprised of the following for the years ended :

	2026	2025
Daily hospital services	$ 64,196,178	$ 64,314,468
Inpatient ancillary services	216,966,512	225,768,393
Outpatient services	444,231,625	413,532,234
Gross patient service revenue	725,394,315	703,615,095
Less contractual allowances and provision for bad debts	(541,925,438)	(534,022,596)
Net patient service revenue	$ 183,468,877	$ 169,592,499

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Gross patient service revenue before any provision for bad debts, summarized by payor, is as follows for the years ended :

	2026	2025
Medicare and Medicare managed care	43%	43%
Medi-Cal and Medi-Cal managed care	40%	39%
Commercial	15%	16%
Self-pay	1%	1%
Others	1%	1%
Total	100%	100%

Medicare and Medi-Cal revenue accounts for a large percentage of the District's gross patient revenues each year. Laws and regulations governing the Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

Non-Designated Public Hospitals (NDPHs), including the District, were authorized, in 2011's Assembly Bill (AB) 113, to use intergovernmental transfers (IGTs) to obtain federal supplemental funds for Medi-Cal inpatient fee-for-service. The IGTs are used to bring NDPHs, in the aggregate, up to their upper payment limit (UPL). The UPL is the federal maximum available under the Medicaid program, as calculated based on the actual costs of providing care. For the years ended June 30, 2026 and 2025, the District recognized amounts under the IGT program of approximately $13,700,000 and $12,700,000, respectively, which have been reported as net patient service revenue.

Note 3 – Cash and Cash Equivalents and Investments

The District has deposits held by various financial institutions in the form of operating cash and cash equivalents. At June 30, 2026 and 2025, the District's cash deposits had carrying amounts of $15,375,312 and $24,837,985, and bank balances of $16,328,297 and $26,625,334 , respectively. All of these funds were held in cash deposits, which are collateralized with the California Government Code (CGC), except for $250,000 per account that is federally insured by the Federal Deposit Insurance Corporation.

Under the provisions of the CGC, California banks and savings and loan associations are required to secure the District's deposits by pledging government securities as collateral. The market value of pledged securities must equal at least 110% of the District's deposits. California law also allows financial institutions to secure the District's deposits by pledging first trust deed mortgage notes having a value of 150% of the District's total deposits. The pledged securities are held by the pledging financial institution's trust department in the name of the District.

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Investments and restricted funds and investments in securities consist of U.S. government securities, certificates of deposit, money market, and corporate bonds and are stated at fair value. Changes in market value between years are reflected as a component of net increase (decrease) in the fair value of investments in the accompanying statement of revenues, expenses, and changes in net position. At June 30, investments were as follows:

	2026	2025
Board designated funds 2019 Bond project fund	$ 33,070,246	$ 32,278,190
Funds held by trustee under bond indenture	5,651,625	5,453,428
Restricted funds	49,003	46,503
Unrestricted investments	147,303,203	142,794,600
Total investments	$ 186,074,077	$ 180,572,721
Short-term investments and restricted funds	$ 6,051,804	$ 5,499,931
Long-term investments and restricted funds	175,906,528	171,333,918
Investments in securities	4,115,745	3,738,872
Total investments	$ 186,074,077	$ 180,572,721

A summary of scheduled maturities by investment type at June 30, 2026 and 2025, is as follows:

	2026			
		Investment Maturities (in years)		
	Fair Value	Less than 1	1 to 5	6 to 10+
Investment type				
Federal agency securities	$ 70,588,785	$ -	$ 70,588,785	$ -
U.S. treasury securities	42,077,936	42,077,936	-	-
Corporate bonds	41,054,233	-	41,054,233	-
Certificates of deposit	16,052,713	-	16,052,713	-
Mutual security funds	6,051,802	6,051,802	-	-
Mutual funds	6,132,863	6,132,863	-	-
Total investments and restricted funds	181,958,332	54,262,601	127,695,731	-
Corporate bonds	302,752	-	302,752	-
Certificates of deposit	149,631	-	149,631	-
Money market funds	7,757	7,757	-	-
Mutual security funds	2,730,583	2,730,583	-	-
Equity securities	925,022	925,022	-	-
Total investments in securities	4,115,745	3,663,362	452,383	-
Total investments	$ 186,074,077	$ 57,925,963	$ 128,148,114	$ -

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	2025			
		Investment Maturities (in years)		
	Fair Value	Less than 1	1 to 5	6 to 10+
Investment type				
Federal agency securities	$ 38,966,064	$ -	$ 38,966,064	$ -
U.S. treasury securities	47,180,988	47,180,988	-	-
Corporate bonds	42,957,832	-	42,957,832	-
Certificates of deposit	30,361,030	-	30,361,030	-
Money market funds	5,499,932	5,499,932	-	-
Mutual security funds	11,868,003	11,868,003	-	-
Total investments and restricted funds	176,833,849	64,548,923	112,284,926	-
Corporate bonds	306,556	-	306,556	-
Certificates of deposit	50,100	-	50,100	
Money market funds	165,084	165,084	-	-
Mutual security funds	1,431,893	1,431,893	-	-
Equity securities	1,785,239	1,785,239	-	-
Total investments in securities	3,738,872	3,382,216	356,656	-
Total investments	$ 180,572,721	$ 67,931,139	$ 112,641,582	$ -

Required disclosures for the District's deposit and investment risks at June 30, 2026, were as follows:

Authorized Investment Type	Maximum Maturity	Maximum Percentage of Portfolio	Maximum Investment in One Issuer
Certificates of deposit	5 years	None	None
Local Agency Investment Fund (LAIF)	N/A	None	None
Tulare County Treasurer's Pooled Money Fund	N/A	None	None
U.S. Treasury Securities	5 years	None	None
Federal agency securities & Gov't sponsored enterprises	5 years	None	None
Passbook savings or money market account	N/A	None	None
Mutual funds	N/A	20%	None
Medium-term corporate notes - A rated	5 years	30%	None

Investment activities of the District are governed by sections of the CGC, which specifies the authorized investments that may be made by the District. The District's investment policy requires that all investing activities of the District comply with the CGC and also sets forth certain additional restrictions that exceed those imposed by the CGC. Investment activities of the Foundation are governed by the Internal Revenue Code; therefore, its investment activities are not subject to the same requirements as the District.

Interest rate risk – Interest rate risk is the risk that changes in interest rates will adversely affect the fair value of an investment. Investments held for longer periods are subject to increased risk of adverse interest rate changes.

Credit risk and concentration of credit risk – Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. State law limits investments in commercial paper to the rating of A1 by Standard & Poor's or P-1 by Moody's Investors Service and limits investments in corporate bonds to the rating of A by Standard and Poor's and Moody's Investors Service. Investments held with fiscal agents are further limited to the specific terms contained in the Trustee Agreements.

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At June 30, 2026 and 2025, in accordance with State law, the District did not have 5% or more of its net investment in commercial paper, corporate bonds, or medium-term notes of a single organization, nor any one money market mutual fund. Investments in obligations of the U.S. government, U.S. government agencies, or government-sponsored enterprises are exempt from these limitations.

Custodial credit risk – For investments, custodial credit risk is the risk that, in the event of the failure of the counterparty, the District will not be able to recover the value of its investments or deposits that are in the possession of an outside party. At year end, the District had no custodial risks associated with its investments.

Note 4 – Patient Accounts Receivable, net

The District grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the District and management does not believe that there are any credit risks associated with these governmental agencies. Contracted and other patient accounts receivable consist of various payors, including individuals involved in diverse activities subject to differing economic conditions, and do not represent any concentrated credit risks to the District.

Patient accounts receivable is comprised of the following as of :

	2026	2025
Medi-Cal and Medi-Cal managed care	$ 75,793,624	$ 72,492,413
Other payors and self-pay	66,987,281	50,960,668
Medicare and Medicare managed care	52,070,362	49,805,393
Gross patient accounts receivable	194,851,267	173,258,474
Less allowances for contractual adjustments and allowance for doubtful accounts	(172,642,632)	(153,862,133)
Net patient accounts receivable	$ 22,208,635	$ 19,396,341

Concentration of net patient accounts receivable as of June 30 were as follows:

	2026	2025
Commercial	31%	29%
Medi-Cal and Medi-Cal managed care	27%	24%
Medicare and Medicare managed care	39%	44%
Other payors	3%	3%
Total	100%	100%

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Note 5 – Capital Assets

The capital asset activity of the District for the years ended June 30, 2026 and 2025, was as follows:

	Balance July 1, 2025	Increases	Decreases	Transfers	Balance June 30, 2026
Capital assets - non-depreciable					
Land	$ 8,331,665	$ -	$ -	$ -	$ 8,331,665
Construction in progress, net	4,209,780	6,256,465	-	(4,852,732)	5,613,513
	12,541,445	6,256,465	-	(4,852,732)	13,945,178
Capital assets - depreciable					
Land improvements	11,510,095	-	-	-	11,510,095
Building and improvements	144,575,183	-	-	399,522	144,974,705
Equipment	74,399,784	-	(81,644)	4,453,210	78,771,350
	230,485,062	-	(81,644)	4,852,732	235,256,150
Less accumulated depreciation for					
Land improvements	9,474,480	267,228	-	-	9,741,708
Buildings and improvements	98,423,487	3,820,798	-	-	102,244,285
Equipment	63,681,115	4,041,210	(81,644)	-	67,640,681
	171,579,082	8,129,236	(81,644)	-	179,626,674
Total capital assets - depreciable, net	58,905,980	(8,129,236)	-	4,852,732	55,629,476
Total capital assets, net	$ 71,447,425	$ (1,872,771)	$ -	$ -	$ 69,574,654

	Balance July 1, 2024	Increases	Decreases	Transfers	Balance June 30, 2025
Capital assets - non-depreciable					
Land	$ 8,331,665	$ -	$ -	$ -	$ 8,331,665
Construction in progress, net	3,077,147	3,470,323	(211,281)	(2,126,409)	4,209,780
	11,408,812	3,470,323	(211,281)	(2,126,409)	12,541,445
Capital assets - depreciable					
Land improvements	11,674,399	-	(164,304)	-	11,510,095
Building and improvements	147,591,657	-	(3,589,651)	573,177	144,575,183
Equipment	101,764,387	710,699	(29,628,534)	1,553,232	74,399,784
	261,030,443	710,699	(33,382,489)	2,126,409	230,485,062
Less accumulated depreciation for					
Land improvements	9,355,729	283,055	(164,304)	-	9,474,480
Buildings and improvements	96,735,707	4,308,125	(2,620,345)	-	98,423,487
Equipment	88,533,266	4,776,383	(29,628,534)	-	63,681,115
	194,624,702	9,367,563	(32,413,183)	-	171,579,082
Total capital assets - depreciable, net	66,405,741	(8,656,864)	(969,306)	2,126,409	58,905,980
Total capital assets, net	$ 77,814,553	$ (5,186,541)	$ (1,180,587)	$ -	$ 71,447,425

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Note 6 – Bonds and Notes Payable

A summary of bonds and notes payable as of June 30, 2026 and 2025, is as follows:

	2026						
	Date of Issue	Date of Maturity	Interest Rates	Annual Principal Installments	Original Issue Amount	Original Premium Amount	Outstanding at June 30, 2026
Revenue bonds							
2019 Series	9/11/2019	7/1/2034	2.00% - 5.00%	$1,905,000 - $2,485,000	$ 30,500,000	$ 2,317,944	$ 20,714,413
2020 Series	9/17/2020	7/1/2030	4.00% - 5.00%	$2,420,000 - $2,915,000	24,125,000	3,748,592	14,092,923
					$ 54,625,000	$ 6,066,536	$ 34,807,336

	2025						
	Date of Issue	Date of Maturity	Interest Rates	Annual Principal Installments	Original Issue Amount	Original Premium Amount	Outstanding at June 30, 2025
Revenue bonds							
2019 Series	9/11/2019	7/1/2034	2.00% - 5.00%	$1,815,000 - $2,485,000	$ 30,500,000	$ 2,317,944	$ 22,787,005
2020 Series	9/17/2020	7/1/2030	4.00% - 5.00%	$2,330,000 - $2,915,000	24,125,000	3,748,592	16,801,571
Notes payable							
Banc of America Public Capital Corporation	5/11/2021	5/11/2026	1.23%	945,591	5,000,000	-	939,806
					$ 59,625,000	$ 6,066,536	$ 40,528,382

The following tables summarize the District's bonds and notes payable transactions for the years ended:

	2026				
	Balance July 1, 2025	Net Borrowings and Issuance Proceeds	Payments and Bond Premium Amortization During the Year	Balance June 30, 2026	Current Portion
Revenue bonds					
2019 Series revenue bonds	$ 21,910,000	$ -	$ (1,905,000)	$ 20,005,000	$ 1,905,000
2019 Series revenue bonds premium	877,005	-	(167,592)	709,413	-
2020 Series revenue bonds	15,600,000	-	(2,330,000)	13,270,000	2,330,000
2020 Series revenue bonds premium	1,201,571	-	(378,648)	822,923	-
Notes payable					
Banc of America Public Capital Corporation	939,806	-	(939,806)	-	-
	$ 40,528,382	$ -	$ (5,721,046)	$ 34,807,336	$ 4,235,000

	2025				
	Balance July 1, 2024	Net Borrowings and Issuance Proceeds	Payments and Bond Premium Amortization During the Year	Balance June 30, 2025	Current Portion
Revenue bonds					
2019 Series revenue bonds	$ 23,725,000	$ -	$ (1,815,000)	$ 21,910,000	$ 1,905,000
2019 Series revenue bonds premium	1,066,665	-	(189,660)	877,005	-
2020 Series revenue bonds	17,840,000	-	(2,240,000)	15,600,000	2,330,000
2020 Series revenue bonds premium	1,635,395	-	(433,824)	1,201,571	-
Notes payable					
Banc of America Public Capital Corporation	1,953,220	-	(1,013,414)	939,806	939,806
Flex Financial	187,927	-	(187,927)	-	-
	$ 46,408,207	$ -	$ (5,879,825)	$ 40,528,382	$ 5,174,806

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As of June 30, 2026, the District's bonds and notes payable requirements to maturity, net of unamortized premium of $1,532,336, are as follows:

Years Ending June 30,	Principal	Interest	Total
2027	$ 4,235,000	$ 1,129,650	$ 5,364,650
2028	4,575,000	958,175	5,533,175
2029	4,745,000	787,575	5,532,575
2030	4,920,000	598,900	5,518,900
2031	5,125,000	391,325	5,516,325
2032 - 2035	9,675,000	581,100	10,256,100
	$ 33,275,000	$ 4,446,725	$ 37,721,725

Revenues of the District are the primary source of repayment of the District's long-term liabilities.

Revenue Bonds, Series 2019 – In September 2019, the District issued $30,500,000 of Sierra View Local Health Care District Revenue Bonds, Series 2019 (Series 2019 Bonds) to redeem the outstanding principal and interest on the Series 2010 Bonds and to fund the construction of two Rural Health Clinics and a new Distinct Part Skilled Nursing Facility within the District. The Series 2019 Bonds were issued with a premium of $2,317,944, at rates ranging from 2.00% to 5.00%. Principal payments are due annually on July 1 and interest payments are due semi-annually on January 1 and July 1.

Revenue Bonds, Series 2020 – In September 2020, the District issued $24,125,000 of Sierra View Local Health Care District Revenue Bonds, Series 2020 (Series 2020 Bonds), to redeem the outstanding principal and interest on the Series 2015 Bonds. The Series 2020 Bonds were issued with a premium of $3,748,592, at rates ranging from 4.00% to 5.00%. Principal payments are due annually on July 1 and interest payments are due semi-annually on January 1 and July 1.

Notes payable – This represents an equipment financing loan with Banc of America Public Capital Corporation, at a rate of 1.23%, to obtain (and reimburse for prior expenditures related to) medical equipment, electronic equipment, electronic health records software, and other projects. The liability is collateralized by certain equipment. This also includes an installment note payable with Flex Financial, at a rate of 0.49%, to obtain medical and electronic equipment. The liability is collateralized by the leased equipment. The liability was fully repaid during the year ended June 30, 2026.

Note 7 – Insurance Plans

The District is exposed to various risks of loss related to torts, theft of, damage to, and destruction of assets, errors, and omissions, injuries to employees, and natural disasters. The District carries insurance for medical malpractice and general comprehensive liability, and workers' compensation claims.

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Workers' compensation insurance – Under the California Workers' Compensation Insurance provisions, an entity can elect to pay the actual claims filed for worker's compensation benefits. The District has an occurrence insurance policy and chose to purchase occurrence insurance policies with significant deductibles for these claims prior to July 1, 2014, and again beginning July 1, 2018. From July 1, 2014, through June 30, 2018, the District was fully insured for these claims with no deductible and a larger premium that was expensed monthly. Effective July 1, 2018, through June 30, 2021, and renewed through July 1, 2027, the District purchased an occurrence insurance policy, which the District plans to maintain by renewing its current policy. The District's coverage under this occurrence insurance policy is $2,000,000 per occurrence, $2,000,000 in the annual aggregate, and a self-insured retention level of $350,000 per claim.

While the ultimate amount of workers' compensation liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements is adequate to cover such claims. The liability has not been discounted. Management is aware of no potential workers' compensation liability that, the settlement of which, if any, would have a material adverse effect on the District's net position for the years ended June 30, 2026 and 2025.

Medical malpractice insurance – The District maintains malpractice liability insurance coverage under various claims-made policies covering losses up to $15,000,000 per occurrence, with a per claim deductible of $50,000. The District plans to maintain the claims-made insurance coverage by renewing its current policy, or by replacing it with equivalent insurance. An unfunded liability related to losses from claims incurred but not reported during the coverage period and unasserted claims, identified under the District's incident reporting system, has been accrued based on estimates. These estimates incorporate past experience as well as other considerations, including the nature of each claim or incident and relevant trend factors.

Following is a summary of the changes in the workers' compensation and medical malpractice insurance liabilities for the years ended:

	2026			
	Balance, July 1, 2025	Increases	Decreases	Balance, June 30, 2026
Workers' compensation	$ 1,929,089	$ 1,731,381	$ (692,469)	$ 2,968,001
Medical malpractice	200,000	-	-	200,000
	$ 2,129,089	$ 1,731,381	$ (692,469)	$ 3,168,001

	2025			
	Balance, July 1, 2024	Increases	Decreases	Balance, June 30, 2025
Workers' compensation	$ 1,989,000	$ 556,539	$ (616,450)	$ 1,929,089
Medical malpractice	200,000	-	-	200,000
	$ 2,189,000	$ 556,539	$ (616,450)	$ 2,129,089

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Note 8 – Employees' Retirement Plans

The District has defined contribution retirement plans covering substantially all of the District's employees. The plans qualify under the Internal Revenue Code Section 401(a). Contributions by the District are based on a percentage of the employee's compensation base salary or wage for the year, subject to certain factors and limitations. The District contributed $3,324,777 and $3,559,423 to the 401(a) plans for the years ended June 30, 2026 and 2025, respectively.

The District also offers its employees a deferred compensation plan (the 457 Plan) created in accordance with Internal Revenue Code Section 457(b). The 457 Plan, available to substantially all District employees upon hire, permits them to defer a portion of their compensation until future years. The deferred compensation is not available to employees until termination, retirement, death, or certain emergency situations.

Note 9 – Disclosures About Fair Value

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements must maximize the use of observable inputs and minimize the use of unobservable inputs. There is a hierarchy of three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs supported by little or no market activity and significant to the fair value of the assets or liabilities.

Following is a description of the valuation methodologies and inputs used for assets and liabilities measured at fair value on a recurring basis and recognized in the accompanying consolidated statements of net position or for which the fair value is disclosed in the notes to the consolidated financial statements, as well as the general classification of such assets and liabilities pursuant to the valuation hierarchy. There have been no significant changes in the valuation techniques during the years ended June 30, 2026 and 2025.

Cash – The carrying amount approximates fair value.

Investments – Where quoted market prices are available in an active market, investments are classified within Level 1 of the valuation hierarchy.

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Fair value of financial instruments – The following tables present the estimated fair values of the District's financial instruments and the level within the fair value hierarchy in which the fair measurements are reported at June 30:

	2026			
	Level 1	Level 2	Level 3	Total
Investments				
Federal agency securities	$ 70,588,785	$ -	$ -	$ 70,588,785
U.S. treasury securities	42,077,936	-	-	42,077,936
Corporate bonds	-	41,356,985	-	41,356,985
Mutual security funds	8,863,446	-	-	8,863,446
Money market funds	6,059,559	-	-	6,059,559
Certificates of deposit	-	16,202,344	-	16,202,344
Equity securities	925,022	-	-	925,022
Total investments by fair value level	$ 128,514,748	$ 57,559,329	$ -	$ 186,074,077

	2025			
	Level 1	Level 2	Level 3	Total
Investments				
Federal agency securities	$ 38,966,064	$ -	$ -	$ 38,966,064
U.S. treasury securities	47,180,988	-	-	47,180,988
Corporate bonds	-	43,264,388	-	43,264,388
Mutual security funds	13,299,896	-	-	13,299,896
Money market funds	5,665,016	-	-	5,665,016
Certificates of deposit	-	30,411,130	-	30,411,130
Equity securities	1,785,239	-	-	1,785,239
Total investments by fair value level	$ 106,897,203	$ 73,675,518	$ -	$ 180,572,721

As required by GASB Statement No. 72, *Fair Value Measurement and Application*, the investments are classified within the level of the lowest significant input considered in determining fair value.

There were no significant transfers between Levels 1, 2, and 3 in the current fiscal year.

Note 10 – Commitments and Contingencies

Construction in progress – As of June 30, 2026 and 2025, the District had recorded approximately $5,614,000 and $4,210,000, respectively, as construction in progress representing costs capitalized for various remodeling, major repair, and expansion projects on the District's premises. Estimated cost to complete all projects as of June 30, 2026, is approximately $2,260,000.

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Funding for the various remodeling, major repair, and expansion projects comes from the board designated fund 2019 Bond Project Fund (2019 Project Fund) which is included in investments and restricted funds (see Note 3) and came from the proceeds of issuing the 2019 Series revenue bonds (see Note 6). As of June 30, 2026 and 2025, there was approximately $33,100,000 and $32,300,000 in the 2019 Project Fund, respectively. The 2019 Project Fund has been used to construct a Rural Health Clinic in Terra Bella, California. The District is looking to construct another Rural Health Clinic outside of Porterville, California, but within the District. Over the last few years, guidance regarding seismic safety regulations has been updated. Based on recent interpretations by the State of California, the District is confident that it can expand its current Distinct Part Skilled Nursing Facility while maintaining the original hospital building. As such, the District is working with independent architects and structural engineers to finalize the plan which should be completed by December 2027.

Litigation – The District is a defendant in various legal proceedings arising out of the normal conduct of its business. In the opinion of management and its legal representatives, the District has valid and substantial defenses, and settlements or awards arising from legal proceedings, if any, will not exceed existing insurance coverage, nor will they have a material adverse effect on the net position, results of operations, or liquidity of the District.

Regulatory environment – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. The District is subject to routine surveys and reviews by federal, state, and local regulatory authorities. The District has also received inquiries from health care regulatory authorities regarding its compliance with laws and regulations. Although the District management is not aware of any violations of laws and regulations, it has received corrective action requests as a result of completed and ongoing surveys from applicable regulatory authorities. Management continually works in a timely manner to implement operational changes and procedures to address all corrective action requests from regulatory authorities. Breaches of these laws and regulations and noncompliance with corrective action requests could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Hospital Seismic Safety Act – The California Hospital Facilities Seismic Safety Act (SB 1953) specifies certain requirements that must be met at various dates in order to increase the probability that a California hospital can maintain uninterrupted operations following a major earthquake. Management believes that the Hospital is currently substantially in compliance with these requirements.

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Arbitrage – The Tax Reform Act of 1986 instituted certain arbitrage restrictions with respect to the issuance of tax-exempt bonds after August 31, 1986. Arbitrage regulations deal with the investment of all tax-exempt bond proceeds at an interest yield greater than the interest yield paid to bondholders. Generally, all interest paid to bondholders can be retroactively rendered taxable if applicable rebates are not reported and paid to the Internal Revenue Service at least every five years. During the current year, the District performed calculations of excess investment earnings on various bonds and financings and, at June 30, 2026, does not expect to incur a significant liability.

Note 11 – Right-of-Use Assets and Lease Liabilities

The District is a lessee for noncancelable leases of equipment with lease terms through 2028. There are no residual value guarantees included in the measurement of the District's lease liabilities nor recognized as an expense for the years ended June 30, 2026 and 2025. The District does not have any commitments that were incurred at the commencement of the leases. The District is subject to variable equipment usage payments that are expensed when incurred. There were no amounts recognized as variable lease payments as lease expense on the consolidated statements of revenues, expenses, and changes in net position for the years ended June 30, 2026 and 2025. No termination penalties were incurred during the fiscal year.

	Balance as of July 1, 2025	Increases	Decreases	Balance as of June 30, 2026
Right-of-use assets	$ 1,074,051	$ -	$ -	$ 1,074,051
Less accumulated amortization	794,895	132,538	-	927,433
Right-of-use assets, net	$ 279,156	$ (132,538)	$ -	$ 146,618

	Balance as of July 1, 2024	Increases	Decreases	Balance as of June 30, 2025
Right-of-use assets	$ 1,074,051	$ -	$ -	$ 1,074,051
Less accumulated amortization	650,735	144,160	-	794,895
Right-of-use assets, net	$ 423,316	$ (144,160)	$ -	$ 279,156

For the years ended June 30, 2026 and 2025, the District recognized $132,538 and $144,160, respectively, in amortization expense included in depreciation and amortization expense on the consolidated statements of revenues, expenses, and changes in net position.

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The future principal and interest lease payments as of June 30, 2026, were as follows:

Years Ending June 30,	Principal Payments	Interest Payments	Total
2027	$ 130,972	$ 6,810	$ 137,782
2028	33,758	366	34,124
	$ 164,730	$ 7,176	$ 171,906

The District evaluated the right-of-use assets for impairment and determined there was no impairment for the years ended June 30, 2026 and 2025.

The District is also a lessor for noncancelable leases of office space with lease terms through 2028. For the years ended June 30, 2026 and 2025, the District recognized $303,640 and $469,351, respectively, in lease revenue released from the deferred inflows of resources related to the office leases included in other revenue on the consolidated statements of revenues, expenses, and changes in net position. No inflows of resources were recognized in the year related to termination penalties or residual value guarantees during fiscal years ended June 30, 2026 and 2025.

Note 12 – Subscription-based Information Technology Arrangements

The District has the following subscription assets, net activity as of June 30:

	Balance as of July 1, 2025	Increases	Decreases	Balance as of June 30, 2026
Subscription assets	$ 8,630,909	$ 639,284	$ 214,044	$ 9,056,149
Less accumulated amortization	5,256,711	1,919,961	207,718	6,968,954
Subscription assets, net	$ 3,374,198	$ (1,280,677)	$ 6,326	$ 2,087,195

	Balance as of July 1, 2024	Increases	Decreases	Balance as of June 30, 2025
Subscription assets	$ 6,399,526	$ 2,823,929	$ 592,546	$ 8,630,909
Less accumulated amortization	3,712,564	1,544,147	-	5,256,711
Subscription assets, net	$ 2,686,962	$ 1,279,782	$ 592,546	$ 3,374,198

For the years ended June 30, 2026 and 2025, the District recognized $1,919,961 and $1,544,147, respectively, in amortization expense included in depreciation and amortization expense on the consolidated statements of revenues, expenses, and changes in net position.

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The future subscription payments as of June 30, 2026, were as follows:

Years Ending June 30,	Principal Payments	Interest Payments	Total
2027	$ 1,655,578	$ 82,506	$ 1,738,084
2028	844,067	21,340	865,407
2029	1,257	1,230	2,487
	$ 2,500,902	$ 105,076	$ 2,605,978

The District evaluated the subscription assets for impairment and determined there was no impairment for the years ended June 30, 2026 and 2025.

Note 13 – Subsequent Events

Subsequent events are events or transactions that occur after the consolidated statement of net position date but before the consolidated financial statements are issued. The District recognizes in the consolidated financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the consolidated statement of net position, including the estimates inherent in the process of preparing the consolidated financial statements. The District's consolidated financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the consolidated statement of net position but arose after the consolidated statement of net position date and before the consolidated financial statements are issued.

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Supplementary Information

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Sierra View Local Health Care District
Consolidating Statements of Net Position
June 30, 2026

	Sierra View Medical Center	Sierra View District Hospital Foundation	Eliminations	Total
ASSETS				
Current assets				
Cash and cash equivalents	$ 15,210,198	$ 165,114	$ -	$ 15,375,312
Short-term investments and restricted funds	6,051,804	-	-	6,051,804
Patient accounts receivable, net of allowances for doubtful accounts of $13,382,842	22,208,635	-	-	22,208,635
Other receivables	29,722,616	-	-	29,722,616
Current maturities of lease receivable	314,043	-	-	314,043
Inventories	4,605,905	-	-	4,605,905
Prepaid expenses and deposits	2,801,744	-	-	2,801,744
Total current assets	80,914,945	165,114	-	81,080,059
Long-term investments and restricted funds	175,906,528	-	-	175,906,528
Investments in securities	-	4,115,745	-	4,115,745
Right-of-use assets, net of amortization	146,618	-	-	146,618
Subscription assets, net of amortization	2,087,195	-	-	2,087,195
Other assets	250,000	-	-	250,000
Lease receivables, net of current maturities	392,591	-	-	392,591
Capital assets		-		
Non-depreciable	13,945,178	-	-	13,945,178
Depreciable, net of accumulated depreciation	55,629,476	-	-	55,629,476
Total capital assets	69,574,654	-	-	69,574,654
Total assets	$ 329,272,531	$ 4,280,859	$ -	$ 333,553,390
DEFERRED OUTFLOWS OF RESOURCES				
Advance refunding of bonds payable, net	$ 1,007,021	$ -	$ -	$ 1,007,021
Total deferred outflows of resources	$ 1,007,021	$ -	$ -	$ 1,007,021
LIABILITIES				
Current liabilities				
Bond interest payable	$ 608,825	$ -	$ -	$ 608,825
Current maturities of bonds payable	4,235,000	-	-	4,235,000
Current maturities of lease liabilities	130,972	-	-	130,972
Current maturities of subscription liabilities	1,655,578	-	-	1,655,578
Accounts payable and accrued expenses	5,344,916	-	-	5,344,916
Accrued payroll and related costs	10,100,048	-	-	10,100,048
Estimated third-party payor settlements	2,517,030	-	-	2,517,030
Total current liabilities	24,592,369	-	-	24,592,369
Self-insurance reserves	3,168,001	-	-	3,168,001
Bonds payable, less current maturities	30,572,336	-	-	30,572,336
Lease liabilities, less current maturities	33,758	-	-	33,758
Subscription liabilities, less current maturities	845,324	-	-	845,324
Total liabilities	$ 59,211,788	$ -	$ -	$ 59,211,788
DEFERRED INFLOWS OF RESOURCES				
Deferred inflows of resources - leases	$ 652,058	$ -	$ -	$ 652,058
Total deferred inflows of resources	$ 652,058	$ -	$ -	$ 652,058
NET POSITION				
Net investment in capital assets	$ 69,369,900	$ -	$ -	$ 69,369,900
Restricted - expendable	5,651,625	542,820	-	6,194,445
Restricted - nonexpendable	-	462,448	-	462,448
Unrestricted	195,394,181	3,275,591	-	198,669,772
Total net position	$ 270,415,706	$ 4,280,859	$ -	$ 274,696,565

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Sierra View Local Health Care District
Consolidating Statements of Net Position (Continued)
June 30, 2025

	Sierra View Medical Center	Sierra View District Hospital Foundation	Eliminations	Total
ASSETS				
Current assets				
Cash and cash equivalents	$ 24,549,195	$ 288,790	$ -	$ 24,837,985
Short-term investments and restricted funds	5,499,931	-	-	5,499,931
Patient accounts receivable, net of allowances for doubtful accounts of $14,220,797	19,396,341	-	-	19,396,341
Other receivables	20,268,454	-	-	20,268,454
Current maturities of lease receivable	301,020	-	-	301,020
Inventories	4,492,912	-	-	4,492,912
Prepaid expenses and deposits	2,619,918	-	-	2,619,918
Total current assets	77,127,771	288,790	-	77,416,561
Long-term investments and restricted funds	171,333,918	-	-	171,333,918
Investments in securities	-	3,738,872	-	3,738,872
Right-of-use assets, net of amortization	279,156	-	-	279,156
Subscription assets, net of amortization	3,374,198	-	-	3,374,198
Other assets	250,000	-	-	250,000
Lease receivables, net of current maturities	706,635	-	-	706,635
Capital assets		-	-	
Non-depreciable	12,541,445	-	-	12,541,445
Depreciable, net of accumulated depreciation	58,905,980	-	-	58,905,980
Total capital assets	71,447,425	-	-	71,447,425
Total assets	$ 324,519,103	$ 4,027,662	$ -	$ 328,546,765
DEFERRED OUTFLOWS OF RESOURCES				
Advance refunding of bonds payable, net	$ 1,258,777	$ -	$ -	$ 1,258,777
Total deferred outflows of resources	$ 1,258,777	$ -	$ -	$ 1,258,777
LIABILITIES				
Current liabilities				
Bond interest payable	$ 693,525	$ -	$ -	$ 693,525
Current maturities of bonds payable	4,235,000	-	-	4,235,000
Current maturities of notes payable	939,806	-	-	939,806
Current maturities of lease liabilities	137,820	-	-	137,820
Current maturities of subscription liabilities	1,482,445	-	-	1,482,445
Accounts payable and accrued expenses	5,497,946	-	-	5,497,946
Accrued payroll and related costs	9,195,437	-	-	9,195,437
Estimated third-party payor settlements	4,408,713	-	-	4,408,713
Total current liabilities	26,590,692	-	-	26,590,692
Self-insurance reserves	2,129,089	-	-	2,129,089
Bonds payable, less current maturities	35,353,576	-	-	35,353,576
Lease liabilities, less current maturities	164,729	-	-	164,729
Subscription liabilities, less current maturities	2,243,374	-	-	2,243,374
Total liabilities	$ 66,481,460	$ -	$ -	$ 66,481,460
DEFERRED INFLOWS OF RESOURCES				
Deferred inflows of resources - leases	$ 946,030	$ -	$ -	$ 946,030
Total deferred inflows of resources	$ 946,030	$ -	$ -	$ 946,030
NET POSITION				
Net investment in capital assets	$ 64,914,933	$ -	$ -	$ 64,914,933
Restricted - expendable	5,453,428	517,157	-	5,970,585
Restricted - nonexpendable	-	462,448	-	462,448
Unrestricted	187,982,029	3,048,057	-	191,030,086
Total net position	$ 258,350,390	$ 4,027,662	$ -	$ 262,378,052

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Sierra View Local Health Care District
Consolidating Statements of Revenues, Expenses, and Changes in Net Position
Year Ended June 30, 2026

	Sierra View Medical Center	Sierra View District Hospital Foundation	Eliminations	Total
Operating revenues				
Net patient service revenue, net of provision for bad debts of $5,263,395	$ 183,468,877	$ -	$ -	$ 183,468,877
Other operating revenue	8,423,273	-	-	8,423,273
Total operating revenues	191,892,150	-	-	191,892,150
Operating expenses				
Salaries and wages	81,029,456	-	-	81,029,456
Supplies	28,165,705	-	-	28,165,705
Professional fees	23,376,547	-	-	23,376,547
Employee benefits	19,774,218	-	-	19,774,218
Depreciation and amortization	10,181,735	-	-	10,181,735
Purchased services	11,200,772	-	-	11,200,772
Other operating expenses	4,295,355	338,492	-	4,633,847
Repairs and maintenance	3,299,653	-	-	3,299,653
Utilities	3,247,598	-	-	3,247,598
Building and equipment rent	432,925	-	-	432,925
Insurance	1,410,173	-	-	1,410,173
Total operating expenses	186,414,137	338,492	-	186,752,629
Income (loss) from operations	5,478,013	(338,492)	-	5,139,521
Noncapital subsidies				
District tax revenues	1,969,424	-	-	1,969,424
Noncapital grants and contributions	-	114,133	-	114,133
Total noncapital subsidies	1,969,424	114,133	-	2,083,557
Total income (loss) from operations and noncapital subsidies	7,447,437	(224,359)	-	7,223,078
Nonoperating revenues (expenses)				
Investment return	6,698,996	183,038	-	6,882,034
Net (decrease) increase in the fair value of investments	(1,143,617)	294,518	-	(849,099)
Interest expense	(863,016)	-	-	(863,016)
Other nonoperating expenses	(421,668)	-	-	(421,668)
Other nonoperating revenues	347,184	-	-	347,184
Total nonoperating revenues	4,617,879	477,556	-	5,095,435
Increase in net position	12,065,316	253,197	-	12,318,513
Net position, beginning of year	258,350,390	4,027,662	-	262,378,052
Net position, end of year	$ 270,415,706	$ 4,280,859	$ -	$ 274,696,565

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Sierra View Local Health Care District
Consolidating Statements of Revenues, Expenses, and Changes in Net Position
Year Ended June 30, 2025

	Sierra View Medical Center	Sierra View District Hospital Foundation	Eliminations	Total
Operating revenues				
Net patient service revenue, net of provision for bad debts of $3,183,581	$ 169,592,499	$ -	$ -	$ 169,592,499
Other operating revenue	8,491,049	-	-	8,491,049
Total operating revenues	178,083,548	-	-	178,083,548
Operating expenses				
Salaries and wages	76,137,451	-	-	76,137,451
Supplies	25,919,073	-	-	25,919,073
Professional fees	23,398,087	-	-	23,398,087
Employee benefits	18,040,796	-	-	18,040,796
Depreciation and amortization	11,055,870	-	-	11,055,870
Purchased services	10,915,328	-	-	10,915,328
Other operating expenses	6,641,166	340,882	-	6,982,048
Repairs and maintenance	3,257,761	-	-	3,257,761
Utilities	3,180,831	-	-	3,180,831
Building and equipment rent	504,446	-	-	504,446
Insurance	1,462,650	-	-	1,462,650
Total operating expenses	180,513,459	340,882	-	180,854,341
Loss from operations	(2,429,911)	(340,882)	-	(2,770,793)
Noncapital subsidies				
District tax revenues	1,806,026	-	-	1,806,026
Noncapital grants and contributions	-	213,270	-	213,270
Total noncapital subsidies	1,806,026	213,270	-	2,019,296
Total loss from operations and noncapital subsidies	(623,885)	(127,612)	-	(751,497)
Nonoperating revenues (expenses)				
Investment return	4,624,833	189,330	-	4,814,163
Net increase in the fair value of investments	4,554,053	272,643	-	4,826,696
Interest expense	(961,397)	-	-	(961,397)
Other nonoperating expenses	(440,927)	-	-	(440,927)
Other nonoperating revenues	2,812,204	-	-	2,812,204
Total nonoperating revenues	10,588,766	461,973	-	11,050,739
Increase in net position	9,964,881	334,361	-	10,299,242
Net position, beginning of year	248,385,509	3,693,301	-	252,078,810
Net position, end of year	$ 258,350,390	$ 4,027,662	$ -	$ 262,378,052

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SIERRA VIEW
MEDICAL CENTER

SEPTEMBER FINANCIALS

FINANCIAL PACKAGE
Sep-26

SIERRA VIEW MEDICAL CENTER

SUPPORTING SCHEDULES

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Sierra View Medical Center
Operating Expense Analysis - Actual vs. Budget
Sep-26 Sep-26

EMPLOYEE BENEFITS	Current Month			Year-to-Date		
Description/Department	Actual	Budget	Variance	Actual YTD	Budget YTD	Variance
Education Admin Nursing	6,000	1,502	4,498	6,000	4,506	1,494
GME-Internal Medicine Empl Benefits Other	11,237	11,600	(363)	66,915	34,800	32,115
F.I.C.A.	477,357	514,721	(37,364)	1,424,732	1,544,163	(119,431)
S.U.I.	10	12,500	(12,490)	41,074	37,500	3,574
Health Insur	708,498	640,834	67,664	2,099,253	1,922,502	176,751
Group Life Insur	21,752	21,000	752	66,573	63,000	3,573
Retirement	255,715	272,209	(16,494)	761,734	816,627	(54,893)
Worker's Comp	203,445	73,000	130,445	366,595	219,000	147,595
Educational Reimbursement	-	1,878	(1,878)	3,350	5,634	(2,284)
Employee Assistance Program	-	1,225	(1,225)	1,280	3,675	(2,395)
Awards & Recognition Committee (ARC)	740	833	(93)	3,690	2,499	1,191
EPPEC	-	-	-	-	-	-
Other Benefits	13,072	4,656	8,416	43,298	13,968	29,330
Totals	**1,697,824**	**1,555,958**	**141,866**	**4,884,494**	**4,667,874**	**216,620**

PROFESSIONAL FEES	Current Month			Year-to-Date		
Description/Department	Actual	Budget	Variance	Actual	Budget	Variance
Medical Physicians						
ICU	88,045	80,327	7,718	254,014	240,981	13,033
Nursery - Medical Physicians	59,092	62,957	(3,865)	150,398	188,871	(38,473)
Sub-Acute	7,500	8,500	(1,000)	23,800	25,500	(1,700)
Emergency Room	260,932	232,110	28,822	670,515	696,330	(25,815)
Emergency Room - Call Coverage	120,375	118,225	2,150	405,675	354,675	51,000
Surgery Clinic	96,342	84,533	11,809	314,871	253,599	61,272
Surgery Clinic - Call Coverage	-	-	-	-	-	-
Urology Clinic	36,000	36,000	-	108,000	108,000	-
Academic Health Clinic	-	-	-	-	-	-
Anesthesiology	284,209	341,667	(57,458)	878,039	1,025,001	(146,962)
Lab - Medical Physicians	28,230	22,033	6,197	38,213	66,099	(27,886)
Cardiac Cath Lab	3,000	2,425	575	9,000	7,275	1,725
Radiology - Medical Physicians	405,140	129,500	275,640	1,081,644	388,500	693,144
Chemotherapy - Medical Physicians	48,206	48,268	(62)	131,461	144,804	(13,343)
Radiation Therapy	3,150	3,150	-	9,450	9,450	-
Respiratory Therapy	2,250	2,250	-	6,750	6,750	-
Other Anc Svcs	145,060	271,000	(125,940)	615,881	813,000	(197,119)
GME Prog - Admin	-	-	-	-	-	-
GME Prog - Intern Med	105,517	77,181	28,336	281,319	231,543	49,776
Medical Staff	3,000	3,625	(625)	9,900	10,875	(975)
Infection Control	-	3,000	(3,000)	-	9,000	(9,000)
Total-Other Medical Physicians - Call Coverage	79,986	34,596	45,390	258,254	103,788	154,466
Total-Other Medical Physicians	50,066	118,589	(68,523)	66,825	355,767	(288,942)
	1,826,099	1,679,936	146,163	5,314,009	5,039,808	274,201
Med Therapists & Other (Travelers) Lab, Echo, Radiology, CT Scan, PT, ST						
Med Therapists & Other (Travelers)	62,165	7,538	54,627	175,047	22,615	152,432
Regisry Nurses						
OB, ED, L&D	84,873	87,779	(2,906)	281,543	258,142	23,401
Traveler Nurses						
ICU	-	-	-	-	-	-
Telemetry	-	-	-	-	-	-
OB	-	1,271	(1,271)	-	3,681	(3,681)
Nursery - Traveler Nurses	-	3,155	(3,155)	15,740	20,692	(4,952)
Emergency	-	-	-	-	-	-
Labor & Delivery	20,144	49,686	(29,542)	85,124	144,427	(59,303)
Surgery - Traveler Nurses	(300)	-	(300)	26,233	-	26,233
Recovery	(1,520)	-	(1,520)	30,371	-	30,371
Cath Lab	-	-	-	-	-	-
Endoscopy	26,885	-	26,885	141,438	-	141,438
Chemotherapy - Traveler Nurses	-	-	-	-	-	-
Total-Other - Traveler Nurses	28,712	-	28,712	57,986	-	57,986
	73,921	54,112	19,809	356,893	168,800	188,093
Consulting (Sub-Acute, Lab, Pharmacy, IT, ACS, Admin)	11,133	12,792	(1,659)	15,126	38,376	(23,251)
Legal (Compliance, Admin, HR)	61,932	44,916	17,016	154,306	134,748	19,558
Auditing Fees (Admin)	24,584	9,583	15,001	43,752	28,749	15,003
Other Contract Services (L&D, Surgery, Dietary, IT, ACS)	31,541	24,373	7,168	94,489	76,204	18,285
Other Prof Fees (GME IM, Admin)	8,245	27,500	(19,255)	34,525	82,500	(47,975)
Totals	**2,184,493**	**1,948,529**	**235,964**	**6,469,689**	**5,849,942**	**619,747**

Sierra View Medical Center
Operating Expense Analysis - Actual vs. Budget
Sep-26

Sep-26

PURCHASED SERVICES	Current Month			Year-to-Date		
Description/Department	Actual	Budget	Variance	Actual	Budget	Variance
Medical Services						
Surgery - Medical Services	-	7,083	(7,083)	(25)	21,249	(21,274)
Lab - Medical Services	91,827	84,278	7,549	239,033	252,834	(13,801)
Radiology - Medical Services	-	-	-	135	-	135
Other Ancillary Services	-	-	-	386	-	386
PET	25,434	30,250	(4,816)	82,652	90,750	(8,098)
Employee Health	-	2,835	(2,835)	-	8,505	(8,505)
	117,261	124,446	(7,185)	322,182	373,338	(51,156)
Other Services	-	-	-	-	-	-
Med-Surg	858	766	92	2,573	2,298	275
Sub-Acute	2,205	4,931	(2,726)	5,539	14,793	(9,254)
Medical Transport	2,263	35,417	(33,154)	42,078	106,251	(64,173)
Urology	-	542	(542)	-	1,626	(1,626)
Rural Clinic	-	3,164	(3,164)	2,395	9,492	(7,097)
Wound Healing	33,206	29,625	3,581	87,562	88,875	(1,313)
Labor & Delivery	7,065	3,767	3,298	21,196	11,301	9,895
Surgery - Other Purchased Services	56	-	56	167	-	167
Lab - Other Purchased Services	52	2,647	(2,595)	4,403	7,941	(3,538)
Radiology - Other Purchased Services	40,792	23,925	16,867	88,175	71,775	16,400
Rad Therapy	20,635	19,792	843	57,500	59,376	(1,876)
Nuclear Med	-	275	(275)	-	825	(825)
Resp Therapy	-	92	(92)	-	276	(276)
Endoscopy	2,228	7,063	(4,835)	16,623	21,189	(4,566)
Education Admin	-	15,000	(15,000)	-	45,000	(45,000)
GME - Admin	-	-	-	-	-	-
GME - Internal Medicine	96	2,462	(2,366)	96	7,386	(7,290)
Non-Pt Food Svc	1,084	1,349	(265)	1,567	4,047	(2,480)
Dietary	441	3,522	(3,081)	1,552	10,566	(9,014)
Laundry & Linen	51,447	53,735	(2,288)	164,246	161,205	3,041
Pharmacy	42,249	41,746	503	132,890	125,238	7,652
Materials Mgmt	6,250	3,425	2,825	19,573	10,275	9,298
Security	124,899	118,917	5,982	388,785	356,751	32,034
Environmental Svcs	8,698	9,145	(447)	27,115	27,435	(320)
Plant Operations	20,308	18,231	2,077	57,629	54,693	2,936
Plant Maintenance	8,750	23,388	(14,638)	31,795	70,164	(38,369)
Information Technology	149,743	154,808	(5,065)	378,788	464,424	(85,636)
ACS	100,071	75,519	24,552	305,455	226,557	78,898
General Accounting	1,252	2,845	(1,593)	2,102	8,535	(6,433)
Patient Financial Svcs	80,304	67,307	12,997	166,949	201,921	(34,972)
Credit &Collections	4,419	6,496	(2,077)	14,575	19,488	(4,913)
Patient Access	16,922	15,156	1,766	69,717	45,468	24,249
Compliance	2,200	3,599	(1,399)	6,599	10,797	(4,198)
Contracts Admin	9,682	6,667	3,015	18,516	20,001	(1,485)
Hospital Admin	15,000	13,458	1,542	44,625	40,374	4,251
Marketing	3,350	5,167	(1,818)	14,965	15,501	(536)
Human Resources	14,954	13,749	1,205	25,716	41,247	(15,531)
Health Information Mgmt	2,621	5,382	(2,761)	11,052	16,146	(5,094)
Nursing Admin	1,820	3,996	(2,176)	18,127	11,988	6,139
Inserv Ed Nurs	12,109	27,686	(15,577)	58,397	83,058	(24,661)
Utilization Mgmt	2,872	2,917	(46)	8,615	8,751	(137)
Performance Improvement	-	4,151	(4,151)	2,500	12,453	(9,953)
Risk Mgmt	5,320	5,406	(86)	15,477	16,218	(741)
Pt Experience	14,323	6,653	7,670	21,484	19,959	1,525
Total-Other Medical Services	20,983	19,265	1,718	50,255	57,795	(7,540)
	831,526	863,153	(31,627)	2,387,371	2,589,459	(202,088)
Credit/Collections	23,102	19,416	3,686	68,501	58,248	10,253
Totals	**971,888**	**1,007,015**	**(35,127)**	**2,778,055**	**3,021,045**	**(242,990)**

Sierra View Medical Center
Operating Expense Analysis - Actual vs. Budget
Sep-26 Sep-26

SUPPLIES	Current Month			Year-to-Date		
Description/Department	Actual	Budget	Variance	Actual	Budget	Variance
Prosthesis	145,825	248,976	(103,151)	663,929	746,926	(82,997)
Surgical Supplies	437,772	382,889	54,883	1,141,297	1,150,832	(9,535)
Medical Supplies	513,319	495,639	17,680	1,566,327	1,510,788	55,539
Pharmaceuticals	1,055,228	872,766	182,462	3,125,601	2,618,831	506,770
Food	75,837	62,961	12,876	206,885	193,222	13,663
Other Non Medical	276,795	344,084	(67,289)	913,664	1,044,042	(130,378)
Office Supplies	46,651	21,608	25,043	133,700	67,171	66,529
Minor Equipment	35,489	60,137	(24,648)	129,879	180,411	(50,532)
Totals	**2,586,916**	**2,489,060**	**97,856**	**7,881,282**	**7,512,223**	**369,059**

OTHER EXPENSE	Current Month			Year-to-Date		
Description/Department	Actual	Budget	Variance	Actual	Budget	Variance
Licenses & Taxes	75,265	77,711	(2,446)	154,427	233,133	(78,706)
Contribution	1,000	4,037	(3,037)	3,964	12,111	(8,147)
Telephone	132,756	105,825	26,931	370,797	317,475	53,322
Dues & Subscriptions	48,372	76,298	(27,926)	200,925	228,894	(27,969)
Outside Training	2,620	15,041	(12,421)	25,825	45,123	(19,298)
Business Meals	2,495	2,344	151	5,408	7,032	(1,624)
Travel	2,598	3,745	(1,147)	7,057	11,235	(4,178)
Recruiting - Physician	35,723	56,723	(21,000)	107,169	170,169	(63,000)
Recruiting - HR	1,393	17,016	(15,623)	8,922	51,048	(42,126)
Other Direct Exp	6,118	28,664	(22,546)	15,880	85,992	(70,112)
Postage	8,000	6,834	1,166	22,500	20,502	1,998
Freight	24,563	19,167	5,396	66,179	57,501	8,678
Advertising & Marketing	2,782	22,896	(20,114)	14,946	68,688	(53,742)
Bank Charges	1,197	775	422	3,446	2,325	1,121
Catering	-	-	-	-	-	-
Recruiting-Admin	-	-	-	-	-	-
Totals	**344,882**	**437,076**	**(92,194)**	**1,007,446**	**1,311,228**	**(303,782)**

Sierra View Local Health Care District
Income Statement

For Period	Sep-26	Sep-25			Sep-26	Sep-25		
	ACTUAL	ACTUAL	VARIANCE	% VARIANCE	ACTUAL YTD	ACTUAL YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	5,234,754	4,947,056	287,698	6%	16,106,961	16,408,688	(301,727)	(2%)
Inpatient - Ancillary	17,125,031	16,407,159	717,872	4%	53,705,078	55,067,060	(1,361,982)	(2%)
Total Inpatient Revenue	**22,359,785**	**21,354,215**	**1,005,570**	5%	**69,812,039**	**71,475,748**	**(1,663,709)**	(2%)
Outpatient - Ancillary	40,205,392	37,603,898	2,601,494	7%	121,433,615	110,086,904	11,346,711	10%
Total Patient Revenue	**62,565,177**	**58,958,113**	**3,607,064**	6%	**191,245,654**	**181,562,652**	**9,683,002**	5%
Medicare	(19,107,001)	(16,162,730)	(2,944,271)	18%	(59,545,834)	(53,634,208)	(5,911,626)	11%
Medi-Cal	(18,776,294)	(22,405,579)	3,629,285	(16%)	(59,659,080)	(64,128,891)	4,469,811	(7%)
Other/Charity	(7,735,070)	(7,799,305)	64,235	(1%)	(21,511,934)	(15,305,659)	(6,206,275)	41%
Discounts & Allowances	(712,234)	31,078	(743,311)	(2,392%)	(1,997,987)	(244,655)	(1,753,331)	717%
Bad Debts	(886,343)	3,834,140	(4,720,482)	(123%)	(2,371,177)	(2,324,803)	(46,374)	2%
Total Deductions	**(47,216,941)**	**(42,502,397)**	**(4,714,545)**	11%	**(145,086,012)**	**(135,638,217)**	**(9,447,795)**	7%
Net Service Revenue	**15,348,235**	**16,455,716**	**(1,107,481)**	(7%)	**46,159,642**	**45,924,435**	**235,207**	1%
Other Operating Revenue	944,370	700,455	243,915	35%	2,479,391	2,121,555	357,836	17%
Total Operating Revenue	**16,292,605**	**17,156,171**	**(863,566)**	(5%)	**48,639,032**	**48,045,990**	**593,042**	1%
Salaries	6,376,952	5,881,918	(495,034)	(8%)	19,414,998	18,267,674	(1,147,324)	(6%)
S&W PTO	686,494	695,268	8,774	1%	2,041,752	2,033,297	(8,455)	(0%)
Employee Benefits	1,697,824	1,529,571	(168,253)	(11%)	4,884,494	4,467,978	(416,516)	(9%)
Professional Fees	2,184,493	2,550,901	366,408	14%	6,469,689	6,247,987	(221,702)	(4%)
Purchased Services	971,888	1,056,646	84,758	8%	2,778,055	2,697,094	(80,961)	(3%)
Supplies & Expenses	2,586,916	2,381,591	(205,325)	(9%)	7,881,282	7,091,241	(790,041)	(11%)
Maintenance & Repairs	288,325	423,404	135,080	32%	885,764	920,441	34,677	4%
Utilities	352,156	565,110	212,954	38%	993,541	1,151,570	158,029	14%
Rent/Lease	25,142	43,854	18,713	43%	101,667	110,779	9,113	8%
Insurance	121,390	117,525	(3,865)	(3%)	391,103	377,632	(13,471)	(4%)
Depreciation/Amortization	790,401	823,180	32,779	4%	2,379,151	2,463,837	84,686	3%
Other Expense	344,882	374,338	29,456	8%	1,007,446	1,128,508	121,062	11%
Impaired Costs	-	-	-	0%	-	-	-	0%
Total Operating Expense	**16,426,863**	**16,443,306**	**16,443**	0%	**49,228,942**	**46,958,039**	**(2,270,903)**	(5%)
Net Gain/(Loss) From Operations	**(134,258)**	**712,865**	**(847,123)**	**(119%)**	**(589,909)**	**1,087,951**	**(1,677,860)**	**(154%)**
District Taxes	140,212	138,477	(1,735)	(1%)	420,636	415,431	(5,205)	(1%)
Investment Income	513,231	652,838	(139,607)	(21%)	1,632,979	1,494,684	138,295	9%
Other Non - Operating Income	29,316	29,056	260	1%	85,260	86,202	(942)	(1%)
Interest Expense	(65,341)	(71,779)	6,439	9%	(189,958)	(220,046)	30,088	14%
Non-Operating Expense	(21,288)	(21,118)	(171)	(1%)	(106,871)	(105,290)	(1,580)	(2%)
Total Non-Operating Income	**596,131**	**727,475**	**(131,344)**	(18%)	**1,842,046**	**1,670,980**	**171,066**	10%
			-				-	
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	**461,873**	**1,440,340**	**(978,467)**	**(68%)**	**1,252,137**	**2,758,931**	**(1,506,794)**	**(55%)**
Net Incr/(Decr) in the Fair Value Invstmt	(1,837,363)	(10,688)	(1,826,675)	17,091%	(2,554,730)	580,511	(3,135,241)	(540%)
Net Gain/(Loss)	**(1,375,490)**	**1,429,652**	**(2,805,142)**	(196%)	**(1,302,593)**	**3,339,442**	**(4,642,035)**	(139%)

Sierra View Local Health Care District
OTHER OPERATING REVENUE & OTHER NON-OPERATING INCOME/EXPENSE
FY 2027

For Period	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-27	May-27	Jun-27	TOTAL
	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL
Operating Revenue													
FOOD SALES	62,221	62,146	62,173										186,540
340B DRUGS SOLD TO NOT PATIENTS	50,462	53,062	307,142										410,666
CASH DISCOUNT ON PURCHASES	726	695	702										2,122
RECYCLING/SALE OF SCRAP	-	-	-										-
REBATES AND REFUNDS	11,611	21,334	30,022										62,967
COMMISSIONS VENDING	940	910	909										2,760
MED REC/ABSTRACT	924	2,229	1,922										5,075
COMMUNITY HEALTH EDUCATION	160	-	-										160
OTHER OPER REVENUE	70	5,271	37,500										42,842
OTHER OPER REV - GME GRANT													-
OTHER OPER REV - TUL COUNTY TREASURER REIMB													-
OTHER OPER REV - PRO FEES	-	-	-										-
OTHER OPER REV - QIP	328,000	328,000	328,000										984,000
OTH OP REV-GRANTS-M-CAL MGD DIR GRANT HQAF	176,000	176,000	176,000										528,000
FOUNDATION DONATIONS	254,015	-	-										254,015
VOLUNTEER LEAGUE DONATION	-	-	-										-
MISC CONTRIBUTIONS	-	-	-										-
CANCER TREATMENT CENTER DONATIONS	-	-	-										-
TOTAL OTHER OPERATING REVENUE	**885,129**	**649,647**	**944,370**	-	-	-	-	-	-	-	-	-	**2,479,146**
													-
DISTRICT TAXES	140,212	140,212	140,212										420,636
													-
INTEREST INC - OTHER INVEST	20,337	14,853	10,577										45,767
INTEREST INC - FIDELITY 365	499,311	402,623	415,748										1,317,682
INTEREST INC - 2019 BOND	97,743	84,880	86,907										269,530
INVESTMENT NCOME	**617,391**	**502,356**	**513,231**	-	-	-	-	-	-	-	-	-	**1,632,979**
													-
GAINS ON SALE/DISPOSAL OF ASSETS	-	-	-										-
LOSSES ON SALES LOSS-DISPOSAL OF ASSETS	-	-	-										-
MOB RENTAL REVENUE	3,212	3,212	3,212										9,637
OTH OFC BLDG RENTAL REVENUE	24,577	24,576	24,576										73,728
OTH NON-OP REV MISC INCOME	282	85	1,528										1,895
OTHER NON OPERATING INCOME	**28,071**	**27,873**	**29,316**	-	-	-	-	-	-	-	-	-	**85,260**
													-
INTEREST EXP - OTHER	(10,791)	(17,868)	(17,361)										(46,020)
INTEREST EXP CAPITAL LEASE (BANC OF AMERICA)	-	-	-										-
INTEREST EXP - 2019 BOND	(29,545)	(29,545)	(29,545)										(88,634)
INTEREST EXP - 2020 BOND	(18,434)	(18,434)	(18,434)										(55,303)
INTEREST EXPENSE	**(58,770)**	**(65,847)**	**(65,341)**	-	-	-	-	-	-	-	-	-	**(189,958)**
OTH OFC BLDG - MINOR EQUIPMENT	-	-	-										-
OTH OFC BLDG - REPAIRS AND MAINTENANCE	-	-	-										-
OTH OFC BLDG - PURCHASED SVCS	-	-	-										-
OTH OFC BLDG - UTIL WATER	(114)	(233)	(290)										(636)
OTH OFC BLDG - UTIL OTHER	-	-	-										-
MOB EXPENSE - MINOR EQUIPMENT	-	-	-										-
MOB EXPENSE - PURCHASED SERVICE	-	-	-										-
NON OPERATING EXPENSE - MISC	-	(379)	(19)										(398)
NON OP EXP - INVESTMENT SVC FEES	(42,882)	(15)	-										(42,897)
NON OP EXP - LOSS EARLY REDMPTN OF BOND	(20,980)	(20,980)	(20,980)										(62,939)
NON OPERATING EXPENSE	**(63,976)**	**(21,607)**	**(21,288)**	-	-	-	-	-	-	-	-	-	**(106,871)**
TOTAL NON-OPERATING INCOME/(EXPENSE)	**662,928**	**582,987**	**596,131**	-	-	-	-	-	-	-	-	-	**1,842,046**
NET INCR/(DECR) FV OF INV FID 365	**(599,369)**	**(117,998)**	**(1,837,363)**	-	-	-	-	-	-	-	-	-	**(2,554,730)**

For Period	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-27	May-27	Jun-27	TOTAL
OTHER OPER REVENUE - DETAIL:													
AS 07/26 JE100 DEP 07/9 COTIVITI, INC	64.35												$ 64.35
AS 07/26 JE100 DEP 07/30 PARTNESHIP HLTHPLA OF CA	6.00												$ 6.00
AS 08/26 JE100 DEP 08/9 COTIVITI INC.		186.36											
AS 08/26 JE100 DEP 08/13 JAVA EXPRESS		196.50											
AS 08/26 JE100 DEP 08/13 CENTENE 2024 HN CHIP		4,845.50											
AS 08/26 JE100 DEP 08/20 US RESTITUTION R. A.		43.13											
AS 09/26 JE100 DEP 09/28 PHY HEALTH PHYSICIANS			37,500.00										
Total	**$ 70.35**	**$5,271.49**	**$37,500.00**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 70.35**

SIERRA VIEW
MEDICAL CENTER

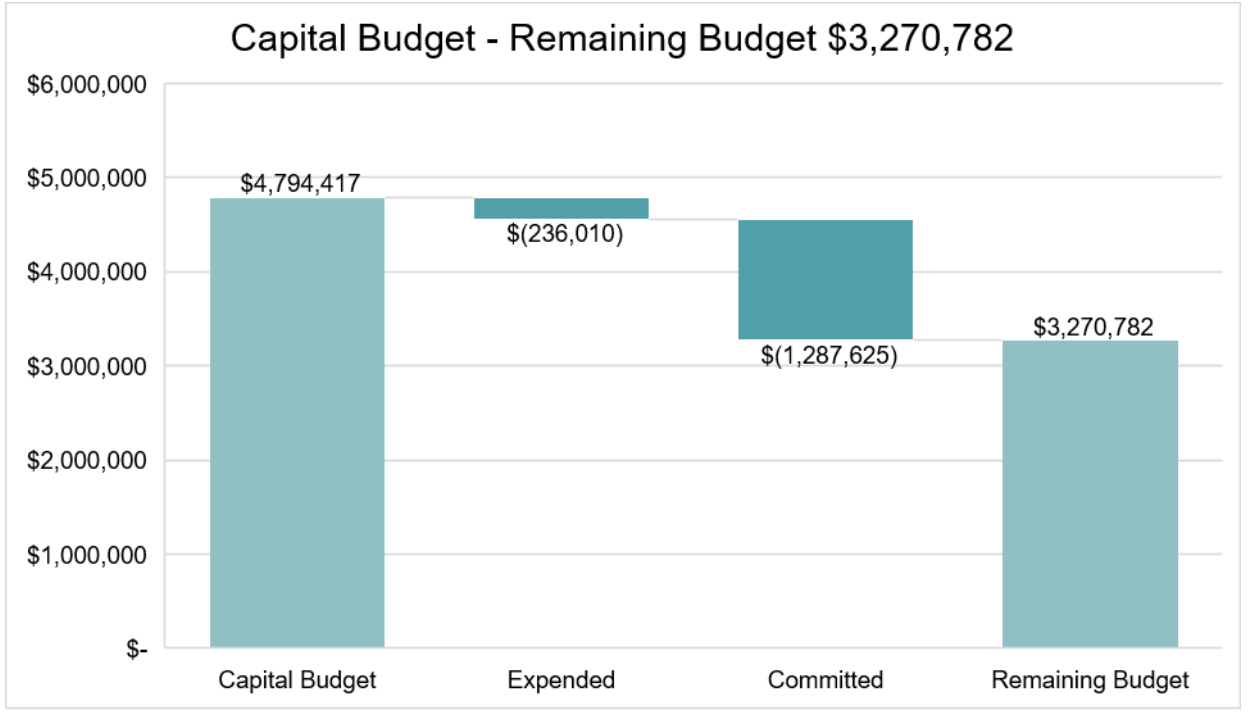
CAPITAL BUDGET REPORT Q1



Quarterly Capital Report
September 30, 2026

SIERRA VIEW
MEDICAL CENTER
A Facility Of Sierra View Local Health Care District.

Capital Spending through 1st Quarter



SIERRA VIEW MEDICAL CENTER

Budget Approved Projects

Projects	Budget	Expected	Variance
Main Hospital X-Ray 1	$ 779,357	$ -	$ 779,357
Nuclear Medicine Replacement	653,427	-	653,427
ED Nurse Call	522,783	-	522,783
DPSNF Nurse Call	429,085	-	429,085
ICU Central Nurses Station for Cardiac Monitoring	387,834	329,688	58,146
Sysmex Hematology Analyzer XN3100	288,701	288,701	-
External Fetal Heart Monitors	266,496	270,168	(3,672)
Echo Machine Replacement	250,000	-	250,000
IR Room Replacement (Design Only)	222,096	-	222,096
Windows Upgrade & DR Plate Upgrade X-Ray 1,2,3	142,684	142,684	-
Endo Scope Replacement	109,158	-	109,158
Ventilator Replacement X5	107,762	104,679	3,083
Remote Telemetry Monitors	100,527	98,691	1,836
Pharmacy Room IV Construction	91,249	-	91,249
Vapotherms	61,231	-	61,231
MACLAB CCW Upgrade	60,512	60,512	(0)
Telemetry Vital Sign Cardiac Monitors	38,502	-	38,502
CT Pyxis Machine	33,012	-	33,012
Budgeted Total	**$ 4,544,417**	**$ 1,295,123**	**$ 3,249,294**

Capital Spending Summary

Projects	Budget	Expected	Variance
Budgeted Total	$ 4,544,417	$ 1,295,123	$ 3,249,294
Contingency	250,000	-	250,000
500 Building Expansion Surgery Clinic		88,002	(88,002)
Tablo Dialysis Machine		76,528	(76,528)
Teleneurology Carts Replacement		37,072	(37,072)
Hologic NovaSure Replacement		16,911	(16,911)
Modlink Install Powerscribble Interface		10,000	(10,000)
Total	**$ 4,794,417**	**$ 1,523,635**	**$ 3,270,782**
	Expended	*236,010*	
	Committed	*1,287,625*	

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INVESTMENT REPORT Q1

INVESTMENT REPORT

Investment Report
September 30, 2026

Presented to:
Sierra View Local Health Care District
Board of Directors

October 27, 2026

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INVESTMENT GUIDANCE

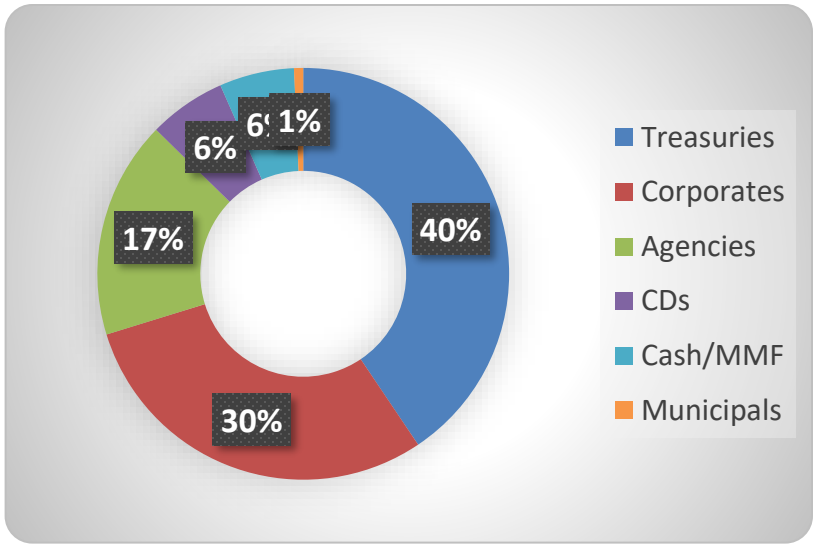
- Sierra View Local Health Care District as a local agency must comply with the investment policy requirements set forth by the State of California.
  - The California Debt and Investment Advisory Commission (CDIAC) provides guidance on current investment statutes through its publication: *Local Agency Investment Guidelines*.

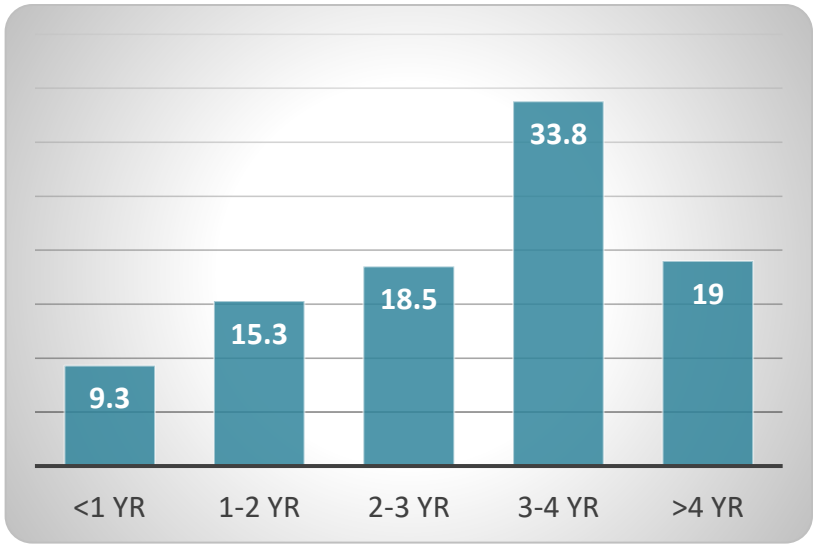
INVESTMENT GUIDANCE

- Maximum maturity of investments is five years.
- Composition of portfolio.
  - Limits the amount (measured as a percentage of the total portfolio) of certain types of investments that may be held.
- District's Investment Policy

Quarterly Summary

Value	Income	Yield	WAM	Modified Duration
$131.9M	$5.14M	3.89%	2.99 yrs	2.50 yrs





Credit Quality
High Quality IG

Cash/Money Mkt
$7.5M

Maturing <1yr
$12.3M

	YTD	1-Year	3-Year	5-Year
SVMC	-0.13%	0.77%	3.77%	1.3%
Benchmark	-0.30%	0.84%	4.33%	1.57%

Benchmark: ICE BOAML 1-5 Year US Corporate & Govt Index

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Transactions - July

Security	Transaction Type	Amount
U.S. Treasury Series AQ-2029	Purchase	($998,492)
Morgan Stanley Bank CD	Purchase	($250,000)
Republic Services Note	Purchase	($500,734)
U.S. Treasury Series AB-2031	Purchase	($998,534)
U.S. Treasury AQ-2026 Maturity	Redemption	$1,000,000
Tompkins Community Bank CD	Redemption	$250,000
Parkway Bank & Trust CD	Redemption	$250,000
FIMM Treasury Portfolio	Sale	$456,296

Transactions - August

Security	Transaction Type	Amount
U.S. Treasury Series G-2031	Purchase	($984,810)
FIMM Treasury Portfolio	Sale	$942,669
Connecticut Light & Power	Sale	$928,936
FHLB Q5-2031	Sale	$990,889
FHLB JK-9029	Sale	$732,935
FHLB 8D-2030	Sale	$986,185
Lockheed Martin	Sale	$1,273,163
McKesson	Sale	$500,705
Meta Platforms	Sale	$505,926
Nano Banc CD	Sale	$250,348
Regions Bank CD	Sale	$250,297
UST AR-2026	Sale	$510,617
UST BM-2026	Sale	$1,005,872
UST U-2030	Sale	$498,877
Wire Transfer to Bank of the Sierra	Transfer	($10,000,000)

Transactions - September

Optum Bank CD	Purchase	($250,000)
U.S. Treasury Series AS-2029	Purchase	($991,328)
U.S. Treasury Series BH-2028	Purchase	($999,302)
Colorado Housing & Finance	Sale	$578,440
Connecticut Housing Finance	Sale	$101,225
Massachusetts Educational Financing Authority	Sale	$323,004
Minnesota Iron Range	Sale	$222,461
Minnesota Housing Finance	Sale	$395,552
South Dakota Housing Development Authority	Sale	$622,531
Texas Transportation Finance Corp	Sale	$500,070
Signature Bank of Arkansas CD	Redemption	$250,000
Rondout Savings Bank CD	Redemption	$250,000

Asset Listing

Detailed asset listing included as separate pdf document.

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CERTIFICATION

I certify, to the best of my knowledge, that this report reflects Sierra View Local Health Care District's cash/investment portfolio in conformity with the State of California Government Code on authorized investments and with the District's Investment Policy.

I further certify the District has the ability to meet all scheduled expenditure requirements for the next six months.

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Questions

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BYLAWS REVIEW

BYLAWS OF THE BOARD OF DIRECTORS
OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

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Pursuant to the provisions of Section 32128 of the Health and Safety Code of the State of California, the Board of Directors of Sierra View Local Health Care District herewith adopts these Bylaws for the governance of the Sierra View Local Heath Care District, superseding all prior codes of Bylaws and Amendments thereto.

ARTICLE I
DEFINITIONS

As used herein, the terms set forth below shall be interpreted as follows:

1.1 Board. "Board" means the Board of Directors of the District.

1.2 District. "District" means the Sierra View Local Health Care District.

1.3 Facilities. "Facilities" means the Hospital and other health care facilities and services operated by the District.

1.4 Hospital. "Hospital" means the Sierra View Medical Center, 465 West Putnam Avenue, Porterville, California.

1.5 Medical Staff. "Medical Staff" means the organized medical staff of the Hospital.

1.6 Practitioner. "Practitioner" means a person, licensed physician (M.D. or D.O.), dentist or podiatrist, inclusive of any allied health professions, who is eligible to apply for, or who has been granted staff privileges at the Hospital. Eligibility is determined pursuant to the Medical Staff bylaws, or, if applicable, the rules and regulations of the Facilities.

1.7 Contents of Sections and Articles. The headings or titles of the various sections and articles are for convenience only and do not control or limit the content of the section(s) or articles to which the heading or title applies. While the manner of numbering of the sections and the sequence of the sections in the Bylaws are to facilitate understanding, such numbering and sequencing shall not prevent the logical reading of the Bylaws as a whole.

ARTICLE II
ORGANIZATION, PURPOSES, POWERS AND DISSOLUTION

2.1 Organization. The District is a political subdivision of the State of California organized under the Local Health Care District Law, Division 23 of the Health and Safety Code.

2.2 Purposes and Powers. The District is organized for the purposes described in the Local Health Care District Law, and shall have and may exercise such powers in the furtherance of its purposes as are now or may hereafter be set forth in the Local Health Care District Law, California Department of Public Health, Title 22, CMS, The Joint Commission and any other applicable statutes, rules or regulations of the State of California. The powers of the District include, but are not necessarily limited to, the following: those enumerated in Division 23, Chapter 2, Article 2, Section 32121 et. seq. of the Health and Safety Code (Appendix A).

2.3 Dissolution. Any proposal for dissolution of the District shall be subject to confirmation by the voters of the District in accordance with Cortese-Knox Local Government Reorganization Act of 1985, Government Code Section 56000 et seq (Appendix B).

ARTICLE III
OFFICES

3.1 Principal Office. The principal office of the District is hereby fixed and located at 465 West Putnam Avenue, Porterville, California, 93257.

3.2 Other Offices. Branch or subordinate offices may at any time be established by the Board at any place or places.

ARTICLE IV
BOARD

4.1 General Powers. The Board is the governing body of the District. All District powers shall be exercised by or under the direction of the Board. The Board is authorized to make appropriate delegations of its powers and authority to officers and employees.

4.2 Annual Board Self-Evaluation. The Board shall evaluate, at least on an annual basis, the performance of its Chief Executive Officer, and also its own performance. The Board's self-evaluation shall provide for an assessment of the contributions made by the leaders of the hospital toward improving organizational performance and patient safety and shall include, but not be limited to the following: a) Measurable objectives should be identified for improving organizational performance and patient safety; b) Information shall be gathered to assess the Leadership's/Board's effectiveness in improving organizational performance and patient safety, utilization pre-established criteria; and, c) from such assessment activities, conclusions should be drawn based upon their findings, with new goals and objectives identified and developed for improving organizational performance and patient safety.

4.3 General Oversight and Responsibilities. The Board provides for the collaboration of leaders in developing, reviewing and revising the organization's policies and procedures as part of the Board's oversight of the quality of patient care services provided at least every three years.

4.3.1 The Board shall be responsible for effective operations of the Patient Grievance Process and will delegate, in writing, the responsibility to a Patient Grievance Committee, to address patient grievance issues.

4.3.2 The Board shall provide for the Annual Review of the following:

i. Compliance Program;
ii. Environment of Care, Emergency Operations Plan & Life Safety Management Programs;
iii. Human Resource Management Report;
iv. Infection Prevention Plan;
v. Medication Error Reduction Plan;
vi. Patient Safety Plan;
vii. Performance Improvement Plan;
viii. Plan for Provision of Patient Care;
ix. Risk Management Plan; ~~and,~~
x. Utilization Management Plan; and,

4.3.3 Strategic Plan. The Board shall provide for a Strategic Plan and/or Master Plan review and revision at least every three years, the purpose to provide for evaluation of interior and exterior space suitable to the nature of the clinical services provided and the ages and other characteristics of the patient population served, as well as processes for providing for the safe use, maintenance, accessibility and supervision of grounds, equipment and special activity areas.

4.3.4 Prosecuting Authority Under the False Claims Act. The Board appoints the District's CEO as the local government official to act as the District's prosecuting authority under the California False Claims Act. In the absence of action by the CEO, the Board may act as the prosecuting authority for the District and/or delegate said authority to another District officer to act as prosecuting authority for the District. The prosecuting authority is charged with investigating, filing and conducting civil legal proceedings on behalf of and in the name of the District, and may use private or government counsel.

4.3.5 Review of Bylaws. At least every three years, or sooner if the Board so chooses, ~~The~~ the Board shall provide for a review of the District's Bylaws and the Bylaws and Rules and Regulations of the Medical Staff ~~at least every three years~~.

4.3.6 Quarterly Performance Reports. The Board shall receive Performance Improvement reports on a quarterly basis to include, but not limited to, information which will be collected and aggregated on an ongoing basis. The reports shall reflect the Performance Improvement activities conducted throughout the organization, as well as quarterly reports related to the conclusions drawn, recommendations made, and actions taken by the Committees.

4.3.7. Board Community Outreach Policy. The Board shall direct the CEO to develop and follow a community outreach policy to encourage residents, including those in underrepresented communities and non-English-speaking communities, to participate in public meetings. The policy shall invite media organization, community groups, non-profits, and other civil groups to Board Meetings. Cal. Gov. Code § 54953.4.

4.4 Operating and Capital Equipment Budget. The Board shall provide for the hospital's administration and finance departments to develop an annual operating budget and long-term capital expenditure plan, including a strategy to monitor the plan's implementation.

4.4.1 The plan must include an annual operating budget that is prepared according to generally accepted accounting principles.

4.4.2 The budget must include all anticipated income and expenses.

4.4.3 The plan must provide for capital expenditures for at least a 3-year period, including the year in which the operating budget is specified.

4.4.4 The plan must include and identify in detail the objectives, and the anticipated sources of financing for each anticipated capital expenditure in excess of $600,000 (or a lesser amount established by the State in which the hospital is located) that relates to any of the following: a) Acquisition of land; b) Improvement of land, buildings, and equipment; or, c) The replacement, modernization and expansion of buildings and equipment.

4.4.5 The plan must be submitted for review to the Office of Statewide Health Planning and Development (OSHPD) and/or the Department of Health Services (if applicable), as required by the State of California.

4.4.6 The plan must be reviewed and updated annually.

4.4.7 The plan must be prepared under the direction of the Board of Directors, the administrative staff, and the medical staff of the hospital.

4.5 Audit. The Board shall provide for the Hospital's financial and administrative leaders to have an annual audit conducted of the hospital's books and records, following approved accounting procedures, and conducted by an outside accounting firm. The Board shall cause to be placed on the agenda of the regular meeting of the Board of Directors, following the completion of the audit, a full presentation and recommendation for approval of the Annual Audit.

4.6 Operation of Facilities. The Board shall be responsible for the operation of the Facilities owned, leased, or operated by the District, according to the best interests of the public health, and shall make and enforce all rules, regulations and bylaws necessary for the administration, governance, protection and maintenance of the Facilities under the Board's management and all property belonging thereto, and may prescribe the terms upon which patients may be admitted thereto. Such rules, regulations and bylaws applicable to the Hospital shall include, but not be limited to, the provisions specified in Health and Safety Code Section 32128, and shall be in accordance with and contain minimum standards no less than the rules and standards of private or voluntary hospitals. Unless specifically prohibited by law, the Board may adopt other rules that could be lawfully adopted by private or voluntary hospitals.

4.7 Rates. The Board shall not contract care for indigent county patients at below the cost for such care. In setting the rates the Board shall, insofar as possible, establish such rates as will permit

the Facilities to be operated upon a self-supporting basis. The Board may establish different rates for residents of the District than for persons who do not reside within the District.

4.8 Number and Qualification. The Board shall consist of five (5) members, one elected from each voting zone within the district, each of whom shall be a registered voter residing in the District, and in the zone for which they hold office during their entire tenure in office. The Board members must be a resident of the zone from which he/she is elected for at least 30 days prior to election. The zones are described in Section 4.15 below.

4.9 Conflict of Interest Code. The Board shall adopt and at all times keep in force a Conflict of Interest Code that complies with applicable state law including but not limited to Gov't Code §§ 87300 and 87302 and Regulation 2 CCR 18730, and their successors and as they may be amended in the future. The Code shall require disclosure of financial interest that may cause a conflict of interest for the position that the Code applies to. The Conflict of Interest Code shall apply to all Directors, the President/CEO, all Vice Presidents and such other employees of the District and consultants to the District as the Board may from time to time designate in its Code. The Code shall require disclosure of financial interest of the persons holding designated positions. Appendix A to the Code shall designate to whom the Code applies. The Code shall designate the scope of disclosures required for each designated position, as Appendix B to the Code. State Form 700, or its successor, shall be used for such disclosures. In addition, to the extent the District adopts internal conflict of interest policies, compliance with such policies shall be in addition to compliance with this state mandated Conflict of Interest Code.

4.10 Additional Conflict of Interest Provisions:

All Directors, policy-making management employees, and medical staff officers shall comply with the following:

(a) Except as provided in sub-section (c) below, each shall not possess any ownership interest in any other hospital serving the same area as that served by the District Hospital of which the person is a director, policy-making management employee, or medical staff officer. For purposes of this section, the possession of any ownership interest, including stocks, bonds or other securities, by the spouse or minor children of any person shall be deemed to be the possession or interest of that person.

(b) Except as provided in sub-section (c) below, each shall not be a director, policy-making management employee, or medical staff officer of any hospital serving the same area as the area served by the District.

(c) No person shall serve concurrently as a director of the District Hospital and as a policy-making management employee of any other hospital serving the same area as the District Hospital, unless the boards of directors of each of those hospitals have determined that the situation will further joint planning, efficient delivery of health care services, and the best interests of the areas served by their respective hospitals, or unless the hospitals are affiliated under common ownership, lease, or any combination thereof.

(d) Any candidate who elects to run for the office of member of the Board of the District, and who owns stock or other interest in or who works for any hospital which does not serve

the same area served by the District, shall disclose on the ballot his or her occupation and place of employment.

(e) It being perceived that the positions of member of the Board and officers of the Medical Staff vested in any one individual will necessarily produce in such individual conflicts of interest, or the strong possibility of conflicts of interest, no officer of the Medical Staff shall be eligible also to serve as a member of the Board during his incumbency as such officer. An officer of the Medical Staff shall be eligible for candidacy for election to the Board and may be appointed to the Board in any case in which any other person could be so appointed but shall not assume office on the Board until he or she has resigned his or her office on the Medical Staff. For purposes of this sub-section (e), Medical Staff Officers include chief, vice chief, past chief, department chairs, department vice chairs, any officer as defined in medical staff bylaws and any other similar position with the medical staff governance having similar conflicts.

4.11 Election and Term of Office. An election shall be held in the District on the first Tuesday after the first Monday in November in each even-number year, at which a successor shall be chosen for each Director whose term is expiring. The term of an outgoing director shall expire on the first Friday of December following such election. The election of Board members shall be by zone within the District and shall be consolidated with the State-wide general election. As to each zone in which there is an election, the candidate receiving the highest number of votes from the zone for which the candidate is running for the office to be filled at the election shall be elected thereto. The term of office of each elected Board member shall be four (4) years, or until the Board member's successor is elected and has qualified, except as otherwise provided by law in the event of a vacancy. There shall be staggered elections. The seats for zones 3 and 5 shall be elected in November 2018 and in each 4 years thereafter, and the seats for zones 1, 2 and 4 shall be elected in November 2020 and in each 4 years thereafter. An orientation shall be provided which familiarizes each new Board member with his or her duties and responsibilities, including the Board's responsibilities for quality care and the Facilities' quality assurance programs. Continuing education opportunities shall be made available to Board members.

4.12 Vacancies.

4.12.1 When a vacancy occurs on the Board of Directors, and except as otherwise specified in Government Code Section 1780, the remaining Board members may fill any vacancy on the Board by appointment until the next District general election that is scheduled one hundred thirty (130) or more days after the effective date of the vacancy, provided the appointment is made within a period of sixty (60) days immediately subsequent to the effective date of such vacancy and provided a notice of this vacancy is posted in three (3) or more conspicuous places in the District, at least one of which must be in the zone for which the vacancy exists, at least fifteen (15) days before the appointment is made. The appointee must reside in the zone in which the vacancy exists. In lieu of making an appointment, the remaining members of the Board may, within sixty (60) days of the vacancy, call an election to fill the vacancy.

4.12.2 If the vacancy is not filled by the Board as specified, or if the Board has not called for an election within sixty (60) days of the vacancy, the Board of Supervisors of the County of Tulare may fill the vacancy within ninety (90) days of the vacancy or the

Board of Supervisors may order the District to call an election to fill the vacancy. Any appointee must reside in the zone in which the vacancy exists. If within ninety (90) days of the vacancy the remaining members of the Board or the Board of Supervisors have not filled the vacancy and no election has been called for, the District shall call an election to fill the vacancy. If the number of remaining Board members falls below a quorum, at the request of the District' Secretary, or a remaining Board member, the Board of Supervisors of the County of Tulare may waive the sixty (60) day period specified above and make an appointment immediately to fill the vacancy, or may call an election to fill the vacancy. The Board of Supervisors shall only fill enough vacancies to provide the Board with a quorum.

Persons appointed to fill the vacancy shall reside in the zone for which the vacancy existed and shall hold office until the next District general election and thereafter until the person elected at such election to fill the vacancy has been qualified, however, persons elected to fill the vacancy shall hold office for the unexpired balance of the term of office.

4.13 Resignation or Removal:

4.13.1 Any Board member may resign effective upon giving written notice to the Chairman, the Secretary or the Board, unless the notice specifies a later time for the effectiveness of such resignation. The term of any member of the Board shall expire if the member is absent from three (3) consecutive regular meetings or from three (3) of any five (5) consecutive meetings of the Board and if the Board by resolution declares that a vacancy exists on the Board.

4.13.2 All or any of the members of the Board may be recalled at any time by the voters following the recall procedure set forth in Division 16 of the Election Code.

4.13.3 A Board Member who has violated any general law or regulation, or any rule, law, ordinance or resolution of the Hospital may be censured after being given notice and an opportunity to correct the violation. The Hospital shall establish a policy that defines the procedure for hearing a motion for censure. Depending on the severity of the violation(s), the Board Member may be indited by the Tulare County Grand Jury for willful or corrupt misconduct of office under Cal. Gov. Code 3060 *et seq.* and, if convicted, removed from office.

4.14 Compensation. The Board shall serve without compensation except that the Board, by a resolution adopted by a majority vote of the members of the Board, may authorize the payment of, not to exceed, One Hundred Dollars ($100.00) per meeting, not to exceed five (5) meetings per month as compensation to each member of the Board of Directors. Each member of the Board shall be allowed the member's actual necessary traveling and incidental expenses incurred by traveling in the performance of official business of the District as approved by the Board. Board Directors shall be eligible for the same health insurance plan available to District Employees.

4.15 Zones and Zone Elections. The District shall be broken up into 5 zones or voting districts. The zones shall be as equal in population as possible, but in no event vary in population size more than as permitted by law. The zones shall be created in compliance with State and Federal law

and avoid gerrymandering. The criteria set out in California Elections Code § 22000(a) shall be considered, including 1) topography, 2) geography, 3) cohesiveness of territory, and 4) community of interest of the division. The zones shall be revised at any time as may be needed, if at all, and reviewed and revised as needed after the results of the decennial ~~dicentenial~~ census conducted by the federal government are known, and such changes, if any, shall be implemented in time for the next general election after the census results are known, unless there is insufficient time, in which case the changes, if any, shall be implemented for the election that follows. In determining any new boundaries, the Board shall comply with the public notice and voting requirements of the Election Code including §§ 22000 and 22001, including at least one public hearing on any adjustment proposal before the public meeting at which the Board is to vote on the proposal.

4.16 Privacy and Access to Information

4.16.1 The District will strive to protect individual privacy. The District will not release information without the consent of the individual involved unless required to do so by law.

4.16.2 Except as otherwise expressly provided for in these Bylaws, each Board member shall have the authority to make requests on behalf of the Board to the Chief Executive Officer or the Chief Executive Officer's designee for access to information that is maintained by the Hospital and reasonably necessary for the Board to hear, discuss or deliberate upon any item that is within the subject matter jurisdiction of the Board. Except as may have been earlier instructed by the Board, the subject information and materials requested by Board member(s) shall not be released until the Board confirms its need for the same at its next meeting. All other requests for access to Hospital information by any individual Board member shall be addressed in accordance with the California Public Records Act and Sierra View Medical Center's Public Records Request policy.

4.17 Fiscal and Financial Training. Board Members and Agency Employees shall undergo fiscal and financial training once every two (2) years. This is in addition to the Ethics Training that must also be completed every two years. The training shall cover laws and principles relating to financial administration and short- and long-term fiscal management, including, but not limited to, the role and responsibilities of financial administration, financial policies, municipal budgets, the budget processes, financial reporting and auditing, capital financing and debt management, mechanisms for local agency revenues, pensions and other postemployment benefits, cash management and investments, the prudent investor standard, the ethics of safeguarding public resources, general fiscal and financial planning principles and any pertinent laws relevant to the District's official public service and role in overseeing the District's operations and relevant to the District's procurement and contracting practices and responsibilities. Cal. Gov. Code § 53235.2 and § 53238.3. Proof of Completion of Training and Post Completion shall be posted on the District website.

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ARTICLE V
BOARD MEETINGS

All meetings of a legislative body such as the District shall be governed by the procedures set forth in Government Code Sections 54950, et seq., as amended (hereinafter the "Brown Act").

5.1 Board Meeting.

~~5.1.1~~ A meeting of the Board is any congregation of a majority of the members at the same time and place to hear, discuss or deliberate upon any item that is within the subject matter jurisdiction of the Board. A meeting is also the use of direction communication, personal intermediaries or technological devices that is employed by a majority of the members of the Board to develop a collective concurrence as to action to be taken on an item by the members of the Board.

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5.1.2 Brown Act Compliance. All meetings of the Board, except for closed sessions, shall be open to the public subject to the provisions of paragraph 5.4.

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~~5.1.3~~ The Board may hold closed session meetings and exclude all persons authorized to be excluded. Breaching confidentiality of closed session not only subjects the Board Member to censure, but civil and criminal sanctions. The Hospital shall create a policy that informs Board Members as to the steps that will be taken by the Board for unauthorized disclosures.

5.2 Regular Meetings. Regular meetings of the Board shall be held as follows:

5.2.1 Time and Place of Meetings. The Board shall hold regular monthly meetings at the District Hospital on the fourth Tuesday of each month at 5:00 p.m. After preliminary matters, Closed Session shall begin immediately. Open Session shall follow, beginning no earlier than the time stated on the posted Agenda but no later than 5:30 p.m. (or as near thereto as practical). If the Closed Session items are not completed before the 5:30 p.m. start time of the Open Session, then the remaining Close Session items may be heard after the Open Session. In such case, there will be an Open Session following the Closed Session to report on the Closed Session items and complete the Agenda. In the event the regular monthly meeting date falls on a legal holiday, the meeting shall be held on the following day. The Board may, by motion, alter the dates, times, format and place for any future meeting and at each Board meeting may confirm or change the date, time, format and/or place of the next Board meeting(s). The meeting in December shall also be governed by 5.2.2 below.

5.2.2 December Meeting Exception. The Board's regular meeting in December shall be held on the third Tuesday at the District Hospital and at the same time and in conjunction with the Annual Organizational Meeting. Except for date, it shall follow the procedure of 5.2.1 as closely as practical.

5.3 Notice. At least seventy-two (72) hours before a regular meeting, the Board shall cause to be posted an agenda containing a brief description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session. A brief general description of the item generally need not exceed twenty (20) words, and when appropriate, may [shall] utilize the agenda descriptions contained in the Brown Act. The agenda shall specify the time and location of the regular meeting and shall be posted in a location that is freely accessible to the members of the public. No action shall be taken on any item not

appearing on the posted agenda, unless such action is permitted and is taken in accordance with the Brown Act unless one of the following conditions exists. For purposes of the Bylaws, "action taken" means a collective decision made by a majority of the members of the Board to make a positive or negative decision, or an actual vote by a majority of the Board upon a motion, proposal, resolution or order.

5.4 Attendance and Participation by Members of the Public.

5.4.1 Public Comment. Every agenda for regular meetings shall provide an opportunity for members of the public to directly address the Board on items of interest to the public that are within the subject matter jurisdiction of the Board, provided that no action shall be taken on any item not appearing on the agenda unless the action is otherwise authorized by Section 5.2. The Board may adopt reasonable regulations to insure that the intent of this Section is carried out, including, but not limited to, regulations limiting the total amount of time allocated for public testimony on particular issues and for each individual speaker.

5.4.2 Disclosure of Identity. Members of the public shall not be required, as a condition of attendance at a Board meeting, to register his or her name or provide other information. If an attendance list, register or other similar document is posted or circulated at the meeting, it shall state clearly that the signing, registering or completion of the document is voluntary and that all persons may attend the meeting regardless of whether a person does so.

5.4.3 Remote Attendance. The Board shall ensure compliance with State requirements for remote attendance by the public. Meetings shall be broadcast using a two-way audiovisual platform with a link for use of the platform on the District website. A dial-in method shall also be provided to the public. In the event of any outage, the Board shall stay the meeting for at least one (1) hour. If service cannot be restored, the Board shall vote, by roll call, to continue the meeting and finding the Board acted in good faith to restore service but could not. Cal. Gov. Code § 54953.4 and § 54953.8.

5.4.4. Removal Policy. If the Chair of the Board determines that any member(s) of the public attending in person or electronically is/are “disruptive” then the Board Chair shall issue a verbal warning. If the disruptive behavior persists then by a majority vote of the Board the individual(s) shall be removed. Disruptive is defined as conduct that disrupts, disturbs, impedes, or renders infeasible the orderly conduct of the meeting; failure to comply with laws or regulations (such as not stopping public comment when period to speak is over); and or makes a “true threat of force. Upon a majority vote for removal the individual(s) shall be escorted out by security and/or the electronic teleconference shall be terminated. Cal. Gov. Code § 54957.9 and § 54957.95 and § 54957.96.

5.4.5 Translation / Interpretation Policy. The Board does not offer translation services for Board meeting in any language. However, if an individual wishes to address the Board during public commit with the assistance of an interpreter, the Board shall provide additional time to accommodate the interpreter. As the number of Spanish Speakers exceeds 20% of the population of the District, the monthly agenda will be translated

from English to Spanish and posted on the District website in accordance with Cal. Gov. Code § 54953.4. Other Board Meeting Materials are posted in English only.

5.4.5. Materials on District Website. Agenda and Meeting materials are available on the District website in a format that is easily downloaded by the user. Public may request the items be emailed to them. There is also a general explanation of the Public Meeting process, procedures for in person and remote attendance, procedures on the public comment process, the ADA accommodation policy, and a calendar with all scheduled regular meeting times, dates and locations, updated if/when a special meeting is called. Materials are in English and Spanish.

5.5 Annual Organizational Meeting. At its Annual Organizational Board meeting as specified in Section 5.2.2, the Board shall organize by the election of one (1) of its members as Chairman, one (1) as Vice Chairman, and one (1) as Secretary. The election may proceed in any reasonable fashion. The Board shall also appoint by Board resolution the Treasurer at the annual meeting.

5.6 Special Meetings.

5.6.1 A special meeting may be called at any time by the Chairman, or by a majority of the Board members, by delivering personally or by mail written notice to each Board member and to each local newspaper of general circulation, radio or television station requesting notice in writing. Such notice must be delivered personally, by mail or by fax at least twenty-four (24) hours before the time of such meeting as specified in the notice. The call and notice shall specify the time and place of the special meeting and the business to be transacted. No other business shall be considered at special meetings. Such written notice may be dispensed with as to any Board member who at or prior to the time the meeting convenes files with the Secretary a written waiver of notice. Such waiver may be given by telegram. Such written notice may also be dispensed with as to any member who is actually present at the meeting at the time it convenes.

5.6.2 The call and notice shall also be posted at least twenty-four (24) hours prior to the special meeting in a location that is freely accessible to members of the public. Notice shall be required pursuant to this section 5.6.2 regardless of whether any action is taken at the special meeting.

5.6.3 In the case of an emergency situation involving matters upon which prompt action is necessary due to the disruption or threatened disruption of public facilities, the Board may hold an emergency meeting without complying with the notice requirements, provided the provisions of the Brown Act are followed.

5.7 Quorum. A majority of the members of the Board shall constitute a quorum for the transaction of business. Except as otherwise provided by law, the act of a majority of the Board members that occurs at a duly noticed meeting with a quorum shall be the act of the Board. The Board shall not take action by secret ballot, whether preliminary or final. When the number of Board members able to vote has been reduced to one or two due to conflict of interest, then less than a majority of the Board is allowable, provided the matter is approved by all of the Board members who could have voted in the affirmative.

5.8 Adjournment and Continuance.

5.8.1 The Board may adjourn any regular, adjourned regular, special or adjourned special meeting to a time and place specified in the order of adjournment. Less than a quorum may so adjourn from time to time. If no Board Members are present at a meeting, the clerk may declare the meeting adjourned to a stated time and place and shall cause written notice to be given in the same manner as provided in section 5.6 of these Bylaws for special meetings, unless such notice is waived as provided for special meetings. A copy of the order or notice of adjournment shall be conspicuously posted on or near the door of the place where the meeting was held within twenty-four (24) hours after the time of the adjournment. When a regular or adjourned regular meeting is adjourned as provided in this Section, the resulting adjourned regular meeting is a regular meeting for all purposes.

5.8.2 The Board may continue any hearing being held, or noticed or ordered to be held at any meeting, to a subsequent meeting by order or notice of continuance provided in the same manner as set forth above for the adjournment of meetings; provided, that if the meeting is continued to a time less than twenty-four (24) hours after the time specified in the order or notice of hearing, a copy of the order of notice of continuance of hearing shall be posted immediately following the meeting at which the order or declaration of continuance was adopted or made.

5.9 Public Meetings. Meetings of the Board shall be open to members of the public, except when statutory authority permits the Board to convene in closed session under the Brown Act. The Board may hold closed sessions during a meeting, following the provisions of the Brown Act and applicable Health and Safety Code and Government Code statutes that shall be noted on the Board of Directors Meeting Agenda.

5.10 Medical Staff Representation. The Medical Staff of the Hospital shall have the right of representation at all meetings of the Board, and on any committee deliberating the discharge of medical staff responsibilities, except closed sessions at which such representation is not requested, by and through the Chief of Staff of the Medical Staff, who shall have the right of attendance, the right to participate in Board discussions and deliberations affecting the discharge of medical staff responsibilities, but who shall not have the right to vote.

5.11 Disrupted Meetings. In the event that any meeting is willfully interrupted by a group or groups so as to render the orderly conduct of such meeting unfeasible, and order cannot be restored by the removal of individuals who were willfully interrupting the meeting, the Board may order the meeting room closed and continue in session. Only matters appearing on the agenda may be considered in such session. Representatives of the press or other news media, except those participating in the disturbance, shall be allowed to attend any session held pursuant to this Section. The Board may establish a procedure for readmitting an individual or individuals not responsible for willfully disrupting the orderly conduct of the meeting.

ARTICLE VI
BOARD COMMITTEES

6.1 Appointment. All committees, whether standing or special (ad hoc), shall be appointed by the Chairman. The chairman of each committee shall be appointed by the Chairman. All committees shall be advisory only to the Board unless otherwise specifically authorized to act by the Board.

6.2 Standing Committee. Standing committees may from time-to-time be created by resolution duly adopted by the Board of Directors. All standing committees in existence at the date of the adoption of these Bylaws shall continue to exist until abolished by resolution of the Board of Directors.

6.3 Special Committees. Special committees may be appointed by the Chairman for special tasks as circumstances warrant, and upon completion of the task for which appointed, such special committee shall stand discharged.

6.4 Additional Consultants. A committee chairman may invite additional individuals with expertise in a pertinent area to meeting with and assist the committee. Such consultants shall not vote or be counted in determining the existence of a quorum and may be excluded from any committee session.

6.5 Meetings and Notice. Meetings of a committee may be called by the Chairman of the Board, the committee, or a majority of the committee's voting members in accordance with the Brown Act.

6.6 Quorum. A majority of the voting members of a committee shall constitute a quorum for the transaction of business at any meeting of such committee. Each committee shall keep minutes of its proceedings and shall report periodically to the Board.

6.7 Manner of Acting. The act of a majority of the members of a committee present at a meeting at which a quorum is present shall be the act of the committee so meeting. No act taken at a meeting at which less than a quorum was present shall be valid unless approved in writing by the absent members. Action may be taken without a meeting by a writing setting forth the action so taken signed by each member of the committee entitled to vote.

6.8 Tenure. Each member of a committee shall hold office until the annual meeting of the Board as specified in Section 5.1.2, and until a successor is appointed. Any member of a committee may be removed at any time by the Chairman subject to the consent of the Board. A member of the Board shall cease to hold committee membership upon ceasing to be a Board member.

ARTICLE VII
OFFICERS

7.1 Chairman. The Board shall elect one (1) of its members as Chairman at the annual organizational meeting, and the Chairman shall hold office until a successor is elected. In the event of a vacancy in the office of Chairman, the Board may elect a new Chairman. The Chairman shall be the principal officer of the District and the Board, and shall preside at all meetings of the Board. The Chairman shall appoint all Board committee members and committee chairman, and shall perform all duties incidental to the office and such other duties as may be prescribed by the Board from time to time.

7.2 Vice Chairman. The Board shall elect one (1) of its members as Vice Chairman at the annual meeting, and the Vice Chairman shall hold office until a successor is elected. In the absence of the Chairman, the Vice Chairman shall perform the duties of the Chairman.

7.3 Secretary. The Board shall elect one (1) of its members Secretary at the annual meeting, and the Secretary shall hold office until a successor is elected. The Secretary shall provide for the keeping of minutes of all meetings of the Board. The Secretary shall give or cause to be given appropriate notices in accordance with these Bylaws or as required by law and shall act as custodian of District records and reports and of the District's seal. The Board may also elect an Assistant Secretary who shall perform the functions of the Secretary in the case of his/her absence or inability to act.

7.4 Treasurer. The Board shall appoint a Treasurer who shall serve at the pleasure of the Board. The Treasurer shall be charged with the safekeeping and disbursal of the funds in the treasury of the District.

7.5 Chief Executive Officer. The Board shall have the authority to select, employ, control and discharge the Chief Executive Officer. The qualifications of the Chief Executive Officer shall include but not be limited to a Master's Degree in Hospital and/or Business Administration, or comparable discipline, and the Chief Executive Officer shall have a minimum of three years previous management experience in hospital administration. The Chief Executive Officer shall report to the Board, and shall be its direct executive representative in the management of the Hospital. The Chief Executive Officer shall be given the necessary authority, and be held responsible for the administration of the Hospital, in all its activities and departments, subject only to such policies as may be adopted and such orders as may be issued by the Board, or any of its committees to which it has delegated power for such action. The Chief Executive Officer shall be responsible for the implementation of policies adopted by the Board. By working with standing and special committees of the Board and joint committees of the Medical Staff of the Hospital, the Chief Executive Officer is to participate in the elaboration of policies which provide the framework for patient care of high quality at reasonable cost. The Chief Executive Officer shall act as the "duly authorized representative" of the Board in all matters in which the Board has not formally designated some other person for that specific purpose. The Board of Directors shall conduct at least an annual evaluation of the Chief Executive Officer's performance. Individual members of the Board shall direct concerns they have regarding operational or personnel matters to the Chief Executive Officer. The authorities and duties of the Chief Executive Officer shall be:

7.5.1 To select, control and discharge all employees authorized by the Board, and pursuant to any regulation that may be adopted by the Board.

7.5.2 To have the ultimate responsibility and accountability for maintaining the organization's ongoing compliance with applicable law and regulation, and for taking prompt action on recommendations from planning, accrediting, or regulatory agencies.

7.5.3 Maintain District records and minutes of Board and Committee meetings. To submit regularly to the Board periodic reports showing the services performed and the financial activities of the Hospital.

7.5.4 To attend all meetings of the Board and its committees when required.

7.5.5 To perform any other duty that may be necessary in the best interests of the Hospital.

7.5.6 To serve as the liaison officer and channel of communications for all official communications between the Board and any of its committees, the Medical Staff and the personnel of the District. Providing periodic reports to the Board and to the Medical Staff[s] on the overall activities of the District and the Hospital[s] or other Facilities, as appropriate, as well as pertinent federal, state and local developments that effect the operation of District Facilities.

7.5.7 To supervise all business affairs such as records of financial transactions, collections and accounts, and purchase and issuance of supplies, and to ensure that all funds are collected and expended to the best possible advantage.

7.5.8 To see that all physical properties of the District are kept in a good state of repair and operating condition.

7.5.9 Providing the Board and its committees with adequate staff support.

7.5.10 Maintenance of adequate insurance or self-insurance covering the physical properties and activities of the District.

7.5.11 Designate other individuals by name and position who are, in the order or succession, authorized to act for the Sierra View Local Health Care District during any period of absence.

7.5.12 Summarily to suspend, in accordance with Article VIII of these Bylaws, the Medical Staff Bylaws and applicable law, all or any portion of the clinical privileges of any Practitioner whenever, in his or her opinion, such suspension is necessary in the best interest of patient care and immediate suspension pursuant to Medical Staff bylaws is not a feasible solution to the problem presented.

7.5.13 Be the local government official that acts as the prosecuting authority for the District under the California False Claims Act and is charged with investigating, filing and conducting civil legal proceedings on behalf of or in the name of the District, using private or government counsel.

7.5.14 Such other duties as the Board may from time to time direct.

ARTICLE VIII
MEDICAL STAFF

8.1 Organization. The Board shall cause to be created a medical staff organization, to be known as the "Medical Staff of the Sierra View District Hospital", whose membership shall be comprised of all Practitioners who are privileged to attend patients in the Hospital with appropriate officers and bylaws and with staff appointments on a biennial basis. The members of the Medical Staff shall be self-governing with respect to the professional work performed in the Hospital, governed in their professional conduct by the highest ethical standards of the medical profession, as outlined in the Code of Ethics applicable to the Practitioner. Membership in the Medical Staff organization shall be a prerequisite to the exercise of clinical privileges in the Hospital, except as otherwise specifically provided in the Medical Staff Bylaws. No Practitioner shall admit patients to the Hospital unless he/she is a member or the Medical Staff and has admitting privileges. Further, a Medical Staff member shall provide medical services to patients only within the scope of the clinical privileges or temporary privileges he/she is granted in accordance with the procedures in the Medical Staff Bylaws. In addition, the general medical condition of each patient in the Hospital will be the responsibility of a qualified physician member of the Medical Staff.

8.2 Bylaws. The Medical Staff shall propose, adopt, and amend by two-thirds vote, Bylaws, Rules and Regulations, not inconsistent with the Bylaws, for its internal governance which states its purposes, functions, and organization and which shall be subject to, and effective only upon, Board approval, which approval shall not be unreasonably withheld. The Bylaws, Rules and Regulations shall be periodically reviewed for consistency with Hospital policy and applicable legal requirements. The Bylaws shall create an effective administrative unit to discharge the functions and responsibilities assigned to the Medical Staff by the Board. Such Medical Staff Bylaws shall state the purpose, functions and organization of the Medical Staff and shall relate to the qualifications of members of the Medical Staff; requirements for the preparation and maintenance of a complete and accurate medical record for each patient; set forth the policies by which the Medical Staff exercises and accounts for its delegated authority and responsibility; the creation of standing and special committees (ad hoc); and the officers, elections and meetings of the Medical Staff, together with such other matters as the Medical Staff shall deem appropriate to the included in such Bylaws. The Medical Staff may adopt rules and regulations consistent with its bylaws for the conduct of the Medical Staff in its practice in the Hospital and shall also establish mechanisms for the selection of the Medical Staff of its officers, departmental chairman and committees. The Bylaws and Rules and Regulations of the Medical Staff shall be subject to approval by the Board and neither the medical staff nor the governing body may unilaterally amend the Medical Staff Bylaws, Rules or Regulations. It is herewith declared to be the policy of the District that the Medical Staff shall, so far as is consistent with the Local Health Care District Law, be self-governing with respect to the professional work performed in the Hospital.

8.2.1 The Medical Staff shall have the initial responsibility to formulate, adopt and recommend Medical Staff bylaws and amendments thereto to the Board, which shall be effective when approved by the Board. No Medical Staff Bylaws or amendments shall become effective without approval of the Board as herein above provided. If the Medical Staff fails to exercise this responsibility in good faith and in a reasonable, timely and responsible manner, and after written notice from the Board of such effect, including a reasonable period of time for a response, the Board may formulate or amend the Medical Staff Bylaws. In such event, Medical Staff recommendations and

views shall be carefully considered by the Board during its deliberations and in its actions.

8.3 Quality Assurance, Performance Improvement. The Board shall require, after considering the recommendation of the Medical Staff, the conduct of specific review and evaluation activities to assess, preserve and improve the overall quality and efficiency of patient care in the Hospital. The Board shall require that the Medical Executive Committee develop the processes for conducting, evaluating and revising such activities as may be required and delineated in a formal, written Performance Improvement Plan. The Board shall require, at least quarterly, that the Medical Executive Committee present a report on the performance improvement activities and the outcome of those activities, to the Board. The Board shall also require mechanisms to assure the provision of one level of care in the Hospital, and to assure that patients with the same health problem are receiving a consistent level of care. The Board, through the Chief Executive Officer, shall provide whatever administrative assistance is reasonably necessary to support and facilitate these activities including the investigation and evaluation of all matters relating to Medical Staff quality assurance.

8.4 Medical Staff Membership and Clinical Privileges.

8.4.1 Requirements. Membership on the Medical Staff shall be restricted to Practitioners who are currently licensed to practice in this State, competent in their respective fields, worthy in character and in professional ethics. In this latter connection, the practice of the division of fees under any guise whatsoever is prohibited and such practice shall be cause for exclusion from the Medical Staff. A prerequisite to admission to or continuation of membership on the Medical Staff is that the Practitioner present proof satisfactory to the Board of his/her ability to respond in damages, arising out of professional negligence, in the sum not less than one million dollars ($1,000,000.00) per occurrence/claim and not less than three million dollars ($3,000,000.00) in aggregate, and that such insurance be provided by a company that is acceptable to the Board and is licensed or approved by and qualified to do business in the State of California. The bylaws of the Medical Staff may provide for additional qualifications for membership and privileges, as appropriate.

8.4.2 Terms, Conditions and Classification. The terms, conditions and classifications of membership status in the Medial Staff, and of the exercise of clinical privileges, shall be determined by the Medical Staff and be specified in the Medical Staff bylaws. Appointments to the Medical Staff may be for a maximum term of two (2) years.

8.4.3 Appointments and Rules of Procedure/Medical Staff Hearings and Appellate Reviews. All appointments and re-appointments to the Medical Staff shall be made by the Board. In all cases, the Board shall take action on applications for appointment or re-appointment respecting clinical privileges of members of the Medical Staff, in coordination with the Medical Staff; however, regardless of the recommendation or other action of the Medical Staff, final responsibility for appointment to the Medical Staff and privileges of the Medical Staff regarding members of the Medical Staff shall rest with the Board, and the Board shall have the power to make appointments to the maximum extent permitted by applicable statutes, the Bylaws, and the Procedural Rules of the Board of Sierra View Local Health Care District (“Rules of Procedure”/“Medical

Staff Hearings and Appellate Reviews”), described below and attached hereto and incorporated herein by reference as Exhibit "A". The procedure to be followed by the Medical Staff and the Board in acting on matters of membership status and clinical privileges shall be specified in the Medical Staff Bylaws. No aspect of Medical Staff membership and/or particular clinical privileges shall be denied on the basis of sex, race, creed, color, national origin, physical or mental impairment, if after reasonable accommodation, the applicant complies with the Medical Staff Bylaws, Rules and Regulations, and policies and procedures and other policies and procedures jointly adopted by the Medical Staff and Board of Directors, or on the basis of any other criterion lacking professional justification.

8.4.4 Board Procedure. In satisfying its responsibilities hereunder, the Board shall exercise functions of an administrative nature and of a judicial nature, as provided herein and in the Rules of Procedure. Procedure of all proceedings under this Section shall be governed by the Rules of Procedure. Such Rules of Procedure may be adopted and from time-to-time amended by the Board and shall have the force and effect of the Bylaws, as to matters of procedure, but may be amended at any regular or special meeting of the Board without introduction at a prior meeting. Exhibit A is intended to be the most current version of Article VII of the Medical Staff Bylaws as approved by both the Medical Staff and the Board. Any amendment to Article VII of the Medical Staff Bylaws approved by the Board shall also be an approval of the same Amendment to Exhibit A. The Board may amend Exhibit A to its own Bylaws, although such Amendment by the Board unilaterally would not be an Amendment to the Medical Staff Bylaws.

8.4.5 Initial Application. All applications for appointment and re-appointment to the Medical Staff and for the granting or clinical privileges shall be submitted the Medical Staff office. The Medical Staff shall forward the same to the Medical Staff for its processing in such manner as shall be provided by the Medical Staff bylaws, and upon completion of processing by the Medical Staff, the Medical Staff shall make a report and recommendations regarding such application to the Board.

8.4.6 Board Action on Recommendation. At its next meeting after receipt of a recommendation of approval by the Medical Staff relating to appointment or re-appointment of any applicant for membership on the Medical Staff, the Board shall act on the matter by making or denying appointment. In taking action, the Board shall not act in an arbitrary or capricious manner. Such initial action shall be taken without a hearing. If the Board’s decision affirms the Medical Staff recommendation, then the decision is final. If the Board's proposed decision is adverse to the Practitioner, the Chief Executive Officer shall promptly notify the applicant of such proposed adverse decision, in accordance with the Rules of Procedure, and such proposed adverse decision shall be held in abeyance until the Practitioner has exercised or has been deemed to have waived his rights as provided by Rules of Procedure and until there has been compliance with Section 8.4.8, if appropriate. The Board may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. At its next meeting after receipt of such subsequent recommendation from the Medical Staff, or after expiration of such time limit without receipt of a

recommendation, the Board shall proceed as provided by the Rules of Procedure and shall make a decision to either provisionally appoint the Practitioner to the Medical Staff or to reject him/her for Medical Staff membership. All decisions to appoint shall include a delineation of Medical Staff privileges which the Practitioner may exercise. The Practitioner's rights to challenge any adverse action shall pend until the Board acts on any subsequent recommendation of the Medical Staff or after its failure to act. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before. If the aggrieved applicant requests a hearing before the Board as provided for by the Rules of Procedure, and if the hearing results in a decision that is favorable to the applicant, the applicant's application shall thereafter be processed in accordance with the appropriate provisions of the Medical Staff bylaws and the Bylaws.

8.4.7 Final Action. In the event the Practitioner waives or fails to exercise his rights under Section 8.4.12 hereof, the Board's proposed decision shall be considered final, except when the Board defers final determination by referring the matter back to the Medical Staff for further consideration as provided in 8.4.6.

8.4.8 Joint Conference Committee. Whenever the Board's proposed decision is contrary to the recommendation of the Medical Staff, the Medical Staff may submit the matter to the Joint Conference Committee established under Article IX of its Bylaws for review and recommendation and the Board shall consider such recommendation before making its decision final.

8.4.9 Notice of Final Action. When the Board's decision is final, it shall send notices of such decision through the Chief Executive Officer to the Chief of the Medical Staff, to the Chief of the Service concerned and by certified mail, return receipt requested, to the Practitioner affected.

8.4.10 No Timely Medical Staff Action. If, after submission to it of an application for appointment as provided in Section 8.5.1 hereof, the Medical Staff shall fail to make recommendation to the Board within ninety (90) days after such submission, the Board may proceed to consider the application without action by the Medical Staff in such manner as is provided by the Rules of Procedure. If action is favorable to the applicant, the Board shall appoint the applicant to the Medical Staff forthwith. If the action is adverse to the applicant, he or she shall have the right of appeal, as provided by the Rules of Procedure. The time within which the Medical Staff is to take action may be extended by the Chief Executive Officer, for good cause shown, for such period as he/she deems reasonable.

8.4.11 Notice to Board of Adverse Action by Medical Staff. In any case in which the Medical Staff recommends action upon an application for appointment which is adverse to the applicant, it shall specify in detail in its report to the Board the reasons for its recommendation. The Board shall not act on the Medical Staff recommendation except it may refer the matter back to Medical Staff for recommendation as provided below. In such case the Practitioner shall have the appeal rights set out in 4.5.8(b) of the Medical Staff Bylaws. The Board may refer the matter to the Medical Staff for re-consideration, but only if it deems that appropriate, provided it creates a reasonable time in which the

Medical Staff may act. In such case, the Practitioner's appeal rights shall pend until the Board acts on any decision of the Medical Staff upon re-consideration, or until it fails to timely act.

8.4.12 Appeals. Any practitioner who is aggrieved by any final action of the Medical Staff or by any action of the Board shall have a right of appeal as set forth in the Rules of Procedure referred to in Section 8.4.3 and the appeal shall be conducted in accordance with such Rules of Procedure.

8.5 Corrective Action; Board Role; Appellate Review.

8.5.1 The Board may take action on any proposed corrective action; it shall take action on proposed corrective action when required under its Bylaws or the Medical Staff Bylaws. Regardless of the recommendation or other action of the Medical Staff, final responsibility for corrective action regarding members of the Medical Staff shall rest with the Board, and the Board shall have the power to take corrective action, to the maximum extent permitted by applicable statutes, the Bylaws, and the Rules of Procedure described in 8.4.3 and 8.4.4 and Exhibit A. The procedure to be followed by the Medical Staff and the Board in acting on matters of corrective action shall be specified in the Medical Staff Bylaws. In all peer review matters the Board shall give great weight to the actions of the peer review bodies of the Medical Staff, except when a different standard is specified, and shall not act in an arbitrary or capricious manner.

8.5.2 If the Medical Staff recommends an action that is a ground for a hearing, the Practitioner shall be given notice of the adverse recommendation and of the right to request a hearing in accordance with the Medical Staff Bylaws. The Board of Directors may be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing or completed the hearing.

8.5.3 If, in the opinion of the Board, disciplinary action as to any Practitioner is required to insure the continued safety of and high standards of care afforded to patients of the Hospital, or because of compelling legal, moral or ethical considerations, and should the Board determine that the Medical Executive Committee's failure to investigate, or initiate disciplinary action, or take adequate disciplinary action, is contrary to the weight of the evidence then in the possession of the Board, the Board may direct the Medical Executive Committee to initiate an investigation or a disciplinary action or review the extent of disciplinary action, but only after consultation with the Medical Executive Committee. In the event the Medical Executive Committee fails to take action in response to a direction from the Board, the Board may take action on its own initiative. If such action is favorable to the Practitioner or constitutes an admonition, reprimand or warning to the Practitioner, it shall become effective as the final decision of the Board. If such action is one that gives rise to a hearing pursuant to the procedures set forth in the Medical Staff bylaws, the Board shall give the Practitioner written notice of the adverse recommendation in accordance with the Rules of Procedure.

8.5.4 Any practitioner who is aggrieved by any final action of the Medical Staff or by any action of the Board shall have a right of appeal as set forth in the Rules of Procedure

referred to in Section 8.5.1 and the appeal shall be conducted in accordance with such Rules of Procedure.

8.5.5 Whenever the Board's proposed decision is contrary to the recommendation of the Medical Staff, the Medical Staff may submit the matter to the Joint Conference Committee established under Article IX of its Bylaws for review and recommendation and the Board shall consider such recommendation before making its decision final.

8.5.6 When the Board's decision is final, it shall send notices of such decision through the Chief Executive Officer to the Chief of the Medical Staff, to the Chief of the Service concerned and by certified mail, return receipt requested, to the Practitioner affected.

8.5.7 Whenever a Practitioner's conduct requires immediate action to be taken to reduce a substantial likelihood of imminent impairment of the life, health or safety of any patient, prospective patient or any other person, the Board or the Chief Executive Officer may summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges of such Practitioner; provided, however, that the Board or the Chief Executive Officer, before the suspension, makes reasonable attempts to contact the governing body of the Medical Staff (the "Medical Executive Committee"). A summary suspension by the Board or the Chief Executive Officer which has not been ratified by the Medical Executive Committee within two (2) working days, excluding weekends and holidays, after the suspension, shall automatically terminate.

8.6 Hearings Prompted by Board of Directors Action. If the hearing is based upon an adverse decision or recommendation of the Board of Directors, wherein the Medical Staff recommendation or decision was not adverse, then the Board of Directors or its designee shall fulfill the duties assigned to the Medical Executive Committee or the Chief of Staff for when the Medical Executive Committee is the body whose decision prompted the hearing. This shall include, but not be limited to, preparing the notice of adverse action or recommended action and right to a hearing, scheduling the hearing, providing the notice of hearing and statement of charges, and designating the judicial review committee, presenter and witnesses.

ARTICLE IX
JOINT CONFERENCE COMMITTEE

There shall exist a Joint Conference Committee, composed of Chairman, Vice Chairman, or their designee of the Board of Directors, to avoid a quorum of the membership of the Board of Directors and two members of the Medical Executive Committee, who shall be the Chief of Staff and the Vice Chief of Staff. Members of the Board shall be selected by the Board Chairman. Member of Administration shall include the Chief Executive Office, Vice President as assigned / appointed by the Chief Executive Officer and the Director of Medical Staff Services, who shall be ex officio members and not be entitled to vote.

The Chief Executive Officer, or a person designated by the Chief Executive Officer, shall act as Secretary to meetings of the Joint Conference Committee, and shall record minutes of all meetings, which minutes shall be kept in the office of the Chief Executive Officer and shall be available for inspection by members of the Medical Staff and Board. Minutes shall be available for review by

interested participants of the Medical Staff and by Board, and provided that all privileges and confidentialities are maintained.

The Chairmanship of the Joint Conference Committee shall alternate yearly between the Board of Directors and the Medical Staff. Meetings of the Joint Conference Committee shall be held at least annually, at dates fixed by its Chairman, and may also be held at the call of the Chairman. The Committee shall transmit all written reports of its activities to the Medical Executive Committee and to the Board of Directors.

The Joint Conference Committee shall conduct itself as a forum for the discussion of matters of Hospital policy and practice, including issues which arise under Article VIII hereof, and of public relations, especially those pertaining to efficient and effective patient care. It shall provide medico-administrative liaison between the Medical Staff, the Board and the Chief Executive Officer. It shall also have the following specific duties:

9.1 Accreditation. It shall be responsible for establishing and maintaining accreditation policies and protocols similar to those of The Joint Commission on the Accreditation of Healthcare Organizations ("TJH") for which purpose it shall form a subcommittee that includes key personnel who are important in implementing the Hospital's accreditation program. From time-to-time, it shall require that the JCAHO survey forms be used as a review method to estimate the accreditation status of the Hospital and it should supervise a biennial survey for purposes of constructive self-criticism. It shall identify areas of suspected noncompliance with TJC standards and shall make recommendations to the Medical Executive Committee and the Board for appropriate action.

9.2 Disaster Planning. It shall be responsible for the development and maintenance of methods for the protection and care of Hospital patients and others at the time of internal and external disaster. Specifically, it shall form subcommittees to adopt and periodically review a written plan to safeguard patients at the time of an internal disaster, particularly fire, and shall assure that all key personnel rehearse fire drills at least four (4) times a year, for each shift; and adopt and periodically review a written plan for the care, reception and evacuation of mass casualties, and shall assure that such plan is coordinated with the inpatient and outpatient services of the Hospital, and that it adequately reflects developments in the Hospital community and the anticipated role of the Hospital in the event of disasters in nearby communities, and that the plan is rehearsed by key personnel at least twice yearly.

9.3 Ad Hoc Committee. Whenever a matter concerning Medical Staff privileges or peer review is referred by the Board back to the Medical Staff because of disagreement and the Medical Executive Committee refers the matter to the Joint Conference Committee to act as an Ad Hoc Dispute Mediation Committee, the Board shall participate therein, and shall deem the decision of such committee as a recommendation to the Board of Directors for final approval.

ARTICLE X
AUXILIARY ORGANIZATIONS

The Board may authorize the formation of auxiliary organizations to assist in the fulfillment of the purposes of the District. Each such organization shall establish its own bylaws, rules and regulations, which shall be subject to Board approval and which shall not be inconsistent with the Bylaws or the policies of the Board.

ARTICLE XI
INDEMNIFICATION OF DIRECTORS AND OFFICERS

Each Board member and officer, including those of the Foundation of the District (here, "Board member or officer") whether or not then in office, shall be indemnified by the District against all liabilities, costs and expenses reasonably incurred by or imposed upon him/her in connection with or arising out of any action, suit or proceeding in which he/she may be involved or to which he/she may be made a party by reason of his/her being or having been Board member or officer of the District, such expenses to include the cost of reasonable settlements made with a view to curtailment of costs of litigation. The District shall not, however, indemnify such Board member or officer with respect to matters as to which he/she shall be finally adjudged in any such action, suit or proceeding to have been derelict in the performance of his/her duty as such Board member or officer, nor shall the District indemnify such Board member or officer or the District itself, unless specifically voted upon and authorized by a majority of the Board. In no event shall anything herein contained be so construed as to authorize the District to indemnify any such Board member or officer at the time of doing it to willful misfeasance, bad faith, gross negligence or reckless disregard of the duties involved in the conduct or his/her office. The foregoing right of indemnification shall not be exclusive of other rights to which any Board member or officer may be entitled as a matter of law.

ARTICLE XII
AMENDMENT

These Bylaws may be amended or repealed by vote of at least three (3) members of the Board at any Board meeting. Such amendments or repeal shall be effective immediately, except as otherwise indicated by the Board.

SECRETARY'S CERTIFICATE

I, the undersigned and duly appointed, qualified and acting Secretary of the Board of Directors for the Sierra View Local Health Care District, do hereby certify that the twenty-two (22) pages attached

hereto constitute a true, complete and correct copy of the current Bylaws of Sierra View Local Health Care District, duly adopted by the Board of Directors on _____.

Dated: _____

_____
Secretary, Sierra View Local Health Care District

(Medical Staff Bylaws Omitted from this Redline as they are unchanged)