IMPERIAL VALLEY
HEALTHCARE DISTRICT

BOARD OF DIRECTORS
Katherine Burnworth, President | Laura Goodsell, Vice-President | James Garcia, Treasurer | Enola Berker, Secretary | Rodolfo Valdez, Director | Felipe Irigoyen, Director| Arturo Proctor, Director

AGENDA
REGULAR MEETING OF THE BOARD OF DIRECTORS
THURSDAY, SEPTEMBER 10, 2026, 6:00 P.M.

Pioneers Memorial Hospital | PMH Auditorium
207 W. Legion Road, Brawley, CA. 92227

Join Microsoft Teams
Meeting ID: 219 457 796 288 557
Passcode: bd2ex3Sx

~ CLOSED SESSION ~ 6:00 p.m.

a. **CONFERENCE WITH REAL PROPERTY NEGOTIATORS**
Property: El Centro Regional Medical Center, 1415 Ross Avenue El Centro, CA 92243 and related healthcare facilities
Agency negotiators: IVHD Ad Hoc (Katherine Burnworth, James Garcia, Laura Goodsell), Legal Counsel (Adriana Ochoa), IVHD CEO Carly Zamora Negotiating parties: Pablo Velez, ECRMC, City of El Centro
Under negotiation: Closing conditions related to Asset Transfer Agreement

b. **EXPOSURE TO LITIGATION (Gov. Code 54956.9(d)(2))**
- April Hale – 8/31/26 Government Claim

1. **Call to Order – 6:30**

2. **Roll Call**

3. **Pledge of Allegiance**

4. **Approval of Request for Remote Appearance by Board Member(s)**, *if Applicable*

5. **Consider Approval of Agenda**
In the case of an emergency, items may be added to the agenda by a majority vote of the Board of Directors. An emergency is defined as a work stoppage, a crippling disaster, or other activity that severely imperils public health, safety, or both. Items on the agenda may be taken out of sequential

order as their priority is determined by the Board of Directors. The Board may take action on any item appearing on the agenda.

6. **Public Comments**
   At this time the Board will hear comments on any agenda item. If any person wishes to be heard, they shall stand; address the president, identify themself, and state the subject for comment. Time limit for each speaker is 3 minutes individually per item to address the Board. Individuals who wish to speak on multiple items will be allowed four (4) minutes in total. A total of 15 minutes shall be allocated for each item for all members of the public. The board may find it necessary to limit the total time allowable for all public comments on items not appearing on the agenda at anyone one meeting to one hour.

7. **Board Comments**
   Reports on meetings and events attended by Directors; Authorization for Director(s) attendance at upcoming meetings and/or events; Board of Directors comments.
   a. Brief reports by Directors on meetings and events attended
   b. Schedule of upcoming Board meetings and/or events
   c. Report by Merger Strategic Planning Ad-Hoc Committee
   d. Finance Committee Update

8. **Consent Calendar**
   Any member of the Board may request that items for the Consent Calendar be removed for discussion. Items so removed shall be acted upon separately immediately following approval of items remaining on the Consent Calendar.

   a. Approve minutes for meetings of August 27, 2026 Regular and Special Meeting.

9. **Items for Discussion and/or Board Action:**
   a. Action Item: Policy and Procedure: Reference Laboratories

   b. Action Item: Policy and Procedure: Standardized Procedure for Registered Nurses: Neonatal Endotracheal Intubation

   c. Action Item: Policy and Procedure: Standardized Procedure for Registered Nurses: Neonatal Thoracentesis/Needle Decompression

   d. Action Item: Policy and Procedure: Sentinel Event

   e. Action Item: Policy and Procedure: Standardized Procedure for Registered Nurses: Neonatal Resuscitation

   f. Action Item: Policy and Procedure: Standardized Procedure for Registered Nurses: Neonatal Umbilical Vessel Catheterization

   g. Action Item: Policy and Procedure: Risk Management Plan

h. Action Item: Policy and Procedure: Standardized Procedure for Registered Nurses: Hypoglycemia in the Newborn

i. Action Item: Policy and Procedure: Intra-Facility Transport of the Intermediate NICU Patient

j. Action Item: Policy and Procedure: Tuberculosis Exposure Protocol

k. Action Item: Policy and Procedure: CODE PINK Infant or Child Abduction

l. Action Item: Policy and Procedure: Bloodborne Pathogen Exposure Control Plan

m. Staff Recommends Action to Authorize: Multi-year agreement with Cepheid
Presented by: Carly Zamora
Contract Value: $945,667 (annual spend-2025)
Contract Term: 3 years
Budgeted: Yes
Budgeted Classification: Supplies

n. For Consideration and Approval: Resolution No. 2026-0910, A Resolution of the Imperial Valley Healthcare District Board of Directors Announcing an Official Position of Support for Measure N, Maintaining Local Hospitals and Emergency Healthcare Services Measure

10. Management Reports

a. Finance: Carly C. Loper, MAcc – Chief Financial Officer
b. Hospital Operations: Carol Bojorquez, MSN, RN – Chief Nursing Officer
c. Clinics Operation: Carly Zamora MSN, RN – Chief of Clinic Operations
d. Executive: Carly Zamora – Interim Chief Executive Officer
e. Legal: Adriana Ochoa – General Counsel

11. Items for Future Agenda

This item is placed on the agenda to enable the Board to identify and schedule future items for discussion at upcoming meetings and/or identify press release opportunities.

12. Adjournment

a. The next regular meeting of the Board will be held on September 24, 2026, at 6:00 p.m. at El Centro Regional Medical Center, 1271 Ross Avenue, El Centro, Ca. 92243.

POSTING STATEMENT

A copy of the agenda was posted September 4, 2026, at 207 W. Legion Road, Brawley, and Ca. 92227 at 9:30 p.m. and other locations throughout the IVHD pursuant to CA Government code 54957.5. Disclosable public records and writings related to an agenda item distributed to all or a majority of the Board, including such records and written distributed less than 72 hours prior to this meeting are available for public inspection at the District Administrative Office where the IVHD meeting will take place. The agenda package and material related to an agenda item submitted after the packets

distribution to the Board is available for public review in the lobby of the office where the Board meeting will take place.

In compliance with the Americans with Disabilities Act, if any individuals request special accommodations to attend and/or participate in District Board meetings please contact the District at (760)351-3333. Notification of 48 hours prior to the meeting will enable the District to make reasonable accommodation to ensure accessibility to this meeting [28 CFR 35.102-35.104 ADA title II].

SHEGERIAN & ASSOCIATES

FAX: 310-860-0771 **TEL:** 310-860-0770 **WEB:** shegerianlaw.com

August 25, 2026

SENT BY CERTIFIED MAIL

Imperial Valley Healthcare District
DBA Pioneers Memorial Healthcare District
207 West Legion
Brawley, California 92201

Imperial Valley Healthcare District
DBA Pioneers Imperial Valley Healthcare District
601 Heber Avenue
Calexico, California 92231

Re: ***Tort Claim Form of Mrs. April Hale***

To Whom It May Concern:

Please be advised that we represent Mrs. April Hale ("Hale"). By this letter, we present the following claim for damages on her behalf, in what is commonly referred to as a tort claim form.

INDIVIDUALS AND ENTITIES AGAINST WHOM CLAIMS ARE BROUGHT

The names of the public entities and public employees who caused Mrs. Hale's injuries include but are not limited to: Imperial Valley Healthcare District dba Pioneers Memorial Healthcare District, and individuals Patricia Robles Martinez and Briana Beers. These entities and individuals shall be referred to collectively in this claim as "Defendants."

FACTS SUPPORTING CLAIM

Hale, a 64-year-old woman, devoted thirty-four years of her professional career to Defendants. Hired on or around September 11, 1991, as a Registered Nurse, Hale spent the ensuing decades developing substantial expertise in lactation consulting and building an exemplary record of service and performance. She consistently received

positive performance reviews and, as recently as 2024, received a formal award recognizing her outstanding performance, dedication, and commitment to excellence. Throughout her thirty-four-year tenure, Hale never received a single write-up, disciplinary action, or other form of corrective counseling.

In or around 2023, Patricia Robles Martinez ("Martinez"), a substantially younger woman in her thirties, became the Director of Obstetrics and Hale's direct supervisor. Almost immediately, Martinez's management practices became a source of significant concern among staff. Employees reported favoritism, excessive micromanagement of those she did not favor, and directives requiring them to perform duties outside the scope of their assigned roles.

Beginning in 2023 and continuing into early 2026, Martinez routinely directed Hale to perform duties outside the scope of her position as a Lactation Consultant without any corresponding increase in compensation. These directives occurred approximately once per week and included requiring Hale to recover patients, a responsibility that was not part of her assigned duties.

In or around March 2025, Hale's department participated in an anonymous employee survey concerning workplace conditions and management. Staff raised serious concerns regarding Martinez's leadership, including allegations of nepotism, an inability to respond effectively during emergencies, and requiring employees to perform duties outside their assigned roles. In or around May 2025, in response to the survey results, Defendants sent Merlina Esparza ("Esparza") to the department, where Esparza acknowledged the seriousness of the concerns. Despite this notice, no apparent corrective action followed.

The concerns persisted. On or around June 17, 2025, Hale and other staff submitted a written complaint to Human Resources ("HR"), formally documenting serious and ongoing concerns regarding Martinez's leadership. The complaint detailed, among other issues, Martinez's inability to effectively manage emergency situations, the resulting loss of staff confidence in her leadership, micromanagement of scheduling, poor communication, lack of clinical competency, and nepotism. Significantly, the complaint reported that "during the interim period when [Martinez] was on leave, morale improved significantly." Hale and her colleagues expressly requested that HR "conduct a formal review of these concerns and assess the ongoing impact of the director's leadership on staff well-being and patient care." Thus, by June 17, 2025, Defendants had received formal written notice of serious concerns regarding Martinez's leadership and its impact on employees and patient care.

In or around July 2025, Human Resources Generalist Briana Beers ("Beers") and an outside consultant interviewed Hale as part of Defendants' investigation into the June 17th complaint. Hale confirmed the concerns identified in the complaint, and Defendants also interviewed most members of the day-shift staff regarding Martinez's leadership. Yet Defendants never informed Hale or her colleagues of the investigation's findings or whether any remedial measures would be implemented. No meaningful corrective action followed, and the conditions about which Hale and her colleagues had complained remained unchanged.

In or around January 2026, Martinez informed Hale that she was required to increase her work schedule from four to five days per week, purportedly to account for a colleague's absence following a death in the colleague's family. Hale was the only employee required to add an additional workday. When Hale explained that, as she was getting older, she lacked the stamina to work five days per week, Martinez immediately asked whether Hale wanted to work part time and whether she was preparing to retire. Hale made clear that she was not. Martinez nevertheless insisted that Hale's position required a five-day schedule and dismissed her caregiving responsibilities for her two-year-old granddaughter as none of Martinez's concern. As a result, Hale was forced to work the additional day and secure outside childcare for her granddaughter.

Also in or around January 2026, Martinez directed Hale to create a consent form for a patient procedure despite the absence of a governing policy. Hale advised Martinez that doing so was improper and required review by the Compliance Department ("Compliance"), but Martinez dismissed her concerns. Hale then consulted Sandra Taylor ("Taylor"), the Neonatal Intensive Care Unit Educator, who similarly advised her to contact Compliance. Hale contacted Rae Jean Murray ("Murray") in Compliance, who confirmed that a consent form could not be created without an underlying policy. Despite this confirmation, Martinez continued to insist that Hale prepare the form.

Following Hale's objections to the increased work schedule and her refusal to create a consent form without an underlying policy and Compliance approval, Martinez's treatment of Hale noticeably deteriorated. Between January and February 2026, Martinez became increasingly confrontational and hostile toward Hale. Given the timing and escalation of Martinez's conduct, Hale believed that this hostility stemmed from her resistance to Martinez's directives and her insistence on following proper compliance procedures.

On or around February 4, 2026, Martinez again pressured Hale to create the consent form despite the continued absence of a governing policy. When Hale refused,

Martinez openly questioned what Hale's job even entailed in the presence of multiple staff members, forcing Hale to explain her duties and responsibilities. During the confrontation, Martinez became argumentative and acknowledged that she did not have Hale's job description. Later that day, Hale obtained her job description directly from Beers and formally complained that Martinez was directing her to perform duties outside the scope of her position and subjecting her to hostile and confrontational treatment. Although Beers subsequently spoke with Martinez, she failed to meaningfully address Hale's complaint or Martinez's conduct. Faced with Martinez's continued insistence, Hale ultimately created the consent form under protest, although it was never implemented.

On or around February 6, 2026, a scheduled meeting between Hale, Martinez, and HR to address the disputed policy and the scope of Hale's job duties was abruptly removed from the calendar without explanation. Hale thereafter confronted Martinez regarding her prior hostile and confrontational treatment. Martinez denied knowing what Hale was referring to and refused to acknowledge her prior conduct.

Less than three weeks later, on or around February 23, 2026, Defendants identified an alleged discrepancy concerning Hale's documentation of a lactation consultation. The subsequent corrective action form states that "a lactation consult was documented as completed for 30 minutes on 02/23/2026 at 14:45 and entered into the chart at 15:54." Just four days later, on or around February 27, 2026, Defendants concluded their investigation and decided to terminate Hale's employment for purported "falsification of records." Defendants reached that decision without interviewing Hale, asking for her account of what occurred, or otherwise affording her an opportunity to explain the alleged discrepancy. In other words, Defendants decided to end the employment of a thirty-four-year employee with an unblemished disciplinary record without first hearing her side of the story.

On March 3, 2026, Martinez and Beers terminated Hale's employment. During the termination meeting, Beers made clear that the outcome had already been decided, telling Hale that regardless of what she said, she was going to be terminated. Hale was 64 years old.

The timing and sequence of these events are striking. After decades of exemplary service without discipline, Hale joined her coworkers in formally complaining about Martinez's leadership. Months later, when Martinez imposed an increased work schedule on Hale alone, Hale raised her age and diminished stamina, prompting Martinez to immediately question whether she was preparing to retire. Hale

subsequently refused Martinez's directive to create a consent form without an underlying policy—a position confirmed by Compliance—and reported Martinez's increasingly hostile treatment to HR. Less than three weeks after Hale's February 6th confrontation with Martinez, Defendants seized upon an alleged charting discrepancy and, within four days, decided to terminate Hale for purported falsification of records without ever obtaining her explanation. When Hale was finally brought into the termination meeting, Beers expressly informed her that nothing she said would change the outcome. Against the backdrop of Hale's thirty-four years of exemplary service, spotless disciplinary history, recent recognition for outstanding performance, Martinez's retirement inquiry, Hale's repeated complaints, and the escalating hostility that followed, the abrupt decision to terminate Hale at age 64 raises a compelling inference that Defendants' stated reason for her termination was pretextual.

POTENTIAL LEGAL THEORIES/CLAIMS

Hale anticipates bringing causes of action based on legal violations and theories including, but not limited to: (1) violations of various Labor Code sections, (*e.g.*, sections 98.6, 98.7, 232.5, 1102.5, 6305, 6310, 6311); (2) negligent hiring, supervision, and retention; (3) intentional infliction of emotional distress; (4) negligent infliction of emotional distress; (5) defamation (Civil Code §§ 45, 46); (6) coerced self-defamation; (7) discrimination and harassment on the basis of age; (8) retaliation in violation of the FEHA; (9) failure to prevent discrimination, harassment, or retaliation; (10) wrongful termination in violation of public policy; and (11) other common law and statutory claims as may be identified.

Additional causes of action and/or theories of relief may be raised on the basis of the facts generally set forth above, as is permitted by *Blair v. Superior Court* (1990) 218 Cal.App.3d 221.

DAMAGES SOUGHT

Hale seeks economic and noneconomic damages, as well as any other types of damages available, according to proof, which will exceed $10,000 and will not be brought as a limited jurisdiction matter. Hale also seeks interest, attorneys' fees, and costs, although the amounts of such interest, fees, and costs are not known at this time.

NOTICE

Hale requests that all notices concerning this claim be sent to us, her counsel of record, Shegerian & Associates, 320 N. Larchmont Boulevard, Los Angeles, California 90004, telephone: (310) 860-0770, facsimile: (310) 860-0771. Our e-mail address is CShegerian@Shegerianlaw.com.

ACTING ON BEHALF

Pursuant to Government Code section 910, our firm is "acting on behalf" of Mrs. Hale in submitting this demand. It is likewise hereby signed by Elvira G. Ybarra-Sanchez on behalf of her, pursuant to Government Code section 910.2.

Elvira G. Ybarra-Sanchez, Esq.

Thank you for your review and consideration of the above.

Very truly yours,

SHEGERIAN & ASSOCIATES

Elvira G. Ybarra-Sanchez

Shegerian & Associates, Inc
6205 LUSK BLVD STE 200
SAN DIEGO CA 92121-3745

$6.62 US POSTAGE
FIRST-CLASS IMI
Aug 25 2026
Mailed from ZIP 92121
2 OZ FIRST-CLASS MAIL LETTER
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ZONE 3
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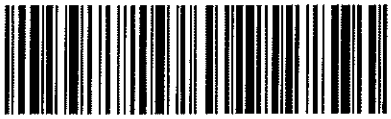

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Imperial Valley Healthcare District
DBA Pioneers Memorial Healthcare District
207 W LEGION RD
BRAWLEY CA 92227-7780

MEETING MINUTES
AUGUST 27, 2026
REGULAR BOARD MEETING

THE IMPERIAL VALLEY HEALTHCARE DISTRICT MET IN REGULAR SESSION ON THE 27TH OF AUGUST AT 1271 ROSS AVENUE, EL CENTRO, CA. ON THE DATE, HOUR AND PLACE DULY ESTABLISHED OR THE HOLDING OF SAID MEETING.

1. CLOSED SESSION ~ 6:00 p.m.

a. CONFERENCE WITH REAL PROPERTY NEGOTIATORS Property: El Centro Regional Medical Center, 1415 Ross Avenue El Centro, CA 92243 and related healthcare facilities Agency negotiators: IVHD Ad Hoc (Katherine Burnworth, James Garcia, Laura Goodsell), Legal Counsel (Adriana Ochoa), IVHD CEO Carly Zamora Negotiating parties: Pablo Velez, ECRMC, City of El Centro Under negotiation: Closing conditions related to Asset Transfer Agreement

b. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION (Gov. Code 54956.9 (d)(4)): One potential mater

c. CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (Gov. Code 54956.9(d)(1)):
Names of Cases:
   i. Bucio v. PMHD (Imperial County Sup. Ct. Case No. ECU004556)
   ii. Parra v. PMHD (San Diego County Sup. Ct. Case No. 26CU018477C)
   iii. Parra v. PMHD (San Diego County Sup. Ct. Case No. 26CU018477C)

BOARD RECONVENED INTO OPEN SESSION AT 6:54 p.m.
No reportable action taken in closed session

2. TO CALL ORDER:
The regular meeting was called to order in open session at 6:54 p.m. by Director Burnworth.

3. ROLL CALL-DETERMINATION OF QUORUM:

President	Kathie Burnworth
Vice-President	Laura Goodsell
Treasurer	James Garcia
Secretary	Enola Berker
Trustee	Felipe Irigoyen
Trustee	Rodolfo Valdez
Trustee	Arturo Proctor

GUESTS:
Adriana Ochoa – Legal/Snell & Wilmer

4. PLEDGE OF ALLEGIANCE WAS LED BY DIRECTOR BURNWORTH.

5. APPROVAL OF REQUEST FOR REMOTE APPREARANCE BY BOARD MEMBERS: None

IMPERIAL VALLEY HEALTHCARE DISTRICT

6. CONSIDER APPROVAL OF AGENDA:

Motion was made by Director Berker and second by Director Proctor to approve the agenda for August 27, 2026. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Garcia, Berker, Irigoyen, Valdez, Proctor

NOES: None

7. PUBLIC COMMENT TIME:

None

8. BOARD COMMENTS:

a. Brief reports by Directors on meetings and events attended.

None

b. Schedule of upcoming Board meetings and events.

None

c. Report by Merger Strategic Planning Ad-Hoc Committee

Adriana reported that the Ad-Hoc Committee met since the last meeting and things are still on good track towards closing in October for the merger with ECRMC.

d. Finance Committee Update.

Director Garcia reported that the Finance Committee met on the 24th and made the recommendation to the board of directors to approve the following:

- Consent calendar item B-Approval and file the financial report for July
- 10B Statement of Work pursuant to the Master Services Agreement between Baker Tilly Advisory Group, LP ("Baker Tilly") and Imperial Valley Healthcare District ("IVHD") for services including preparation of Medicare, Medi-Cal and HCAI cost reports and supporting workpapers for fiscal year ending June 30, 2026.
- 10C Medical Directorship agreement for Alidad Zadeh, D.O. at Pioneers Skilled Nursing Center.
- 10D Professional Service Agreement for George A. Rapp, M.D.
- 10E Medical Directorship Agreement for George A. Rapp, M.D.
- 10F Medical Directorship agreement for George Fareed, M.D. at Pioneers Skilled Nursing Center.
- 10G Medical Directorship agreement for Mehboob Ghulam, D.O., at Pioneers Skilled Nursing Center.
- 10H Hydrovida (Planned Service Agreement – 3 years)

9. CONSENT CALENDAR:

Motion was made by Director Goodsell and second by Director Irigoyen to approve the Consent Calendar. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Garcia, Berker, Irigoyen, Valdez, Proctor
NOES: None

10. ACTION ITEMS:

a. MEDICAL STAFF REPORT – Recommendations from the Medical Executive Committee for Medical Staff Membership and/or Clinical Privileges, policies/ procedures/forms, or other related recommendation

Motion was made by Director Berker and second by Director Garcia to approve the recommendations from the Medical Executive Committee for Medical Staff Membership
and/or Clinical Privileges, policies/ procedures/forms, or other related recommendations. Motion passed by the following wit:

AYES: Burnworth, Goodsell, Garcia, Berker, Irigoyen, Valdez, Proctor
NOES: None

b. Staff Recommends Action to Authorize: Authorize the approval of the Statement of Work pursuant to the Master Services Agreement between Baker Tilly Advisory Group, LP
("Baker Tilly") and Imperial Valley Healthcare District ("IVHD") for services including preparation of Medicare, Medi-Cal and HCAI cost reports and supporting workpapers for fiscal year ending June 30, 2026.
Presented by: Carly Loper, CFO
Contract Value: estimate - $92,440 (excluding appeals)
Contract Term: One Year Agreement (reports for FY ending June 30, 2026)
Budgeted: Yes
Budgeted Classification: Purchase Services

Motion was made by Director Irigoyen and second by Director Garcia to approve the Authorize the approval of the Statement of Work pursuant to the Master Services Agreement between Baker Tilly Advisory Group, LP ("Baker Tilly") and Imperial Valley Healthcare District ("IVHD") for services including preparation of Medicare, Medi-Cal and HCAI cost reports and supporting workpapers for fiscal year ending June 30, 2026. Motion passed by the following wit:

AYES: Burnworth, Goodsell, Garcia, Berker, Irigoyen, Valdez, Proctor
NOES: None

c. Staff Recommends Action to Authorize: Authorization to approve Medical Directorship agreement for Alidad Zadeh, D.O. at Pioneers Skilled Nursing Center.
Presented by: Carly Zamora
Contract Value: not to exceed $54,000 annually
Contract Term: 3 years
Budgeted: Yes
Budgeted Classification: Professional Fees

Motion was made by Director Irigoyen and second by Director Garcia to approve the Authorization to approve Medical Directorship agreement for Alidad Zadeh, D.O. at

Pioneers Skilled Nursing Center. Motion passed by the following wit:

AYES: Burnworth, Goodsell, Garcia, Berker, Irigoyen, Valdez, Proctor
NOES: None

d. Staff Recommends Action to Authorize: Authorization to approve Professional Service Agreement for George A. Rapp, M.D.
Presented by: Carly Zamora
Contract Value: approximately $800,000 value varies depending on wRVU
Contract Term: 3 years
Budgeted: Yes
Budgeted Classification: Professional Fees

Motion was made by Director Irigoyen and second by Director Garcia to approve the Authorization to approve Professional Service Agreement for George A. Rapp, M.D. Motion passed by the following wit:

AYES: Burnworth, Goodsell, Garcia, Berker, Irigoyen, Valdez, Proctor
NOES: None

e. Staff Recommends Action to Authorize: Authorization to approve Medical Directorship Agreement for George A. Rapp, M.D.
Presented by: Carly Zamora
Contract Value: not to exceed $18,000 annually
Contract Term: 3 years
Budgeted: Yes
Budgeted Classification: Directorship

Motion was made by Director Irigoyen and second by Director Garcia to approve the Authorization to approve Medical Directorship Agreement for George A. Rapp, M.D. Motion passed by the following wit:

AYES: Burnworth, Goodsell, Garcia, Berker, Irigoyen, Valdez, Proctor
NOES: None

f. Staff Recommends Action to Authorize: Authorization to approve Medical Directorship agreement for George Fareed, M.D. at Pioneers Skilled Nursing Center.
Presented by: Carly Zamora
Contract Value: not to exceed $54,000 annually
Contract Term: 3 years
Budgeted: Yes
Budgeted Classification: Professional Fees

Motion was made by Director Irigoyen and second by Director Garcia to approve the

Authorization to approve Medical Directorship agreement for George Fareed, M.D. at Pioneers Skilled Nursing Center. Motion passed by the following wit:

AYES: Burnworth, Goodsell, Garcia, Berker, Irigoyen, Valdez, Proctor

NOES: None

g. Staff Recommends Action to Authorize: Authorization to approve Medical Directorship agreement for Mehboob Ghulam, D.O., at Pioneers Skilled Nursing Center.
Presented by: Carly Zamora
Contract Value: not to exceed $54,000 annually
Contract Term: 3 years
Budgeted: Yes
Budgeted Classification: Professional Fees

Motion was made by Director Irigoyen and second by Director Garcia to approve the Authorization to approve Medical Directorship agreement for Mehboob Ghulam, D.O., at Pioneers Skilled Nursing Center. Motion passed by the following wit:

AYES: Burnworth, Goodsell, Garcia, Berker, Irigoyen, Valdez, Proctor
NOES: None

h. Staff Recommends Action to Authorize: Hydrovida (Planned Service Agreement – 3 years)
Presented by: Carly Zamora
Contract Value: $174,240.00
Contract Term: (3) year term 8/7/2026 – 8/7/2029
Budgeted: N/A
Budgeted Classification: N/A

Motion was made by Director Irigoyen and second by Director Garcia to approve the Hydrovida (Planned Service Agreement – 3 years). Motion passed by the following wit:

AYES: Burnworth, Goodsell, Garcia, Berker, Irigoyen, Valdez, Proctor
NOES: None

11. MANAGEMENT REPORTS:

a. Finance: Carly C. Loper, MAcc – Chief Financial Officer

Carly went over the financial report for July.

b. Hospital Operations: Carol Bojorquez, MSN, RN – Chief Nursing Officer

Carol went over the CNO report.

c. Clinics Operation: Carly Zamora MSN, RN – Chief of Clinic Operations

Carly went over the Clinic Operations report

d. Executive: Carol Zamora – Interim Chief Executive Officer

Carly reported that there has been a lot of work and that the board approved the resolution. There is a lot of work in collaboration with UCSD. There is a total of 6 grants. They
have submitted 4 and will be submitting the 5th one tomorrow. There are a lot of dollars they are arranging from recruitment and retention of physicians and staff to behavior health, family medicine, OB and technology. She is really hoping they get some of those dollars into healthcare here in the community. Also, with the merger they have been really busy for the last couple of years and there are things that cannot be done until the merger happens and then once that happens, they need to ensure those things get done.

Pablo reported that for the CFO position has been posted and they have about 12 applicants. He was pleasantly surprised at how many people have applied with experience. They have received a lot of people from Northern Californian,

e. Legal: Adriana Ochoa – General Counsel

No report.

12. ITEMS FOR FUTURE AGENDA:
None

13. ADJOURNMENT: With no future business to discuss, Motion was made unanimously to adjourn meeting at 7:32 p.m.

IMPERIAL VALLEY HEALTHCARE DISTRICT

MEETING MINUTES
August 27, 2026
SPECIAL BOARD MEETING

THE IMPERIAL VALLEY HEALTHCARE DISTRICT MET IN REGULAR SESSION ON THE 27th OF AUGUST AT 1271 ROSS AVENUE CITY OF EL CENTRO, CA. ON THE DATE, HOUR AND PLACE DULY ESTABLISHED OR THE HOLDING OF SAID MEETING.

1. **TO CALL ORDER:**
   The regular meeting was called to order in open session at 6:54 p.m. by Director Burnworth.

2. **PUBLIC COMMENT TIME:**
   None

3. **ITEMS FOR DISCUSSION AND/OR BOARD ACTION:**
   a. Approval of Resolution No. 2026-0827, A Resolution of the Board of Directors of the Imperial Valley Healthcare District DBA Pioneers Memorial Hospital Authorizing Execution of a Grant Agreement with the California Department of Health Care Access and Information and
   Acceptance and Expenditure of up to Two Million Dollars ($2,000,000)

   Motion was made by Director Berker and second by Director Garcia to approve the Approval of Resolution No. 2026-0827, A Resolution of the Board of Directors of the Imperial Valley Healthcare District DBA Pioneers Memorial Hospital Authorizing Execution of a Grant Agreement with the California Department of Health Care Access and Information and
   Acceptance and Expenditure of up to Two Million Dollars ($2,000,000). Motion passed by the following wit:

   AYES: Burnworth, Goodsell, Garcia, Berker, Irigoyen, Valdez, Proctor
   NOES: None

4. **ADJOURNMENT:** With no future business to discuss, Motion was made unanimously to adjourn meeting at 7:32 p.m.

Imperial Valley Healthcare District

Title: **Reference Laboratories**	Policy No. LAD-001 Page 1 of 2
Current Author: Annabel Limentang	Effective: 1/1/2008
Latest Review/Revision Date: March 4, 2026	Manual: Lab Dept Specific / Administration

Collaborating Departments: Medical Staff		Keywords: Reference Lab	
Approval Route: List all required approval			
MARCC **X**	PSQC	Other:	
Clinical Service		MSQC **X**	MEC **X**	BOD **X**

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 Reference laboratory list reviewed and approved by medical staff at least every twelve months. Other reference laboratories may be used to meet service requirements of the medical staff.

2.0 Scope: Clinical Laboratory – Pioneers Memorial Hospital

3.0 Policy:

3.1 The laboratory director recommends reference laboratory services to the clinical staff for acceptance.

4.0 Definitions:

4.1 CLIA'88 – Clinical Laboratory Improvement Amendments 1988
4.2 Reference Laboratory – Clinical or surgical pathology laboratory performing tests not available on site
4.3 CDPH – California Department of Public Health

5.0 Procedure:

5.1 Laboratory must be licensed.
  5.1.1 Laboratory must be CLIA'88 licensed.
  5.1.2 Laboratory located in California requires CDPH license.
5.2 Reference Laboratories:
  5.2.1 Quest Diagnostics
  5.2.2 Imperial County Health Department
  5.2.3 LifeStream
  5.2.4 California Department of Health Services-Genetic Disease Branch
  5.2.5 St. Joseph Medical Center Laboratory, Burbank
  5.2.6 Prometheus Laboratory
  5.2.7 El Centro Regional Medical Center Laboratory
  5.2.8 Sharp Hospital Laboratory
  5.2.9 Pacific Rim Pathology
  5.2.10 NeoGenomics Laboratories, Inc.
  5.2.11 Antelope Valley Histology, LLC

6.0 References: Not applicable

7.0 Attachment List: Not applicable

8.0 Summary of Revision:

8.1 Update reference laboratory list; 2-year review.

Imperial Valley Healthcare District*REVIEWED ANNUALLY*

Title: **Standardized Procedure for Registered Nurses: Neonatal Endotracheal Intubation**	Policy No. CLN-00236 Page 1 of 7
Current Author: S. Taylor, RNC-NIC, BSN	Effective: 11/1/1995
Latest Review/Revision Date: 02/18/2026	Manual: Clinical / Nursery/NICU

Collaborating Departments: Perinatal; Neonatal NICU Medical Director, NICU Manager	Keywords: Intubation, Neonatal Intubation		
Approval Route: List all required approval			
MARCC	Other:		
Clinical Service Credentials 3/2026 OB/Peds 4/2026	MSQC 5/2026	MEC 5/2026	BOD 6/2026

APPROVALS		
AUTHORITY	**SIGNATURE**	**DATE**
CHIEF EXECUTIVE OFFICER		
CHIEF NURSING OFFICER		
PHYSICIAN DEPARTMENT CHAIR		
PMHD BOARD OF DIRECTORS		

NOTE: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 This standardized procedure is designed to establish guidelines that allow the Neonatal Advanced NRP RN to perform neonatal endotracheal intubation.

2.0 Scope: Neonatal Advanced NRP RN only

3.0 Policy:

3.1 Only approved RNs may function under any Standardized Procedure. The Advanced NRP RN may perform endotracheal intubation on neonates as outlined in procedure.

3.2 Circumstances under which the competency validated Advanced NRP RN may perform endotracheal intubation:

3.2.1 In the Perinatal/Neonatal Department of Pioneers Memorial Hospital

3.2.2 In the Emergency Department of Pioneers Memorial Hospital

3.3 When possible, the physician should be contacted before the procedure. In all emergencies, the primary physician will be notified as soon as possible while advanced life support is being initiated.

3.4 Scope of Supervision – The competency validated Advanced NRP RN will receive:

3.4.1 Indirect supervision by the attending physician

3.4.2 A physician will be available at all times for consultation

3.5 In the event that this procedure is altered via a physician's written or verbal order, the Advanced NRP RN will inform the physician that he/she is not certified to carry out the altered plan and must either adhere to the procedure or relinquish responsibility to the physician.

3.6 RN Requirements

3.6.1 Education/Training/Experience
- 3.6.1.1 The Advanced NRP RN will have been a Registered Nurse for a minimum of 3 years with at least 3 years of Neonatal Nursery experience
- 3.6.1.2 The RN will be certified in all aspects of NRP

3.6.2 Initial and Ongoing Competency Evaluation
- 3.6.2.1 Initial competency will be validated by the physician or experienced Advanced NRP RN
- 3.6.2.2 The Advanced NRP RN will successfully complete three (3) endotracheal intubations under direct supervision of the physician or experienced Advanced NRP RN before being allowed to perform the procedure without direct supervision

3.6.3 Annual Competency Assessment
- 3.6.3.1 Complete three (3) successful endotracheal intubations supervised by a physician or experienced Advanced NRP RN
- 3.6.3.2 If minimum number of annual procedures is not obtained, the following are options for competency maintenance:
  - 3.6.3.2.1 Attend skills lab offered biannually (procedure review & simulation)
  - 3.6.3.2.2 Competency validation test and demonstration of skill

3.6.4 This Standardized Procedure will be subject to periodic review by the appropriate interdisciplinary committees

4.0 Definitions:

4.1 Endotracheal Intubation – The placement of a flexible plastic tube into the trachea to maintain an open airway or to serve as a conduit through which certain drugs may be administered
4.2 CO2 – Carbon dioxide
4.3 LMA – Laryngeal Mask Airway
4.4 NRP – Neonatal Resuscitation Program
4.5 Competency Validation – Has completed required education, demonstrated competency and completes ongoing competency validation as required
4.6 EMR – Electronic Medical Record
4.7 RSI – Rapid Sequence Intubation

5.0 Procedure:

5.1 Database

5.1.1 Subjective
- 5.1.1.1 Historical information relevant to present illness

5.1.2 Objective
- 5.1.2.1 Physical examination with focus on pulmonary and cardiovascular systems

5.1.3 Assessment

5.1.3.1 Decision for endotracheal intubation will be based upon subjective and objective data and in collaboration with the attending physician when not an emergent life-saving maneuver

5.1.4 Plan

5.1.4.1 Parents/primary caregivers will be provided with the appropriate information prior to initiation of the endotracheal intubation procedure if not an emergent lifesaving procedure, and obtain consent as per hospital protocol

5.1.4.2 A chest x-ray will be obtained upon completion of the procedure

5.1.4.3 Inability to intubate the trachea

5.1.4.4 Inability to oxygenate or ventilate effectively

5.1.4.5 Trauma, including tracheal or hypoxemia, bradycardia, cardiac arrest

5.1.4.6 If the patient's condition is unstable

5.1.4.7 If there are any complications or unexpected outcomes from the procedure

5.2 Indications

5.2.1 When continued positive pressure ventilation or mechanical ventilation is required

5.2.2 To resolve a critical upper airway obstruction or protect airway due to the inability to clear secretions

5.2.3 To provide selective bronchial ventilation

5.2.4 To obtain a sterile specimen for tracheal culture

5.2.5 To provide ventilation for suspected congenital diaphragmatic hernia

5.2.6 To administer surfactant therapy

5.3 Contraindications

5.3.1 In the neonatal population, there is not conclusive contraindication for intubation. Cervical injuries would be contraindication for use of a laryngoscope; however injuries of this type are infrequent in this patient population.

5.4 Equipment

5.4.1 Select appropriate size of endotracheal tube

5.4.1.1 2.5 for infant less than 1000 grams

5.4.1.2 3.0 for infant 1001-2000 grams

5.4.1.3 3.5 for infant 2001-3700 grams

5.4.1.4 3.5-4.0 for infant 3701-4500 grams

5.4.2 Sterile stylet (optional)

5.4.3 Laryngoscope – blades for term and preterm infants

5.4.3.1 #0 blade for preterm infants

5.4.3.2 #1 blade for full term infants

5.4.4 Positive pressure device – resuscitation bag/mask, manometer and oxygen/air source with blander and analyzer, oxygen tubing

5.4.5 Wall suction and 6fr, 8fr and 10fr suction catheters

5.4.6 Stethoscope

5.4.7 Carbon dioxide (CO_2) detector

5.4.8 Pulse oximeter with neonatal probe
5.4.9 Personal protective equipment such as gloves
5.4.10 Adhesive tape or endotracheal intubation securing device

5.5 Considerations
5.5.1 Prepare equipment prior to starting the procedure. Keep equipment ready and available near bedside of patients that will likely require intubation
5.5.2 Use appropriate sized tubes for the patient to minimize airway trauma
5.5.3 Each intubation attempt should be limited to 30 seconds to minimize hypoxia of patient
5.5.4 Interrupt an unsuccessful attempt with bag and mask ventilation. The one exception is a diagnosed or suspected diaphragmatic hernia
5.5.4.1 If the patient has a known congenital diaphragmatic hernia, try to avoid bag and mask ventilation prior to intubation
5.5.5 Ensure the visualization of the larynx. Have an assistant maintain good position of the patient without hyperextending or rotating the neck
5.5.6 Do not use pressure or force that may cause trauma. Avoid using a rocking motion with the laryngoscope, using extensive pressure on the external trachea, or pushing the tube against any obstruction.
5.5.7 Make sure all attachments are secure and in a careful position to avoid dislodging, kinking or moving the endotracheal tube.
5.5.8 Avoid pushing the endotracheal tube in too far to avoid right main stem bronchus intubation.
5.5.9 Recognize factors that may lead to spontaneous extubation, such as increased oral secretions, infant activity, frequent repositioning, tube slippage
5.5.10 RSI when in the presence of a physician
5.5.10.1 RSI in the neonate has been shown to reduce the number of intubation attempts and decrease the amount of time needed for neonatal intubation. RSI should be strongly considered prior to intubation, except for emergent intubation during resuscitation or in the delivery room. Medications with rapid onset and short duration of action are preferred. Preferred medications include analgesic agents or anesthetic dose of a hypnotic drug, vagolytic agents and rapid-onset muscle relaxants.

5.6 Guidelines for Procedure/Practice:
5.6.1 Prior to procedure, perform “Time Out” Universal Protocol according to hospital policy
5.6.2 Proceed with RSI if clinically indicated and/or appropriate
5.6.3 Choose the appropriate sized tube based on weight or gestational age. Stylet is optional. While maintaining aseptic technique, thread sterile stylet inside endotracheal tube being careful to not advance the stylet beyond the end of the tube.
5.6.4 Choose appropriately sized blade, Open blade and ensure working light. Hold blade in left hand with thumb and first three fingers with blade directed at patient.

5.6.5 Clear oropharynx with gentle suctioning using suction catheter
5.6.6 Empty stomach
5.6.7 Pre-oxygenate infant with bag and mask ventilation as indicated. Follow heart rate and oxygenation on monitor.
5.6.8 Position and stabilize infant with head midline and neck slightly extended in the sniffing position. It may be helpful to place a roll underneath the patient's shoulders.
5.6.9 Open a sterile towel to place equipment on (blade and ETT) between attempts
5.6.10 Open infant's mouth with right index finger, depress and move tongue towards the left side of the mouth. Do not use the laryngoscope to open mouth.
5.6.11 Insert laryngoscope blade into the mouth sliding the blade along the tongue until the tip is resting in the vallecula (area between base of tongue and epiglottis). In extremely premature infant, it may be appropriate to use the blade tip to lift epiglottis.
5.6.12 Lift the laryngoscope blade slightly, lifting the tongue out of the way to expose the pharyngeal area allowing visualization of the epiglottis and glottis. Lift the entire blade with one motion. Do not use a rocking motion.
5.6.13 Suction if necessary
5.6.14 Identify marks. It may be helpful to have an assistant apply gentle pressure on eternal trachea to bring the glottis into view.
5.6.15 Once vocal cords and trachea are visualized, with the endotracheal tube in the right hand, introduce it to the right side of the mouth to maintain direct visualization of the glottis. When the vocal cords are apart, place the tube through the cords approximately 2 cms, or until the vocal cord guide is at the level of the cords.
5.6.16 If the cords are together, wait for them to open. Do not touch the cords with the tube. Do not force the tube between closed cords. If the cords do not open in seconds, stop and ventilate with bag and mask.
5.6.17 Try to limit the intubation attempt to 30 seconds. If infant's vital signs become unstable or if the endotracheal tube is thought to be misplaced in the esophagus, remove tube and administer positive pressure ventilation. Place endotracheal tube on sterile towel to maintain sterile/clean equipment before next intubation attempt.
5.6.18 Once the tube has passed through vocal cords, stabilize the tube and carefully remove the laryngoscope. Continue to stabilize the tube and carefully remove the stylet, if used.
5.6.19 Confirm placement by placing a CO2 detector on end of tube, attach a ventilation bag and assess for color change when giving positive pressure ventilation. Have assistant listen to chest to ensure equal breath sounds and chest rise bilaterally. No breath sounds should be heard over the stomach.
5.6.20 Verify tube depth. Once verified, secure the tube to the infant's face using adhesive tape or other endotracheal tube securing device.

Weight (kg)	Depth of insertion

	(cm mark at upper lip)
Babies less than 750 grams	5.5-6
1	7
2	8
3	9
4	10

5.6.21 Obtain chest x-ray to verify correct placement (tip of endotracheal tube at T2-3)

5.7 Documentation

5.7.1 A written consent per hospital protocol will be obtained and placed in the patient's medical record prior to the procedure if not a lifesaving procedure. If consent is not obtained in advance, the parent/guardian is to be notified as soon as possible after procedure.

5.8 Laryngeal Mask Airway application

5.8.1 LMA's may be utilized for resuscitation in neonates over 1500gms. Size 1

5.8.2 Using clean technique, removed the device from the sterile package

5.8.3 Deflate the cuff following manufactures recommendations

5.8.4 Stand at the baby's head and position the infant in a sniffing position

5.8.5 Hold the device along the airway tube with the closed bottom if the mask facing the baby's palate and the open bowl of the mask facing towards the baby's chin

5.8.6 Open the baby's mouth by pressing gently downward on the baby's chin

5.8.7 Insert the leading tip of the mask into the baby's mouth, on top of the tongue, with the bottom of the mask pressed against the baby's palate

5.8.8 Glide the device downward and backward, following the contour of the palate, with a continuous but gentle push until you feel definitive resistance

5.8.9 Holding the tube in place, attach a CO2 detector and PPV device.

5.8.10 Begin PPV and secure the device following the manufactures recommendation for cuff inflation

5.8.11 If the LMA is correctly inserted and you are providing ventilation that inflates the lungs, you should detect exhaled CO2 within 8-10 positive pressure breaths. You should see synchronized chest wall movement and hear equal breath sounds when you listen with a stethoscope. You should not hear a large leak of air coming from the mouth or see a growing bulge in the baby's neck.

5.8.12 Babies can breathe spontaneously through the device, crying and grunting sounds may be audible

5.8.13 Removing the LMA:

5.8.13.1 The airway can be removed when the baby establishes effective spontaneous respirations and the device is no longer needed or when an endotracheal tube can be inserted successfully.

5.8.13.2 When the device is to be removed, suction secretions from the mouth and throat before you remove the device.

5.8.13.3 Deflate the cuff before removal of the LMA

6.0 References:

6.1 American Academy of Pediatrics, American Heart Association, Neonatal Resuscitation Textbook 9th edition (2025)

6.2 Trevisanutp, D. MD, et al "The Laryngeal Mask Airway: Potential Applications in Neonates" (2022) https://fn.bmj.com/content/89/6/F485

6.3 University of California, San Francisco Medical Center, Standardized Procedure (2008) http://www.ucsfmedicalcenter.org/medstaffoffice/Standardized_Procedures/Neonatal%20Intubation.pdf

6.4 Rady Children's Hospital Standardized Procedure SP 2-01 "Neonatal Endotracheal Intubation" (2017)

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Reviewed and submitted without change

Imperial Valley Healthcare District*REVIEWED ANNUALLY*

Title: **Standardized Procedure for Registered Nurses: Neonatal Thoracentesis/Needle Decompression**	Policy No. CLN-02518 Page 1 of 5
Current Author: S. Taylor, RNC-NIC, BSN	Effective: 4/19/2018
Latest Review/Revision Date: 02/18/2026	Manual: Clinical / Nursery/NICU

Collaborating Departments: Neonatal, NICU Medic Director NICU Manager	Keywords: Neonate Thoracentesis, Needle decompression

Approval Route: List all required approval			
MARCC	Other:		
Clinical Service Pediatrics 4/2026	MSQC 5/2026	MEC 5/2026	BOD 5/2026

APPROVALS		
AUTHORITY	**SIGNATURE**	**DATE**
CHIEF EXECUTIVE OFFICER		
CHIEF NURSING OFFICER		
PHYSICIAN DEPARTMENT CHAIR		
PMHD BOARD OF DIRECTORS		

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 This standardized procedure is designed to establish guidelines that allow the Neonatal Advanced NRP RN to perform neonatal emergency thoracentesis.

2.0 Scope: Neonatal Advanced NRP RN

3.0 Policy:

3.1 Only approved RNs may function under any Standardized Procedure. The Advanced NRP RN may perform thoracentesis on neonates as outlined in the procedure.

3.2 Circumstances under which the competency validated Advanced NRP RN may perform thoracentesis:

3.2.1 In the Perinatal/Neonatal Department of Pioneers Memorial Hospital

3.2.2 In the Emergency Department of Pioneers Memorial Hospital.

3.3 When possible, the physician should be contacted before the procedure. In all emergencies, the primary physician will be notified as soon as possible while advanced life support is being initiated.

3.4 Scope of Supervision – The competency validated Advanced NRP RN will receive:

3.4.1 Indirect supervision by the attending physician

3.4.2 A physician will be available at all times for consultation.

3.5 In the event that this procedure is altered via a physician's written or verbal order, the Advanced NRP RN will inform the physician that he/she is not certified to carry out the altered plan and must either adhere to the procedure or relinquish responsibility to the

physician.

3.6 RN requirements:

3.6.1 Education/Training/Experience – below will be documented and maintained in the employee file:

3.6.1.1 The Advanced NRP RN will have been an RN for a minimum of three (3) years with at least three (3) years of Neonatal Nursery experience.

3.6.1.2 The RN will be certified in all aspects of NRP.

3.6.1.3 The Advanced NRP RN will demonstrate competencies in skills lab that will be held biannually

3.6.2 Initial and Ongoing Competency Evaluation:

3.6.2.1 Initial competency will be validated by the physician or experienced Advanced NRP RN

3.6.3 Annual Competency Assessment:

3.6.3.1 Completed three (3) successful thoracentesis supervised by a physician or experienced Advanced NRP RN

3.6.3.2 If minimum number of annual procedures are not obtained, the following are options for competency maintenance:

3.6.3.2.1 Attend skills lab offered biannually (procedure review & simulation)

3.6.3.2.2 Competency validation test and demonstration of skill

3.6.4 This standardized procedure will be subject to periodic review by the appropriate interdisciplinary committees.

4.0 Definitions:

4.1 Thoracentesis – (closed chest needle aspiration) to remove air or fluid from the pleural space.

4.2 Competency Validation – Has completed required education, demonstrated competency and completes ongoing competency validation as required.

4.3 NRP – Neonatal Resuscitation Program Certification

5.0 Procedure:

5.1 Database:

5.1.1 Subjective:

5.1.1.1 Historical information relevant to present illness

5.1.2 Objective:

5.1.2.1 Physical examination with focus on pulmonary, cardiovascular and neurological systems.

5.1.2.1.1 Symptoms may vary from irritability and restlessness to apneic spells, tachypnea, grunting and retractions and in severe cases, bradycardia, cyanosis and shock. A tension pneumothorax must be diagnosed and treated promptly.

5.1.2.1.2 Clinical signs of a tension pneumothorax include:

5.1.2.1.2.1 Abrupt worsening of the respiratory or circulatory status

5.1.2.1.2.2 Hypertension followed by hypotension with decreased pulse pressure.
5.1.2.1.2.3 Tachycardia followed by bradycardia
5.1.2.1.2.4 Absent or decreased breath sounds on affected side.

5.1.3 Assessment:
5.1.3.1 Decision for needle thoracentesis will be based upon subjective and objective data and in collaboration with attending physician prior to the initiation of the procedure when not an emergent/lifesaving procedure.

5.1.4 Plan:
5.1.4.1 Parents/primary caregivers will be provided with the appropriate information prior to initiation of the thoracentesis procedure if not an emergent lifesaving procedure, and obtain consent as per hospital protocol.
5.1.4.2 A chest x-ray will be obtained upon completion of procedure.
5.1.4.3 Documentation of the procedure performed, outcome and any complications will be recorded in the electronic medical record.

5.2 Indication:
5.2.1 Symptomatic treatment of air or fluid accumulation in the pleural space

5.3 Contraindications
5.3.1 Confirmed/suspicion of diaphragmatic hernia.
5.3.2 Small air or fluid collection without significant hemodynamic symptoms.
5.3.3 Spontaneous pneumothorax that, in the absence of lung disease, is likely to resolve without intervention.

5.4 Equipment:
5.4.1 Cardio/respiratory and pulse oximeter in place with alarms on.
5.4.2 Transilluminator
5.4.3 Sterile gloves and gown
5.4.4 Non-sterile hat and mask
5.4.5 Thoracentesis insertion kit, including:
5.4.5.1 Chlorhexidine antiseptic solution (Povodine if infant less than 1000gms).
5.4.5.2 Sterile towels/drape
5.4.5.3 Three-way stopcock
5.4.5.4 20 ml syringe
5.4.5.5 2 x 2 sterile gauze pads
5.4.5.6 Transparent dressing and tape
5.4.5.7 IV extension tubing
5.4.5.8 23 gauge butterfly

5.5 Guidelines for procedure/practice – Thoracentesis
5.5.1 Prior to the procedure, analgesia will be administered prophylactically as/if needed in accordance with the “Pain Management” policy CLN-00223.
5.5.2 Gather equipment
5.5.3 Connect the 3-way stopcock and syringe to IV extension tubing.
5.5.4 Turn the stopcock “off” to the remaining outlet (off to atmosphere)

5.5.5 Sterile technique is required throughout the procedure.
5.5.6 Have an assistant position the infant appropriately. The most preferred position is supine with affected side slightly elevated. Restrain the infant's arms and legs.
5.5.7 Identify entry site. Use second or third intercostal space along the midclavicular line.
5.5.8 Prep skin with antiseptic solution.
5.5.9 Puncture skin at a 45ϖ angle, angling over the third or fourth rib, and advance needle at a 90ϖ angle. Inserting the needle over the top of the rib will avoid blood vessels and nerves that run along the bottom of the rib.
5.5.10 As needle enters pleural space, decrease angle to approximately 15ϖ horizontal.
5.5.11 Attach the butterfly to the stopcock and syringe. The stopcock allows for aspiration of free air or fluid into the syringe and emptying of the syringe while maintaining a closed system.
5.5.12 Aspirate air into syringe attached to 3-way stopcock and evacuate via open position. When free air of fluid is obtained, stabilize the catheter and continue to aspirate until preparation for chest tube insertion is complete, or until the air leak or fluid accumulation is evacuated. Continue intermittently as patient's condition warrants.
5.5.13 Removed butterfly needle once air evacuation is compete.
5.5.14 Cleanse site and apply sterile dressing over site using 2x2 gauze and transparent dressing.
5.5.15 Monitor closely for signs of re-accumulation of pleural air.
5.5.16 Assess, treat and reassess pain according to "Pain Management' policy.

5.6 Complications:
5.6.1 Hemorrhage.
5.6.2 Infection.
5.6.3 Needle injury to lung or adjacent structures.
5.6.4 Damage to breast tissue.
5.6.5 Pain.

5.7 Documentation:
5.7.1 A written consent per hospital protocol will be obtained and placed in the patient's medical record prior to procedure if not a lifesaving procedure. If consent is not obtained in advance, the parent/guardian is to be notified as soon as possible after procedure.
5.7.2 Document according to the hospital policy: date, time, butterfly size, location, amount of air/fluid evacuated, patient's tolerance of procedure and any medications used.
5.7.3 A procedure note will be added to the electronic medical record.

6.0 References:

6.1 Verklan, M. T., Walden, M.et al, Core Curriculum for Neonatal Intensive Care Nursing, 6th Ed. (2020). Elsevier
6.2 Gardner, S.L, Carter, B.S. et al, Merenstein & Gardner's Handbook of Neonatal

intensive Care, 9th ed (2021). Elsevier

6.3 Neonatal Thoracentesis policy SP 2-06 & SP 3-06, Rady Children's Hospital, San Diego (2016 & 2017)

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Reviewed and submitted without change

Imperial Valley Healthcare District

Title: **Sentinel Event**	Policy No. ADM-00480
	Page 1 of 6
Current Author: Merlina Esparza/Mersedes Martinez	Effective: 2/16/2007
Latest Review/Revision Date: 04/27/2026 R1	Manual: Administration/Risk

Collaborating Departments: Senior Leaders, Legal Counsel (Doug Habig), Chair of Quality – Dr. Su	Keywords: Adverse Event, adverse outcome, root cause analysis, RCA, sentinel event reporting, TJC sentinel event reporting

Approval Route: List all required approval				
MARCC X	PSQC X	Other:		
Clinical Service _____		MSQC	MEC X	BOD X

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 The purpose of this policy is based on a belief that in order to improve performance, the organization must conduct timely, thorough, and credible investigations of sentinel events by understanding the systems and processes leading to the incident, in accordance with Just Culture principles, The Joint Commission Sentinel Event Policy, California Department of Public Health (CDPH) adverse event reporting requirements, and applicable Centers for Medicare and Medicaid Services (CMS) Conditions of Participation.

2.0 Scope:

2.1 District wide - including: volunteers, consultants, students, contracted employees, licensed independent practitioners, and physicians and applies to all clinical and non-clinical care settings, including inpatient, outpatient and ancillary services in compliance with TJC, CDPH, and CMS regulatory requirements.

3.0 Policy:

3.1 Imperial Valley Healthcare District (IVHD) is committed to taking proactive steps to reduce and prevent errors in order to improve patient care and comply with The Joint Commission National Patient Safety Goals, CMS Conditions of Participation and state regulatory requirements.

3.2 IVHD is committed to understanding the processes, attitudes and behavior and system vulnerabilities that contribute to sentinel events, adverse events, and near misses, consistent with TJC's system-based approach to patient safety.

3.3 IVHD is committed to making sustainable changes in systems and processes, as well as attitudes and behavior to reduce the probability of reoccurrence and to meet TJC expectations for root cause analysis (RCA)/investigation and action planning.

3.4 No disciplinary or retaliatory action will be taken against individuals for reporting safety/quality concerns, except in cases of reckless behavior or willful violation, consistent with Just Culture principles, CMS whistleblower protections, and organizational policy.

3.5 All "Never 28" Adverse Events as defined by California Department of Public Health (CDPH) will be managed as Sentinel Events, reported in accordance with Title 22, California Health and Safety Code 1279.1, and CMS reporting expectations as applicable. <*Attachment A – Never 28 Adverse Events to Report to California Department of Public Health*>.

3.6 Sentinel events meeting The Joint Commission reviewable sentinel event criteria will be managed in accordance with The Joint Commission Sentinel Event Policy, including timely RCA/investigation completion and leadership oversight, regardless of voluntary or self-reporting status.

4.0 Definitions:

4.1 Sentinel Event – An unexpected occurrence involving death, permanent harm, or severe temporary harm, as defined by The Joint Commission not related to the normal course of the patient's illness or underlying condition.

4.2 Serious Injury – Specifically includes loss of limb or function or severe temporary harm requiring life sustaining interventions.

4.3 Serious Disability – A physical or mental impairment that substantially limits one or more of the major life activities, or loss of bodily function lasting more than seven (7) days or still present at the time of discharge, consistent with CDPH and CMS definitions of reportable harm.

4.4 Care for the Care Giver – A multidisciplinary support team comprised of Risk Management, Quality, Human Resources and Medical Leadership to address the emotional and psychological needs of staff involved in adverse or sentinel events consistent with TJC recommendations for support following adverse events.

5.0 Procedure:

5.1 Management of potential/actual sentinel event shall follow The Joint Commission Sentinel Event Policy, CDPH reporting statues, and CMS Conditions of Participation. <*Attachment B – Sentinel Event Checklist*>

- 5.1.1 Notify the physician, stabilize and treat the patient.
- 5.1.2 Support the patient and/or family.
- 5.1.3 Address the patient/families immediate medical and psychosocial needs, including consultation with Social Services and/or Pastoral Services to provide psychological or counseling support.
- 5.1.4 Notify department leader immediately or House Supervisor if after hours.
- 5.1.5 Notify Risk Management: 760-351-4484 within 60 minutes.
- 5.1.6 Notify Administration, if after hours House Supervisor will notify Administrator on- call.
- 5.1.7 Collect all potential evidence or documents, this may include:
  - 5.1.7.1 All relevant documents
  - 5.1.7.2 Medication(s)
  - 5.1.7.3 Equipment

5.1.7.4 Photography

5.1.8 Protect and forward all potential evidence to Risk Management to retain for examination (i.e. insurers, coroners, etc.)

5.1.9 Administrative representative will notify Chief of Staff and/or Chief of Service.

5.1.9.1 Address disclosure of the event *See policy ADM-00134; Communication with Patient/Family after a Harm Event*

5.1.10 Complete a Quality Review Report (QRR)

5.1.11 Care for the Caregiver

5.1.11.1 Offer support for staff and providers.

5.1.11.2 If assistance is accepted, refer staff and providers to Employee Assistance Program and Care for the Caregiver team.

5.2 Sentinel Event Determination

5.2.1 The administrative representative and Risk Manager, in collaboration with the medical staff leader, shall determine whether the occurrence meets criteria for: A sentinel event, CDPH reportable adverse event, CMS reportable event <*Attachment A – Never 28 Adverse Events to Report to California Department of Public Health*>.

5.3 If the occurrence is deemed a Sentinel Event the following will be notified if not already aware:

5.3.1 Chief Nursing Officer

5.3.2 Risk Management

5.3.3 Compliance Officer

5.3.4 Department Manager

5.3.5 Public Relations (if communication to the community is required or media presence is anticipated)

5.3.6 Chair of Department or Designee when indicated.

5.4 IVHD shall meet all mandatory external reporting requirements, including: CDPH reporting timeliness and mechanisms, CMS reporting when events affect Medicare and Medicaid beneficiaries, and coordinate with The Joint Commission if applicable.

5.4.1 If the adverse event is ongoing, urgent or emergent threat to the welfare, health or safety of patients, personnel or visitors, CDPH must be notified within 24 hours via email CalHEART https://healthcareportal.cdph.ca.gov/. or telephone or fax at 619-688-6190 or 619-688-6444 respectively.

5.4.2 Otherwise CDPH must be notified within 5 calendar days of the adverse event detection.

5.4.3 The following individuals are authorized to report events to CDPH:

5.4.3.1 Chief Executive Officer

5.4.3.2 Chief Nursing Officer

5.4.3.3 Quality Resource Director

5.4.3.4 Risk Manager

5.4.3.5 Compliance Officer

5.5 The Risk Manager is responsible for
- 5.5.1 Contacting and reporting events to liability carrier (BETA Healthcare Group) and hospital attorney <*See policy ADM-00477; Claims Management*>
- 5.5.2 Receiving and compiling all reports, documents and /or materials for Risk Management, Quality Review and Legal Counsel.
- 5.5.3 Gathering and securing all pertinent items including:
  - 5.5.3.1 List of staff involved
  - 5.5.3.2 Relevant documents, materials, and equipment
- 5.5.4 Notifying the Health Information Management (HIM) Director, Patient Accounting Supervisors and Medicare Biller of account number to ensure proper billing and auditing take place <*See policy ADM-00127; Financial Adjustment for Adverse/Sentinel Event*>

5.6 Root Cause Analysis/investigation shall be conducted in accordance with The Joint Commission's Framework for RCA, emphasizing system and process failures, contributing human and organizational factors and elimination of reliance on individual blame. <*Attachment D – A Framework for Root Cause Analysis* and *Attachment E – Action Plan and Sentinel Event RCA Matrix*>
- 5.6.1 Risk Manager or designee is responsible for:
  - 5.6.1.1 Assembling the RCA team
  - 5.6.1.2 Facilitating team meetings
  - 5.6.1.3 Monitoring and reporting progress on RCA
- 5.6.2 Team members include individuals with the most knowledge of the event and will carry out determined action plan.
- 5.6.3 The RCA/investigation should be initiated as soon as possible and completed within timelines consistent with Regulatory expectations (typically within 45 calendar days of event occurrence, unless otherwise extended).
- 5.6.4 The team shall document RCA activities <*Attachment D – A Framework for Root Cause Analysis/Investigation and Action Plan*>
- 5.6.5 The RCA/investigation must be thorough, credible and acceptable by:
  - 5.6.5.1 Determine if the event was due to human error, at risk behavior, or reckless behavior and/or any other factors directly associated with the event
  - 5.6.5.2 Analyzing underlying systems and processes through a series of asking "why"
  - 5.6.5.3 Identifying risk points and their potential contributions to this type of event
  - 5.6.5.4 Determining potential improvement in systems or processes that may decrease the likelihood in the future
  - 5.6.5.5 To be credible the RCA/investigation must include the following:
    - 5.6.5.5.1 Participation by leadership and individual(s) most closely involved in the systems and processes under

review

5.6.5.5.2 Be internally consistent, do not contradict or leave obvious questions unanswered.

5.6.5.5.3 Provide an explanation for all findings if not applicable (N/A).

5.6.5.5.4 Include consideration of any relevant policies, procedures, and literature.

5.6.5.6 To be acceptable the Action Plan must include the following:

5.6.5.6.1 Identification of changes to be implemented in order to reduce risk, or rationale for not undertaking the changes

5.6.5.6.2 Identification of the action or change to be implemented, who is responsible for the implementation and how effectiveness of the actions will be measured or evaluated.

5.6.6 If the RCA/investigation finds the sentinel event to be caused by the performance or competence of a medical staff member holding clinical privileges, the corrective action will be managed through the outlined medical staff committee process under the supervision and direction of the Medical Executive Committee (MEC).

5.7 Action Plan

5.7.1 The corrective action plans shall meet Joint Commission standards for clarity, measurability, leadership accountability and sustainability, and shall be monitored for effectiveness in accordance with CMS quality oversight expectations.

5.7.2 Upon completion of the RCA/investigation, the team must develop and implement a corrective action plan to address direct and root causes, as well as, any special or common cause variations to reduce the risk of reoccurrence.

5.7.3 The Action Plan must be developed and finalized timely (typically 30 calendar days).

5.7.4 Responsibility for implementation, oversight, testing and managing timeliness must be assigned.

5.7.5 The action plan implementation and improvements must identify how the effectiveness of each action is measured and evaluated, as well as, establish a monitoring plan for ongoing effectiveness.

5.8 Reporting and Governance

5.8.1 Report to Patient Safety and Quality Council (PSQC), Medical Staff Quality Council) and Medical Executive Committee (MEC), a blinded summary of the sentinel event, the root cause(s) identified, corrective action and lessons learned.

5.8.2 Report to Board of Directors (BOD) a blinded report of trends and corrective actions.

5.8.3 Disseminate Lessons Learned to all appropriate staff through multiple methods.

5.8.4 An annual review of sentinel event cases will be reviewed to ensure compliance

with policy.

6.0 References:

6.1 Policy ADM-00134; Communication with the Patient/Family After a Harm Event
6.2 Policy ADM-0047; Claims Management
6.3 Policy ADM-00127; Financial Adjustment for Adverse/Sentinel Events
6.4 Policy ADM-00079; Just Culture
6.5 Title 22, Division 5, Chapter 1, Article 70737
6.6 Senate Bill 1301, Alquist, Chapter 647, Statutes of 2006 (All Facilities Letter July 27, 2007)
6.7 California Health and Safety Code Statutes 1279.1
6.8 California Evidence Code Section 1157
6.9 The Joint Commission. Sentinel Event Policy and Procedures
6.10 Centers for Medicare & Medicaid Services (CMS). Conditions of Participation- Quality Assessment and Performance Improvement (QAPI)

7.0 Attachment List

7.1 Attachment A – Never 28 Adverse Events to Report to California Department of Public Health
7.2 Attachment B – Sentinel Event Checklist
7.3 Attachment C – Adverse Event Reporting Form
7.4 Attachment D – A Framework for Root Cause Analysis and Action Plan
7.5 Attachment E – Sentinel Event RCA Matrix
7.6 Attachment F – Glossary of Terms

8.0 Summary of Revisions:

8.1 Updated PMHD to IVHD
8.2 Added author: Mersedes Martinez
8.3 Changed PMHD to IVHD
8.3 5.4.1 added CalHEART email address
8.4 Minor grammar changes throughout
8.5 Added 5.3.6

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

"NEVER – 28"
ADVERSE EVENTS TO REPORT TO CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

Adverse Event Type

- **Surgical Events**
  - Surgery on the wrong body part
  - Surgery on the wrong patient
  - Wrong surgical procedure performed on the patient
  - Retained instruments inpatient discovered after surgery invasive procedure
  - Unexpected death during surgery or within 24 hours after anesthesia begins

- **Device or Products Events: Patient death or serious disability associated with**
  - The use of contaminated drugs, devices, biologic
  - The use or function of a device in a manner other than the device's intended use
  - Intravascular air embolism, excluding during certain neurosurgical procedures

- **Patient Protection Events**
  - Discharge of an infant to the wrong person
  - Patient death or serious disability associated with elopement from the health care facility
  - Patient suicide, attempted suicide, or deliberate self-harm resulting in serious disability
  - Intentional injury to a patient by a staff member, another patient, visitor, or other
  - Unanticipated death of a full term infant

- **Environmental Events**
  - Any incident in which a line designated for oxygen or other came to be delivered to a patient and contains the wrong gas or is contaminated by toxic substances
  - Patient death or serious disability while being cared for in a health care facility associated with:
    - A burn incurred from any source
    - A slip, trip or fall
    - An electric shock
    - The use of restraints or bedrails

- **Care Management Events**
  - Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
  - Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy

- Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results
- Death/serious disability related to hypoglycemia, onset in hospital
- Death/serious disability associated with failure to identify and treat hyperbilirubinemia in neonates during first 28 days of life
- Stage 3 or 4 ulcer acquired after admission (unless progression to Stage 3 was from a Stage 2 identified at admission)
- Death/serious disability from spinal manipulation at hospital
- Medication error leading to the death or serious disability of patient due to incorrect administration of drugs. For example:

  → Omission error
  → Dosage error
  → Dose preparation error
  → Wrong time error
  → Wrong rate of administration error
  → Wrong administrative technique error
  → Wrong patient error
  → Wrong medication

- **Criminal Events**
  - Any instance of care ordered by or provided by an individual impersonating a clinical member of staff
  - Abduction of a patient
  - Death or significant injury of patient or staff resulting from physical assault
  - Sexual assault of patient

AND/OR

Never #28

An adverse event, or series of events, that causes the death or serious disability of a patient, personnel, or visitor. (As stated in the California Senate Bill 1301)

Sentinel Event Checklist
Event Number:

Deadline	Action	Responsible Person	Comment	Date & Time Completed	Completed by
Immediately (Within 60minutes)	Notify physician, stabilize/treat patient, and ensure family needs are met.	Nurse or Charge RN			
	Notify Department Leader immediately or House Supervisor if after hours	Nurse or Charge RN			
	Update patient care plan to address problem(s) associated with the event	RN/ Charge RN Director or House Sup.			
	Notify Risk Management ext. 4484	Director or House Sup			
	Assess and arrange if necessary staff support assistance	House Supervisor/Department Director			
	Initiate investigation • Collect names and contact information of staff/witnesses • Collect and secure evidence • Gather relevant documentation • Commence interview process • initiate QRR	Director or House Sup or Risk Manager			
	• Notify Administrative Representative(s), CNO, CEO, Quality Director	Director and Risk Manager			
	Notify Chief of Service & Chief of Staff	Risk and/or Administration			
	Disclose event to patient/family – provide information and appropriate support • Social Worker • Pastoral Support	Risk and Administration to determine			
	Determine if potential Sentinel/Reportable Event to: • CDPH (24 hrs if ongoing, or 5 calendar days) • Law Enforcement, • Adult or Child Protective Services	Risk, Administration and/or Chief of Staff			

Sentinel Event Checklist
Event Number:

	• Licensing Boards				
Within 24 hours	Notify required agencies of reportable event as per policy/requirement	Risk, House Supervisor, Department Designee as need, Administration			
	Notify Public Relations if applicable	Administration			
	Initiate RCA • Schedule meetings • Determine if provider peer review required • Document immediate action to prevent recurrence	Risk, Quality, Department Designee			
	Notify billing to hold charges until review is complete	Risk			
	Place chart in legal	Risk			
	Report to Beta Healthcare Group (liability carrier)	Risk			
	Notify PMHD Legal Counsel if applicable	Risk			
To follow	RCA activity • Flow chart process • Determine root cause • Human Factors/System Design • Maintain minutes • Medical Staff Peer Review Determination • Develop Corrective Action • Implement Corrective Action • Monitor Corrective Action • Disseminate Lessons Learned • Document on SE log • Report to PSQC, MSQC, MEC and BoD	RCA Team			

Sentinel Event Checklist
Event Number:

*Time frames are not definite

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

Adverse Event Reporting Form

Date:

California Department of Health Services
Licensing and Certification District Office
7575 Metropolitan Drive, Suite 211
San Diego, California 92108

Fax #: 619-688-6444 Alternate Fax #: 619-688-6036

To Whom It May Concern:

This hospital believes it may have detected the adverse event indicated below as defined in Health and Safety Code Section 1279.1, and is hereby reporting pursuant to Health and Safety Code Section 1279.1 as well as Title 22, California Code of Regulations, Section 70737 (the "unusual occurrence" reporting requirement).

Due to the short timeframe required for reporting in the law, the information this hospital has may be incomplete. If further investigation shows that no adverse event as defined in this law took place, you will be notified. However, in order to comply with the law's short timeframe, this hospital is taking a precautionary measure and reporting accordingly.

This hospital may have detected the adverse event checked below:

☐ 1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. This does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

☐ 2. Surgery performed on the wrong patient.

☐ 3. The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. This does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

☐ 4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

☐ 5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

☐ 6. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

☐ 7. Patient death or serous disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but it not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

☐ 8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

☐ 9. An infant discharged to the wrong person.

☐ 10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.

☐ 11. A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for the admission to the health facility.

☐ 12. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

☐ 13. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

☐ 14. A maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

☐ 15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.

☐ 16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 miligrams per deciliter.

☐ 17. A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

☐ 18. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.

☐ 19. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock.

☐ 20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

☐ 21. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.

☐ 22. A patient death associated with a fall while being cared for in a health facility.

☐ 23. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

☐ 24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

☐ 25. The abduction of a patient of any age.

☐ 26. The sexual assault of a patient within or on the grounds of a health facility.

☐ 27. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility. *[Note: if this item is checked because a staff member suffered death or significant injury due to a physical assault on the grounds of the facility, please indicate the staff member's name at the bottom of the form, rather than a patient's name or code.]*

☐ 28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor. [*Note: An "adverse event" is defined as the incidents described in items 1 through 27, above. Thus, it is not clear that this category requires the reporting of any events not noted above. If a hospital has an adverse event that causes the death or serious disability of a patient, personnel, or visitor but is not listed above, legal counsel should be consulted to determine whether it is reportable.]*

Hospital's code to link this report to its file regarding this potential adverse event: (MRUN) #__ - __ - __

Brief statement regarding this event:

If you should require further information, please contact _____, _____ Department, at 760-351-____ or 760-351-_____.

Sincerely,

Name
Title

***Note**: "Serious disability" means:*

(a) *A physical or mental impairment that substantially limits one or more of the major life activities of an individual, if the impairment lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or*
(b) *The loss of bodily function, if the loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or*
(c) *The loss of a body part.*

Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event at IVHD
Appendix 3

ROOT CAUSE ANALYSIS

Date of RCA:
RCA Team:

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
What happened?	Sentinel Event	What are the details of the event? (Brief description) Include: Age, Sex, ASA Class if surgical case, event outcome, medical history, medication history, psychiatric history, autopsy results if applicable, and any other pertinent information				
	Sentinel Event	When did the event occur? (Date, day of week, time)				
	Sentinel Event	What areas or service lines were impacted?				

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
Why did it happen?	The process or activity in which the event occurred.	The process or activity in which the event occurred. What are the steps in the process, as designed? How is it usually done? A flow diagram may be used				
What were the most proximate factors?	The process or activity in which the event occurred.	What steps were involved in the event? What steps or lack of contributed to the event? Were there any steps that did not occur as intended?				

RCA INSTRUCTIONS: Not all questions will apply and there may be others that will emerge in the course of the analysis. However, all should be fully considered in "root cause" & risk reduction.
The three columns on the right are provided to be checked off for later reference:

- "Root cause?" should be answered "Yes" of "No" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant, but is not a root cause, be sure that it is addressed later with a "Why?" question. Root causes should have an action item.
- "Ask 'Why?" should be checked off whenever it is reasonable to ask why finding occurred, or didn't occur – drill down further. It is expected that any significant findings that are not identified as root causes themselves have "roots".

"Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each should have an action item and its # placed in this column.

Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event at IVHD
Appendix 3

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
(Typically "special cause" variation)	Human factors	What human factors were relevant to the outcome? Consider: fatigue, personal problems, inability to focus, complex critical thinking skills needed, failure to follow policies, substance abuse, boredom, rushing to complete task?				

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
	Equipment factors	How did the equipment performance affect the outcome? Consider any equip used including AED, crash carts, suction, oxygen, etc. Were biomedical checks done/up to date? Was equip available? Was staff in-serviced on the equip? Were alarms or displays operating properly?				
	Controllable environmental factors	What controllable factors directly affected the outcome? Consider site markings, overhead pager system, visitors.				
	Uncontrollable environmental or external factors	What can be done to protect against the effects of and of the uncontrollable factors? Are they truly beyond the organization's control? Natural disaster?				

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- "Ask 'Why?" should be checked off whenever it is reasonable to ask why finding occurred, or didn't occur – drill down further. It is expected that any significant findings that are not identified as root causes themselves have "roots".

"Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each should have an action item and its # placed in this column.

Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event at IVHD

Appendix 3

	Other	Are there any other factors that have directly influenced this outcome? Consider forms, signage, etc.				
	Other	What other areas are impacted? Where else could this happen?				

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
Why did that happen? What systems and processes underlie those proximate factors?	Human Resources factors	To what degree is staff properly qualified and currently competent at the time of the event? Consider: orientation, scope of practice, certifications, performance or discipline issues				
(Common cause variation here may lead to special cause variation in dependent processes)	Human Resources factors	How did actual staffing compare with ideal levels? Include actual staffing ratios				
Systems	Human Resources factors	What are the plans for dealing with contingencies that would tend to reduce effective staffing levels? Consider: staffing plan for crisis, registry, etc.				
Systems	Human Resources factors	To what degree is staff performance in the operant process(es) addressed? Did the staff perform as expected? Did staff follow policies?				
Systems	Human Resources factors	How can orientation and in-service training be improved?				

RCA INSTRUCTIONS: Not all questions will apply and there may be others that will emerge in the course of the analysis. However, all should be fully considered in "root cause" & risk reduction.
The three columns on the right are provided to be checked off for later reference:

- "Root cause?" should be answered "Yes" of "No" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant, but is not a root cause, be sure that it is addressed later with a "Why?" question. Root causes should have an action item.
- "Ask 'Why?" should be checked off whenever it is reasonable to ask why finding occurred, or didn't occur – drill down further. It is expected that any significant findings that are not identified as root causes themselves have "roots".

"Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each should have an action item and its # placed in this column.

Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event at IVHD

Appendix 3

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
System	Information Management issues	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous? Consider the availability assessments medications, orders, etc. Was level of automation appropriate? Did staff follow policies?				
System	Communication	To what degree is communication among participants adequate? Consider: MD to MD, RN to RN, MD to RN, RN to Tech, Tech to Tech, etc. Was information timely?				
System	Barriers to communication	What are the barriers to communication of potential risk factors? Is there reluctance to report risks? Is SBAR used? Any language barriers, etc.?				

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
System	Environmental management issues	To what degree was the physical environment appropriate for the processes being carried out? Consider: space, access, lighting, noise, etc.				
	Environmental management issues	What systems are in place to identify environmental risks? Does the staff know how to report a safety risk? Was a risk identified in this event?				

RCA INSTRUCTIONS: Not all questions will apply and there may be others that will emerge in the course of the analysis. However, all should be fully considered in "root cause" & risk reduction.
The three columns on the right are provided to be checked off for later reference:

- "Root cause?" should be answered "Yes" of "No" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant, but is not a root cause, be sure that it is addressed later with a "Why?" question. Root causes should have an action item.
- "Ask 'Why?" should be checked off whenever it is reasonable to ask why finding occurred, or didn't occur – drill down further. It is expected that any significant findings that are not identified as root causes themselves have "roots".

"Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each should have an action item and its # placed in this column.

	Environmental management issues	What emergency and failure-mode responses have been planned and tested? Consider: drills, back-up generators, mock codes, etc.				

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
System	Leadership factors: Corporate culture	To what degree is the culture conducive to risk identification and reduction? How does the facility encourage change or suggestions for risks? How does leadership show that quality is important?				
System	Leadership factors: Corporate culture	To what degree is the prevention of adverse outcomes communicated as a high priority? Describe leadership's role in adverse outcome prevention and how it is put into practice? How are these values reflected back by staff?				
System	Questions Regarding Future Planning	Was available technology used as intended? Consider: CT, Pyxis, Nighthawk services, electronic charting? What are future plans for redesign or implementing technology?				

RCA INSTRUCTIONS: Not all questions will apply and there may be others that will emerge in the course of the analysis. However, all should be fully considered in "root cause" & risk reduction.
The three columns on the right are provided to be checked off for later reference:

- "Root cause?" should be answered "Yes" of "No" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant, but is not a root cause, be sure that it is addressed later with a "Why?" question. Root causes should have an action item.
- "Ask 'Why?" should be checked off whenever it is reasonable to ask why finding occurred, or didn't occur – drill down further. It is expected that any significant findings that are not identified as root causes themselves have "roots".

"Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each should have an action item and its # placed in this column.

ACTION PLAN

Instructions: For each of the findings identified in the analysis as needing an action, indicate the planned action expected, implementation date and associated measure of effectiveness. OR If after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time. Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action. Consider whether pilot testing of a planned improvement should be conducted. Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.

Risk Reduction Strategies	Measure of Success	MOS Target	MOS Actual	Sample Size	Person(s) Responsible
Action Item #1:					
Action Item #2:					

Risk Reduction Strategies	Measure of Success	MOS Target	MOS Actual	Sample Size	Person(s) Responsible
Action Item #3:					
Action Item #4:					

Risk Reduction Strategies	Measure of Success	MOS Target	MOS Actual	Sample Size	Person(s) Responsible
Action Item #5:					
Action Item #6:					

RCA INSTRUCTIONS: Not all questions will apply and there may be others that will emerge in the course of the analysis. However, all should be fully considered in "root cause" & risk reduction.
The three columns on the right are provided to be checked off for later reference:

- "Root cause?" should be answered "Yes" of "No" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant, but is not a root cause, be sure that it is addressed later with a "Why?" question. Root causes should have an action item.
- "Ask 'Why?" should be checked off whenever it is reasonable to ask why finding occurred, or didn't occur – drill down further. It is expected that any significant findings that are not identified as root causes themselves have "roots".

"Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each should have an action item and its # placed in this column.

Bibliography

Instructions: Cite any books or journal articles that were considered in developing this analysis and action plan:

1.
2.

RCA INSTRUCTIONS: Not all questions will apply and there may be others that will emerge in the course of the analysis. However, all should be fully considered in "root cause" & risk reduction.
The three columns on the right are provided to be checked off for later reference:

- "Root cause?" should be answered "Yes" of "No" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant, but is not a root cause, be sure that it is addressed later with a "Why?" question. Root causes should have an action item.
- "Ask 'Why?" should be checked off whenever it is reasonable to ask why finding occurred, or didn't occur – drill down further. It is expected that any significant findings that are not identified as root causes themselves have "roots".

"Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each should have an action item and its # placed in this column.

Root Cause Analysis
Matrix
Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

Note: Updates are highlighted in **RED**
Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

	Suicide (24 hr care)	Med. Error	Procedural Complication	Wrong site surgery	Treatment delay	Restraint death	Elopement death	Assault/ rape/ homicide	Transfusion death	Patient Abduction	Unanticipated death of full term infant	Unintended Retention of foreign body	Fall related
Behavioral assessment process (1)	X					X	X	X					
Physical assessment process (2)	X	X	X	X	X	X	X				X		X
Patient identification process		X		X					X				
Patient observation procedures	X				X	X	X	X	X		X		X
Care planning process	X		X			X	X				X		X
Continuum of care	X	X			X	X							X
Staffing levels	X	X	X	X	X	X	X	X	X	X		X	X
Orientation & training of staff	X	X	X	X	X	X	X	X	X	X	X	X	X
Competency assessment/ credentialing	X	X	X	X	X	X	X	X	X	X	X	X	X
Supervision of staff (3)	X	X	X		X	X			X			X	
Communication with patient/ family	X	X		X	X	X	X			X			X
Communication among staff members	X	X	X	X	X	X	X	X	X	X	X	X	X
Availability of information	X	X	X	X	X	X			X		X		X
Adequacy of technological support		X	X										
Equipment maintenance/ management		X	X		X	X					X		X
Physical environment (4)	X	X	X	X		X	X	X	X	X			X
Security systems and processes	X						X	X		X			
Medication Management (5)		X	X		X				X		X		X

(1) Includes the process for assessing patient's risk to self (and to others, in cases of assault, rape, or homicide where a patient is the assailant).
(2) Includes search for contraband.
(3) Includes supervision of physicians-in-training.
(4) Includes furnishings; hardware (e.g., bars, hooks, rods); lighting; distractions.
(5) Includes selection & procurement, storage, ordering & transcribing, preparing & dispensing, administration, and monitoring.

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GLOSSARY OF TERMS

Accrediting Watch An attribute of an organization's Joint Commission accreditation status. A health care organization is placed on Accreditation Watch when a reviewable sentinel event has occurred and has come to the Joint Commission's attention and a thorough and credible root cause analysis of the sentinel even and action plan have not been completed within a specified time frame.

Action Plan The product of the root cause analysis which identifies the strategies that an organization intends to implement to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.

Adverse Drug Event (adverse drug error) any incident in which the use of a medication (drug or biologic) at any dose, a medical device, or a special nutritional product (for example, dietary supplement, infant formula, medical food) may have resulted in and adverse outcome in a patient.

Aggregate Data Information collected and reported by organizations as a sum or total over a given time period, for example, monthly or quarterly.

Benchmarking Continuous measurement of a process, product, or service compared to those considered industry leaders, or to a similar activist in the organization in order to find and implement ways to improve it. This is one of the foundations of both total quality management and continuous quality improvement. Internal benchmarking occurs when similar processes within the same organization are compared with best practices within the industry. Functional benchmarking refers to benchmarking in a similar function or process, such as scheduling, in another industry.

Complication A detrimental patient condition that arises during the process of providing health care, regardless of the setting in which the care is provided. For instance, perforation, hemorrhage, bacteremia, and adverse reactions to medication (particularly in the elderly) are four complications of colonoscopy and its associated anesthesia and sedation. A complication may prolong an inpatient's length of stay or lead to other undesirable outcomes.

Flowchart (*Flow Diagram*) a pictorial summary that shows the symbols and words the steps, sequence, and relationship of the various operations involved in the performance of a function or process.

Near Miss When an error does not result in and adverse event for a patient, because the error was "caught," it is a near miss.

Measurement of Success (*MOS*) A numerical or quantifiable measure usually related to an audit that determines if an action was effective related to an audit that determines if an action was effective and sustained due four months after Evidence of Standards Compliance approval.

Medical Error A medical error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice; products, procedures, and systems.

Near Miss Used to describe any process variation which did not affect an outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Such a “near miss” falls within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by the Joint Commission under its Sentinel Event Policy.

Outcome The result of the performance (or nonperformance) of a function(s) or process (es)

Process A goal-directed, interrelated series of actions, events, mechanisms, or steps.

Proximate Cause An act or omission that naturally and directly produces a consequence. It is the superficial or obvious cause for an occurrence. Treating only “symptom,” or the proximate special cause, may lead to some short-term improvements, but will not prevent the variation from recurring.

Root Cause The most fundamental reason for the failure or inefficiency of a process.

Root Cause Analysis A process for identifying the basic or casual factor(s) that underline variation in performance, including the occurrence or possible occurrence of a sentinel event.

Surveillance Ongoing monitoring using methods distinguished by their practicability, uniformity, and rapidity, rather than by complete accuracy. The purpose of surveillance is to detect changes in trend or distribution to initiate investigative or control measures. Active surveillance is not systematic. Cases may be reported through written incident reports, verbal accounts, electronic transmission, or telephone hot lines, for example.

Underlying Cause The systems or process cause that allows for the proximate cause of an event to occur. Underlying causes may involve special-cause variation, common-cause variation, or both.

Variation The difference in results obtained in measuring the same phenomenon more than once. The sources of variation in a process over time can be grouped into two major classes: common causes and special causes. Excessive variation frequently leads to waste and loss, such as the occurrence of undesirable patient health outcomes and increased cost of health services. Common-cause variation, also called endogenous cause variation or systematic cause variation, in a process is due to the process itself and is produced by interactions of variables of that process inherent in all processes, not a disturbance in the process. It can be removed only by making basic changes in the process. Special-cause variation, also called exogenous-cause variation or extra systematic cause variation, in performance results from assignable causes. Special-cause variation is intermittent, unpredictable, and unstable. It is not inherently present in a system; rather, it arises from causes that are not part of the system as designed.

Imperial Valley Healthcare District

Title: **Standardized Procedure for Registered Nurses: Neonatal Resuscitation**	Policy No. CLN-00250 Page 1 of 9
Current Author: Sandra Taylor, RNC-NIC, BSN	Effective: 10/1/2001
Latest Review/Revision Date: 06/24/2026	Manual: Clinical / OB

Collaborating Departments: Perinatal, Neonatal, ED Dr Alshareef, NICU Manager	Keywords: Resuscitation of Newborn

Approval Route: List all required approval			
MARCC 06/2026 PSQC	Other:		
Clinical Service Credentials; OB/Pediatrics 07/2026	MSQC 07/2026	MEC 07/2026	BOD 08/2026

Approvals		
Authority	**Signature**	**Date**
Administration		
Chief Nursing Officer		
Physician Department Chair		
PMH Board of Directors		

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

REVIEWED ANNUALLY

1.0 Purpose:

1.1 To outline the standardized procedure for neonatal resuscitation in the delivery room, the emergency department or the Neonatal intensive Care unit of PMH.

1.2 The purpose of resuscitation is to provide full oxygenation, ventilation and support of the circulation, using cardiac massage and, as necessary, intravascular medications.

2.0 Scope:

2.1 Neonatal RNs
2.2 Perinatal RNs
2.3 Neonatal Advanced NRP RNs
2.4 Pediatricians/attending physician

3.0 Policy:

3.1 All Perinatal/Neonatal RNs will maintain certification in the Neonatal Resuscitation Program (NRP) per the requirement set forth by the American Academy of Pediatrics (AAP).

3.1.1 The AAP requires NRP Provider Card renewal every 2 years.

3.1.1.1 These cards are delineated as either Essential or Advanced provider.

3.1.2 PMH requires that all RN staff have current NRP Provider Cards to work in the Perinatal/Neonatal Departments.

3.1.2.1 All NICU nursing staff will hold an Advanced Provider Card

3.1.2.2 All Perinatal nursing staff and Respiratory Care practitioners will hold an Essential provider Card at a minimum. They may also hold an

Advanced NRP card

3.2 For all deliveries, at least 1 person should be present who is skilled in neonatal resuscitation and is responsible only for the infant. This person must be skilled in the initiation of resuscitation, the use of bag-mask ventilation, and the performance of chest compressions.

3.3 Additional personnel should be available to assist in tasks that may be required as part of resuscitation, including all aspects of neonatal resuscitation. If the delivery is identified as high-risk, 2 or more skilled individuals should be assigned to the infant at delivery.

3.4 Advanced NRP RN will be called for all neonatal resuscitations in the Perinatal Unit. <See policy CLN-00208; High-Risk Delivery, Criteria for Attendance by Neonatal Staff>

3.5 The Advanced NRP RN nurse may perform all aspects of the procedure listed in this policy.

3.5.1 The Essential NRP certified RN may utilize the bag and mask component of this policy and assist the Advanced NRP RN as needed

3.6 Standardized procedure function(s):

3.6.1 The Advanced NRP RN may perform neonatal resuscitation with oxygenation, ventilation, cardiac massage, and intravascular/endotracheal medications as outlined in the procedure.

3.7 Circumstances under which the Advanced NRP RN may perform the procedure in:

3.7.1 Setting – The competency validated Advanced NRP RN may perform the procedure in:

3.7.1.1 The Perinatal Unit of PMH

3.7.1.2 The NICU of PMH

3.7.1.3 The Pediatric Unit of PMH

3.7.1.4 The Emergency Department of PMH

3.8 If a resuscitation requires more personnel, a Code Neo should be called by dialing **4444** from any place within the facility as needed. See Attachment A for criteria and further information

3.9 Scope of Supervision:

3.9.1 The competency validated Advanced NRP RN will receive indirect supervision by the attending physician

3.9.2 A pediatrician/attending physician will be available at all times for consultation.

3.9.3 Under all circumstances the ALS/NRP RN will carry out urgent delivery room and neonatal resuscitation according to the procedure or until a physician arrives.

3.9.4 In the event that this procedure is altered via a physician's written or verbal order, the Advanced NRP RN will inform the physician that he/she is not certified to carry out the altered plan and must either adhere to the procedure or relinquish responsibility to the physician.

3.9.5 Patient condition to notify the physician:

3.9.5.1 The Advanced NRP RN or designee will immediately notify the attending pediatrician/physician whenever advanced life support (beyond simple stimulation or initial bag and mask support) is being initiated.

3.9.5.2 The Advanced NRP RN will notify the pediatrician/physician whenever the delivery of an extremely small or complicated infant is anticipated so the pediatrician/physician may attend.
3.9.5.3 Issues involving viability of life
3.9.5.4 Any unsuccessful resuscitation

3.10 RN requirements
3.10.1 Education/Training/Experience
3.10.1.1 The Advanced NRP RN will keep current with the requirement of Recertification per AAP guidelines (every 2 years with RQI NRP)
3.10.1.2 The Essential NRP provider will have completed an online NRP class and remain current on their certification with hands on demonstration for completion of certification
3.10.1.3 Annual competency validation assessments will be performed during manual skills (Mock Codes) a minimum of biannually by the NICU Clinical Educator
3.10.1.4 In conjunction with the Mock codes, written test covering normal newborn care, NICU care and math calculations will be completed with a required $\geq$80% pass rate.
3.10.1.4.1 Remediation will be done if unsuccessful with either manual skills or written tests

3.11 This Standardized Procedure will be subject to periodic review by the appropriate interdisciplinary committees not to exceed every 2 years.

4.0 Definitions:

4.1 Neonate – Defined as an infant <30 days of age
4.2 PPV – Positive pressure ventilation
4.3 PIP – Peak inspiratory pressure
4.4 SpO^2 – Peripheral capillary oxygen saturation
4.5 CPR – Cardiopulmonary resuscitation
4.6 ETT – Endotracheal tube
4.7 LMA – Laryngeal Mask Airway
4.8 RQI – Resuscitation Quality Improvement
4.9 NRP – Neonatal Resuscitation Program as provided by the American Academy of Pediatrics = Evidence Based Approach to care of the newborn at birth
4.10 Advanced NRP RN – Advanced Neonatal Resuscitation Certified Registered Nurse
4.11 Essential NRP RN – Essential Neonatal Resuscitation Certified Registered Nurse
4.12 MR.SOPA – Mask reposition, suction, open airway, increase pressure, alternate airway
4.13 AAP – American Academy of Pediatrics
4.14 PMH – Pioneers Memorial Hospital

5.0 Procedure:

5.1 Database:
5.1.1 Subjective:
5.1.1.1 Historical information relevant to present illness

5.1.1.2 History including reactions/allergies to medications
5.1.2 Objective:
5.1.2.1 Physical exam with focus on pulmonary and cardiovascular systems
5.1.2.2 Assessment: Decision for emergency medication administration will be based upon subjective and objective data and in collaboration with attending physician when not an emergent lifesaving maneuver
5.1.3 Plan:
5.1.3.1 Patients and families will be provided with the appropriate information on emergency medication as soon as possible after administration.
5.1.3.2 The Advanced NRP RN will notify the pediatrician or neonatologist to be present whenever the delivery of an extremely small or complicated infant is anticipated.
5.1.3.3 In all emergencies, the primary physician will be notified as soon as practical while advanced life support is being initiated. Under all circumstances, the Advanced NRP RN will perform urgent delivery room and/or neonatal resuscitation and emergency medication administration according to the procedure or until a physician arrives.

5.2 Informed consent is required prior to the procedure unless it is deemed an emergency and parental or guardian consent cannot be obtained.
5.3 A “Time Out” procedure is required to be performed according to policy.
5.4 Indications:
5.4.1 Cardiopulmonary arrest
5.4.2 Severe and rapid deterioration in patient’s condition
5.5 Precautions:
5.5.1 Know the infant’s weight
5.5.1.1 If the infant’s weight is not available, an estimate of the infant’s weight is made for calculation of medication dosages until a time when an accurate weight can be measured.
5.6 Equipment:
5.6.1 Radiant warmer
5.6.2 Cardiac monitor
5.6.3 Pulse oximeter
5.6.4 Laryngeal Mask Airway tubes
5.6.4.1 0.5
5.6.4.2 1.0
5.6.5 Endotracheal tubes
5.6.5.1 2.5
5.6.5.2 3.0
5.6.5.3 3.5
5.6.5.4 4.0
5.6.6 Stylet of appropriate size
5.6.7 Resuscitation bag connected to an oxygen source, able to provide up to 100% FiO^2
5.6.8 Infant oxygen masks

5.6.8.1 Pre-term
5.6.8.2 Term
5.6.9 Oxygen blender
5.6.10 Manometer
5.6.11 Suction apparatus
5.6.12 Suction Catheters
5.6.12.1 5-6 Fr
5.6.12.2 8 Fr
5.6.12.3 10 Fr
5.6.12.4 14 Fr
5.6.13 Bulb syringe
5.6.14 Laryngoscope handle
5.6.15 Laryngoscope blades
5.6.15.1 0 Miller
5.6.15.2 1 Miller
5.6.16 Meconium aspirator
5.6.17 Emergency medications with appropriate size syringes
5.6.17.1 Epinephrine 1:10,000
5.6.17.2 Normal Saline for volume replacement
5.6.18 Stethoscope
5.6.19 Adhesive tape
5.6.20 Umbilical catheter tray
5.6.21 Umbilical tape
5.6.22 Umbilical catheters
5.6.22.1 3.5 Fr single lumen
5.6.22.2 5.0 Fr single lumen
5.6.23 Three way stopcocks
5.6.24 NG tubes
5.6.24.1 5 Fr
5.6.24.2 8 Fr

5.7 Steps in the procedure – The following are steps of a maximum effort. They may be suspended at any time if the infant responds appropriately. The infant will then be monitored according to its acuity.
5.7.1 All delivery room equipment will be checked for function and availability at the beginning of every shift.
5.7.2 The Advanced NRP RN is responsible for checking and reviewing appropriate antepartum and intrapartum history to help identify those at risk for delivering a depressed or sick infant. It is important to be forewarned for impending deliveries of ill newborns. Perinatal/Labor & Delivery RN should inform the Neonatal RN regarding any concerns prior to delivery, if known.
5.7.3 Be aware that the parents may hear and remember what is said in the delivery room.

5.8 Action Steps:
5.8.1 Turn on the radiant warmer

5.8.2 As the infant is being delivered, observe:
- 5.8.2.1 Whether the oropharynx was suctioned well
- 5.8.2.2 When infant has spontaneous, effective breathing/crying
- 5.8.2.3 Any muscle tone and/or activity
- 5.8.2.4 If the infant is term (≥37 weeks)

5.8.3 If the newborn does not require immediate resuscitation, defer the umbilical cord clamping for at least 60 seconds per NRP recommendations

5.8.4 If the infant is missing any one of the three listed above, (term, tone, breathing) place the infant under the radiant heat source

5.8.5 Position the head and neck so the airway is open
- 5.8.5.1 Place infant supine with the head and neck neutral or slightly extended in the “sniffing” position
- 5.8.5.2 A shoulder roll may be placed under the infant’s shoulders and is useful if the infant has a large occiput from molding, edema or prematurity

5.8.6 Clearing secretions if needed
- 5.8.6.1 If infant is not breathing, is gasping, has poor tone or secretions are obstructing the airway
- 5.8.6.2 Secretions may be removed from the upper airway by suctioning gently with the bulb syringe.
- 5.8.6.3 Brief gentle suction is usually adequate to removed secretions. Suction the mouth before the nose.
- 5.8.6.4 Be careful not to suction vigorously or deeply. Vigorous suction may injure tissues.
- 5.8.6.5 Stimulation of the posterior pharynx during the first minutes after birth can produce a vagal response leading to bradycardia or apnea.
- 5.8.6.6 Is using a suction catheter, the suction control should be set so that the negative pressure reads approximately 80 to 100 mm Hg when the tubing is occluded.
- 5.8.6.7 If secretions are thick enough to completely obstruct the airway, directly suction the trachea with a meconium aspirator attached to an endotracheal tube.
  - 5.8.6.7.1 Using 80-100 mm Hg, connect to suction tubing to the meconium aspirator and attach directly to the endotracheal tube connector. Gradually withdraw the tube to removed secretions from the trachea and posterior pharynx before reinserting a new endotracheal tube for ventilation.

5.8.7 Dry infant and remove wet blanket
- 5.8.7.1 Drying is not necessary for very preterm infant’s less than 32 weeks’ gestation. They should be covered immediately in polyethylene plastic. This intervention will reduce heat loss.

5.8.8 Provide gentle tactile stimulation, if needed
- 5.8.8.1 Positioning, clearing secretions and drying the infant will frequently provide enough stimulation to initiate breathing. If the infant does not

have adequate respirations, brief additional tactile stimulation may stimulate breathing.

5.8.8.2 Gently rub the infant's back, trunk or extremities.

5.8.8.3 Overly vigorous stimulation is not helpful and can cause injury.

5.8.9 If the infant has persistent central cyanosis, place pulse oximeter probe on infant. The preferred site will be the right hand. This is the pre-ductal site. The targeted pre-ductal Spo2 after birth:

5.8.9.1 2 minutes = 65% – 75%

5.8.9.2 3 minutes = 70% – 75%

5.8.9.3 4 minutes = 75% – 80%

5.8.9.4 5 minutes = 80% – 85%

5.8.9.5 10 minutes = 85% – 95%

5.8.10 If the infant is apneic or has ineffective respirations to keep the heart rate >100, start positive pressure ventilation (PPV) with a bag and mask.

5.8.11 Initial oxygen concentration for infants:

5.8.11.1 $\geq$35 weeks = 21%

5.8.11.2 32-34 weeks = 21% - 30%

5.8.11.3 <32 weeks - $\geq$30%

5.8.12 Use pressure sufficient to move the infant's chest. The PIP is determined by the weeks" gestation of the neonate

5.8.12.1 >32 weeks – 25-30 cm H2O

5.8.12.2 <32 weeks – 20-25 cm H2O

5.8.12.3 Higher pressures may be needed during the first several breaths and in infants with decreased lung compliance (PIP between 30-40 cm H_2O)

5.8.13 PPV should be done at a rate of 30-60 breaths per minute with 21% – 100% FiO^2

5.8.13.1 Begin with 21% FiO^2 and increase or decrease FiO^2 as needed

5.8.14 Check the heart rate by auscultating the apical pulse or palpate the umbilical cord.

5.8.15 If the heart rate is not increasing within 15 to 30 seconds of starting PPV and you do not see chest movement, start ventilation corrective steps (MR.SOPA)

5.8.16 Chest compressions are indicated, if after 30 seconds of PPV, the heart rate is below 60. (Do not proceed to chest compressions until you have established an open airway and ventilation that inflates the lungs).

5.8.16.1 Chest compressions are given at a ratio of 3 compressions and 1 breath. These should be 90 compressions and 30 breaths in a 1 minute cycle.

5.8.16.2 Chest compressions are given to a depth of one-third of the diameter of the chest and are coordinated with ventilations.

5.8.17 Continue with chest compressions with ventilator assistance until the heart rate is 80 or greater, or instructed to discontinue CPR by a physician assuming responsibility for the neonate's care.

5.8.18 Notify the pediatrician/attending physician that resuscitation is in progress.

5.8.19 If after 1-2 minutes of cardiac massage and PPV with bag and mask, and the

infant are not responding appropriately, the infant should have an alternate airway inserted with the appropriate size LMA. The LMA steps may be considered at any time the infant is not responding to PPV with the bag and mask.

5.8.20 A face mask (bag and mask) or LMA are now the primary device for ventilation instead of an endotracheal tube per new NRP guidelines

5.8.21 If endotracheal intubation is needed, follow the procedure outlined in policy CLN-00236; Endotracheal Intubation – Standardized Procedure.

5.8.22 If the infant has an advanced airway and chest compressions continue and the heart rate is <60 after 30 additional seconds of chest compressions and ventilation, medications should be given.

5.8.23 If vascular access is needed, follow the procedure outlined in policy CLN-00258; Neonatal Umbilical Vessel Catheterization – Standardized Procedure

5.8.24 Epinephrine 1:10,000, is indicated if the heart rate is <60 beats per minute

5.8.24.1 Should be given intravenously – 0.1 to 0.3 mL/kg (**0.2 mL/kg** is the recommended dose by NRP)

5.8.24.2 May be given directly into the trachea (via LMA or ETT) – 0.5 to **1.0 mL/kg**

5.8.24.3 Epinephrine may be repeated every 3-5 minutes

5.8.25 Volume expansion with normal saline is indicated when there is evidence of acute bleeding or signs of hypovolemia.

5.8.25.1 Normal Saline, **10 mL/kg** is given IV over 5-10 minutes

5.8.26 O Rh-negative packed red blood cells should be considered as part of the volume replacement when severe fetal anemia is documented or expected.

5.8.26.1 10 mL/kg over 5-10 minutes

5.8.27 Continue with Advanced NRP procedure until a pediatrician or attending physician arrives. The decision to stop resides with the physician.

5.8.28 The infant should be stabilized as much as possible and then transported to the NICU for further evaluation and treatment.

5.9 Documentation:

5.9.1 The Advanced NRP RN will document attendance at the delivery and associated interventions.

5.9.2 Document time of spontaneous respirations

5.9.3 Time and length of bag and mask ventilation

5.9.4 Intubation time and number of attempts

5.9.5 If need for chest compressions, time started and duration

5.9.6 Any medications given, time and response

5.9.7 Disposition of infant

6.0 References:

6.1 American Academy of Pediatrics, American Heart Association, *Textbook of Neonatal Resuscitation*, 9th Ed (2025)

6.2 Rady Children's Hospital, San Diego, "Neonatal Resuscitation in the Delivery Area, Nursery or on Transport" SP 2-07 (2016)

6.3 March of Dimes "The STABLE program 7th ed. (2024)
6.4 Verklan, MT, et al, *Core Curriculum for Neonatal intensive Care Nursing,* 6th ed (2021*)*
6.5 Gardner, Carter, et al, *Merenstein & Gardner's Handbook of Neonatal Intensive Care,* 9th ed (2021)

7.0 Attachment List:

7.1 Attachment A - Guidelines for Activation of "Code Neo"

8.0 Summary of Revisions:

8.1 Updated References
8.2 Updated body of policy to reflect current NRP guidelines
8.3 Reinstated this policy from a "Work Instruction" to a Standardized Procedure

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Guidelines for Activation of "Code Neo"

1. The Code Neo Team consists of an NICU based intra-disciplinary team that responds to all neonatal emergencies within Pioneers Memorial Hospital
2. Coverage is 24/7
3. The appropriate team is activated by the NICU Charge Nurse
4. The Code Neo Team includes: NICU Charge Nurse (Advanced NRP RN), Respiratory Therapy. Pediatrician will be notified immediately for assistance/attendance per policy
5. In the event of simultaneous emergencies, the Emergency Department with Respiratory Therapy will be called
6. In the event an infant is subject to a Code Neo call, the infant will be transferred to the NICU for monitoring and evaluation by the attending pediatrician, if this has not occurred yet
7. For an infant born precipitously in the Emergency Department, the NICU Team will transport the required equipment to the location of the infant.
8. The infant will be transported to the NICU via the infant transport isolette or an open bed once the infant is stabilized to move to the NICU
9. The neonatal attending physician will assume the role of the code team leader when present. Otherwise any Advanced NRP credentialed clinician may assume the role of the code team leader to organize the resuscitative efforts of the newborn
10. All clinicians are responsible for documenting assessment and interventions in the neonates EMR
11. Designate the team members of their roles as soon as possible
    a. Team Leader (Charge NRP RN or Pediatrician/Neonatologist)
    b. Personnel responsible for airway management
    c. Personnel responsible for assisting/chest compressions
    d. Personnel responsible for medication set up and administration
    e. Personnel responsible for documenting events/treatments/communication with others and family
    f. Personnel responsible for gathering extra supplies and running lab work to lab
12. Criteria for Code Neo
    a. Any infant that requires NRP resuscitation that includes advanced airways, chest compressions or medications
    b. Apnea persisting past 1 minute of positive pressure ventilation(PPV) with bag and mask
    c. Bradycardia not responding to PPV (Heart rate persistently <80 bpm)
    d. Central cyanosis that persists > 5minutes
    e. Cyanosis (Circumoral, unresponsive to blow by oxygen administration of 100% Fio2)
    f. "Floppy baby" (absent muscle tone/lack of respiratory effort = stunned infant requiring resuscitation)
    g. Persistent oxygen saturation less than 85% (>10 minutes of life)
    h. Seizure like activity, change in behavior/lethargy

i. Decreased muscle tone
j. Respiratory rate persistently >70 bpm at 10 minutes of life
k. Grunting/flaring/retractions
l. HR persisting >200 bpm
m. Any incident where infant is dropped of has a fall
n. Initial presentation after home birth
o. Uncontrolled bleeding of the infant
p. Unexplained pain
q. Unresolved parental concern
r. Any Staff concerns

13. How to activate a Code Neo Response
    a. Call 4444
14. Any staff member from any department call the NICU to request help must use the G.I.R.L. acronym to state the following:
    a. Gestational Age of the infant
    b. Indications for call (reason for impending birth or Code Neo Response)
    c. Relevant information for the NICU Team
    d. Location of the infant

Imperial Valley Healthcare District ***ANNUAL REVIEW***

Title: **Standardized Procedure for Registered Nurses:** **Neonatal Umbilical Vessel Catheterization**	Policy No. CLN-00258 Page: 1 of 7
Current Author: S. Taylor, RNC-NIC, BSN	Effective: 11/1/1995
Last Review/Revision Date: 03/18/2026	Manual: Clinical / OB

Collaborating Departments: Neonatal, Pharmacy, NIC Medical Director, NICU Manager		Keywords: Umbilical Catheterization	
Approval Route: List all required approval			
MARCC 3/2026	Other:		
Clinical Service Credentials/Peds/OB 4/2026, 4/2025	MSQC 4/2026	MEC 4/2026	BOD 5/2026

APPROVALS		
AUTHORITY	**SIGNATURE**	**DATE**
CHIEF EXECUTIVE OFFICER		
CHIEF NURSING OFFICER		
PHYSICIAN DEPARTMENT CHAIR		
PMHD BOARD OF DIRECTORS		

NOTE: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 This standardized procedure is designed to establish guidelines that allow the Neonatal Advanced Life Support (ALS) Registered Nurse (RN) to perform umbilical vessel catheterization (arterial and venous).

1.2 The purpose of umbilical catheterization is to obtain direct access to arterial circulation with placement of a sterile radiopaque catheter into the aorta via an umbilical artery to provide a means of obtaining arterial blood gases and for continuous monitoring of blood pressure. In addition, umbilical artery catheterization may be a means for fluid/electrolyte balance and pharmacologic support and treatment. The purpose of umbilical venous catheterization is to establish a route for emergency administration of IV fluids and medications, to provide nutrition and to provide venous access for IV fluids and medication.

2.0 Scope: Neonatal ALS RN only

3.0 Policy:

3.1 Standardized Procedure Function – patients requiring umbilical vessel catheterization

3.2 Only approved RNs may function under any Standardized Procedure. The ALS RN may perform umbilical vessel catheterization on neonates as outlined in the procedure.

3.3 Circumstances under which the RN may perform Umbilical Vessel Catheterization:

3.3.1 Setting – The competency validated ALS RN may perform umbilical vessel catheterization in the Perinatal Unit or impatient area, including the Emergency Department of PMH.

3.3.2 Scope of Supervision – The competency validated ALS RN will receive:
- 3.3.2.1 Indirect supervision by the attending Pediatrician/Neonatologist
- 3.3.2.2 A Pediatrician/Neonatologist will be available at all times for consultation.
- 3.3.2.3 In the event that this procedure is altered via a physician's written or verbal order, the ALS RN will inform the physician that he/she is not verified to carry out the altered plan and must either adhere to the procedure or relinquish responsibility to the physician.

3.3.3 Patient conditions to notify physician:
- 3.3.3.1 In all emergencies, the attending Pediatrician/Neonatologist will be notified as soon as practical while advanced life support is being initiated.
- 3.3.3.2 The attending Pediatrician/Neonatologist will be notified immediately if any of the following complications occur:
  - 3.3.3.2.1 Severe uncontrolled bleeding from the umbilical stump
  - 3.3.3.2.2 Blanching/cyanosis of the skin, loss of femoral pulses or other evidence of emboli
  - 3.3.3.2.3 Inability to obtain blood after insertion of catheter despite traction and/or tension
  - 3.3.3.2.4 Catheter malposition
  - 3.3.3.2.5 Vasospasm
  - 3.3.3.2.6 Thrombus
  - 3.3.3.2.7 Hypertension
  - 3.3.3.2.8 Unstable patient
  - 3.3.3.2.9 Unsuccessful procedure
  - 3.3.3.2.10 Any complications or unexpected outcomes of the procedure

3.3.4 RN requirements
- 3.3.4.1 Education/Training/Experience:
  - 3.3.4.1.1 The ALS nurse will have been a RN for a minimum of 3 years with at least 3 years of Neonatal Nursery experience.
  - 3.3.4.1.2 The ALS RN will attend the Advanced Life Support didactic classes (minimum of 24 hours) held at Rady Children's Hospital, San Diego or a comparable training facility. All quizzes and tests administered in the classes with an 80% pass rate.
- 3.3.4.2 Initial and Ongoing Competency Evaluation:
  - 3.3.4.2.1 Initial competency will be validated by the physician or experienced ALS RN.
  - 3.3.4.2.2 The ALS RN will successfully complete three (3) umbilical vessel catheterizations under direct supervision of the physician or experienced ALS RN before being allowed to perform the procedure without direct supervision.
- 3.3.4.3 Annual competency assessment:
  - 3.3.4.3.1 Complete 3 successful umbilical vessel catheterizations supervised by a physician or experienced ALS RN.

3.3.4.3.2 If minimum number of annual procedures is not obtained, the following are options for competency maintenance:

3.3.4.3.2.1 Attend skills lab offered biannually (procedure review & simulation)

3.3.4.3.2.2 Competency validation test and demonstration of skill

3.3.4.4 RNs authorized to perform standardized procedure function – a written record of initial and ongoing competency will be maintained in the employee file in the Perinatal Department and a roster of RN competency validation will be set to the Education Department annually.

3.3.4.5 This Standardized Procedure will be subject to periodic review by the appropriate interdisciplinary committees not to exceed every 2 years.

4.0 Definitions:

4.1 PMH – Pioneers Memorial Hospital
4.2 UAC – Umbilical Artery Catheter
4.3 UVC – Umbilical Venous Catheter
4.4 EMR – Electronic Medical Record

5.0 Procedure:

5.1 Database

5.1.1 Subjective:

5.1.1.1 Historical information relevant to present illness

5.1.1.2 History including reactions/allergies to medications

5.1.2 Objective:

5.1.2.1 Physical examination with focus on pulmonary, cardiovascular and neurological systems

5.1.3 Assessment:

5.1.3.1 Decision for umbilical vessel catheterization will be based upon subjective and objective data and in collaboration with attending physician prior to the initiation of the procedure when not an emergent, lifesaving procedure.

5.1.4 Plan:

5.1.4.1 Patients and families will be provided with the appropriate information prior to initiation of the umbilical vessel catheterization if not an emergent/lifesaving procedure, and obtain consent as per hospital protocol.

5.2 Indication:

5.2.1 Primary

5.2.1.1 Emergency vascular (venous catheter) access for fluid and medication infusion and for blood drawing, central venous pressure monitoring (if the catheter crosses the ductus venosus)

5.2.1.2 Exchange Transfusion

5.2.2 Secondary

5.2.2.1 Long-term central venous access

5.3 Contraindications:
- 5.3.1 Omphalitis
- 5.3.2 Omphalocele
- 5.3.3 Necrotizing enterocolitis or intestinal hypoperfusion
- 5.3.4 Peritonitis
- 5.3.5 Evidence of vascular compromise in lower extremities
- 5.3.6 Acute abdomen etiology

5.4 Equipment:
- 5.4.1 Umbilical catheter tray
- 5.4.2 Appropriate size umbilical catheter, either single or double lumen
- 5.4.3 Sterile gown and gloves
- 5.4.4 Hat and mask
- 5.4.5 Povidone-iodine solution for infants less than 1000 grams
- 5.4.6 Chlorhexidine prep solution for infants over 1000 grams unless contraindicated due to allergy or patient condition, then Povidone-iodine and saline will be used
- 5.4.7 Heparinized flush
  - 5.4.7.1 Infants $\leq$ 1500 grams, mix at concentration of 0.5 units heparin to 1 ml normal saline
  - 5.4.7.2 Infants > 1500 grams, mix at concentration of 1 unit heparin to 1 ml normal saline
  - 5.4.7.3 3-0 silk suture
  - 5.4.7.4 IV solution as ordered
  - 5.4.7.5 Light and heat source
  - 5.4.7.6 Cardiac monitor

5.5 Essential steps in procedure:
- 5.5.1 Perform Universal Protocol “time out” according to hospital policy, prior to procedure.
- 5.5.2 Make necessary measurements to determine length of catheter to be inserted, adding length of umbilical stump.
- 5.5.3 Explain procedure to parent(s), if available.
- 5.5.4 Open the umbilical tray, maintaining sterility and adding needed items not included in the tray.
- 5.5.5 Generally infants weighing <1500 grams will have a 3.5 Fr catheter placed in the umbilical artery. A 5.0 Fr catheter may be utilized for umbilical venous catheterization.
- 5.5.6 Have assistant hold appropriately prepared heparinized flush. Leave flush syringe attached to 3-way stopcock on your tray.
- 5.5.7 Attach umbilical catheter to 3-way stopcock.
- 5.5.8 Flush stopcock and umbilical catheter with heparinized flush. Leave flush syringe attached to 3-way stopcock.
- 5.5.9 Have assistant hold umbilical cord up and away from the infant’s abdomen. Cleanse the umbilical cord stump and adjacent skin with proper solution as listed in 5.4.5 and 5.4.6. Beginning at the base of the cord and working in a circular

motion outward on the skin to about 2 inches. Cleanse the cord clamp of present.

5.5.9.1 When using Povidone-iodine solution, allow to dry for 30 seconds and then remove with saline wipe.

5.5.9.2 When using Chlorhexidine, allow to dry for 30 seconds prior to procedure.

5.5.10 Place sterile drape on the infant with an open hole over the prepped cord.

5.5.11 Place sterile umbilical tape around the cord stump with a loose tie.

5.5.11.1 Tighten only enough to prevent bleeding and place, if possible, around Wharton's jelly rather than skin.

5.5.11.2 It may be necessary to loosen the tie when inserting the catheter.

5.5.12 Using sterile scalpel, cut off the cord stump approximately 0.5-1.5cms above the skin. Avoid "sawing" of the cord. The umbilical tape may be pulled snug to prevent bleeding when the cord is cut.

5.5.13 Locate the umbilical vessels, 2 arteries and a vein. The umbilical arteries will have a thick wall while the umbilical vein will have a thinner wall.

5.5.14 Using hemostats, clamp the Wharton's jelly on either side of the cord. Apply tension and expose the vessels.

5.5.15 For UAC:

5.5.15.1 Using the points of the curved iris forceps or vein introducer, gently dilate the lumen of the artery by inserting the device to the depth of approximately 0.5cm. Repeat this several times until the lumen is dilated. Use an up and down motion. Do not pull or twist.

5.5.15.2 When the vessel is dilated, insert the fluid filled catheter into the lumen of the artery. Use a downwards approach and advance gently. Advance the catheter to the appropriate distance. Slight obstructions or resistance at the junction of the umbilical artery and fascial plane may be relieved by gently upwards traction on the cord stump and/or applying steady gently pressure on the catheter for 15-30 seconds.

5.5.15.3 Using attached syringe, aspirate. There should be free flow of blood.

5.5.15.4 If no blood is obtained, remove the catheter and try advancing one more time.

5.5.15.5 The catheter should be advanced to the appropriate tip placement.

5.5.15.5.1 For high UAC tip placement, the appropriate length can be obtained by multiplying the infant's weight (kg) by 3, then adding 9. [Kg x 3 +9]

5.5.15.5.1.1 This will give a UAC placement between T6 and T10.

5.5.15.5.2 For low UAC tip placement, the tip should be between L3 and L4. Length can be calculated by measuring the distance from the shoulder to the umbilicus.

5.5.16 For UVC:

5.5.16.1 Identify thin walled vein, close to periphery of umbilical stump.

5.5.16.2 Grasp cord stump with toothed forceps.

5.5.16.3 Gently insert tips of iris forceps into lumen of vein and remove any clots.

5.5.16.4 Introduce fluid filled catheter, attached to the stopcock and syringe, approximately 2 to 3cms into vein (measuring from anterior wall).
5.5.16.5 Apply gentle suction to syringe.
5.5.16.6 If there is not easy blood return, catheter may have a clot in tip. Withdraw catheter while maintaining gently suction. Removed clot and reinsert catheter.
5.5.16.7 If there is smooth blood return, continue to insert catheter for full estimated distance.
5.5.16.7.1 Appropriate UVC length can be calculated by multiplying the infant's weight (kg) by 3, then, adding 9, then dividing by 2 and adding 1. [(kg x3 + 9) /2+1]
5.5.16.7.2 The tip of the UVC should be at the junction of the inferior vena cava and the right atrium, projecting just above the diaphragm on x-ray.
5.5.16.8 If the catheter meets any obstruction prior to measured distance:
5.5.16.8.1 It has, most commonly, entered the portal system, or
5.5.16.8.2 Wedged in the intrahepatic branch of the umbilical vein
5.5.16.9 Withdraw catheter 2 to 3cms, gently rotate and reinsert in an attempt to get tip through the ductus venosus
5.5.16.10 If the catheter is in the portal circulation, leave the misdirected catheter in its place. Pass a new 5 Fr catheter into the same vessel. Once the catheter is in good position, remove the misdirected catheter. This procedure has a success rate of 50%.
5.5.17 In the event the catheter cannot be advanced, or no blood can be obtained, remove the catheter and notify the Pediatrician/Neonatologist for further orders.
5.5.18 When the catheter has been advanced to the appropriate length and blood can be aspirated, note the centimeter mark at the level of the skin.
5.5.19 With a needle holder, secure sutures to the stump using a purse string closure. After x-ray for catheter placement confirms proper placement, using the same suture, tie around catheter to hold in place. Temporarily tape catheter(s) in place until x-ray is completed.
5.5.20 Obtain a chest x-ray immediately after line placement to verify proper location of tip.
5.5.21 If the line needs adjustment, the line may be withdrawn to the appropriate level but cannot be advanced once the sterile field has been disassembled.
5.5.22 In the delivery room, when emergency vascular access is needed, the umbilical catheter will be flushed with saline and attached to a 3-way stopcock.
5.5.22.1 Don sterile gloves
5.5.22.2 Prep the cord with Povidone-iodine solution or chlorhexidine solution as appropriate.
5.5.22.3 Tie umbilical tape around the base of the cord.
5.5.22.4 Cut cord 1-2cms above the base.
5.5.22.5 Place a 5 Fr umbilical catheter into the vein until a blood return is obtained. This should be 3-5cms. If the catheter is inserted further,

there is a risk of infusing hypertonic solution into the liver and causing damage to the liver.

5.5.22.6 Secure the catheter by taping firmly to the infant's abdomen.

5.5.22.7 When the resuscitation is completed, remove the catheter.

5.6 Documentation:

5.6.1 Document procedure in the nurse's notes of the EMR

5.6.1.1 Time of procedure

5.6.1.2 Reason(s) for procedure

5.6.1.3 Size of catheter(s) length of insertion

5.6.1.4 X-ray placement of catheter

5.6.1.5 Circulation of buttocks, legs, toes, strength of femoral pulses before and after catheter placement

5.6.1.6 Infant's tolerance to procedure

5.6.2 A written consent per hospital protocol is obtained and placed in the infant's medical record prior to procedure if not a lifesaving procedure. If consent is not obtained in advance, parent/guardian is to be notified as soon as possible after procedure.

5.6.3 Utilize the "Special Care Nursery Procedure Note" to record the procedures performed by the ALS RN. One copy will be placed in the individuals' personal file in the Intermediate NICU.

6.0 References:

6.1 Magnan, J.P., Kulkami, M., Umbilical Vein Catheterization (2022) https://emedicine.medscape.com/article/80469-overview

6.2 Sawyer, T., Kulkami, M., Umbilical Artery Catheterization (2022) https://emedicine.medscape.com/article/1348931-overview

6.3 University of California, San Francisco – Standardized Procedure Neonatal Umbilical Vessel Catheterization (2008) http://www.ucsfmedicalcenter.org/medstaffioffice/Standardized_Procedure/Neonatal%20Umbilical%20Vessel%20Catheterization.pdf

6.4 Rady Children's Hospital, San Diego (2017) Neonatal Umbilical Vessel Catheterization, Standardized Procedure SP 2-02

7.0 Attachment: Not applicable

8.0 Summary of Revisions:

8.1 Reviewed and submitted without change

Title: **Risk Management Plan**	Policy No. ADM-00476 Page 1 of 3
Current Author: Merlina Esparza/ Mersedes Martinez	Effective: 4/23/1993
Latest Review/Revision Date: 04/27/2026	Manual: Administration / Risk

Collaborating Departments: Quality Chair of Quality- Dr. Su	Keywords:

Approval Route: List all required approval				
MARCC X	PSQC X	Other: Safety Committee		
Clinical Service _____	MSQC	MEC X	BOD X	

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 The Risk Management Plan is designed to identify actual and potential situations, which could put the organization, employees or customers at risk.

1.2 All employees and medical staff are to support and participate in the risk management plan by working safely and identifying, reporting and/or alleviating conditions and practices that may cause injury to patients, guests and staff, as well as organizational loss.

2.0 Scope: District wide

3.0 Policy:

3.1 The Risk Manager is responsible for the implementation and operation of the Risk Management Plan for Imperial Valley Healthcare District (IVHD).

3.2 The Risk Manager reports directly to the Quality Director.

4.0 Definitions: Not applicable

5.0 Procedure:

5.1 Plan Components

5.1.1 Loss prevention, consisting of identification of potentially compensable events, medical-malpractice claims, risk assessment and occurrence reporting from Quality Review Reports (QRR's)

5.1.2 Facilitation of Root Cause Analysis (RCA's)

5.1.3 Participation of Failure Modes and Effect Analysis

5.1.4 Educational program development, organization-wide and department specific as needed

5.1.5 Event reporting to California Department of Public Health (CDPH), The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS) or other regulatory/accreditation bodies, as required.

5.1.6 Reporting to organizational committees

5.2 Plan Activities

5.2.1 Loss control and prevention

5.2.1.1 Identify notices of intention, claims, quality reviews, risk assessments, incident reports and survey findings.

5.2.1.2 Conduct a thorough investigation on all claims and provide essential

case information to the facility's counsel and liability insurance carrier.

5.2.1.3 Submit recorded occurrences, quantified and trended quarterly and annually to the Patient Safety and Quality Council (PSQC) and other committees as appropriate.

5.2.1.4 Utilize sources to assess risks inherent to the environment, including, but not limited to quality review reports, potential compensable events and medical-malpractice claims.

5.2.2 Root Cause Analysis

5.2.2.1 Risk Management is responsible for facilitating a credible and thorough RCA on events when there is a suspected deviation from a known standard of care and/or an internal/external policy, including requirements outlined by The Joint Commission and CMS Conditions of Participation.

5.2.2.2 Risk Management will collaborate with appropriate hospital personnel to complete the RCA process in accordance with IVHD policy and applicable regulatory and accreditation standards. (*See policy Sentinel Event; ADM-00480*)

5.2.2.3 Risk Management will assist in coordinating and participating in the development of a Corrective Action Plan (CAR) when the need for one is identified during a RCA.

5.2.3 Failure Mode and Effects Analysis

5.2.3.1 Risk Management is responsible for participating in at least one Failure Mode and Effects Analysis (FMEA) annually in an effort to proactively address patient safety, risk reduction and loss prevention, consistent with CMS Quality Assessment and Performance Improvement (QAPI) requirements and The Joint Commission patient safety standards.

5.2.4 Education

5.2.4.1 Risk Management conducts orientation education monthly to new employees to include Quality Review Reporting, Loss Prevention, and Risk Services.

5.2.4.2 Risk Management conducts department specific and individual training during departmental rounds, in-services and/or staff meetings as needed.

5.2.5 Risk Management Reporting

5.2.5.1 Reporting to Governing Board, Medical Staff, PSQC, Safety Committee, Chief Financial Officer (CFO) and other organizational committees as requested.

5.2.5.2 At a minimum a Quarterly report to PSQC

5.2.5.3 Lesson Learned when appropriate.

5.2.5.4 Safety Committee as requested.

5.2.5.5 Leadership Council as requested.

5.2.5.6 Claims will go directly to Governing Board's legal counsel for reporting.

5.2.5.6.1 All claims will be presented to the Governing Board.

6.0 References:

6.1 IVHD policy Sentinel Event; ADM-00480
6.2 NIAHO standards: Quality Management
6.3 The Joint Commission (TJC) Comprehensive Accreditation Manual for Hospitals- Patient Safety and Performance Improvement Standards
6.4 Centers for Medicare and Medicaid Services (CMS) Conditions of Participation – Quality Assessment and Performance Improvement (QAPI)
6.5 CMS State Operations Manual as applicable

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Updated author
8.2 Changed PMHD to IVHD.
8.3 Added 5.1.5
8.4 Added 5.2.2.1
8.5 Added 5.2.2.2
8.6 Added 5.2.3.1
8.7 Added References 6.3 to 6.5

Imperial Valley Healthcare District

Title: **Standardized Procedure for Registered Nurses: Hypoglycemia in the Newborn**	Policy No. CLN-02506
	Page 1 of 9
Current Author: Sandra Taylor, RNC-NIC, BSN	Effective: 2/1/1987
Last Review/Revision Date: 02/18/2026	Manual: Clinical / OB

Collaborating Departments: Perinatal/Neonatal; NICU Medical Director, NICU Manager		Keywords: hypoglycemia, glucose, blood glucose, Accu-check	
Approval Route: List all required approval			
MARCC	Other:		
Clinical Service Pediatrics 4/2026	MSQC 5/2026	MEC 5/2026	BOD 5/2026

APPROVALS		
AUTHORITY	**SIGNATURE**	**DATE**
ADMINISTRATION		
CHIEF NURSING OFFICER		
PHYSICIAN DEPARTMENT CHAIR		
BOARD OF DIRECTORS		

NOTE*: If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

REVIEWED ANNUALLY

1.0 Purpose:

1.1 To provide guidelines for obtaining blood glucose in neonates at risk for developing hypoglycemia and to delineate the appropriate interventions for hypoglycemia in newborns in the Perinatal Couplet Care area and the Intermediate NICU.

2.0 Scope: Perinatal and Neonatal Staff

3.0 Policy:

3.1 Neonatal blood glucose testing and interventions will be initiated by competency validated RNs.

3.1.1 Circumstances under which RN may perform Standardized Procedure function(s):

3.1.2 Setting:

3.1.2.1 Competencies validated RN may perform neonatal blood glucose testing and intervention in any area of Pioneers Memorial Hospital providing care to the newborn

3.1.3 Scope of Supervision:

3.1.3.1 Neonatal blood glucose testing and intervention is done under the direct or indirect supervision of the physician.

3.2 Blood glucose concentration should only be measured in any infant who have clinical manifestations or who are known to be at risk.

3.2.1 Routine screening and monitoring of blood glucose concentrations is not needed in the healthy term newborn infant after a normal pregnancy and delivery

3.3 Newborns meeting one of the following criteria are to be observed for hypoglycemia and

bedside blood glucose monitoring and/or serum glucose testing will be implemented:

3.3.1 Within 1 hour of birth:
- 3.3.1.1 Large for gestational age (LGA) with birth weight greater than the 90TH percentile on the infant growth chart (Attachment D [male] or E [female], gender specific)
- 3.3.1.2 Small for gestational age (SGA) with birth weight less than the 10TH percentile in the infant growth chart (Attachment D [male] or E [female], gender specific)
- 3.3.1.3 Premature (37 weeks or less by examination)
- 3.3.1.4 Postmaturity (> 42 weeks gestation by examination)
- 3.3.1.5 Asphyxiated or hypoxic infant (Apgar $\leq$ 5 at 5 minutes of age)
- 3.3.1.6 Cold stressed infant (temperature less than 97.0°F at any time or less than 97.7°F after rewarming intervention
- 3.3.1.7 Admission to the Intermediate NICU
- 3.3.1.8 Respiratory distress including – tachypnea greater than or equal to 80 bpm with grunting, flaring, retracting and/or O_2 desaturation (<88% spo2) in the first hour of life

3.3.2 Within 30 minutes – 1 hour of life:
- 3.3.2.1 Infants of diabetic mothers (insulin dependent or gestational diabetes)

3.3.3 At 2 hours of life:
- 3.3.3.1 All infants with tachypnea greater than or equal to 70 bpm without other signs of distress
- 3.3.3.2 Any infant that met criteria as listed above in 3.3.1

3.3.4 At 6 hours, 12 hours and 24 hours of age:
- 3.3.4.1 All infants that were found to be LGA, SGA, <37 weeks, >42 weeks, Respiratory distress (as listed above in 3.3.1.8) or NICU admissions

3.3.5 At any time for infants exhibiting any of the following signs:
- 3.3.5.1 Apnea
- 3.3.5.2 Respiratory distress including – tachypnea greater than or equal to 70 bpm with grunting, flaring, retraction, and/or O_2 desaturation
- 3.3.5.3 Temperature instability – temperature less than 97.7°F after intervention
- 3.3.5.4 Hypotonia
- 3.3.5.5 Lethargy
- 3.3.5.6 Jitteriness
- 3.3.5.7 Seizure activity
- 3.3.5.8 Poor feeding – poor suck/swallow coordination for 2 consecutive feedings for infants greater than 12 hours of age

3.3.6 Note: If the infant is being fed, the test should be done prior to feeding

3.3.7 For any infant who is receiving IV therapy, testing should be done once every shift

3.4 The physician will be notified when point of care glucose value is:

3.4.1 Less than 25 mg/dl after intervention for infants less than 24 hours old

3.4.2 Less than 25 mg/dl at any time for infants equal to or greater than 24 hours of age
3.4.3 Less than 45 mg/dl with any of the following signs for infants less than 24 hours of age:
3.4.3.1 Apnea
3.4.3.2 Hypotonia
3.4.3.3 Lethargy
3.4.3.4 Seizure activity
3.4.3.5 Respiratory distress including: tachypnea greater than or equal to 80 bpm with grunting, flaring, retracting and/or O_2 desaturation
3.4.4 Less than 45 mg/dl with any signs and symptoms after intervention for infant less than 24 hours of age
3.4.5 Less than 50 mg/dl with any of the following signs for infants at or greater than 24 hours of age:
3.4.5.1 Apnea
3.4.5.2 Hypotonia
3.4.5.3 Lethargy
3.4.5.4 Seizure activity
3.4.5.5 Respiratory distress including: tachypnea greater than or equal to 80 bpm with grunting, flaring, retracting and/or O_2 desaturation
3.4.6 Less than 50 mg/dl after intervention for infants equal to or greater than 24 hours of age
3.4.7 Between 25-44 mg/dl after intervention with 2ND dose of glucose gel for infant less than 24 hours of age without signs
3.4.8 Between 25-44 mg/dl after intervention with 2nd dose of glucose gel for infants less than 24 hours of age with ONLY signs of jitteriness and/or tachypnea greater than or equal to 80 bpm
3.4.9 Between 25-49 mg/dl for infants equal to or greater than 24 hours old with ANY of the following signs ONLY:
3.4.9.1 Jitteriness
3.4.9.2 Temperature instability
3.4.9.3 Poor feeding
3.4.9.4 Poor suck/swallow coordination for 2 consecutive feedings

3.5 The physician will be notified for all infants at any time with rebound hypoglycemia
3.6 For frequency of testing aimed at infants receiving parenteral therapy <*Refer to policy CLN-02517; Intermediate NICU Standards of Practice*>
3.7 RN Requirements:
3.7.1 Education/Training/Experience:
3.7.1.1 RNs successfully oriented to units caring for neonates will perform neonatal blood glucose testing and intervention after successful completion of blood glucose point of care testing competency validation and neonatal blood glucose testing and intervention posttest
3.7.2 Initial and Ongoing Competency Evaluation:
3.7.2.1 Initial competency evaluation includes successful completion of:

3.7.2.1.1 Blood glucose point of care testing initial competency validation
3.7.2.1.2 Standardized Procedure: Blood Glucose in Neonates posttest with score of 100%
3.7.2.2 Annual competency evaluation includes successful completion of:
3.7.2.2.1 Blood glucose point of care testing annual competency validation
3.7.2.2.2 Validation of hypoglycemia management documentation on 1 patient/year, or if this opportunity is not possible, completes Standardized Procedure: Blood Glucose in Neonates posttest with score of 100%

3.8 RN authorized to perform standardized procedure function(s):
3.8.1 A written record of initial and annual competency will be maintained in the employee file in their respective unit. A roster of RNs competency validated to perform blood glucose testing and intervention will be sent to the Chief Nursing Officer and Lab Point of Care coordinator annually by the nursing unit manager.

4.0 Definitions:

4.1 PO – per os – oral
4.2 BPM – breaths per minute
4.3 AC – before feeding
4.4 mL – Milliliters
4.5 Glucose gel – 40% Dextrose oral gel for the treatment of hypoglycemia
4.6 Rebound hypoglycemia – a second episode of hypoglycemia following a previous hypoglycemia event that had resolved with appropriate treatment.
4.7 INICU – Intermediate Neonatal Intensive Care Unit

5.0 Procedure:

5.1 Treatment Pathways – Chose appropriate pathway based on infant's age, point of care blood glucose results and presenting symptoms (*See Attachments A, B and C*).

***NOTE**: must review the infants' history for any prior hypoglycemic events. If infant had any prior hypoglycemia, go directly to PATHWAY IV*

5.1.1 PATHWAY I
5.1.1.1 Infants less than 24 hours of age with point of care blood glucose less than 45 mg/dl without signs of hypoglycemia (*See Attachment A*)
5.1.1.1.1 Under direct supervision of the nurse, place the infant skin to skin with mother if possible to achieve physiologic stability
5.1.1.1.2 Administer glucose gel based on infant's birth weight

INFANT'S BIRTH WEIGHT IN KILOGRAMS	AMOUNT OF GLUCOSE GEL IN mL	DOSE OF 40% GLUCOSE GEL IN GRAMS
1.8 – 2.4 kg	1 mL	0.4 g
2.5 – 2.9 kg	1.25 mL	0.5 g
3 – 3.4 kg	1.5 mL	0.6 g

3.5 – 3.9 kg	1.75 mL	0.7 g
4 – 4.4 kg	2 mL	0.8 g
4.5 – 4.9 kg	2.25 mL	0.9 g
5 kg and above	2.5 mL	1 g

5.1.1.1.3 Feed Infant
- 5.1.1.1.3.1 If breastfeeding, attempt to breastfeed immediately
- 5.1.1.1.3.2 If bottle feeding, bottle feed 5-15 mLs

5.1.1.1.4 Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

5.1.1.1.5 If the repeat point of care glucose is:
- 5.1.1.1.5.1 Less than 45 mg/dl with any signs and symptoms or less than 25 mg/dl, proceed to PATHWAY IV
- 5.1.1.1.5.2 Between 25-39 mg/dl, without signs, administer glucose gel again and immediately breastfeed or bottle feed 5-15 mLs

5.1.1.1.6 Repeat point of care glucose 30 minutes after intervention

5.1.1.1.7 If the point of care glucose remains 25-39 mg/dl, obtain STAT serum glucose and notify the physician immediately for further orders

5.1.1.1.8 If not physician response to notification within 20 minutes, call physician on call for the INICU

5.1.1.1.9 Once the point of care glucose is greater than or equal to 45 mg/dl, obtain AC (before feeding) point of care glucose two times
- 5.1.1.1.9.1 If one of the AC points of care glucose values is less than 45 mg/dl and infant is otherwise asymptomatic, call physician for further orders
- 5.1.1.1.9.2 If either AC point of care glucose is less than 45 mg/dl with any signs and symptoms or less than 25 mg/dl, proceed to PATHWAY IV

5.1.2 <u>PATHWAY II</u>

5.1.2.1 Infants less than 24 hours of age, point of are blood glucose less than 45 mg/dl with only signs of jitteriness and/or tachypnea greater than or equal to 70 bpm without other signs of distress (*See Attachment A*)

5.1.2.1.1 Under direct supervision of the nurse, place the infant skin to skin with mother if possible to achieve physiologic stability

5.1.2.1.2 Administer glucose gel based on infant's birth weight

INFANT'S BIRTH WEIGHT IN KILOGRAMS	AMOUNT OF GLUCOSE GEL IN mL	DOSE OF 40% GLUCOSE GEL IN GRAMS
1.8 – 2.4 kg	1 mL	0.4 g
2.5 – 2.9 kg	1.25 mL	0.5 g

3 – 3.4 kg	1.5 mL	0.6 g
3.5 – 3.9 kg	1.75 mL	0.7 g
4 – 4.4 kg	2 mL	0.8 g
4.5 – 4.9 kg	2.25 mL	0.9 g
5 kg and above	2.5 mL	1 g

5.1.2.1.3 Feed Infant
- 5.1.2.1.3.1 If breastfeeding, attempt to breastfeed immediately
- 5.1.2.1.3.2 If bottle feeding, bottle feed 5-15 mLs. Bottle feed only if respiratory rate is less than 70 bpm. If respiratory rate is greater than or equal to 70 bpm, notify the physician

5.1.2.1.4 Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

5.1.2.1.5 If the repeat point of care glucose is:
- 5.1.2.1.5.1 Less than 45 mg/dl with an signs and symptoms other than jitteriness and/or tachypnea greater than or equal to 70 bpm, OR less than 25 mg/dl, proceed to PATHWAY IV
- 5.1.2.1.5.2 Between 25-44 mg/dl, and the infant is asymptomatic or shows ONLY signs of jitteriness and/or tachypnea greater than or equal to 70 bpm without other signs of distress, administer glucose gel again and immediately breastfeed or bottle feed 5-15 mLs. Bottle feed ONLY if respiratory rate is less than 70 bpm

5.1.2.1.6 Repeat point of care glucose 30 minutes after intervention

5.1.2.1.7 If point of care glucose remains 25-44 mg/dl, obtain STAT serum glucose and notify physician immediately for further orders

5.1.2.1.8 If no physician response to notification within 20 minutes, call physician on call for the INICU

5.1.2.1.9 Once the point of care glucose value is greater than or equal to 45 mg/dl, obtain AC point of care glucose two times
- 5.1.2.1.9.1 If one of the AC points of care glucose values is less than 45 mg/dl and infant is otherwise asymptomatic, call physician for further orders
- 5.1.2.1.9.2 If either AC point of care glucose is less than 45 mg/dl with any signs and symptoms or less than 25 mg/dl, proceed to PATHWAY IV

5.1.3 <u>PATHWAY III</u>

5.1.3.1 Infants equal to or greater than 24 hours of age with point of care glucose 25-49 mg/dl with ANY of the following signs ONLY (*See Attachment B*)

5.1.3.1.1 Jitteriness
5.1.3.1.2 Temperature instability
5.1.3.1.3 Poor feeding – poor suck/swallow coordination for 2 consecutive feedings

5.1.3.2 Notify the physician STAT

5.1.3.3 Under direct supervision of the nurse, place the infant skin to skin with mother of baby if possible to achieve physiologic stability. If cold stressed (temperature less than 97.0°F), infant needs to be taken to Intermediate NICU for assessment and placed in open bed with radiant warmer for warmth and observation

5.1.3.4 Administer glucose gel based on infant's birth weight

Infant's Birth Weight in Kilograms	Amount of Glucose Gel in mL	Dose of 40% Glucose Gel in Grams
1.8 – 2.4 kg	1 mL	0.4 g
2.5 – 2.9 kg	1.25 mL	0.5 g
3 – 3.4 kg	1.5 mL	0.6 g
3.5 – 3.9 kg	1.75 mL	0.7 g
4 – 4.4 kg	2 mL	0.8 g
4.5 – 4.9 kg	2.25 mL	0.9 g
5 kg and above	2.5 mL	1 g

5.1.3.5 Feed Infant:
5.1.3.5.1 If breastfeeding, attempt to breastfeed immediately
5.1.3.5.2 If bottle feeding, bottle feed 5-15 mLs. Bottle feed only if respiratory rate is less than 70 bpm

5.1.3.6 Repeat the point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

5.1.3.7 If the repeat point of care glucose remains less than 50 mg/dl, obtain STAT serum glucose and notify the physician immediately for further orders

5.1.3.8 If no physician response to notification within 20 minutes, call the physician on call for the INICU

5.1.3.9 If repeat point of care glucose value is greater than or equal to 50 mg/dl, obtain AC point of care glucose two times
5.1.3.9.1 If either one of these values is less than 50 mg/dl, obtain STAT serum glucose and call the physician immediately for further orders
5.1.3.9.2 If no physician response to notification within 20 minutes, call physician on call for the INICU

5.1.4 <u>PATHWAY IV</u>

5.1.4.1 Infant less than 24 hours of age with a point of care glucose less than 45 mg/dl OR infants greater than or equal to 24 hours of age with a point of care glucose less than 50 mg/dl with any of the following signs (*See Attachment A or B*)

5.1.4.1.1 Apnea
5.1.4.1.2 Respiratory distress including: tachypnea greater than or equal to 70 bpm with grunting, flaring, retracting and/or O_2 desaturation
5.1.4.1.3 Hypotonia
5.1.4.1.4 Lethargy
5.1.4.1.5 Seizure activity

5.1.4.2 Infants equal to or greater than 24 hours of age with point of care glucose less than 25 mg/dl at any time
5.1.4.3 As indicated in PATHWAY I and II
5.1.4.4 Infants with rebound hypoglycemia
***NOTE**: Review history for previous hypoglycemia event*
5.1.4.4.1 Do Not feed or gavage infant
5.1.4.4.2 If the infant is not already in the INICU, contact the INICU to transfer the infant into the INICU immediately
5.1.4.4.3 Notify the physician of the transfer. If no response within 20 minutes, call the physician on call for the INICU
5.1.4.4.4 Obtain a STAT serum glucose
5.1.4.4.5 Administer IV glucose (*Physician response should not delay the IV glucose administration*)
5.1.4.4.5.1 Glucose dose for bolus administration is 2 mL/kg of D10W given over 15 minutes
5.1.4.4.6 Repeat the point of care glucose 30 minutes after completion of the IV bolus
5.1.4.4.7 Notify the physician for further orders
5.1.4.4.8 Once the point of care glucose is 45 mg/dl or greater, obtain a point of care glucose every 2-3 hours two time
5.1.4.4.9 Maximal concentration of glucose in peripheral IV is D12.5W
5.1.4.4.10 If infant requires IV dextrose concentrations of >12.5%, insert an umbilical venous catheter

5.2 Documentation in the Electronic Medical Record:
5.2.1 Point of Care Glucose values
5.2.2 Laboratory Glucose values
5.2.3 Signs of hypoglycemia
5.2.4 Interventions
5.2.5 Response to interventions
5.2.6 Physician notification, as applicable

6.0 References:

6.1 New Intrauterine Growth Curves Based on US data – Pediatrics, Volume 125, pages e214-e244 (2010) American Academy of Pediatrics https://pediatrics.aappublications.org/content/125/2/e214
6.2 Postnatal Glucose Homeostasis in Late-Preterm and Term Infants – Clinical Report form American Academy of Pediatrics. Pediatrics Vol 127 No 3 March 1, 2011. Pp 575-

579. http://pediatrics.aappublications.org/content/127/3/575.full

6.3 Fanaroff, A.A>, & Martin, R.J. (2020). Neonatal-Perinatal Medicine (11th ed.) St Louis: Elsevier/Mosby

6.4 Intensive Care Nursery House Staff Manual. (2004). Neonatal Hypoglycemia. pg. 154-154. The Regents of the University of California http://www.ucsfbenioffchildrens.org/pdf/manuals/52_Hypoglycemia.pdf

6.5 Adamkin, D.H., et al. (2011) "Clinical Report – Postnatal glucose homeostasis in late-preterm and term infants" Pediatrics; 127. pg. 575-579

6.6 Thompson-Branch, A., (2017) AAP Sets Guidelines for Neonatal Hypoglycemia https://pedsinreview.aappublications.org/content/38/4/147

6.7 Huntsman, R.J., et al (2008) Nonepileptic motor phenomena in the Neonate http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2606074/

6.8 Sharp Hospital San Diego Policy & Procedure 47621.99 "Standardized Procedure – Blood Glucose in Neonates – Criteria for Obtaining & Interventions for Hypoglycemia" (2016)

6.9 Giouleka, S. et al (2023) "Diagnosis and Management of Neonatal Hypoglycemia: A Comprehensive Review of Guidelines" https://pmc.ncbi.nlm.nih.gov/articles/PMC10378472/

7.0 Attachment:

7.1 Attachment A – Interventions for Hypoglycemia for infants less than 24 hours of age

7.2 Attachment B– Interventions for Hypoglycemia for infants greater than 24 hours of age

7.3 Attachment C – Blood Glucose in Neonates – Criteria for Obtaining and Interventions for Hypoglycemia

7.4 Attachment D – Intrauterine Growth Curves (2 sided) – Male

7.5 Attachment E – Intrauterine Growth Curves (2 sided) - Female

8.0 Summary of Revisions:

8.1 Reviewed and submitted without change

Pathway I (less than 24 hours)
BG less than 45mg/dl without signs/symptoms

Under direct supervision of the nurse, place infant skin to skin with mother of baby if possible to achieve physiologic stability.

Administer glucose gel per dosing guidelines

Breastfeed immediately OR bottle feed 5- 15 mLs

Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

BG less than 45 mg/dl **with** any s/s **OR** less than 25 mg/dl, **proceed to Pathway IV.**

See Pathway IV

If BG is 25-44 mg/dl **without signs**, administer glucose gel **again** and immediately breastfeeding OR bottle feed 5-15 mLs

Repeat BG 30 minutes after administering 2nd dose of glucose gel

If BG remains 25-44 mg/dl, obtain STAT serum glucose and notify physician immediately for further orders.

If BG is 45 mg/dl or greater, obtain BG 2 more times. If one of these values is less than 40 mg/dl and infant is asymptomatic, call physician for further orders.

If either point of care blood glucose is less than 45 mg/dl **with** any signs and symptoms **OR** less than 25mg/dl **proceed to Pathway IV**

Attachment A CLN-02506, Interventions for Hypoglycemia
For infants less than 24 hours of age

Pathway II (Less than 24 hours)

BG less than 45 mg/dl with ONLY signs of jitteriness and/or tachypnea greater than or equal to 80

Under direct supervision of the nurse, place infant skin to skin with mother of baby if possible to achieve physiologic stability.

Administer glucose gel per dosing guidelines

Attempt to breastfeed immediately OR bottle feed 5-15 mLs. Bottle feed **ONLY** if RR less than 80. **(If RR is 80 or greater, NOTIFY PHYSICIAN).**

Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

BG less than 45 mg/dl **with** any s/s **OR** less than 25 mg/dl, **proceed to Pathway IV.**

If BG is 25-44 mg/dl **without new or additional s/s**, administer glucose gel **again** and immediately breastfeeding OR bottle feed 5-15 mLs. Bottle feed **ONLY** if RR less than 80.

See Pathway IV

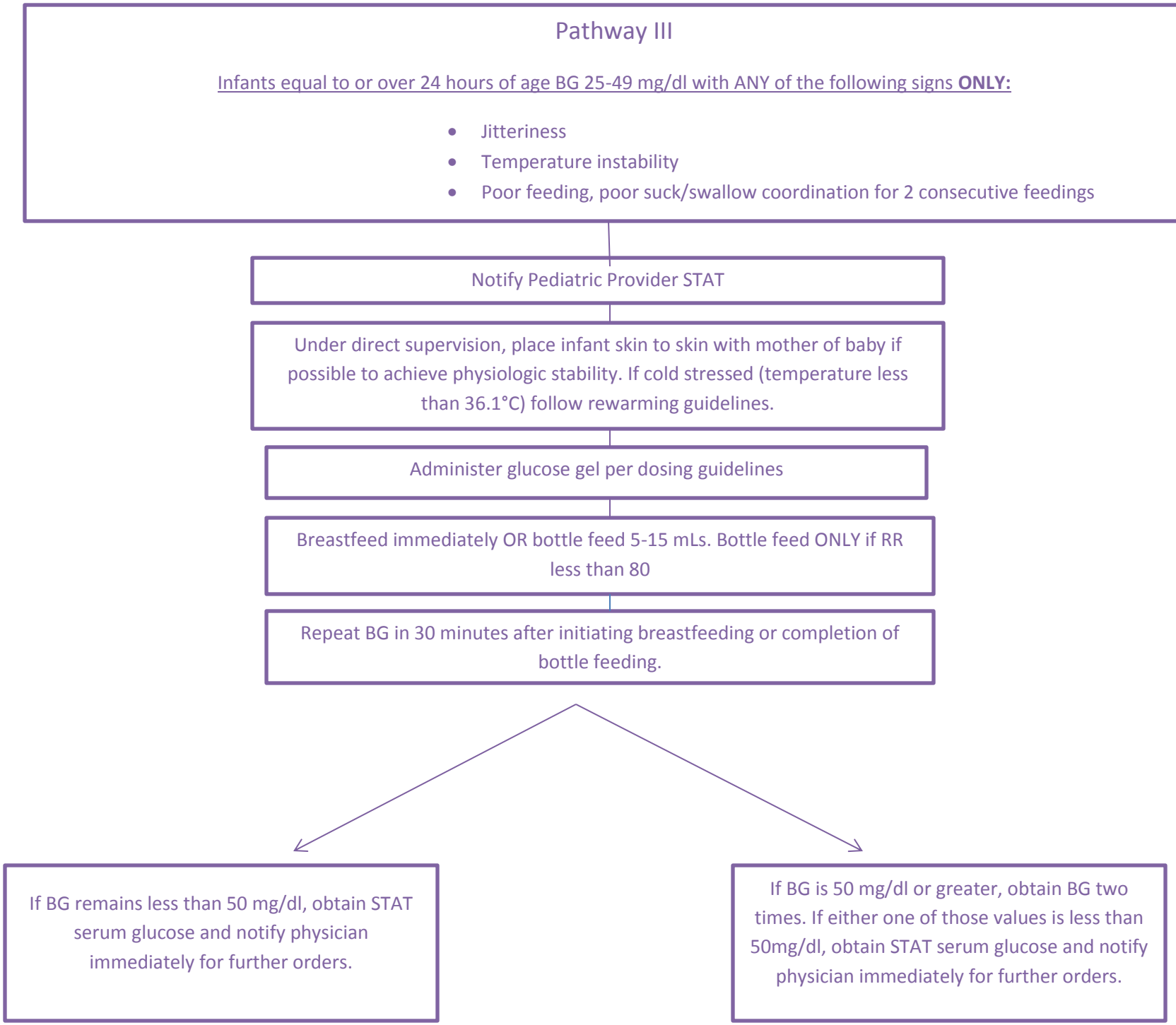
Repeat BG 30 minutes after administering 2nd dose of glucose gel

If BG remains 25-=44 mg/dl, obtain STAT serum glucose and notify physician immediately for further orders.

If BG is 45 mg/dl or greater, obtain BG two more times. If one of these values is less than 40 mg/dl and infant is asymptomatic, call physician for further orders.

If either point of care blood glucose is less than 45 mg/dl **with** any signs and symptoms **OR** less than 25mg/dl **proceed to Pathway IV**

Attachment B CLN-02506 Interventions for Hypoglycemia
For infants greater than 24 hours of age



Attachment C CLN-02506 Blood Glucose in Neonates, Criteria for Obtaining and Interventions for Hypoglycemia

Imperial Valley Healthcare District

Title: **Intra-Facility Transport of the Intermediate NICU Patient**	Policy No. CLN-02526 Page 1 of 2
Current Author: Sandra Taylor, RNC-NIC, BSN	Effective: 5/30/2018
Latest Review/Revision Date: 03/18/2026	Manual: Clinical / OB

Collaborating Departments: Neonatal, Cardio NICU Medical Director, NICU Manager	Keywords: Neonate transport

Approval Route: List all required approval				
Administration 3/2026	PSQC	Other:		
Clinical Service Pediatrics 4/2026		MSQC 5/2026	MEC 5/2026	BOD 5/2026

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To establish a standard of care for transporting neonatal patients to other departments within Pioneers Memorial Hospital

2.0 Scope: Perinatal/Neonatal Staff

3.0 Policy:

3.1 All infants will be transported in an open crib or isolette.

4.0 Definitions:

4.1 INICU – Intermediate NICU
4.2 RT – Respiratory Therapist
4.3 EMR – Electronic Medical Record

5.0 Procedure:

5.1 Designated staff member will call the receiving department prior to transfer to insure department's readiness for patient.
5.2 Intermediate NICU patients will be transported in transport isolette/resuscitation bed with an INICU nurse. Patients requiring mechanical ventilation will be accompanied by the INICU RN and RT.
5.3 The interdisciplinary team (physician, RN, RT) will determine if the acuity warrants additional personnel such as the RT or the physician to assist with the transport.
5.4 Confirm patient identity using two-identifier system. Refer to policy CLN -00242; "Identification of the Newborn."
5.5 The RN is responsible for:
- 5.5.1 Overseeing the transport
- 5.5.2 Staying with the patient throughout the procedure
- 5.5.3 Ongoing patient monitoring and safety
- 5.5.4 Attaching resuscitation bag to full oxygen cylinder
- 5.5.5 Ensuring a mask is present
- 5.5.6 Ensuring bulb syringe is present
- 5.5.7 Maintaining airway security and patency
- 5.5.8 Managing and monitoring oxygen flow and oxygen saturation

5.5.9 Documentation in the EMR

5.6 The RT is responsible for (if assisting with transport):
- 5.6.1 Assisting RN as needed
- 5.6.2 Check respiratory equipment or monitoring ventilator for correct connections and proper function as needed
- 5.6.3 Documentation in EMR

5.7 Family Centered Care: The parents are invited to accompany the patient on transport. If they are unable to attend, the physician and/or INICU RN will update the parents about the patient's clinical status as soon as possible.

5.8 Documentation:
- 5.8.1 The transport will be documented in the EMR.
- 5.8.2 The RT will document the ventilator check for intubated patients.

6.0 References:

6.1 Riley, L.E., & Stark, A.R. (Eds.) (2017). *Guidelines for Perinatal Care 8th Edition*. American Academy of Pediatrics and the American College of Obstetricians and Gynecology.

6.2 Bowles. Sue, and Sandra S. Beauman, (Eds.) (2019). Policies, Procedures, and Competencies for Neonatal Nursing Care. Glenview, Il: National Association of Neonatal Nursing Care

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Reviewed and submitted without change

Imperial Valley Healthcare District

Title: **Tuberculosis Exposure Protocol**	Policy No. HRD-00121 Page 1 of 2
Current Author: Lizbette Cordova, RN	Effective: 10/1/1995
Latest Review/Revision Date: 03/01/2026	Manual: HR / Employee Health

Collaborating Departments: Infection Control, Dr. Mohammed Al-Jasim	Keywords: TB, Exposure		
Approval Route: List all required approval			
	PSQC	Other: Safety Committee 04/2026	
Clinical Service _____	MSQC 04/2026	MEC 04/2026	BOD 04/2026

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To ensure prompt identification of employees exposed to tuberculosis (TB) while caring for patients.

2.0 Scope: District wide

3.0 Policy:

3.1 Employee Health is notified of possible exposure by Infection Control, Public Health Department (PHD), Laboratory or Department Nurse. Employee Health will maintain a log of possible TB exposures.

4.0 Definitions:

4.1 QFT- QuantiFERON
4.2 TB – Tuberculosis
4.3 Exposure is considered when active TB is diagnosed, and no isolation precautions were taken.

5.0 Procedure:

5.1 Employee is notified by Department Manager, Infection Control or Employee Health of possible exposure to TB.
5.2 Employee will have a baseline QuantiFERON – QFT (TB blood test) done as soon as possible and again at 8 to 10 weeks post-exposure.
5.3 If the exposed Employee is a known positive QFT, a Health Status Update form should be completed instead
  5.3.1 If Employee has had QFT and/or HSU form completed in the past 10 weeks, it may be used as the baseline.
5.4 If the QFT is positive at 8 to 10 weeks post exposure, a repeat confirmatory test shall be performed
5.5 If the repeat confirmatory test is positive, a chest x-ray will be done and Health Status Update form will be completed. Employee will be referred to the Occupational Health Provider for follow-up and the ICPHD will be notified of the employee's QFT conversion
5.6 Any Employee with symptoms of TB (persistent cough, fever, anorexia, weight loss, night sweats) should see the Employee Health Nurse and/or Infection Control Nurse for appropriate referral.

6.0 References:

6.1 Imperial County Public Health Department, TB Control Program
6.2 Title 8, Section 5199, Cal/OSHA Aerosol Transmissible Disease Standard
6.3 Aerosol Transmission Plan ATP, CLN-02378
6.4 IVHD Form HRD-00122A; Health Status Update Form
6.5 CDC TB Prevention in Health Care Setting: Baseline Tuberculosis Screening and Testing for Health Care Personnel, 12/19/2023
6.6 TB Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019, MMWR

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Annual Review; updated PMHD to IVHD
8.2 Removed section 5.7 Failure to comply, as this process is not followed.
8.3 Added Dr. Al-Jasim as physician reviewer
8.4 Added References 6.5 and 6.6
8.5 Added clarification regarding if QFT is positive at 8 to 10 weeks post exposure (conversion), a repeat confirmatory test shall be performed

Imperial Valley Healthcare District

Title: **CODE PINK Infant or Child Abduction**	Policy No. CLN-01307
	Page 1 of 3
Current Author: Sandra Taylor, RNC, BSN	Effective: 12/1/1995
Latest Review/Revision Date: 03/18/2026	Manual: Clinical / OB

Collaborating Departments: Admitting; Security; OB; ER; Nursing; NICU Medical Director; NICU Manager	Keywords: infant abduction, code pink, infant security

Approval Route: List all required approval				
MARCC x	PSQC	Other: Safety Committee		
Clinical Service OB/Peds x		MSQC x	MEC x	BOD x

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To provide a plan of action to be initiated by all hospital personnel when an infant or child abduction is known or suspected.

1.2 Pioneer Memorial Hospital is committed to the safe and compassionate care of all patients and their families. The abduction of an infant or child from the hospital is unlawful and poses a threat to both the wellbeing of the infant/child, the parents, and other patients of PMH.

1.3 To assure that all-appropriate hospital personnel and outside agencies are notified for timely and appropriate action.

1.4 To attempt to thwart an abduction and quickly locate and reunite the infant and their family as soon as possible.

1.5 To outline the role and responsibility of the hospital staff.

2.0 Scope: District wide

3.0 Policy:

3.1 Suspected abduction of an infant or child from Pioneers Memorial Hospital shall be immediately reported to Brawley Police Department by notifying the switchboard 4444 and they will call 911. PMH leadership will be promptly notified of any suspected abduction.

3.2 All employees:

3.2.1 Shall complete annual training on infant/child abduction prevention. Managers will assigns contract employees for training on an as needs basis.

3.2.2 Are required to report any suspicious behavior that could endanger patient care.

3.2.3 Shall have a PMH picture identification badge indicating clearance for transporting the infant within the facility.

3.3 CODE PINK is the hospital-wide code for possible infant or child abduction.

3.3.1 The Switchboard Operator will announce the CODE PINK either in OB or Pediatrics.

3.3.2 Perinatal staff and/or Pediatric staff will respond immediately to Code Pink alarms and verify if an infant or child is missing. Then verify the location of the alarm.

3.3.3 If abduction is verified, staff will notify the Switchboard Operator and they will notify the Brawley Police Department.

3.3.4 A representative of Administration will be in charge during a verified Infant or

Child Abduction. However, if this occurrence is after normal business hours, the House Supervisor is in charge and will contact the Administrator on-call and the Perinatal Director or Pediatrics Manager.

3.3.5 The Brawley Policy Department will assume full responsibility upon arrival.

4.0 Definitions:

4.1 PMH – Pioneers Memorial Hospital

5.0 Procedure:

5.1 Nursing Unit Responsibilities

5.1.1 When the Infant or Child Abduction alarm goes off or when a staff member knows or suspects that an infant or child is missing and the infant or child cannot be readily located, the nurse will immediately and simultaneously notify the following:

5.1.1.1 Charge Nurse

5.1.1.2 Dial 4444 and notify the Switchboard Operator of a CODE PINK.

5.1.1.3 The CODE PINK will be announced over the PA System

5.1.1.4 The Perinatal Department Director or Pediatric Nurse Manager

5.1.2 Recheck the entire area to confirm the infant or child is missing. Ask the mother the circumstances of discovering the infant or child is missing.

5.1.3 Seal off the Unit. Do not allow anyone to exit the Unit. The Charge Nurse will assign one staff member to each exit.

5.1.4 Allow no one to leave the areas until dismissed by the Police Officer in charge.

5.1.5 All available hospital personnel will immediately go to the entry and exit doors nearest to their department to stop all traffic flow and remain there until relieved by Security Personnel. Hospital Personnel will attempt to stop anyone who appears suspicious or follow him or her if they attempt to leave the hospital. Security Personnel will check outside and in parking areas. Only previously designated personnel should go to the Perinatal or Pediatric department to avoid confusion and to expedite the search for the infant or child.

5.1.6 Once Perinatal/Pediatric Department Personnel are relieved at the outside exits, they will return the unit and begin extensive and systematic search of all patients' rooms, storage areas, bathroom, and public area.

5.1.7 The Charge Nurse will notify the infant's or child's pediatrician. If infant abduction occurred in the Perinatal Department, the Charge Nurse will notify the mother's Obstetrician.

5.1.8 The Laboratory will be notified to hold the infant's cord blood for possible DNA testing and identification.

5.1.9 The mother and family members will be moved to a different room. No one should enter or disturb the room in order to preserve any evidence that may be useful during a subsequent investigation.

5.1.10 The Switchboard Operator and Admitting will take a "No Information" status for the patient.

5.1.11 A Social Worker will go immediately to be with the mother. The nurse,

Pediatrician, Obstetrician and the Administrator will confer with the parents.

5.1.12 All Perinatal or Pediatric personnel will remain in the department until authorities complete the questioning process.

5.1.13 All personnel will refrain from discussing the incident with anyone except the appropriate authorities. No hospital personnel are authorized to make a public statement concerning the incident or communicate with the media.

5.1.14 Administration, Social Services, and Nursing will confer and develop a specific plan to meet the unique needs of the parents regarding their specific requests such as visitors, media coverage, and notifying family members. It will also be decided on how and what to tell others.

5.1.15 Defer all requests for information to the Administrator.

5.1.16 Confidentiality is of the utmost importance.

5.2 Security Responsibility

5.2.1 Security will notify Safety/Security & EMS Manager.

5.2.2 Security and/or Safety/Security & EMS Manager will update the Brawley Police Department of the situation and findings.

5.2.3 Make sure personnel secure all exits.

5.2.4 Determine number of employees necessary to secure all hospital exits and establish search details.

5.2.5 Secure all hospital exits; interview everyone leaving the hospital.

5.2.6 Establish a search detail until Police Department arrives.

5.2.7 Follow the directions of the Police Department after their arrival.

5.2.8 Direct all media to the appropriate area.

5.3 Administrator Responsibilities

5.3.1 Coordinate above activities.

5.3.2 Establish a Command Operation Center in the Classroom or another designated area.

5.3.3 Establish a Media Room in the Administration Office if necessary.

5.4 Hospital Preparedness

5.4.1 A suspected Infant/Child Abduction Drill shall be done at least four times each year to familiarize personnel with the procedure and to improve effectiveness of the response.

5.4.2 Security or Maintenance will submit a written evaluation (PM Form) to the Facility Services Manager regarding their observations of the drill. Suggestions for changes in current Security practices or for future drills may be included.

6.0 References: Not applicable

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Reviewed and submitted without change

Imperial Valley Healthcare District

Title: **Bloodborne Pathogen Exposure Control Plan**	Policy No. CLN-02303
	Page 1 of 7
Current Author: Lizbette Cordova, RN	Effective: 04/21/2010
Latest Review/Revision Date:03/01/2026	Manual: Clinical – Infection Control

Collaborating Departments: Infection Control; Human Resource Department, Dr. Mohammed Al-Jasim, Environmental Services	Keywords: Infectious Disease, Blood Exposure
Approval Route: List all required approval	
PSQC	Other: Safety Committee 04/2026
Clinical Service _____	MSQC 04/2026 / MEC 04/2026 / BOD 04/2026

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 The purpose of the Bloodborne Pathogen Exposure Control Plan is to comply with Standard (Title 8, Chapter 4, Section 5193, http://www.dir.ca.gov/title8/5193html) and protect healthcare workers and employees from bloodborne infectious diseases by eliminating or reducing the risk of this type of exposure.

2.0 Scope: District wide

3.0 Policy:

3.1 Imperial Valley Healthcare District (IVHD) is committed to providing a safe work environment for our entire staff. The following exposure control plan (ECP) is provided to eliminate or minimize occupational exposure to bloodborne pathogens in accordance with OSHA standard 29 CFR 1910.1030, "Occupational Exposure to Bloodborne Pathogens."

4.0 Definitions:

4.1 Blood – Human blood, human blood components, and products made from human blood.

4.2 Bloodborne Pathogens – Pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

4.3 Contaminated – The presence or the reasonably anticipated presence of blood or other potentially infectious materials on a surface in or on an item.

4.4 Clinical Laboratory – A workplace where diagnostic or other screening procedures are performed on blood and other potentially infectious materials

4.5 Decontamination – The use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal.

4.6 Exposure Incident – A specific eye, mouth, or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials (OPIM) that result from the performance of an employee's duties.

4.7 EVS – Environmental Services

4.8 Hand Washing Facilities – Facilities providing adequate supplies of running potable water, soap, and single use towels or hot air dying machines and/or hand anti-microbial gel dispensers throughout the hospital.

4.9 HBV – Hepatitis B virus

4.10 HCV – Hepatitis C virus

4.11 HCW – Health Care Worker – Any employee, medical staff or other healthcares professional that has the potential for bloodborne or other exposures and works in our facility.

4.12 HIV – Human Immunodeficiency

4.13 Occupational Exposure – Reasonably anticipated skin, eye mucous membrane, or parenteral contact with blood or potentially infectious materials that may result from the performance of an employee's duties.

4.14 OPIM – Other Potentially Infectious Materials are as follows:

- 4.14.1 Human Body Fluids – semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, amniotic fluid, saliva in dental settings, any other body fluid that is visibly contaminated with blood such as saliva or vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as emergency response.
- 4.14.2 Any unfixed tissue or organ (other than intact skin) from human (living or dead)
- 4.14.3 Any of the following, if known or reasonably likely to contain or be infected with HIV, HBV, or HCV
  - 4.14.3.1 Cell, tissue, or organ cultures from humans or experimental animals
  - 4.14.3.2 Blood, organs, or other tissues from experimental animals
  - 4.14.3.3 Culture medium or other solutions

4.15 Parental Contact – piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts, and abrasions.

4.16 PPE – Personal Protective Equipment – Specialized clothing or equipment worn or used by HCW for protection against a hazard. General work clothes (e.g. uniforms, pants, shirts or blouses) not intended to function as protection against a hazard is not considered to be personal protective equipment. Personal protective equipment will be considered "appropriate only if it does not permit blood or OPIM to pass through to or reach the HCW's work clothes, street clothes, undergarments, skin, eye, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the PPE will be used.

4.17 Regulated Waste

- 4.17.1 Liquid or semi-liquid blood or OPIM
- 4.17.2 Contaminated items that:
  - 4.17.2.1 Contain liquid or semi-liquid blood, or are caked with dried blood or OPIM.
  - 4.17.2.2 Are capable of releasing these materials when handled or compressed
- 4.17.3 Contaminated sharps
- 4.17.4 Pathological and microbiological wastes containing blood or OPIM
- 4.17.5 Regulated waste includes "medical waste" regulated by Health and Safety Codes

4.18 Sharp – Any object used or encountered in the industries covered by subsection (a) that can be reasonably anticipated to penetrate the skin or/and other part of the body, and to result in an exposure incident, including, but not limited to, needle devices, scalpels, lancets, broken glass, and broken capillary tubes.

4.19 Standard Precautions – An approach to infection prevention. According to the concept of Standard Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

5.0 Procedure:

5.1 Responsibilities:

5.1.1 Employee Health Services is responsible for coordinating the annual review and update of the Bloodborne Pathogen Exposure Control Plan. Employee Health provides the initial employee training of the Exposure Control Plan during general orientation and works with Infection Control Department to identify and select safety devices. They also serve as a resource for infection prevention and control information.

5.1.1.1 Employee Health Services is responsible for evaluating the circumstances surrounding exposure incidents, providing the hepatitis B vaccination for all employees who are at risk of occupational exposure to bloodborne pathogens, and for reporting safety-related incidents to the Safety Committee. Employee records for vaccinations, exposures and exposure follow-up, and confidential Sharp Injury Log are maintained by Employee Health Services.

5.1.2 The Safety Officer will assist Infection Control in overseeing the use of standard precautions by all HCW/personnel for Imperial Valley Healthcare District. The Safety Officer also provides input for review and update of the Exposure Control Plan as appropriate and reports safety-related incidents to the Safety Committee.

5.1.3 Human Resources is responsible for maintaining documentation of annual training.

5.1.4 Department Directors are responsible for:

5.1.4.1 Determining which employees have potential occupational exposure to bloodborne disease.

5.1.4.2 Ensuring that employees receive all required training and education

5.1.4.3 Ensuring that personal protective equipment is available for employee use

5.1.4.4 Ensuring that employees use safe practices and PPE when there is a potential of exposure to bloodborne pathogens

5.1.4.4.1 Monitoring employees for compliance with Standard Precautions and work practice controls

5.1.4.4.2 Maintaining current department-specific policies and procedures addressing engineering and work practice controls and PPE

5.1.4.4.3 Training and counseling employees who are not using safe practice while handling sharps and/or bloodborne pathogens

5.1.5 Employees are responsible for:
- 5.1.5.1 Knowing what tasks they perform that have potential for bloodborne exposure and using safe practices, PPE, and devices as appropriate.
- 5.1.5.2 Reviewing the Bloodborne Pathogens and associated policies as part of their annual review
- 5.1.5.3 Maintaining a clean and safe environment

5.2 Employee Exposure Risk Determination (*See Attachment A-Exposure Risk by Job Title*)
- 5.2.1 Constant Category Risk: Is a job classification in which the employees have occupational exposure 2/3 or more of the time
- 5.2.2 Frequent Category Risk: Is a job classification in which employees have exposure 1/3 to 2/3 of the time
- 5.2.3 Occasionally Category Risk: Is a job classification in which employees have exposure 1/3 of the time
- 5.2.4 Not Present Category Risk: Is a job classification in which employee exposure does NOT exist

5.3 Exposure Control
- 5.3.1 Work Practice Controls and Procedures have been implemented to minimize exposure to bloodborne pathogens. Each Department Manager is responsible for implementing, evaluating, and monitoring compliance with work practices on an ongoing basis..
- 5.3.2 Engineering and work practice controls include: Needleless systems where applicable, use of needles with engineered safety devices, and disposal of sharps in sharp containers
- 5.3.3 Personal Protective Equipment is provided to our employees at no cost. Training in the use of the appropriate PPE for the task or procedures employees will perform is provided by department directors
  - 5.3.3.1 Types of PPE available include: gloves, gowns, masks, and eye protection.

5.4 Standard precautions are used to prevent contact with blood or other potentially infectious materials and are to be applied to all patients. When necessary, transmission-based precautions are used in addition to standard precautions. (See policy CLN-02308; Isolation Guidelines)

5.5 Specimen Handling and Contact with Blood or Body Fluids:
- 5.5.1 Eating, drinking, applying cosmetics, or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of Occupational exposure to blood or body fluids.
  - 5.5.1.1 Clinical departments may clearly identify areas of the department where bloodborne pathogens may be present, such as areas where clinical specimens' or blood glucose monitoring devices may be placed. Direct patient care areas are included in these designated areas.

5.5.1.2 Clinical departments may clearly identify areas of the department where items which may carry bloodborne pathogens may not be present, such as clean work areas or staff rest areas. Gloves should not be worn in these areas. Items which may carry bloodborne pathogens shall not be placed in theses identified areas.

5.5.1.3 Staff may drink liquids, while working as allowed by their director in designated clean department areas where bloodborne pathogens are not kept. Care should be taken to minimize the risk of spilling by covering liquid.

5.5.1.4 Staff food and drink are not allowed in patient refrigerators.

5.5.2 Food, drink, and oral medications will not be kept in refrigerators, freezers, shelves, cabinets, on countertops where blood or body fluids may be present.

5.5.3 Specimens' of blood or body fluids will be placed in containers that prevent leakage during collection, handling, processing, storage, transportation or shipping.

5.5.4 If an exposure occurs, mucous membranes and eyes will be immediately flushed copiously with water following exposure to blood or body fluids (See policy HRD-00127; Postexposure prophylaxis after occupational exposure to blood & body fluids).

5.6 Housekeeping:

5.6.1 Environmental Services (EVS) is responsible for maintaining the facility in a clean and sanitary manner. Policies and procedures have been developed and implemented to ensure that cleaning methods and schedules are appropriate. The Infection Control and Medical Staff Quality Committee (MSQC) will review and approve all policies and procedures that address cleaning, disinfection, and/or sterilization of equipment or environmental surfaces that become contaminated. (See Policy Hazardous Materials and Waste Management Plan EOC-00111)

5.6.2 Regulated Waste is placed in closable containers that prevent leakage and are appropriately labeled and closed before removal.

5.6.3 Contaminated sharps are discarded immediately in containers that are puncture-resistant, leakproof, and labeled.

5.7 Hepatitis B Vaccination (See Policy Hep B Vaccination Program: HRD-00109))

5.7.1 The Hep B Vaccination series is available at no cost to employees with exposure to Hep B. Vaccination is encouraged unless: Documentation exists that the employee has previously received the series; antibody testing reveals the employee is immune, or the vaccine is contraindicated.

5.7.2 Employees who decline the vaccine must sign a declination. Employees who decline may request and obtain the vaccination at a later date at no cost.

5.7.3 Documentation of refusal of the vaccination is kept at Employee Health

5.8 Post Exposure Evaluation and Follow-up (See Policy Post Exposure to BBF/Sharps HRD-00-127 & BBP Exposure Protocol HRD 00101))

5.8.1 If exposure occurs, employee is to render first aid (clean wound/flush area), report injury to the immediate supervisor/house supervisor, complete the work injury packet, and report to Emergency Room for evaluation and possible collection of HBV, HCV and ,HIV.

5.8.2 Procedures for Evaluating Exposure Incident

5.8.2.1 Employee Health will review the circumstances of all exposure incidents to determine

5.8.2.1.1 Engineering Control Use

5.8.2.1.2 Work Practices followed

5.8.2.1.3 Device Description

5.8.2.1.4 PPE Use

5.8.2.1.5 Procedure being performed

5.8.3 Sharp Injury Log (see Policy Sharp Injury Log HRD-11119))

5.8.3.1 Is kept and maintained by Employee Health

5.9 Recordkeeping

5.9.1 Training Records

5.9.1.1 All employees who have occupational exposure to BBP will receive training on bloodborne pathogen exposure control.

5.9.1.2 Training records will be kept by the education department

5.9.2 Medical Records

5.9.2.1 Confidential exposure medical records will by kept by employee health. These confidential records must be kept for the duration of employment plus 30 years.

5.9.3 OSHA Record Keeping

5.9.3.1 If an exposure incident meets OSHA's recordkeeping requirements, it will be logged into IVHD OSHA log.

6.0 References:

6.1 CAL/OSHA and NIOSH, Calif. Code of Regulations: Title 8, Division 1, Chpt. 4, Subchapter 7, Group 16, Art. 109, 5193, http://www.dir.ca.gov/title8/5193.html

6.2 Sharp Injury Log HRD-11119

6.3 Bloodborne Pathogen Exposure Protocol HRD- 00101

6.4 Post Exposure to Blood and Body Sharps HRD-00127

6.5 Hazardous Materials and Waste Management Plan EOC-00111

6.6 Hepatitis B Vaccination Program HRD-00109

7.0 Attachment List:

7.1 Attachment A – Exposure Risk by Job Title

8.0 Summary of Revisions:

8.1 Added Attachment A- Exposure Risk by Job Title

8.2 Added section 5.7, Hep B vaccine with referral to Hep B policy

8.3 Added section 5.8 Post Exposure with refence to policy
8.4 Added Reference to Hazardous Materials and Waste Management Plan

JOB TITLE	HOME DEPARTMENT	EXPOSURE CATAGORIE
003 - Director Patient Acct-Reg	008530 - Patient Accounting	NP
008 - Director Clinical Lab Ser	007500 - Clinical Lab	C
009 - Radiology Manager	007630 - Radiology Diagnostic	O
010 - Director Health Info Mgmt	008700 - Medical Records	O
0102 - Lead Clinical Manager	006010 - ICU	C
0105 - Clin Nurse Ed - Lead CM	006170 - Medical - Surgical	C
0106 - Facilites Manager	008460 - Engineering	O
0107 - Human Resources Manager	008650 - Human Resources	NP
0110 - Phlebotomy Manager	007500 - Clinical Lab	C
0120 - TJC Program Manager	008720 - Nursing Administration	F
0129 - Accounting Manager	008510 - General Accounting	NP
013 - Director Child Care	008880 - Child Care	F
0131 - Sterile Processing Mgr	008380 - Sterile Processing	C
0136 - Maintenance Sup -DPNF	006580 - Skilled Nursing Care	O
0137 - Marketing Director - DPNF	006580 - Skilled Nursing Care	NP
0138 - Dir of Rehab - DPNF	006580 - Skilled Nursing Care	O
0141 - Business Office Mgr DPNF	006580 - Skilled Nursing Care	NP
0143 - Dir of Nutritional - DPNF	006580 - Skilled Nursing Care	NP
0144 - Social Serv Supervisor- DPNF	006580 - Skilled Nursing Care	O
0145 - Medical Records Sup-DPNF	006580 - Skilled Nursing Care	NP
0146 - Activities Coord DPNF	006580 - Skilled Nursing Care	F
0152 - Executive Director SNF	008610 - Hospital Administration	O
016 - Director Material Mgmt	008400 - Purchasing	NP
017 - Controller	008510 - General Accounting	NP
0180 - Clerk of the Board	008650 - Human Resources	NP
020 - Dir Medical Staff Service	008710 - Medical Staff	NP
023 - Director Physical Therapy	007770 - Physical Therapy	F
026 - Chief Financial Officer	008610 - Hospital Administration	NP
051 - RN Manager	006290 - Pediatrics	C
052 - House Supervisor RN	008720 - Nursing Administration	C
053 - Lead House Supervisor RN	008720 - Nursing Administration	F
054 - Chief Nursing Officer	008720 - Nursing Administration	O
064 - Information Tech Manager	008480 - Information Systems	NP
067 - Director of Perinatal Ser	008720 - Nursing Administration	O
069 - BioMedical Coord	008470 - Communications	NP
072 - Clinical Manager-Educator	006010 - ICU	C
0728- Administrative Nursing Manager	8720	O
074 - Dir Nutrition Services	008340 - Dietary	NP
0903 - Construction Manager	008460 - Engineering	O
0913 - Director of Cardio	007720 - Inhalation Therapy	O
0917 - Director of Facility Services	008460 - Engineering	0
092 - Director Case Management	008750 - Continuum of Care	O
0921 - Safety-EMS-ER Prep Mgr	008420 - Security	F
0922 - EVS Manager	006580 - Skilled Nursing Care	F
0924 - Chief of Clinic Operation	007189 - Clinic Administration	O
0927 - OR Manager	007420 - Surgery and Recovery	F
0928 - Director of MedSurg and	008720 - Nursing Administration	O

CODES	
NP	Not Present
O	Occasionally
F	Frequently
C	Constantly

0929 - Professional Billing Mgr	007189 - Clinic Administration	NP
0930 - Director of Cath Lab and Per	008720 - Nursing Administration	O
096 - Director of Emergency Dep	007010 - Emergency Room	O
098 - Chief Executive Officer	008610 - Hospital Administration	NP
1005 - Speech Language Pathologi	007780 - Speech Therapy	F
1008 - LIS Manager	007520 - Pathology Lab	C
102 - Perinatal Scrub Technician	006400 - LDRP	C
103 - Clinical Lab Scientist	007500 - Clinical Lab	C
105 - Radiologic Technologist	007630 - Radiology Diagnostic	O
1058 - RN Float Pool	008730 - Nursing Float Pool	C
1100 - RN Educator	006010 - ICU	C
1115 - Clinical System Developer	008480 - Information Systems	NP
1118 - Billing-Comp-Pharmacy Tec	008390 - Pharmacy	NP
1120 - Histology Technician	007520 - Pathology Lab	C
1122 - Integration Coordinator	008480 - Information Systems	NP
1126 - Clinical Documentation Sp	008750 - Continuum of Care	O
1128 - Risk Manager	008752 - Risk Management	O
1131 - BLS Instructor	008740 - Inservice Education	O
1134 - Sterile Processing Tech	008380 - Sterile Processing	C
1136 - Anesthesia Technician	007420 - Surgery and Recovery	C
1149 - Pharmacy Tech-HUC	007010 - Emergency Room	NP
1151 - RN Case Manager	008750 - Continuum of Care	O
1152 - Radiological-Surg Tech	007630 - Radiology Diagnostic	C
1154 - Infection Control Practit	008751 - Infection Control	O
1156 - Infect Disease Pharmacist	008390 - Pharmacy	NP
1158 - Interventional Rad-Cardiac Catheterization Te	007649 - Interventional Radiology	C
116 - Teacher Day Care	008880 - Child Care	F
1161 - Emergency Dept Tech	007010 - Emergency Room	C
1166 - System Administrator	008480 - Information Systems	NP
1167 - Pharmacist MDP Coord	008390 - Pharmacy	NP
117 - Pharmacist	008390 - Pharmacy	NP
1171 - Lead CT Tech	007680 - Radiology EMI	C
1172 - Training Development Mgr	008650 - Human Resources	NP
1174 - Lead Technician Maint	008460 - Engineering	O
1175 - Endoscopy Tech	007420 - Surgery and Recovery	C
1176 - Surgery Scheduler	007420 - Surgery and Recovery	NP
1177 - MA-Intake Clerk	007183 - Pioneers Health Ctr	NP
1181 - Lead Patient Op Reg Clerk	008560 - Admitting	O
1182 - Lead CLS-QA Specialist	007500 - Clinical Lab	C
1185 - Surgery Tech I	007420 - Surgery and Recovery	C
1188 - Boiler Plant Operator	008460 - Engineering	O
119 - Medical Social Worker	008750 - Continuum of Care	O
1194 - Network Technician	008480 - Information Systems	NP
1195 - Core Abstraction Peer Rev	008754 - Quality Management	NP
1196 - Lead Mammography Tech	007630 - Radiology Diagnostic	C
1197 - OR Scrub Technician	007420 - Surgery and Recovery	C
1266 - Jr System Administrator	008480 - Information Systems	NP
134 - Physical Therapist Staff	007770 - Physical Therapy	F
136 - Physical Therapy Assistant	007770 - Physical Therapy	F

145 - Senior Accountant	008510 - General Accounting	NP
160 - Case Manager - LVN	008750 - Continuum of Care	O
162 - Pharmacy Tech I	008390 - Pharmacy	NP
164 - Pharmacy Tech II	008390 - Pharmacy	NP
165 - Lead Ultrasound Tech	007670 - Radiology Ultrasound	O
167 - 340B Analyst	008390 - Pharmacy	NP
170 - Lead Clinical Lab Scienti	007500 - Clinical Lab	C
173 - Lead Telemetry Technician	006010 - ICU	C
176 - Echocardiogram Tech	007590 - ECHO	O
180 - Ultrasound Technician	007670 - Radiology Ultrasound	O
188 - Mammography Tech RT	007670 - Radiology Ultrasound	C
195 - Registered Dietitian	008340 - Dietary	NP
196 - Diagnostic Technician	007560 - EKG	O
197 - Surgery Tech II	007420 - Surgery and Recovery	C
199 - Pharmacy Buyer-Inventory Specialist	008390 - Pharmacy	NP
201 - RN MED-SURG	006170 - Medical - Surgical	C
2025 - Cath Lab-IR Scrub Tech	007649 - Interventional Radiology	C
206 - RN Permittee	006010 - ICU	C
209 - Radiology-ER Nurse	007630 - Radiology Diagnostic	C
210 - Lactation Consultant RN	006400 - LDRP	C
213 - RN III	006010 - ICU	C
214 - RN I	006010 - ICU	C
217 - RN II	006010 - ICU	C
219 - RN I Oncology	007640 - Infusion Therapy Center	C
220 - Clinic RN I	007188 - C-WHAP Clinic	F
221 - Transition of Care RN	008750 - Continuum of Care	C
225 - Nurse Intern	006170 - Medical - Surgical	C
227 - Antenatal Test Nurse	006400 - LDRP	C
230 - Newborn Hearing Screening	006400 - LDRP	F
231 - RN DPNF	006580 - Skilled Nursing Care	C
232 - Student Nurse Intern	008720 - Nursing Administration	C
233 - Interim Base Station Ad	008475 - Radio Room	C
234 - RN I DPNF	006580 - Skilled Nursing Care	C
235 - Nurse Residency Program C	008720 - Nursing Administration	O
238 - Community Health Worker	007194 - Cal AIM Grant	F
250 - Cath-IR Lab Registered Nurse II	007649 - Interventional Radiology	C
251 - Perioperative Services Registered Nurse II	007420 - Surgery and Recovery	C
271 - Perioperative Services Registered Nurse I	007420 - Surgery and Recovery	C
2800 - Clinic Lead	007186 - Peds RHC Main	F
301 - LVN	006170 - Medical - Surgical	C
307 - Clinic LVN	007183 - Pioneers Health Ctr	F
312 - LVN CDP DPNF	006580 - Skilled Nursing Care	C
392 - CNA DPNF	006580 - Skilled Nursing Care	C
401 - Nurse Assistant	006170 - Medical - Surgical	C
402 - Distribution Associate	008400 - Purchasing	O
403 - Phlebotomist	007500 - Clinical Lab	C
406 - Medical Assistant I	007183 - Pioneers Health Ctr	F
407 - Dept Aide Transporter	007630 - Radiology Diagnostic	C

410 - Physical Therapy Aide	007770 - Physical Therapy	F
411 - Dept Aide Radiology	007630 - Radiology Diagnostic	F
424 - Medical Assistant II	007183 - Pioneers Health Ctr	F
427 - Nurse Asst-Health Unit Cl	006170 - Medical - Surgical	C
428 - Employee Health Assistant	008660 - Employee Health	F
435 - Lab Tech Support Assoc	007500 - Clinical Lab	C
442 - Medical Assistant III	007083 - Calexico Rural Health Ctr	C
443 - CNA	006170 - Medical - Surgical	C
444 - Medical Assistant-Scribe	007191 - WHAP	F
5001 - Control Clerk HIM Tech III	008700 - Medical Records	O
5002 - Assistant To CNO	008720 - Nursing Administration	NP
501 - Secretary	007420 - Surgery and Recovery	C
5022 - Lead Recept-Aide	007770 - Physical Therapy	F
5027 - Intake Registration Clerk	007189 - Clinic Administration	NP
503 - Transcriptionist II	008700 - Medical Records	O
5031 - Fin-Chg Master Analyst	008530 - Patient Accounting	NP
5032 - Scanning-Customer Assist	008700 - Medical Records	NP
5034 - Record Copy Serv-Release	008700 - Medical Records	O
5035 - Quality Data-Project Mgr	008754 - Quality Management	O
5036 - Supply Chain Technician	008380 - Sterile Processing	C
5037 - Lead Office Coordinator	008560 - Admitting	NP
5038 - Administrative Assistant	008710 - Medical Staff	NP
5040 - Benefits Coordinator	008650 - Human Resources	NP
5044 - HR Generalist	008650 - Human Resources	NP
5047 - Accounts Rec Billing Lead	008530 - Patient Accounting	NP
5051 - HR Assistant	008650 - Human Resources	NP
5052 - Anesthesia Assistant Clerk	007450 - Anesthesia	O
5054 - Billing File Clerk	008530 - Patient Accounting	NP
5057 - Mat Mgmt Storeroom Coord	008400 - Purchasing	O
5059 - Support Services Coord	008460 - Engineering	NP
506 - Health Unit Clerk	006070 - Neo-Natal ICU	C
5062 - PT Experience Concierge	008754 - Quality Management	NP
5063 - Hospital Centralized Scheduling Call Center I	008560 - Admitting	C
5066 - PT Registration Float	008560 - Admitting	NP
5069 - CC Intake-Referral Auth	007189 - Clinic Administration	NP
507 - Material Management Clk-B	008400 - Purchasing	NP
5070 - Intake-Scribe	007197 - Urology Center	NP
5072 - Activities Asst DPNF	006580 - Skilled Nursing Care	F
5074 - Central Supply DPNF	006580 - Skilled Nursing Care	NP
5075 - CNA DPNF	006580 - Skilled Nursing Care	C
5076 - Cook DPNF	006580 - Skilled Nursing Care	O
5077 - Dietary Aide DPNF	006580 - Skilled Nursing Care	O
5079 - Housekeeping Lndry DPNF	006580 - Skilled Nursing Care	F
508 - Accounts Payable Clerk I	008510 - General Accounting	NP
5081 - Medical Records DPNF	006580 - Skilled Nursing Care	NP
5082 - Bus Office Asst DPNF	006580 - Skilled Nursing Care	NP
5084 - PT Asst DPNF	006580 - Skilled Nursing Care	O
5085 - Receptionist DPNF	006580 - Skilled Nursing Care	NP
5086 - Occ Therapist DPNF	006580 - Skilled Nursing Care	F

5087 - Physical Therapist DPNF	006580 - Skilled Nursing Care	F
509 - PBX Operator	008560 - Admitting	O
5093 - Diet Assist Dishwash DPNF	006580 - Skilled Nursing Care	O
5094 - Cert Occ Th Asst DPNF	006580 - Skilled Nursing Care	O
5095 - Admissions Asst DPNF	006580 - Skilled Nursing Care	NP
5096 - ED-CEO Assistant	008610 - Hospital Administration	NP
5097 - Rehab Aide DPNF	006580 - Skilled Nursing Care	F
5101 - Care Management Assistant	008750 - Continuum of Care	O
5104 - Support Services Manager	008460 - Engineering	NP
5105 - HR Recruiter & Engagement Coordinator	008650 - Human Resources	NP
5106 - Facility Support Assist-DPNF	006580 - Skilled Nursing Care	C
5107 - Patient Account Specialist	008530 - Patient Accounting	NP
5108 - Manager of Outpatient Clinics	007189 - Clinic Administration	F
5109 - Manager of Rural Health Clinics	007189 - Clinic Administration	O
5110 - Director NICU and PEDS	008720 - Nursing Administration	O
5112 - Director of RHC	007189 - Clinic Administration	O
5113 - Cardio Diagnostic Services Coordinator	007560 - EKG	O
5114 - Director of Outpatient Clinics	007189 - Clinic Administration	O
5115 - Clinic Call Center Representative	007189 - Clinic Administration	NP
5116 - Medical Biller I	007189 - Clinic Administration	F
5119 - Business Office Manager	008530 - Patient Accounting	NP
5120 - Medical Biller Reviewer	007189 - Clinic Administration	NP
5121 - Population Healthcare Lead	007198 - PRIME	F
513 - Cashier I	008530 - Patient Accounting	NP
5130 - Unit Manager- DPNF	006580 - Skilled Nursing Care	C
5131 - Scheduler DPNF	006580 - Skilled Nursing Care	NP
515 - Patient Registration Cler	008560 - Admitting	NP
517 - Medical Records Clerk	008700 - Medical Records	O
518 - HIM Tech II	008700 - Medical Records	O
521 - HIM Coordinator	008700 - Medical Records	O
524 - Patient Financial Counsel	008530 - Patient Accounting	NP
534 - Office Coordinator	008560 - Admitting	F
537 - Insurance Verifier	008560 - Admitting	F
540 - Transcriptionist III Lead	008700 - Medical Records	O
541 - Certified Coder	008700 - Medical Records	O
542 - Lead Patient Reg Clerk	008560 - Admitting	F
544 - Accounts Payable Coord	008510 - General Accounting	NP
545 - Lead Cashier	008530 - Patient Accounting	NP
560 - Surgery Processor	008560 - Admitting	O
561 - Intake Clerk	007760 - Gastro Intestinal Srvcs	NP
565 - Coder I	008700 - Medical Records	O
566 - Exec Asst To CFO-Payroll	008510 - General Accounting	NP
572 - Medical Staff Coord	008710 - Medical Staff	NP
5732 - Director of Patient Access Centralized Regist	008560 - Admitting	C
5733 - Senior Director of Revenue Cycle	008510 - General Accounting	NP
5734 - Ambulatory Centralized Reg-Scheduling Manager	007189 - Clinic Administration	C
5735 - Infection Control Data Abstractor LVN	008751 - Infection Control	O

5736 - OP IP Centralized Reg Scheduling Manager	008560 - Admitting	C
5739 - Clinical Manager-NICU	006070 - Neo-Natal ICU	C
5740 - Lead Care Manager	007194 - Cal AIM Grant	F
5742 - PATIENT CARE TECHNICIAN	006170 - Medical - Surgical	C
5780 - Respiratory Care Practitioner	007720 - Inhalation Therapy	O
5781 - RN NEW GRAD	006170 - Medical - Surgical	C
581 - Cashier II	008530 - Patient Accounting	NP
5880 - RN ICU	006010 - ICU	C
5889 - RN NICU	006070 - Neo-Natal ICU	C
598 - Financial Charges Audit C	008530 - Patient Accounting	NP
601 - Cook	008340 - Dietary	NP
603 - Food Service Associate	008340 - Dietary	NP
604 - Diet Assistant	008340 - Dietary	NP
607 - Environmental Assistant I	008440 - Housekeeping	F
608 - Maintenance Generalist	008460 - Engineering	O
609 - Construction Worker I	008460 - Engineering	O
610 - Maintenance Specialist I	008460 - Engineering	O
614 - Environment Assistant II	007420 - Surgery and Recovery	F
617 - Receiving Lead	008400 - Purchasing	NP
621 - Dishwasher	008340 - Dietary	O
623 - Dietary Floater	008330 - Cafeteria and Coffee Shop	NP
626 - Maintenance Specialist II	008460 - Engineering	O
629 - Construction III -Painter	008460 - Engineering	O
630 - Dept Aide - EVS	008440 - Housekeeping	F
631 - Lead EVS Assistant	008440 - Housekeeping	F
632 - Nutritional Serv Assoc I	008340 - Dietary	NP
633 - Nutritional Serv Supervis	008340 - Dietary	NP
636 - Cafeteria Assistant	008330 - Cafeteria and Coffee Shop	NP
638 - Lead Cook	008340 - Dietary	NP
641 - Maintenance Assistant DPNF	006580 - Skilled Nursing Care	O
650 - Floor Technician	008440 - Housekeeping	O
8001 - RN ER	007010 - Emergency Room	C
801 - Nurse Practitioner	007083 - Calexico Rural Health Ctr	C
802 - Physician Assistant	007083 - Calexico Rural Health Ctr	F
805 - Certified Nurse MidwifeNP	007191 - WHAP	C
8050 - RN OB	006400 - LDRP	C
902 - Director of Imaging	007630 - Radiology Diagnostic	C
914 - Manager of Case Mgmt	008750 - Continuum of Care	O
987 - RN Couplet Care	006400 - LDRP	C
988 - Pyxis Architect	008390 - Pharmacy	NP
990 - Lead Radiology Tech	007630 - Radiology Diagnostic	C
990 - Lead Radiology Tech	007630 - Radiology Diagnostic	F
991 - Employee Health Nurse RN	008660 - Employee Health	O
994 - Clinical IS Spec II	008480 - Information Systems	NP
997 - Bio Med Tech	008470 - Communications	NP
998 - Telemetry Technician	006010 - ICU	C

IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD MEETING DATE: September 2026

SUBJECT: Multi-year agreement with Cepheid

BACKGROUND: Cepheid provides molecular testing solutions for IVHD-PMH patients i.e. Flu A/B, RSV and COVID combo, Chlamydia/gonorrheae, Streptococcus A/B, C. difficile. Current agreement offers discounted pricing (GPO-HPG) and expires in September 2026. The vendor has agreed to keep the discounted prices with the renewal agreement. This also includes new additional analyzer (GeneXpert-16 modules) placement instrument with hardware and service provided at no charge for duration of term to support additional volume and new tests i.e. Vaginitis Panel. New minimum annual reagent commitment is $392,760; annual spend is $945,667 (2025).

KEY ISSUES:

- This is an instrument rental agreement for Pioneers Memorial Hospital which will replace the existing HealthTrust agreement.
- Expired agreement with previous GPO, will incur higher cost of supplies based on the new GPO (Premier) pricing.

CONTRACT VALUE: $945,667 (annual spend-2025)

CONTRACT TERM: 3 years

BUDGETED: Yes

BUDGET CLASSIFICATION: Supplies

RESPONSIBLE ADMINISTRATOR: Carly Zamora, Interim CEO

DATE SUBMITTED TO LEGAL: _____ **REVIEWED BY LEGAL:** ☐ Yes ☐ No

FIRST OR SECOND SUBMITTAL: ☐ 1st ☐ 2nd

RECOMMENDED ACTION: Approve renewal of agreement.

REAGENT RENTAL AGREEMENT
Cover Page

Customer:
Name: Imperial Valley Healthcare District dba Pioneers Memorial Hospital
Principal Place of Business Address:
207 W Legion Rd,
Brawley, CA 92227-7780

Contact:
Name: Annabel Limentang
Email: alimentang@pmhd.org
Phone: 7603513274

GPO; IDN; DISTRIBUTOR (if not listed, N/A):
GPO: N/A
IDN: N/A
Distributor: N/A

Agreement:			**Addenda**:
Contract #:	CON-032711		Instruments and Members Addendum
Effective Date:	Last Signature Date		
Initial Term:	36	months after Effective Date	
Sign by Date:	09-01-2026		

For Cepheid Internal Use:

☐ Blended *SAP ID #:* 1000019662

This agreement is entered into as of the Effective Date by Customer and Cepheid and consists of this Cover Page and the attached General Provisions and exhibits (this "Agreement"). Capitalized terms used but not defined in this Agreement shall have the meanings ascribed to them in this Cover Page.

I.	**Reagent Products**:	Exhibit A attached
II.	**Purchase Commitment**:	$392,760.00 annual Reagent Product spend
III.	**Notices**:	Exhibit B attached
IV.	**Shipping Term**:	FOB Origin
V.	**Payment Term:**	Net 30 days from date of invoice

Customer must sign and return an executed copy of this Agreement to Cepheid on or before the Sign by Date specified in the Cover Page or other date subsequently agreed to by Cepheid. Any blank fields in this Agreement for Contract Number or SAP ID Number may be completed by Cepheid at the time Cepheid executes this Agreement.

IN WITNESS WHEREOF, an authorized representative of each party has executed this Agreement.

CUSTOMER:		**CEPHEID**:	
By	_____	By	_____
Name	_____	Name	_____
Title	_____	Title	_____
Date	_____	Date	_____

EXHIBIT A:
REAGENT PRODUCTS

Part Number	Product Description	# Tests/Kit	Price/Kit
GXCDIFF/EPI-10	KIT,CDIFF/EPI,GX,IVD,10-TEST	10	$300.00
GXCT/NG-10	KIT,CT/NG,GX,IVD	10	$200.00
GXGBSLBXC-10	KIT,10-TEST,GBS,LB,XC,US-IVD	10	$240.00
GXMRSA-NXG-10	KIT,10-TEST,MRSA NXG,IVD,GX	10	$330.00
XPRSMVP-10	KIT,XPRESS,MVP,US-IVD,10 TEST	10	$620.00
XPRSTREPA-10	KIT,XPRESS,STREPA,US-IVD,10 TEST	10	$220.00
XPRS4PLEX-10	KIT,IVD,XPRESS,COV-2/FLU/RSV PLUS,10TEST	10	$680.00
GXBCRABL-US-10	KIT,BCR-ABL ULTRA,US-IVD,10-TEST	10	$1,089.01
GXCARBAR-10	KIT,CARBA-R,IVD,GX	10	$504.34
GXHCV-10	KIT,GX,10-TEST.HCV,US-IVD	10	$324.60
GXFIIFV-US-10	KIT,FII/FV,10-TESTS,GX, US-IVD	10	$544.50
XPRSGBS-10	KIT,10-TEST,GBS,XPRESS,US-IVD	10	$267.74
GXMRSA/SA-BC-10	KIT,MRSA/SA BC,10-TESTS,GX,IVD	10	$598.05
GXMRSA/SA-SSTI-10	KIT,MRSA/SA SSTI,10-TESTS,GX,IVD	10	$691.76
GXMTB/RIF-US-10	KIT,MTB,IVD,US	10	$620.06
GXNOV-10	KIT,GX,10-TEST,NOROVIRUS,US-IVD	10	$504.34
GXSACOMP-10	KIT,SA COMP,10-TESTS,GX,IVD	10	$520.93
GXTV-10	KIT,XPERT TV_US,10-TEST	10	$216.85
GXVANA-10	KIT,VANA,10-TESTS,GX,US-IVD	10	$384.85
XPRSFLU-10	KIT,XPRESS,FLU,US-IVD,10 TEST	10	$414.08
XPRSFLU/RSV-10	KIT,XPRESS,FLU/RSV,US-IVD,10 TEST	10	$539.08
XPRS-COV2-10	KIT,10 TEST,XPRESS COVID PLUS,US-IVD	10	$420.64
GXGI-10	KIT, 10-TEST, GI PANEL, GX, US-IVD	10	$930.00[1]

[1] If Cepheid offers Customer special discounts for Xpert GI Panel (10 tests per kit) (Part #: GXGI-10) via a Sales Quote, and the price in the Sales Quote is lower than the price in this Agreement, Cepheid will continue to honor the Sales Quote, including the lower price, for Customer's eligible orders until the Sales Quote expires.

EXHIBIT B:
NOTICES

Unless otherwise specified in this Agreement, notices under this Agreement must be in writing and hand-delivered, sent by nationally recognized overnight courier, with proof of delivery, or sent by certified mail, return receipt requested, to the other party as follows:

If to Customer:

[Customer]
[Attn: Recipient Name or Dept]
[Address 1]
[Address 2]
[Email Address]

If to Cepheid:

Cepheid
Attn: US Business Operations
904 Caribbean Way
Sunnyvale, CA 94089

with a copy to:

[Customer]
[Attn: Recipient Name or Dept]
[Address 1]
[Address 2]

with a copy to:

Cepheid
Attn: Legal Department
904 Caribbean Way
Sunnyvale, CA 94089

Notice shall be deemed given on the date delivered if hand-delivered, on the date shown on the proof of delivery if sent by overnight courier, and on the date shown on the return receipt if sent by certified mail. A party may change its address for notices by providing the other party with written notice of the change. Notwithstanding anything to the contrary herein, email notices expressly permitted under this Agreement, if any, shall be sent only to the email address above, and notice shall be deemed given one business day after successfully transmitted.

General Provisions

1. PURCHASE COMMITMENT. Customer agrees to purchase the annual Purchase Commitment specified on the Cover Page during each successive twelve (12) month period of the Term, subject to an initial grace period of three (3) months from the Effective Date. The Purchase Commitment will be measured and tracked quarterly. If, based on the aggregate purchases of Reagent Products under this Agreement, Customer is not in compliance with the Purchase Commitment after the end of any quarter, Customer must make up the shortfall during the next quarter. If Customer does not make up the shortfall during that quarter, Cepheid may invoice Customer for a fee equal to the amount Customer was short of meeting the Purchase Commitment ("Shortfall"). If Customer is not in compliance with the Purchase Commitment after the end of any year, Cepheid may contact Customer to place an order for the Shortfall. If Customer does not place the order for the Shortfall within thirty (30) days thereafter, Cepheid may terminate this Agreement due to Customer's Default (defined below).

2. STANDARD TERMS. The terms and conditions available on Cepheid's website (https://www.Cepheid.com/en_US/support/order-management) on the Effective Date (the "Standard Terms") apply to this Agreement, and are hereby incorporated herein by reference.

3. PRICES; PRICE CHANGES.

(i) Purchase Prices. The prices for Reagent Products purchased from Cepheid are listed in Exhibit A (as such prices may be adjusted in accordance with this Agreement, "Prices").

(ii) Price Changes. After the first twelve (12) months of this Agreement, Cepheid may increase any Prices in this Agreement once during each successive twelve (12) month period of the Term by providing Customer with at least 30 days' prior written notice (which may be provided by email). Price increases may apply to all Prices listed in this Agreement at the time of the notice regardless of when a product or service was added and will not exceed 5.00%.

(iii) Changes in Law. Notwithstanding anything to the contrary in this Agreement, Cepheid, acting in good faith, may adjust its prices, charges, and fees to account for increases in its costs of performance not covered by Section 3. (ii) ("Price Changes") above, where such increases are the result of changes in applicable law, rule, or regulation; provided, that, in any such instance, (a) the adjustment or adjustments made by Cepheid are, in the aggregate, proportionate to such increases and, therefore, merely restorative of the parties' essential economic bargain, and (b) upon request, Cepheid shall provide a summary of the changes in law, rule, or regulation giving rise to the adjustment or adjustments.

4. ORDERS FOR PRODUCT PURCHASES.

(i) GPO and/or IDN Affiliation. If a GPO and/or IDN is specified on the Cover Page, the following subsections also apply:

(a) GPO and/or IDN Agreement. If a specific Reagent Product is available for purchase pursuant to a purchasing agreement between Cepheid and the GPO and/or IDN (the "GPO/IDN Agreement"), orders for that Reagent Product are also subject to the applicable terms of the GPO/IDN Agreement. The terms of the GPO/IDN Agreement control with respect to such orders, except for pricing, which remains as set forth in this Agreement. Customer acknowledges that one or more Reagent Products may not be available for purchase pursuant to the GPO/IDN Agreement.

(b) New GPO/IDN Agreement. If the GPO/IDN Agreement becomes inapplicable to orders for any Reagent Product for any reason, including if it expires or terminates, then: (I) if another agreement with the GPO/IDN applies ("New GPO/IDN Agreement"), the New GPO/IDN Agreement will apply to orders for the applicable Reagent Product and replace the GPO/IDN Agreement for purposes of this Agreement; or (II) if no New GPO/IDN Agreement applies, all orders will be governed exclusively by the terms of this Agreement. Customer will promptly notify Cepheid in writing if the GPO/IDN Agreement becomes inapplicable for any reason, including if Customer stops participating under the GPO and/or IDN Agreement.

5. PRODUCT CHANGES. Cepheid reserves the right to discontinue any product. If Cepheid discontinues any product listed in this Agreement, Cepheid will inform Customer as far in advance as reasonably possible and offer Customer a substitute product of similar functionality as the affected product if available ("Substitute Product"). Cepheid may elect to offer a substitute product through a sales quote. In such cases, Customer will submit an order pursuant to the sales quote. Upon Cepheid's acceptance of the initial order for the substitute product, the substitute product and corresponding price in the sales quote will be deemed added to this Agreement, and no further amendment will be needed.

6. TERM. The term of this Agreement commences on the Effective Date, and unless earlier terminated in accordance with its terms or extended by mutual written agreement of the parties, will remain in effect for the Initial Term (the "Term").

7. DEFAULT; TERMINATION. The following will be deemed a "Default" under this Agreement: (a) a party ceases to do business or receivership or insolvency proceedings are instituted by or against it; (b) a party materially breaches this Agreement and fails to cure such breach within thirty (30) days after the other party provides it with written notice of the breach; or (c) Customer fails to place an order for any Shortfall within the time required by this Agreement. Upon Default by a party, the other party may terminate this Agreement upon written notice to the Defaulting party. Notwithstanding the foregoing, either party may terminate this Agreement at any time, without cause, by providing the other party with at least sixty (60) days' prior written notice of such termination; provided, however, that Customer may exercise this right to terminate the Agreement without cause if it is in compliance with the Purchase Commitment as of the date of termination.

8. CONFIDENTIAL INFORMATION. The parties agree to keep the terms of this Agreement (other than any online terms incorporated by reference) confidential. Neither party will: (i) use such information for any purpose other than to perform under this Agreement, for its internal reporting purposes, or to comply with applicable law ("Purpose"); or (ii) disclose such information to any third party, other than to its affiliates, employees, auditors, attorneys, and regulators that have a need to know for the Purpose and are subject to obligations to hold the information in strict confidence and not to use it for any reason other than the Purpose or disclose the information to any third party. A party will be responsible for any improper use or disclosure by anyone to whom it discloses such information. Notwithstanding the foregoing, the parties acknowledge and agree that Customer is a public entity subject to the California Public Records Act ("CPRA"). To the extent Customer receives a request under the CPRA for disclosure of any information that Cepheid has designated as confidential, Customer shall, to the extent permitted by law, provide Cepheid with prompt written notice of such request prior to disclosure. Cepheid may, at its sole expense, seek a protective order or other appropriate remedy to prevent disclosure. If Cepheid fails to obtain such protective order or other remedy within the time required for Customer to respond to the request, Customer may disclose the requested information to the extent required by the CPRA without liability to Cepheid. Cepheid acknowledges that Customer's obligations under the CPRA supersede any conflicting confidentiality obligations set forth in this Agreement, and nothing in this Agreement shall be construed to prevent Customer from complying with the CPRA or any other applicable public records law.

9. MEMBERS.

a. Member Participation. If applicable, Customer and Customer's owned, operated, and/or affiliated facilities listed in any attached Addenda ("Members") may acquire products and services pursuant to this Agreement. If Members are designated as "Distribution Member" or similar, such Members will purchase Reagent Products from the Distributor specified on the Cover Page (if any). Members may be added or removed from Exhibit A upon: (a) amendment by the parties; or (b) written notice by Customer to Cepheid, which notice must be on Customer's letterhead and signed by an authorized representative of Customer. Customer represents and warrants that it: (a) has the requisite authority to represent and bind each Member for purposes of the Member's participation under this Agreement; and (b) will ensure that each Member complies with the applicable terms of this Agreement.

b. Enforceability of Terms. By acquiring products or services under this Agreement, Members agree to be bound by the terms of this Agreement without exception or modification. Such Members are intended third-party beneficiaries to this Agreement, and Cepheid will have the right to enforce its terms as if such Members had originally signed this Agreement. There are no other third-party beneficiaries to this Agreement.

10. PRIOR AGREEMENTS. This Agreement constitutes the entire agreement between the parties concerning the subject matter hereof and supersedes all prior written and oral agreements, representations, and understandings between the parties concerning such subject matter, including the Placed Equipment Agreement (the "Prior Agreement") between Pioneer Memorial

Hospital and Cepheid, with an effective date of November 19, 2025.

INSTRUMENTS AND MEMBERS ADDENDUM

This addendum (this “Addendum”) is entered into by Imperial Valley Healthcare District dba Pioneers Memorial Hospital (“Customer”) and Cepheid as of the Effective Date of the Agreement (defined above). This Addendum supplements and modifies the Reagent Rental Agreement to which it is attached (the “Agreement”) and is incorporated into and made a part thereof. Capitalized terms used but not defined herein shall have the meanings ascribed to them in the Agreement. In the event of any conflict between the terms of the Agreement and those of this Addendum, the terms of this Addendum shall control.

1. Placed Instruments. Cepheid will supply Customer with the Cepheid-owned GeneXpert instruments and instrument accessories specified on Exhibit A (and other instrument accessories Cepheid determines, in its discretion, are required to support the use of Cepheid products) for use by Customer during the Term of the Agreement at the specified locations. Instruments may not be relocated from their installed locations without Cepheid’s written agreement. Instruments are warranted in accordance with Cepheid’s standard twelve (12) month limited warranty and will be new or “Certified Pre-Owned” (“CPO”), as determined in Cepheid’s discretion at the time of shipment. Part numbers and product descriptions for new versus CPO Instruments may differ. Instruments remain the sole and exclusive property of Cepheid at all times (unless title is transferred). Customer and third parties will have no right, title, or interest in or to the Instruments, except as expressly provided in the Agreement.

2. Post-Warranty Instrument Service. If indicated in the attached Exhibit A, Cepheid will provide service coverage for each Instrument from the expiration of the Instrument’s twelve (12) month warranty through the end of the Term. If Exhibit A does not indicate that service is included, Customer must purchase a Service Plan to cover each Instrument from the expiration of the Instrument’s twelve (12) month warranty through the end of the Term.

3. Instrument Care and Use. Customer agrees to: (i) use the Instruments only at their approved locations and only to run Cepheid reagent tests; and (ii) use and maintain the Instruments in good condition and working order in accordance with their applicable labeling, inserts, and manuals, and other product-related information and materials published by Cepheid or any regulatory authority. Customer must not, directly or indirectly, including by allowing any third party to: (a) move, part with possession of, modify, repair, rent, lease, license, loan, sell, transfer, mortgage, pledge, encumber, decompile, disassemble, or reverse engineer the Instruments, including their hardware, software, or firmware; (b) abuse, neglect, or otherwise misuse the Instruments; or (e) modify or remove any labels, symbols, serial numbers, or other indicia of Cepheid ownership affixed to or appearing on the Instruments. Promptly upon request by Cepheid, Customer must inform Cepheid of the location of any Instrument. Customer must also provide Cepheid with prompt access during normal business hours and other reasonable assistance so Cepheid can provide instrument or warranty service or inspect any Instrument.

4. Instrument Loss or Damage. Upon delivery of the Instruments and until returned to Cepheid in accordance with the terms of the Agreement or title is transferred to Customer, Customer assumes and will bear the risk of all loss or damage to the Instruments (other than for reasonable wear and tear resulting from Customer’s proper use (“Wear and Tear”) or any loss or damage caused by Cepheid). Cepheid reserves the right to invoice Customer for: (i) the replacement value of an Instrument or the cost of its repair (at Cepheid’s then-current rates) for such loss or damage, including if discovered within a reasonable time after the end of the Term, or if Customer fails to comply with the Instrument return requirements in the Agreement; or (ii) a restocking fee of $2,000 per module if Customer refuses, prevents, or delays delivery or installation of an Instrument or is permitted to return or exchange an Instrument during the Term, except as caused by Cepheid. Customer must inform Cepheid immediately upon becoming aware of any loss or damage to an Instrument.

5. Instrument Returns. Within fifteen (15) days after any expiration or termination of the Agreement or a request by Cepheid following a Default by Customer, Customer must return all Instruments to Cepheid in the condition in which originally delivered, Wear and Tear and any loss or damage caused by Cepheid excepted. Customer agrees to comply with all reasonable return instructions provided by Cepheid. If Customer returns any equipment to Cepheid for any reason, Customer will ensure that it saves any data it wishes to retain, and removes and deletes all data from such equipment, prior to its return. Customer understands and agrees that Cepheid may delete any data remaining on returned equipment and shall have no responsibility or liability with respect to such data.

6. Cepheid C360. By signing this Addendum or the agreement to which it is attached, Customer also agrees to the Cepheid C360 Terms and Conditions, available on Cepheid's website (https://www.cepheid.com/en_US/systems/Connectivity/Cepheid-C360) (the "C360 Terms"), for the use of **Cepheid's C360 Support and Analytics software** ("C360 Software"). Notwithstanding anything to the contrary in the Agreement, the C360 Terms shall not constitute part of the Agreement and are and shall remain a separate and distinct agreement between the parties. During the Term, Customer shall: (i) not terminate the C360 Terms; and (ii) shall ensure all Instruments remain connected to C360 Software as of the date this Addendum becomes effective, continuously uploading the required data. For all Cepheid products delivered to Customer pursuant to the Agreement ("Delivered Products"), Customer shall transmit/upload to C360 Software and provide Cepheid with the necessary data, including data sub-categories, as described in the C360 Terms (the "Data Upload Requirement") to enable proper operation of the C360 Software. The Data Upload Requirement shall include tests conducted with all Delivered Products, including those conducted prior to the C360 Terms becoming effective. The provisions of this section shall supersede and prevail over any conflicting provisions in the C360 Terms, including, without limitation, any provision allowing Customer to terminate the C360 Terms during the Term or which conflict with the Data Upload Requirement, except when Cepheid makes unilateral and materially adverse changes to the C360 Terms or the C360 Software. In the event of such unilateral materially adverse change, the Customer may cease use of the C360 Software or terminate the C360 Terms. If Cepheid supplies Customer with any additional Instruments in order to support Customer's use of the C360 Software, such as a Wi-Fi adapter, Customer agrees that it shall use and return such Instruments in accordance with the terms of this Agreement.

EXHIBIT A:
INSTRUMENTS AND MEMBERS

INSTRUMENT SUMMARY		
☒ Post-warranty Instrument service is included at no additional charge		
Part Number	**Instrument Description**	**Total Qty**
GXXVI-16-TSK	GX XVI, 16 MODULES, TOUCHSCREEN KIOSK	2
GX-UPS-110V	UPS FOR GX1 UP TO GX16 SYSTEMS, 110V	2
PRINTER-BW	B&W PRINTER FOR GENEXPERT AND SMARTCYCLE	2

INSTRUMENTS BY LOCATION				
SAP ID	**SITE NAME**	**CITY, STATE**	**PLACED INSTRUMENT PART #**	**QTY**
1000019662	Pioneer Memorial Hospital	Brawley, CA	GXXVI-16-TSK*	1
			GX-UPS-110V*	1
			PRINTER-BW*	1
			GXXVI-16-TSK	1
			GX-UPS-110V	1
			PRINTER-BW	1

***** Instruments placed under the Prior Agreement.

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RESOLUTION NO. 2026-0910

A RESOLUTION OF THE IMPERIAL VALLEY HEALTHCARE DISTRICT BOARD OF DIRECTORS ANNOUNCING AN OFFICIAL POSITION OF SUPPORT FOR MEASURE N, MAINTAINING LOCAL HOSPITAL AND EMERGENCY HEALTHCARE SERVICES MEASURE

WHEREAS, the Imperial Valley Healthcare District ("**IVHD**" or the "**District**") was formed pursuant to Assembly Bill 918 (Chapter 549, Statutes of 2023), adding Chapter 11 (commencing with Section 32499.5) to Division 23 of the Health and Safety Code, establishing a local health care district designated as the Imperial Valley Healthcare District within the County of Imperial, and IVHD owns and operates Pioneers Memorial Hospital; and

WHEREAS, IVHD has executed an asset transfer agreement with the City of El Centro and El Centro Regional Medical Center to acquire El Centro Regional Medical Center and all of its related healthcare facilities, which transaction is anticipated to close in or around October 2026; and

WHEREAS, Pioneers Memorial Hospital and El Centro Regional Medical Center are the only two hospitals in Imperial County, and in 2023, both hospitals received Distressed Hospital Loans from the State of California, demonstrating the dire financial situation the two hospitals are facing; and

WHEREAS, Senate Bill 1070 (2024) legally obligated the IVHD Board of Directors to recommend a permanent funding source mechanism to be presented to voters via ballot measure by no later than the November 2026 election; and

WHEREAS, in March 2026, an independent third-party consultant presented a debt capacity analysis to IVHD, identifying a range of tax revenue needed to support IVHD's healthcare facilities from $7 million to $12.5 million annually, depending on the size of a future seismic improvement project; and

WHEREAS, on June 25, 2026, the Board of Directors adopted Resolution No. 2026-0625A, calling for a general election to be consolidated with the Statewide General Election on November 3, 2026, for the purpose of submitting to the qualified voters of the District a ballot measure proposing the imposition of an annual special parcel tax to provide for the continued operation and maintenance of the District's hospitals and associated services, which has been designated by the County of Imperial as Measure N; and

WHEREAS, Measure N, which the Board of Directors has referred to the voters of the District, would impose an annual special parcel tax of $111.00 per parcel on all taxable parcels of real property within the District, estimated to produce approximately $8.9 million annually; and

WHEREAS, if approved by the voters, the proceeds of the special tax shall be used exclusively to (1) maintain local access to advanced, life-saving emergency medical care, (2)

fund ongoing hospital operations and maintenance, including the acquisition of up-to-date medical technology and equipment, (3) achieve an expansion of healthcare services, including improved cancer and heart care, and expanded pediatric and children's health services, (4) ensure the hospitals have qualified doctors and nurses, and (5) achieve a financial position that will allow the District to finance seismic upgrades necessary to meet earthquake safety standards required by law; and

WHEREAS, without a dedicated, voter-approved funding source, the District's hospitals face the risk of service reductions, quality-of-care decline, or potential closures, and in the event of a closure, patients who are not able to receive medical care locally would have to travel approximately 2.5 hours to cities like San Diego or Riverside; and

WHEREAS, California Code of Regulations, title 2, section 18420.1, subdivision (e)(2), provides that the announcement of an agency's position at a public meeting or within the agenda or hearing minutes prepared for the meeting is not considered a contribution or an independent expenditure, and Government Code section 54964, subdivision (c), provides that a local agency may expend funds to provide information to the public about the possible effects of a ballot measure on the activities, operations, or policies of the local agency if the information constitutes an accurate, fair, and impartial presentation of relevant facts; and the Board of Directors, having reviewed the terms and potential effects of Measure N on the District's operations and the communities it serves, desires to state its official position for the public record.

WHEREAS, the Board of Directors, having reviewed the terms and potential effects of Measure N on the District's operations and the communities it serves, desires to state its official position for the public record.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of Imperial Valley Healthcare District as follows:

SECTION 1. FINDINGS

The Board of Directors finds and determines the following:

a) Measure N, if approved by voters, would provide approximately $8.9 million in annual revenue dedicated exclusively to hospital services, operations, maintenance, technology, expanded healthcare services, recruitment and retention of qualified medical professionals, and financing of legally required seismic upgrades.

b) Without a dedicated, voter-approved funding source, the District's hospitals face the risk of service reductions, quality-of-care decline, or potential hospital closures, which would require Imperial Valley patients to travel hours to cities such as San Diego or Riverside for medical care.

c) Measure N includes accountability provisions, including an annual independent audit and annual reporting to the Board of Directors on all funds collected, expended, and projects funded.

SECTION 2. ANNOUNCEMENT OF OFFICIAL POSITION OF SUPPORT

The Board of Directors of Imperial Valley Healthcare District hereby announces, for the public record, support for Measure N. It is the official position of the Board that Measure N serves the operational needs of the District, addresses the critical healthcare infrastructure needs of Imperial County, and is in the best interest of the communities the District serves.

SECTION 3. DIRECTION TO RECORD POSITION

The Secretary of the Board of Directors is directed to cause this Resolution to be entered into the minutes of the meeting at which it is adopted and to make it available for public inspection as part of the official records of the District.

SECTION 4. NO EXPENDITURE OF PUBLIC FUNDS FOR CAMPAIGN PURPOSES

Nothing in this Resolution shall be construed as authorizing or directing the expenditure of District funds to support or oppose the approval or rejection of Measure N in a manner prohibited by Government Code section 54964, Government Code section 8314, or any other applicable law. This Resolution reflects only the Board's official position adopted at a duly noticed public meeting.

SECTION 5. EFFECTIVE DATE

This Resolution shall take effect immediately upon its adoption.

IT IS SO RESOLVED. Passed and adopted by the Board of Directors of the Imperial Valley Healthcare District at a regular meeting held on September 10, 2026.

_____

Katherine Burnworth
President of the Imperial Valley Healthcare District Board of Directors

ATTEST:

_____

Enola Berker
Secretary of the Imperial Valley Healthcare District Board of Directors

SECRETARY'S CERTIFICATE

I, Enola Berker, Secretary of the Board of Directors of Imperial Valley Healthcare District, a California healthcare district, County of Imperial, California, attest and certify as follows:

The attached is a full, true, and correct copy of Resolution No. 2026-0910 duly adopted at the regular meeting of the Board of Directors of Imperial Valley Healthcare District, which was duly held on September 10, 2026, at which meeting a quorum of the members of the Board of Directors were present; and at such meeting such resolution was adopted by the following vote:

YES:

NO:

ABSTAIN:

ABSENT:

I have carefully compared the same with the original minutes of such meeting on file and of record in my office; the attached resolution is a full, true and correct copy of the original resolution adopted at such meeting and entered in such minutes; and such resolution has not been amended, modified, or rescinded since the date of its adoption, and the same is now in full force and effect.

WITNESS my hand this 10th day of September 10, 2026.

_____

Secretary of the Imperial Valley Healthcare District Board of Directors