SIERRA VISTA HOSPITAL GOVERNING BOARD
REGULAR MEETING
Elephant Butte Lake RV Resort Center
9-24-26

TABLE OF CONTENTS

Agenda.....GB 1-4
August 30, 2026 Regular/ Annual Minutes.....GB 5-11
August Financial Analysis.....FC 5
Key Statistics August.....FC 6
Statistics by Month.....FC 7
12 Month Statistics.....FC 8
Detailed Stats by Month.....FC 9-10
August Volume Trends.....FC 11
August Income Statement.....FC 12
Income Statement by Month.....FC 13
12 Month Income Statement.....FC 14
August Balance Sheet.....FC 15
Balance Sheet by Month.....FC 16
August Financial Trends.....FC 17
Policies.....BQ 12-65
HR Report.....GB 12-15
CNO Report.....GB 16-17
CEO Report.....GB 18

SIERRA VISTA HOSPITAL AND CLINICS

AGENDA
SIERRA VISTA HOSPITAL
GOVERNING BOARD REGULAR MEETING

September 24, 2026 **12:00pm** **Elephant Butte Lake RV Event Center**

MISSION STATEMENT: **Provide** high quality, highly reliable and medically proficient healthcare services to the citizens of Sierra County.

VISION STATEMENT: Become the trusted, respected, and desired destination for the highest quality of healthcare in the state of New Mexico; exceed compliance and quality expectations and improve the quality of life for our patients and community.

VALUES: Stewardship. Honest. Accountable. Respect. Professional. Kindness. Integrity. Trust. (SHARP KIT)

GUIDING PRINCIPLES: High quality for every patient, every day.

TIME OF MEETING: 12:00pm

PURPOSE: Regular Meeting

COUNTY
Bruce Swingle, **Chair**
Jesus Baray, Member

CITY OF TRUTH OR CONSEQUENCES
Greg D'Amour, **Secretary**
Edna Trager, Member

VILLAGE OF WILLIAMSBURG
Serina Bartoo, **Vice-Chair**

EX-OFFICIO
Shauna Cameron, CEO
Amanda Cardona, VCW
Amber Vaughn, County Manager
Gary Whitehead, City Manager, TorC
Deb Stubblefield, JPC Chair

SUPPORT STAFF:
Ming Huang, CFO
Aaron Dow, CIO
Heather Milton, HR Director
Marsha Sensat, ICNO
Laura Ledebur, Director of Quality

Ovation:
Erika Sundrud
Phillip Stubblefield

AGENDA ITEMS	PRESENTER	ACTION REQUIRED
1. **Call to Order**	Bruce Swingle, Chairperson	
2. **Pledge of Allegiance**	Bruce Swingle, Chairperson	
3. **Roll Call**	Jennifer Burns	Quorum Determination
4. **Approval of Agenda**	Bruce Swingle, Chairperson	Amend/Action

"Are there any items on this agenda that could cause a potential conflict of interest by any Governing Board Member?"

5. **Approval of minutes**	Bruce Swingle, Chairperson	
A. August 27, 2026 Regular Meeting		Amend/Action
6. **Public Input** – 3-minute limit		Information
7. **Old Business-**	Bruce Swingle, Chairperson	
8. **New Business-**		
A. Board Education- Compliance	Phillip Stubblefield	Education
9. **Finance Committee- Serina Bartoo, Chairperson**		
A. August Financial Report	Ming Huang, CFO	Action

10. Board Quality- Greg D'Amour, Chairperson

A. Policy Review — Action

- Doula support within SVH and Clinics – Marsha Sensat
- Employee Health Vaccine Standing Order
- Emergency Cart Medications
- Occupation Exposure to Blood Borne Pathogens
- Standing Orders
- Vancomycin Pharmacokinetic Dosing Policy
- MRSA and HAI Screening and Prevention
- IP Control Guidelines Coronavirus Disease (COVID-19)

11. Administrative Reports

A. Human Resources	Heather Milton, HR Director	Report
B. CNO Report	Marsha Sensat, ICNO	Report
C. CEO Report	Shauna Cameron, CEO	Report
D. Governing Board	Bruce Swingle, Chair	Report

Motion to Close Meeting:

12. Executive Session – In accordance with Open Meetings Act, **NMSA 1978, Chapter 10, Article 15, Section 10-15-1 (H) 2,7,9 including credentialing under NM Review Organization Immunity Act, NMSA Section 41-2E (8) and 41-9-5 the Governing Board will vote to close the meeting to discuss the following items:**

Order of business to be determined by Chairperson:

10-15-1(H) 2 – Limited Personnel Matters

A. Privileges — Shauna Cameron, CEO

Initial Appointment:
Jared Holman, NP

Two-year Reappointment:
Armando Beltran, MD (ESS)
Chandran Vedamanikam, MD

10-15-1 (H) 7 – Attorney Client Privilege/ Pending Litigation

A. Risk Report — Laura Ledebur, Risk

10-15-1 (H) 9 – Public Hospital Board Meetings- Strategic and long-range business plans

A. Ovation Report to Board — Erika Sundrud, Ovation
1. Quarterly Strategic Update
B. Master Facility Update — Shauna Cameron, CEO
C. Quality Report/ Update — Laura Ledebur, Quality
D. Committee Review Summaries — Laura Ledebur, Quality
E. CEO Discussion with Board — Shauna Cameron, CEO

Roll Call to Close Meeting:

13. Re-Open Meeting – As required by **Section 10-15-1(J), NMSA 1978 matters discussed in executive session were limited only to those specified in the motion to close the meeting.**

10-15-1(H) 2 – Limited Personnel Matters — Action

A. Privileges

Initial Appointment:
Jared Holman, NP

Two-year Reappointment:
Armando Beltran, MD (ESS)
Chandran Vedamanikam, MD

10-15-1 (H) 7 – Attorney Client Privilege/ Pending Litigation

A. Risk Report — Report

10-15-1 (H) 9 – Public Hospital Board Meetings- Strategic and long-range business plans

A. Ovation Report to Board — Report
1. Quarterly Strategic Update — Report
B. Master Facility Update — Report
C. Quality Report/ Update — Report
D. Committee Review Summaries — Report

E. CEO Discussion with Board — Discussion

14. Other — Discussion

Next Regular Meeting- October 22 or 29, 2026

15. Adjournment — Action

SIERRA VISTA HOSPITAL
GOVERNING BOARD REGULAR MEETING
MINUTES

August 27, 2026 **12:00pm** **Elephant Butte Lake RV Event Center**

1. The Governing Board of Sierra Vista Hospital met August 27, 2026 at Elephant Butte Lake RV Resort Event Center for a regular meeting. Bruce Swingle, Chairperson, called the meeting to order at 12:06.

2. Pledge of Allegiance –

3. Roll call – Jennifer Burns, Recording Secretary:

County:
Bruce Swingle, **Chair**, Present
Jesus Baray, Present

City:
Greg D'Amour, **Secretary**, Present
Edna Trager, Present

Village of Williamsburg:
Serina Bartoo, Vice-**Chair**, Present

There is a quorum of voting Governing Board members.

Ex-Officio:
Shauna Cameron, CEO, P
Amanda Cardona, VCW, A
Amber Vaughn, CM, A
Gary Whitehead, CM, TorC, A
Jim Paxon, Former JPC Chair, P

Support Staff:
Ming Huang, CFO, P
Heather Milton, HR, P
Karen Iacuone, IQD, P by Web
Dr. Sonia Seufer, COS, P
Aaron Dow, CIO, P
Laura Lebebur, Quality Director, P

Ovation:
Erika Sundrud, Present

4. Approval of Agenda

Serina Bartoo motioned to approve the agenda. Greg D'Amour seconded. Motion carried unanimously.

"Are there any items on this agenda that could cause a potential conflict of interest by any Governing Board Member?" None

5. Approval of minutes Bruce Swingle, Chairperson

A. July 30, 2026 Regular Meeting

Serina Bartoo motioned to approve the July 30, 2026 minutes. Greg D'Amour seconded. Motion carried unanimously.

6. Public Input – 3-minute limit

None

7. Old Business-

A. Capital Disposition - Ming Huang, CFO. We are no longer using any of the equipment on the disposition list. The list includes the old CT machine, two ambulances and OR equipment. Once the board approves the list, we will submit it to the state for approval. We will sell what we can and donate what we don't sell.

Greg D'Amour motioned to approve the equipment disposition list. Serina Bartoo seconded. Motion carried unanimously.

8. New Business-

A. Appointment of Committees - Bruce Swingle, Chairperson, asked Serina Bartoo to serve on the Finance Committee. There are no other changes to the current committee appointments. Bruce Swingle presented Serina Bartoo a certificate of appreciation for her service as board chairperson. "You served at a very difficult time."

B. Secretaries Report

Conflict of interest - Greg D'Amour, Secretary, reported that there are no conflicts of interest to report.

Dr. Seufer stated that there was a meeting last week with a Cerner representative. He seemed to understand the problems that we have been experiencing since the implementation of Cerner. He has emailed suggestions for improving the issues with referrals. He has been communicating with Aaron (CIO) about some of the other issues and hopefully, we will have some of these problems fixed. It seems like somebody is listening and we are optimistic about that. We have a new medical assistant starting today. The AI charting is fabulous.

9. Finance Committee- Bruce Swingle, Chairperson

A. July Financial Report - Ming Huang, CFO, directed board members to page FC 9. Patient days for July were 73, 14 days less than June. There were 791 outpatient visits, 33 less than June. The RHC had 559 visits, 28 more than June and the ER saw 682, 10 less than June. Days cash on hand at the end of July were 240 days. This is a decrease from June is due to payment of insurance in the amount of $1,688,310. Accounts receivable net days were 42 and accounts payable days were 19.

Gross patient revenue for July was $5,412,223. After subtracting deductions, we have net patient revenue of $2,344,250. After adding other operating revenue which includes HDAA and Pharmacy 340B

program funds and non-operating revenue including GRT, mil levy and investment income, we have a total operating revenue of $3,778,886. Supply expenses are higher for July because of the 340B program. We have higher revenue, but we also had higher drug expenses. Contract services included cyber security at $48,069, temporary CT rental of $37,500 and expenses for the Interim CNO who started at the end of July. Total operating expenses are $2,892,085. EBITDA is $886,800 which is a 23% margin.

Bruce Swingle asked about the other hospitals in New Mexico who were on the brink of closing before the HDAA funds kicked in. Erika Sundrud replied that this is a buffer period. The funds have definitely helped but we all have to do better every single day. Shauna stated that other hospitals have said that they wouldn't have made it. We have got to be sustainable on our own. We will not have these funds forever.

Greg D'Amour motioned to approve the finance report. Edna Trager seconded. Motion carried unanimously.

B. Capital Budget - Ming Huang, CFO. These are larger expenses that will need the board's approval. Priorities range from low to high and from FY27 to FY31. Lab, ER/ MedSurg, EMS, Pharmacy and Information systems are the primary departments on the FY27 five-year capital budget. Ming explained the details of the expected expenditures.

Greg D'Amour motioned to approve the FY27 Capital Budget. Serina Bartoo seconded. Motion carried unanimously.

C. GRT Payment Report - Ming Huang, CFO. This report is broken down by date, GRT amount received from the City of Truth or Consequences, City of Elephant Butte, Village of Williamsburg and Sierra County. Elephant Butte stopped paying the GRT in May 2023 and started paying again in January 2026. They did sign a repayment agreement and they are current. We received two payments in the month of July from the Village of Williamsburg, one for June and one for July. For FY26, we received $1,341,235.37 in GRT. We paid $1,392,907.18 to the NMFA for the loan. The difference is ($51,671.79) paid out of hospital operating revenue for FY26.

D. Authorized Signer on accounts - Ming Huang, CFO. Because Bruce Swingle is the new board chair, we need to remove Serina Bartoo as an authorized signer on our bank accounts and add Bruce.

Serina Bartoo motioned to remove herself as authorized signer on Bank of the Southwest accounts ending 4398 and 1829 and add Bruce Swingle as authorized signer. Greg D'Amour seconded. Motion carried unanimously.

10. Board Quality- Greg D'Amour, Chairperson

A. Policy Review

- Comprehensive Addiction and Recovery (CARA)
- Restraints and Seclusion
- Moderate Sedation "Conscious Sedation"
- Management of Behavioral Health and At-Risk Patient
- Administration of Blood or Blood Products
- SPD SOP
- High Alert and Look-Alike/ Sound -Alike Medications

Greg D'Amour stated that Board Quality met on Wednesday, August 26, 2026 and reviewed these policies. All policies have been reviewed and approved by Medical Staff. Based on the recommendation of the

Board Quality Committee, Greg D'Amour motioned approval of all above listed policies. Edna Trager seconded. Motion carried unanimously.

B. Infection Control Authority- Greg D'Amour stated that annually, the Medical Staff appoints an Infection Control Authority for the hospital. They have re-appointed Bettina Fitzgerald.

Greg D'Amour motioned based on the recommendation of the Board Quality Committee, approval of the appointment of Bettina Fitzgerald as Infection Control Authority. Serina Bartoo seconded. Motion carried unanimously.

11. Administrative Reports

A. Human Resources - Heather Milton, HR Director. Staffing has not had much change but there has been restructuring. The numbers are stable. Our utilized FTE count has gone down from 211 in June to 189 in July. Based on productivity, the targeted FTE count has been lowered to 185. The only change in vacancies is the Acute care MedSurg manager position has been filled. The turnover rate appears high, but it is only based on one month.

We have a Quality and Risk Director; Laura Ledebur started with us this week. Targeted leadership training will start in September providing leaders with targeted education on leadership responsibilities, workforce management, communication, and key human resources topics. A committee has been created for enhanced onboarding and orientation. Two orientations will be held every quarter. Current staff will attend once per year, and new hires will attend at the next available orientation after their hire date. The first orientation will be on October 8th.

1. SVH Personnel Policy Sections – This will be tabled for now as the policies will go through our policy review committee first and then come to the board.

B. CNO Report – Shauna Cameron, CEO for Marsha Sensat, ICNO. We have our night shift coverage for house supervisor and continue to look for weekend day and nighttime coverage. We have filled the MedSurg manager position. Interviews are pending for ED manager. We split the education and clinical informatics position so we will have a Cerner clinical informatics person house wide and a clinical educator house wide.

We have run mock codes for training for our nurses in the ER and will do some for MedSurg as well. Annual competencies will be held in October. We have been looking at our conditions of participation for CMS and going through each department to make sure that we are survey ready and following regulations as we should. We fix things that we find immediately. For larger issues, we put together an action plan and work with the managers to take care of them. Educational opportunities based on high-risk low volume have been identified. "Just in time" training is also being provided by Marsha in real time situations.

Edna Trager asked about filling the Mammo Tech position. Heather Milton stated that it is a challenging position to fill. Our previous tech is filling in PRN, and we do have some interest in the position.

C. CEO Report - Shauna Cameron, CEO. Stated that she has been out in the community in our primary and secondary service areas including the T or C farmer's market. Comments have been positive and many expressed that they have seen good changes at the hospital. We went to Hillsboro on Monday of this week and talked to a group of 30 people. We want to know what they need from us and how we can help in their community. They asked if there was a possibility of a mobile unit for both behavioral health and medical. Transportation to and from the hospital is an issue for them. We could do telehealth visits to start. After more community discussions, we will work on what will work best to serve our patients in the outlying community. The internet connection should be checked for strength.

The Health Fair will be on September 17th starting at 3:30. We have people coming from Las Cruces and the County to set up booths. There will be a salsa competition with our local restaurants. There will be music, shows and a petting zoo. This will be huge.

We did get the funds for the boiler. Once the paperwork is done, we will order the boiler and get it installed. We received $840,000 through the Rural Health Care delivery fund. Part of those funds are for Cerner optimization and registration software. Patients will be able to register for their appointment through their phone or online.

Jared Holman will be starting in the RHC in September. We are waiting for our results from Ovation for the RHC assessment. Our pathologist, Jeremy Parsons, has resigned and is moving back to Virginia. We have an interim that will fill in for him until we can find a permanent replacement.

D. Governing Board - Bruce Swingle, Chair, reiterated his appreciation of Serina Bartoo's leadership as Chairperson.

Jim Paxon, former JPC Chairperson, stated that this is his last meeting. The JPC met on August 20th. Jim is terming out as County Commissioner. Jim joined the JPC when the new hospital was under construction and it was an exciting time. There have been no periods of less excitement since. There have been so many accomplishments that the JPC and Governing Board have worked together on. Two of the major accomplishments we've seen is getting through the withdrawal of Elephant Butte and reducing the size of both boards. Both boards are much more agile, agendas are easier to get through, and the cooperation of both boards is at an all-time high. We are in the best position that we can be. Mayor Deb Stubblefield was elected as Chairperson of the JPC and Mayor Rolf Hechler was elected Vice-Chair. This Governing board doesn't have any "can't"; it's only got "let's get out and do!"

Bruce Swingle thanked Jim for his service as Chairperson on the JPC.

Motion to Close Meeting:

Greg D'Amour motioned to close the meeting. Serina Bartoo seconded. Bruce Swingle read the following:

12. Executive Session – In accordance with Open Meetings Act, **NMSA 1978, Chapter 10, Article 15, Section 10-15-1 (H) 2,7,9 including credentialing under NM Review Organization Immunity Act, NMSA Section 41-2E (8) and 41-9-5 the Governing Board will vote to close the meeting to discuss the following items:**

Order of business to be determined by Chairperson:

10-15-1(H) 2 – Limited Personnel Matters

A. Privileges — Shauna Cameron, CEO

Initial Appointments (6-month provisional):

Stephnie Leeson, FNP-C

Jocelyn Fiachetti, LCSW

Two-year Reappointment:

Nichelle Vigil, NP

RadPartners Reappointment:

Elaina Zabak, MD

Kwasi Addae-Mensah, MD

10-15-1 (H) 7 – Attorney Client Privilege/ Pending Litigation

A. Risk Report — Shauna Cameron, CEO

10-15-1 (H) 9 – Public Hospital Board Meetings- Strategic and long-range business plans

A. Ovation Report to Board — Erika Sundrud, Ovation
   1. Strategic Plan
B. QAPI FY26 — Karen Iacuone, Quality
C. Quality Report/ Update — Karen Iacuone, Quality
D. Committee Review Summaries — Karen Iacuone, Quality
E. Patient Safety Dashboard — Karen Iacuone, Quality
F. Joint Conference Committee (JCC) Update — Edna Trager / Shauna Cameron
G. MFP Revision Update — Shauna Cameron, CEO
H. Cyber Security Update — Aaron Dow, CIO
I. CEO Discussion with Board — Shauna Cameron, CEO

Roll Call to Close Meeting:

Jesus Baray – Y Greg D'Amour – Y
Serina Bartoo – Y Edna Trager – Y Bruce Swingle - Y

13. Re-Open Meeting – As required by **Section 10-15-1(J), NMSA 1978 matters discussed in executive session were limited only to those specified in the motion to close the meeting.**

10-15-1(H) 2 – Limited Personnel Matters

A. Privileges — Action

Initial Appointments (6-month provisional):
Stephnie Leeson, FNP-C
Jocelyn Fiachetti, LCSW
Two-year Reappointment:
Nichelle Vigil, NP
RadPartners Reappointment:
Elaina Zabak, MD
Kwasi Addae-Mensah, MD

Greg D'Amour motioned based on the recommendation of the Board Quality Committee, approval of all above listed privileges. Serina Bartoo seconded. Motion carried unanimously.

10-15-1 (H) 7 – Attorney Client Privilege/ Pending Litigation

A. Risk Report — No Action

10-15-1 (H) 9 - Public Hospital Board Meetings- Strategic and long-range business plans

A. Ovation Report to Board — No Action
   1. Strategic Plan — No Action
B. QAPI FY26

Jesus Baray motioned based on the recommendation of the Board Quality committee, approval of the QAPI FY26 plan. Edna Trager seconded. Motion carried unanimously.

C. Quality Report/ Update	No Action
D. Committee Review Summaries	No Action
E. Patient Safety Dashboard	No Action
F. Joint Conference Committee (JCC) Update	No Action
G. MFP Revision Update	No Action
H. Cyber Security Update	No Action
I. CEO Discussion with Board	Discussion

14. Other

The next regular Governing Board meeting will be held on September 24, 2026 at 12:00. Finance Committee will meet at 11:00 on September 24, 2026 and Board Quality will meet on Wednesday, September 23, 2026 at 10:00.

15. Adjournment

Serina Bartoo motioned to adjourn. Greg D'Amour seconded. Motion carried unanimously.

_____

Jennifer Burns, Recording Secretary

_____ _____

Bruce Swingle, Chairperson Approved

SIERRA VISTA HOSPITAL AND CLINICS

Financial Analysis

August 31st, 2026

Days Cash on Hand for August 2026 are 254 which equals $24,035,293

Accounts Receivable Net days are 39

Accounts Payable days are 17

Hospital Excess Revenue over Expense

The **Net Income** for the month of August was $341,228 vs. a Budget Income of $516,892.

Hospital Gross Revenue for August was $6,359,438 or $885,460 more than the budget. Patient Days were 72 – 1 less than July. Outpatient visits were 707 – 84 less than July. RHC visits were 642 – 83 more than July and ER visits were 743 – 61 more than July.

Revenue Deductions for August were $3,940,199.

Other Operating Revenue was $877,065.

Non-Operating Revenue was $278,353.

Hospital Operating Expenses for August were $2,782,173. Supplies were higher because of dug expenses for pharmacy 340B program. Higher electricity bill caused the increase of Utilities. Other Operating Expenses included the recruitment expense of $32,513 for a new nurse practitioner.

EBITDA for August was $792,484 vs. a Budget of $961,753. YTD EBITDA is $1,680,394 vs. a Budget of $1,923,506.

The Bond Coverage Ratio in August was 510% vs. an expected ratio of 130%.

Sierra Vista Hospital
KEY STATISTICS
August 31, 2026

MONTH						BENCHMARK RANGE		YEAR TO DATE				
Actual 8/31/26	Budget 8/31/26	Variance to Budget	Prior Year 8/31/25	Variance to Prior Year	DESCRIPTION	QHR 75th	QHR 50th	Actual 8/31/26	Budget 8/31/26	Variance to Budget	Prior Year 08/31/25	Variance to Prior Year
					Growth							
					Net Patient Revenue Growth Rate	6%	5%	3%				
					Admissions							
27	34	(7)	21	6	Acute	153	88	56	34	22	37	19
1	2	(1)	4	(3)	Swing	17	12	1	2	(1)	5	(4)
28	**36**	**(8)**	**25**	**3**	**Total Admissions**	**170**	**101**	**57**	**36**	**21**	**42**	**15**
2.6	2.9	(0.3)	3.8	(1.2)	ALOS (acute and swing)	3.3	4.0	2.5	2.9	(0)	3.5	(0.93)
72	103	(31)	95	(23)	Patient Days (acute and swing)			145	103	42	146	(1)
707	869	(162)	886	(179)	Outpatient Visits	9,242	5,329	1,498	869	629	1,892	(394)
642	623	19	701	(59)	Rural Health Clinic Visits	3,924	3,193	1,201	623	578	1,397	(196)
707	703	4	726	(19)	ER Visits	1,761	1,362	1,425	703	722	1,446	(21)
4%	5%	-1.2%	3%	1%	ER Visits Conversion to Acute Admissions	10%	6%	4%	5%	-1%	3%	1%
					Profitability							
22%	15%	7%	22%	0%	EBITDA % Net Rev	7%	4%	23%	15%	8%	24%	-2%
10%	15%	-5%	10%	0%	Operating Margin %	2%	2%	11%	15%	-4%	13%	-2%
62%	46%	16%	60%	2%	Rev Ded % Net Rev	47%	50%	60%	46%	14%	60%	-1%
17%	2%	15%	13%	4%	Bad Debt % Net Pt Rev	2%	6%	14%	2%	12%	13%	2%
90%			97%		Outpatient Revenue %	83%	78%	90%			97%	-7%
$ 22,712			$ 6,874	$15,839	Gross Patient Revenue/Adjusted Admission			$22,712			$ 6,874	$15,839
$ 8,640			$ 2,774	$5,867	Net Patient Revenue/Adjusted Admission			$8,640			$ 2,774	$5,867
48%	40%	8%	48%	0%	Salaries % Net Pt Rev	35%	40%	48%	40%	8%	52%	-4%
10%	7%	3%	10%	0%	Benefits % Net Pt Rev	11%	12%	10%	7%	3%	9%	1%
10%	8%	2%	9%	1%	Supplies % Net Pt Rev	10%	13%	11%	8%	3%	9%	2%
					Cash and Liquidity							
254					Days Cash on Hand	236	106	254			139	115
58					A/R Days (Gross)	47	57	58			64	(6)
39					A/R Days (Net)	41	53	39			42	(3)
17					Days in AP	30	35	17			28	(12)
11.9					Current Ratio	4.3	2.6	11.9			7.4	4.5

Sierra Vista Hospital
STATISTICS by Month
August 31, 2026
(SUBJECT TO AUDIT)

Description	Month Ending 6/30/2027	Month Ending 5/31/2027	Month Ending 4/30/2027	Month Ending 3/31/2027	Month Ending 2/28/2027	Month Ending 1/31/2027	Month Ending 12/31/2026	Month Ending 11/30/2026	Month Ending 10/31/2026	Month Ending 9/30/2026	Month Ending 8/31/2026	Month Ending 7/31/2026
Admissions												
Acute											27	29
Swing											1	-
Total Admissions	-	-	-	-	-	-	-	-	-	-	28	29
ALOS (acute and swing)	-	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	2.6	2.5
Patient Days (acute and swing)											72	73
Outpatient Visits											707	791
Rural Health Clinic Visits											642	559
ER Visits											743	682
ER Visits Conversion to Acute Admissions	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	4%	4%
Clinic Visits												
RHC & Walk-In											642	559
Behavioral Health											329	323
Total Visits	-	-	-	-	-	-	-	-	-	-	971	882
Profitability												
EBITDA % Net Rev	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	22%	23%
Operating Margin %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	10%	12%
Rev Ded % Net Rev	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	62%	57%
Bad Debt % Net Pt Rev	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	17%	12%
Outpatient Revenue %											90%	90%
Gross Patient Revenue/Adjusted Admission	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$ 22,712	$ 18,663
Net Patient Revenue/Adjusted Admission	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$ 8,640	$ 8,084
Salaries % Net Pt Rev	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	48%	48%
Benefits % Net Pt Rev	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	10%	11%
Supplies % Net Pt Rev	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	10%	12%
Cash and Liquidity												
Days Cash on Hand	-	-	-	-	-	-	-	-	-	-	254	240
A/R Days (Gross)	-	-	-	-	-	-	-	-	-	-	58	62
A/R Days (Net)	-	-	-	-	-	-	-	-	-	-	39	42
Days in AP	-	-	-	-	-	-	-	-	-	-	17	20
Current Ratio	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	11.9	11.6

Sierra Vista Hospital
TWELVE MONTH STATISTICS
August 31, 2026
(SUBJECT TO AUDIT)

Description	Month Ending 8/31/2026	Month Ending 7/31/2026	Month Ending 6/30/2026	Month Ending 5/31/2026	Month Ending 4/30/2026	Month Ending 3/31/2026	Month Ending 2/28/2026	Month Ending 1/31/2026	Month Ending 12/31/2025	Month Ending 11/30/2025	Month Ending 10/31/2025	Month Ending 9/30/2025
Admissions												
Acute	27	29	25	30	35	27	32	29	40	31	29	19
Swing	1	-	3	4	3	2	4	2	-	1	2	2
Total Admissions	**28**	**29**	**28**	**34**	**38**	**29**	**36**	**31**	**40**	**32**	**31**	**21**
ALOS (acute and swing)	2.6	2.5	3.1	4.5	2.3	4.9	3.5	4.1	2.5	3.3	3.2	2.9
Patient Days (acute and swing)	72	73	87	153	88	142	127	128	98	106	98	61
Outpatient Visits	707	791	824	821	918	929	855	824	807	669	935	950
Rural Health Clinic Visits	642	559	531	528	587	614	649	703	568	525	669	701
ER Visits	743	682	692	751	676	713	650	703	845	631	704	624
ER Visits Conversion to Acute Admissions	4%	4%	4%	4%	5%	4%	5%	4%	5%	5%	4%	3%
Clinic Visits												
RHC & Walk-In	642	559	531	528	587	614	649	703	568	525	669	701
Behavioral Health	329	323	277	322	307	348	304	308	301	254	349	318
Total Visits	**971**	**882**	**808**	**850**	**894**	**962**	**953**	**1,011**	**869**	**779**	**1,018**	**1,019**
Profitability												
EBITDA % Net Rev	22%	23%	24%	55%	27%	29%	44%	10%	30%	28%	0%	29%
Operating Margin %	10%	12%	13.6%	47.6%	15.2%	17.5%	34%	-3%	20%	16%	-15%	18%
Rev Ded % Net Rev	62%	57%	59%	48%	54%	52%	37%	61%	51%	57%	67%	47%
Bad Debt % Net Pt Rev	17%	12%	10.1%	12.1%	8.3%	10.0%	4%	17%	7%	10%	13%	4%
Outpatient Revenue %	90%	90%	91%	87%	86%	88%	86%	86%	87%	86%	86%	92%
Gross Patient Revenue/Adjusted Admission	$ 22,712	$ 18,663	$ 6,061	$ 6,572	$ 4,334	$ 7,810	$ 5,431	$ 6,315	$ 4,236	$ 4,444	$ 6,807	$ 5,109
Net Patient Revenue/Adjusted Admission	$ 8,640	$ 8,084	$ 2,507	$ 3,388	$ 1,981	$ 3,781	$ 3,431	$ 2,475	$ 2,082	$ 1,928	$ 2,264	$ 2,722
Salaries % Net Pt Rev	48%	48%	46%	43%	45%	44%	33%	65%	40%	50%	76%	40%
Benefits % Net Pt Rev	10%	11%	10%	8%	10%	8%	7%	14%	8%	7%	14%	8%
Supplies % Net Pt Rev	10%	12%	10%	12%	7%	6%	6%	11%	8%	8%	12%	6%
Cash and Liquidity												
Days Cash on Hand	254	240	278	243	208	209	187	175	189	159	154	158
A/R Days (Gross)	58	62	68	65	67	62	63	68	62	66	61	65
A/R Days (Net)	39	42	44	41	39	37	39	49	37	41	37	44
Days in AP	17	20	25	12	12	18	15	16	14	19	19	24
Current Ratio	11.9	11.6	9.0	10.7	9.6	9.5	9.8	8.3	9.7	9.5	8.0	8.2

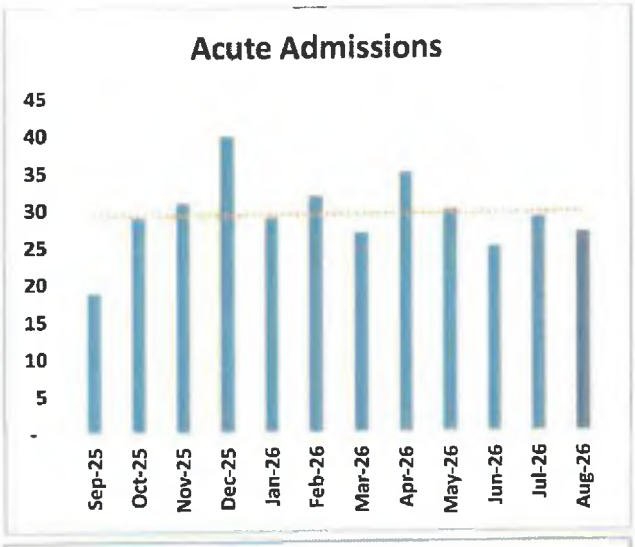
Sierra Vista Hospital
Detailed Stats by Month
8/31/2026
(SUBJECT TO AUDIT)

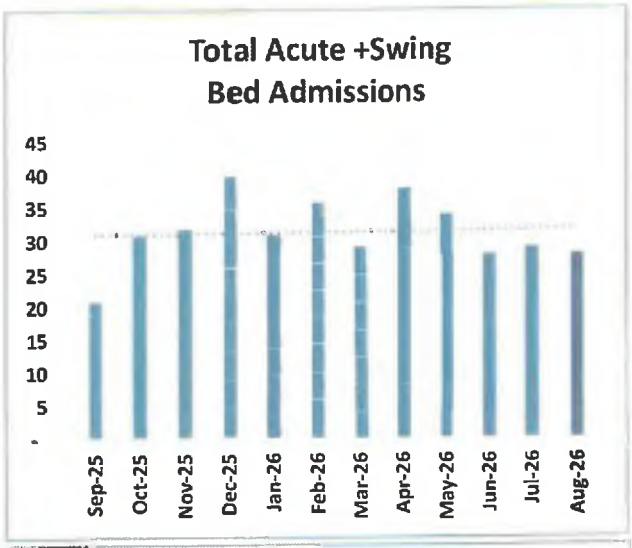
	FY2027	Avg FY2027	Month Ending 6/30/2027	Month Ending 5/31/2027	Month Ending 4/30/2027	Month Ending 3/31/2027	Month Ending 2/28/2027	Month Ending 1/31/2027	Month Ending 12/31/2026	Month Ending 11/30/2026	Month Ending 10/31/2026	Month Ending 9/30/2026	Month Ending 8/31/2026	Month Ending 7/31/2026
Description														
Total Acute Patient Days	130	65											66	64
Total Swingbed Patient Days	15	8											6	9
Total Acute Hours (based on Disch Hrs)	3,112	1,556	-	-	-	-	-	-	-	-	-	-	1,590	1,522
TOTAL ACUTE														
Patient Days	130	65											66	64
Admits	56	28											27	29
Discharges	54	27											25	29
Discharge Hours	3,112	1,556											1,590	1,522
Avg LOS	2.4	2.4	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	2.6	2.2
Medicare Acute														
Patient Days	81	41											51	30
Admits	30	15											18	12
Discharges	29	15											17	12
Discharge Hours	1,939	970											1,230	709
Avg LOS	2.8	2.8	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	3.0	2.5
SWING - ALL (Medicare/Other)														
Patient Days	15	8											6	9
Admits	1	1											1	0
Discharges	2	1											1	1
Discharge Hours	401	201											175	226
Avg LOS	7.5	7.5	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	6.0	9.0
Observations														
Patient Days	55	28											29	26
Admits	34	17											19	15
Discharge Hours	1,324	662											702	622
Emergency Room														
Total ER Patients	1,425	713											743	682
Admitted	47	24											24	23
Transferred	148	74											84	64
Ambulance														
Total ALS/BLS runs	657	329											341	316
911 Calls	520	260											267	253
Transfers	137	69											74	63
OP Registrations	1,498	749											707	791
Rural Health Clinic														
Total RHC Visits	1,201	601											642	559
Avg Visits per day	54	27											29	25
Behavioral Health														
Patients Seen	652	326											329	323

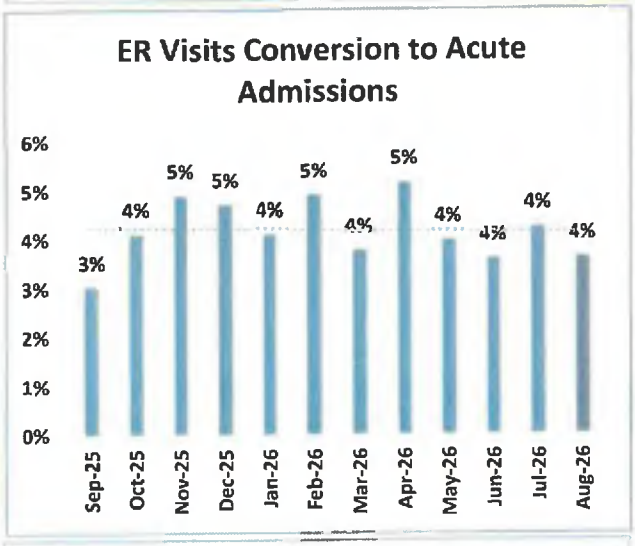
Sierra Vista Hospital
Detailed Stats by Month
8/31/2026
(SUBJECT TO AUDIT)

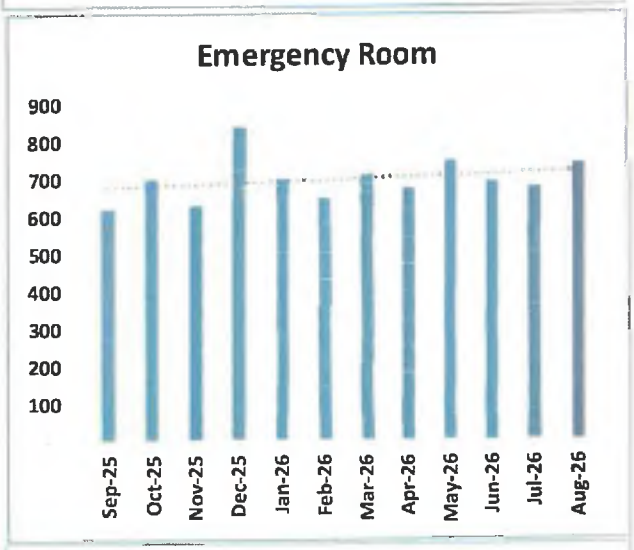
	FY2027	Avg FY2027	Month Ending 6/30/2027	Month Ending 5/31/2027	Month Ending 4/30/2027	Month Ending 3/31/2027	Month Ending 2/28/2027	Month Ending 1/31/2027	Month Ending 12/31/2026	Month Ending 11/30/2026	Month Ending 10/31/2026	Month Ending 9/30/2026	Month Ending 8/31/2026	Month Ending 7/31/2026
Dietary														
Inpatient Meals	1,151	576											595	556
Outpatient Meals	308	154											182	126
Cafeteria Meals	9,376	4,688											4,526	4,850
Functions	525	263											286	239
Laboratory														
In-house Testing	37,098	18,549											19,585	17,513
Sent Out Testing	1,448	724											718	730
Drugscreens	61	31											23	38
Physical Therapy														
PT Tx Units	1,484	742											721	763
OT Tx Units	-												-	-
ST Tx Units	88	44											44	44
Radiology														
X-Ray Patients	891	446											462	429
CT Patients	881	441											452	429
Ultrasound Patients	187	94											98	89
Mammogram Patients	30	15											30	-
MRI Patients	94	47											57	37
Nuclear Medicine Patients	2	1											-	2
DEXA	6	3											6	-
Sleep Study														
Home Testing	12	6											6	6
Inhouse	10	5											2	8

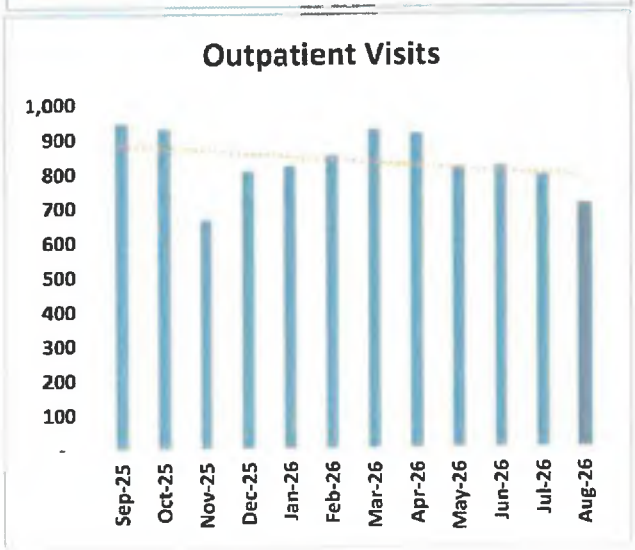
Volume Trends

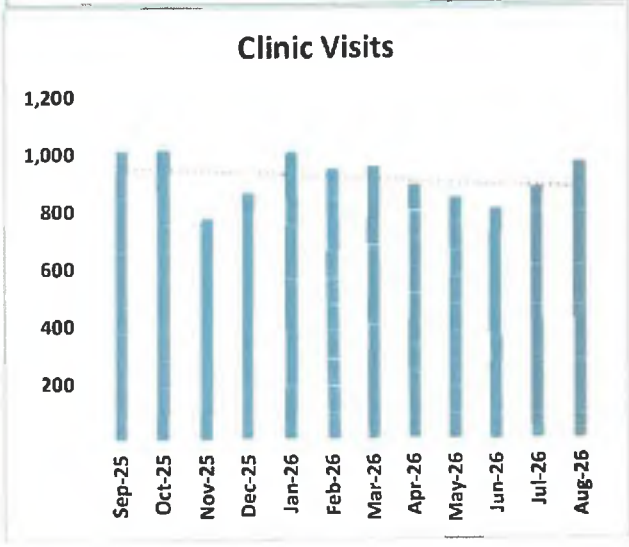












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Sierra Vista Hospital
INCOME STATEMENT
August 31, 2026

MONTH						YEAR TO DATE				
Actual 8/31/26	Budget 8/31/26	Variance to Budget	Prior Year 8/31/25	Variance to Prior Year	DESCRIPTION	Actual 8/31/26	Budget 8/31/26	Variance to Budget	Prior Year 8/31/25	Variance to Prior Year
$ 6,359,438	$ 5,473,977	$ 885,460	$ 5,728,007	$631,431	**Gross Patient Revenue**	$ 11,771,661	$ 10,947,955	$ 823,706	$ 11,575,044	$196,617
					Revenue Deductions					
$ 3,145,739	2,406,027	739,713	2,716,587	$429,153	Contractual Allowances	5,736,337	4,812,053	924,283	5,674,292	$62,045
$ 482,773	259,931	222,842	347,559	$135,213	Bad Debt	793,761	519,862	273,899	677,387	$116,374
$ 311,687	312,991	(1,304)	386,919	($75,232)	Other Deductions	478,075	625,982	(147,906)	613,510	(135,435)
$ 3,940,199	$ 2,978,948	$ 961,251	$ 3,451,065	$ 489,134	**Total Revenue Deductions**	$ 7,008,173	$ 5,957,897	$ 1,050,276	$ 6,965,189	$ 42,983
$ -	0	(0)	34,326	($34,326)	Other Patient Revenue	0	0	(0)	34,326	(34,326)
$ 2,419,238	$ 2,495,029	$ (75,790)	$2,311,267	$107,971	**Net Patient Revenue**	$ 4,763,488	$ 4,990,058	$ (226,570)	$ 4,644,180	$ 119,308
38%	46%	(8%)	40%	(2%)	**Gross to Net %**	40%	46%	(5%)	40%	0%
$ 877,065	1,017,159	(140,093)	954,057	($76,992)	Other Operating Revenue	2,009,676	2,034,317	(24,642)	1,823,798	185,878
$ 278,353	242,381	35,972	359,733	($81,379)	Non-Operating Revenue	580,379	484,762	95,617	1,128,502	(548,124)
$ 3,574,657	$ 3,754,569	$ (179,912)	$ 3,625,057	$ (50,400)	**Total Operating Revenue**	$ 7,353,543	$ 7,509,137	$ (155,595)	$ 7,596,480	(242,938)
					Expenses					
$ 1,423,539	$1,460,395	($36,855)	$1,361,986	$61,553	**Salaries & Benefits**	$2,818,385	$2,920,789	(102,405)	$2,871,288	($52,903)
$ 1,170,754	1,206,364	(35,610)	1,115,046	55,709	Salaries	2,286,284	2,412,728	(126,444)	2,393,205	(106,921)
$ 238,360	234,399	3,960	225,406	12,954	Benefits	493,174	468,799	24,375	438,743	54,431
$ 14,425	19,631	(5,206)	21,535	(7,109)	Other Salary & Benefit Expense	38,927	39,262	(335)	39,339	(412)
$ 238,703	189,174	49,528	208,274	30,428	Supplies	512,814	378,348	134,466	397,616	$115,199
$ 569,179	645,076	(75,897)	728,657	(159,478)	Contract Services	1,295,178	1,290,152	5,026	1,443,506	($148,328)
$ 201,751	203,007	(1,256)	195,433	6,318	Professional Fees	401,414	406,014	(4,599)	385,827	$15,587
$ 3,246	4,842	(1,597)	5,074	(1,828)	Leases/Rentals	7,060	9,685	(2,625)	10,998	($3,938)
$ 70,429	45,645	24,784	54,993	15,436	Utilities	118,128	91,289	26,838	112,937	$5,191
$ 45,896	47,583	(1,688)	101,773	(55,878)	Repairs / Maintenance	91,366	95,167	(3,800)	180,465	($89,099)
$ 167,252	160,250	7,002	149,270	17,982	Insurance	334,730	320,500	14,231	288,805	$45,925
$ 62,179	36,844	25,336	26,101	36,078	Other Operating Expenses	94,072	73,687	20,385	51,229	$42,843
$2,782,173	$2,792,815	($10,642)	2,831,562	($49,389)	**Total Operating Expenses**	$5,673,148	$5,585,631	$87,518	$5,742,670	($69,522)
$792,484	$961,753	($169,269)	$793,495	($1,011.50)	**EBITDA**	$1,680,394	$1,923,506	($243,112)	$1,853,810	($173,416)
22%	26%	(3%)	22%	0%	**EBITDA Margin**	23%	26%	(3%)	24%	(2%)
					Non - Operating Expenses					
$ 301,648	$295,801	$5,847	$298,975	$2,673	Depreciation and Amortization	603,295	$591,601	11,694	$597,949	$5,346
$ 94,057	97,737	($3,680)	96,943	($2,886)	Interest	188,335	195,474	(7,138)	$193,789	($5,454)
$ 55,551	51,324	$4,227	52,856	$2,695	Tax/Other	105,686	102,649	3,037	$104,042	$1,644
$451,256	$444,862	$6,394	$448,774	$2,482	**Total Non Operating Expense**	$897,317	$889,723	$7,593	$895,780	$1,536
341,228	$516,892	($175,664)	$344,722	($3,494)	**NET INCOME (LOSS)**	$783,077	$1,033,783	($250,706)	$958,030	($174,952)
10%	14%	(4%)	10%	0%	**Net Income Margin**	11%	14%	(3%)	13%	(2%)

Sierra Vista Hospital
INCOME STATEMENT by Month
August 31, 2026

Description	Month Ending 6/30/2027	Month Ending 5/31/2027	Month Ending 4/30/2027	Month Ending 3/31/2027	Month Ending 2/28/2027	Month Ending 1/31/2027	Month Ending 12/31/2026	Month Ending 11/30/2026	Month Ending 10/31/2026	Month Ending 9/30/2026	Month Ending 8/31/2026	Month Ending 7/31/2026
Revenues												
Gross Patient Revenue											$ 6,359,438	$ 5,412,223
Revenue Deductions												
Contractual Allowances											3,145,739	2,590,597
Bad Debt											482,773	310,988
Other Deductions											311,687	166,388
Total Revenue Deductions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,940,199	$ 3,067,973
Other Patient Revenue											0	0
Net Patient Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,419,238	$ 2,344,250
Gross to Net %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	38%	43%
Other Operating Revenue											877,065	1,132,610
Non-Operating Revenue											278,353	302,026
Total Operating Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,574,657	$ 3,778,886
Expenses												
Salaries & Benefits	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,423,539	$1,394,846
Salaries											1,170,754	1,115,530
Benefits											238,360	254,814
Other Salary & Benefit Expense											14,425	24,502
Supplies											238,703	274,112
Contract Services											569,179	725,999
Professional Fees											201,751	199,664
Leases/Rentals											3,246	3,815
Utilities											70,429	47,699
Repairs / Maintenance											45,896	45,471
Insurance											167,252	167,478
Other Operating Expenses											62,179	31,893
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,782,173	$2,890,975
EBITDA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$792,484	$887,910
EBITDA Margin	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	22%	23%
Non - Operating Expenses												
Depreciation and Amortization											$301,648	$301,648
Interest											94,057	94,278
Tax/Other											55,551	50,135
Total Non Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$451,256	$446,061
NET INCOME (LOSS)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$341,228	$441,849
Net Income Margin	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	10%	12%

Sierra Vista Hospital
TWELVE MONTH INCOME STATEMENT
August 31, 2026

Description	Month Ending 8/31/2026	Month Ending 7/31/2026	Month Ending 6/30/2026	Month Ending 5/31/2026	Month Ending 4/30/2026	Month Ending 3/31/2026	Month Ending 2/28/2026	Month Ending 1/31/2026	Month Ending 12/31/2025	Month Ending 11/30/2025	Month Ending 10/31/2025	Month Ending 9/30/2025
Revenues												
Gross Patient Revenue	$ 6,359,438	$ 5,412,223	$ 5,656,567	$ 5,586,473	$ 5,489,244	$ 5,662,278	$ 4,887,668	$ 4,893,831	$ 5,647,822	$ 4,739,735	$ 5,275,087	$ 5,364,961
Revenue Deductions												
Contractual Allowances	3,145,739	2,590,597	2,595,261	2,016,532	2,445,397	2,276,888	1,416,986	2,364,170	2,266,003	2,140,343	2,874,405	2,149,035
Bad Debt	482,773	310,988	263,861	396,333	226,727	303,690	117,089	388,353	218,764	229,673	258,219	130,496
Other Deductions	311,687	166,388	457,815	293,531	307,529	340,611	265,423	223,434	387,967	316,036	387,955	228,545
Total Revenue Deductions	$ 3,940,199	$ 3,067,973	$ 3,316,936	$ 2,706,395	$ 2,979,653	$ 2,921,190	$ 1,799,498	$ 2,975,958	$ 2,872,734	$ 2,686,052	$ 3,520,580	$ 2,508,076
Other Patient Revenue	0	0	0	0	0	0	0	1	577	2,325	0	851
Net Patient Revenue	$ 2,419,238	$ 2,344,250	$ 2,339,631	$ 2,880,077	$ 2,509,591	$ 2,741,088	$ 3,088,170	$ 1,917,874	$ 2,775,665	$ 2,056,008	$ 1,754,507	$ 2,857,736
Gross to Net %	38%	43%	41.4%	52%	46%	48%	63%	39%	49%	43%	33%	53%
Other Operating Revenue	877,065	1,132,610	1,043,614	1,778,901	816,930	677,362	821,998	984,589	871,800	1,053,020	881,478	635,748
Non-Operating Revenue	278,353	302,026	473,975	2,106,701	304,617	378,865	400,469	311,824	216,800	328,177	319,842	376,662
Total Operating Revenue	$ 3,574,657	$ 3,778,886	$ 3,857,220	$ 6,765,679	$ 3,631,138	$ 3,797,315	$ 4,310,637	$ 3,214,287	$ 3,864,265	$ 3,437,205	$ 2,955,827	$ 3,870,147
Expenses												
Salaries & Benefits	1,423,539	1,394,846	1,336,927	1,489,452	1,418,519	1,458,206	1,272,469	1,537,565	1,369,070	1,198,263	1,593,370	1,407,966
Salaries	1,170,754	1,115,530	1,082,205	1,237,212	1,130,664	1,203,468	1,025,515	1,255,535	1,115,468	1,022,145	1,327,514	1,133,388
Benefits	238,360	254,814	234,042	238,819	263,172	230,241	212,886	266,230	227,504	138,533	247,665	242,697
Other Salary & Benefit Expense	14,425	24,502	20,679	13,421	24,683	24,496	34,068	15,800	26,099	37,585	18,190	31,881
Supplies	238,703	274,112	230,534	337,464	181,100	157,095	174,806	217,563	221,434	163,803	206,937	176,933
Contract Services	569,179	725,999	589,000	690,520	544,503	580,655	501,696	632,927	615,293	652,646	627,604	679,489
Professional Fees	201,751	199,664	214,934	210,466	210,973	210,514	203,574	222,320	196,113	207,101	205,305	206,800
Leases/Rentals	3,246	3,815	2,922	2,922	4,032	2,912	2,912	4,738	4,834	4,493	6,349	4,793
Utilities	70,429	47,699	53,955	50,022	47,654	47,650	38,565	37,754	36,645	43,104	38,129	47,637
Repairs / Maintenance	45,896	45,471	80,601	48,698	57,418	51,624	37,987	43,807	42,173	47,233	72,216	35,678
Insurance	167,252	167,478	214,138	151,551	151,554	151,137	151,554	155,427	137,689	124,655	139,057	137,741
Other Operating Expenses	62,179	31,893	217,652	63,361	41,800	28,337	23,063	28,519	68,056	34,381	55,486	32,564
Total Operating Expenses	$2,782,173	$2,890,975	$2,940,662	$3,044,456	$2,657,553	$2,688,130	$2,406,626	$2,880,621	$2,691,308	$2,475,680	$2,944,453	$2,729,601
EBITDA	$792,484	$887,910	$916,558	$3,721,223	$973,585	$1,109,185	$1,904,011	$333,666	$1,172,957	$961,526	$11,374	$1,140,546
EBITDA Margin	22%	23%	23.8%	55%	27%	29%	44%	10%	30%	28%	0%	29%
Non - Operating Expenses												
Depreciation and Amortization	301,648	301,648	251,071	346,178	281,674	289,679	265,799	289,486	253,406	290,466	298,662	290,764
Interest	94,057	94,278	94,499	94,718	94,936	95,153	95,368	95,583	95,796	96,161	96,219	96,429
Tax/Other	55,551	50,135	45,729	56,968	43,682	58,799	66,569	31,530	57,702	37,089	55,205	50,769
Total Non Operating Expenses	$451,256	$446,061	$391,299	$497,863	$420,291	$443,631	$427,736	$416,598	$406,904	$423,717	$450,087	$437,963
NET INCOME (LOSS)	$341,228	$441,849	$525,258	$3,223,360	$553,293	$665,554	$1,476,274	($82,932)	$766,053	$537,809	($438,713)	$702,583
Net Income Margin	10%	12%	13.6%	48%	15%	18%	34%	(3%)	20%	16%	(15%)	18%

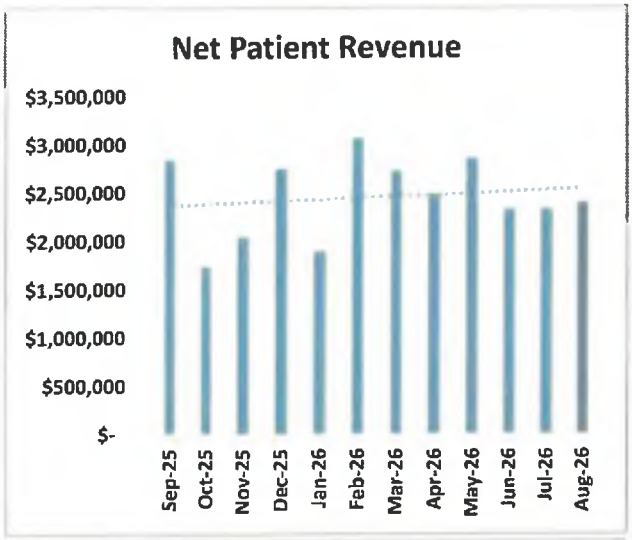
Sierra Vista Hospital
BALANCE SHEET
August 31, 2026

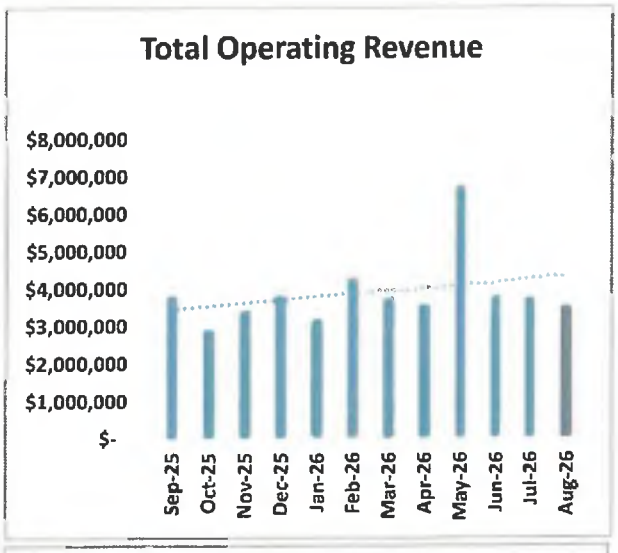
August 31, 2026 (Unaudited)	DESCRIPTION	June 30, 2026 (Unaudited)
	Assets	
	Current Assets	
$ 23,883,246	Cash and Liquid Capital	$ 24,685,172
$ 152,048	US Bank Clearing	$ 755,915
$ 24,035,293	**Total Cash**	**$ 25,441,086**
$ 11,378,896	Accounts Receivable - Gross	$ 12,105,187
$ 8,244,831	Contractual Allowance	$ 8,546,720
$ 3,134,065	**Total Accounts Receivable, Net of Allowance**	**$ 3,558,467**
$ 5,232,811	Other Receivables	$ 4,067,721
$ 390,217	Inventory	$ 482,636
$ 1,604,395	Prepaid Expense	$ 105,119
$ 34,396,781	**Total Current Assets**	**$ 33,655,029**
	Long Term Assets	
$ 59,737,918	Fixed Assets	$ 59,688,855
$ 26,825,778	Accumulated Depreciation	$ 26,222,482
$ 74,832	Construction in Progress	$ 60,801
$ 32,986,973	**Total Fixed Assets, Net of Depreciation**	**$ 33,527,175**
$ 32,986,973	**Total Long Term Assets**	**$ 33,527,175**
$ 2,259,469	**New Hospital Loan**	**$ 3,463,552**
$ 69,643,223	**Total Assets**	**$ 70,645,756**
	Liabilities & Equity	
	Current Liabilities	
$ 788,154	Account Payable	$ 1,136,271
$ 738,491	Interest Payable	$ 1,508,761
$ 54,951	Accrued Taxes	$ 45,540
$ 1,155,442	Accrued Payroll and Related	$ 910,993
$ 150,000	Cost Report Settlement	$ 150,000
$ 2,887,038	**Total Current Liabilities**	**$ 3,751,565**
	Long term Liabilities	
$ 26,264,885	Long Term Notes Payable	$ 27,034,311
$ 26,264,885	**Total Long Term Liabilities**	**$ 27,034,311**
$ -	**Unapplied Liabilities**	**$ -**
$ 249,548	**Capital Equipment Lease**	**$ 262,995**
$ 29,401,471	**Total Liabilites**	**$ 31,048,871**
$ 39,458,675	**Retained Earnings**	**$ 30,710,316**
$ 783,077	**Net Income**	**$ 8,886,569**
$ 69,643,223	**Total Liabilities and Equity**	**$ 70,645,756**

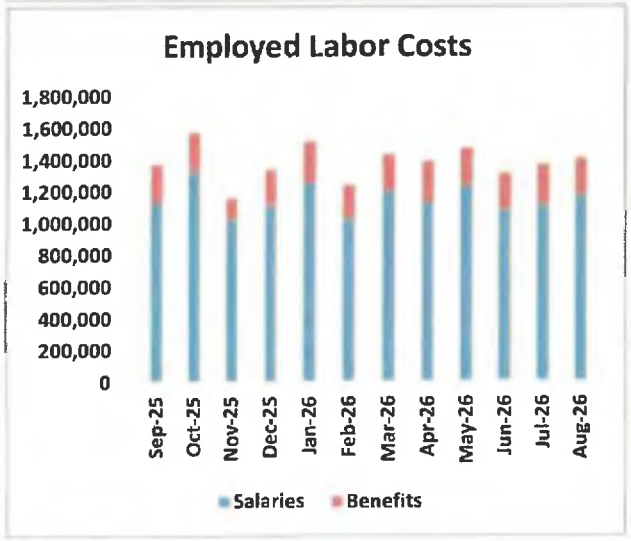
Sierra Vista Hospital
BALANCE SHEET by Month
August 31, 2026

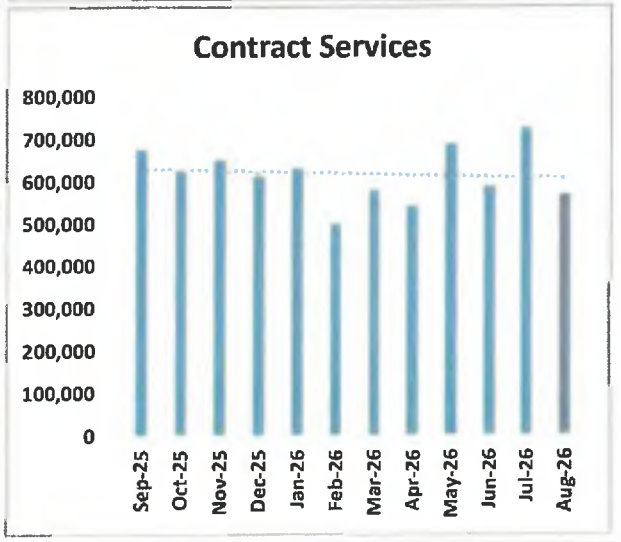
	Month Ending 6/30/2027	Month Ending 5/31/2027	Month Ending 4/30/2027	Month Ending 3/31/2027	Month Ending 2/28/2027	Month Ending 1/31/2027	Month Ending 12/31/2026	Month Ending 11/30/2026	Month Ending 10/31/2026	Month Ending 9/30/2026	Month Ending 8/31/2026	Month Ending 7/31/2026
Assets												
Current Assets												
Cash and Liquid Capital											23,883,246	23,939,835
US Bank Clearing											152,048	(49,418)
Total Cash	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$24,035,293	$23,890,417
Accounts Receivable - Gross											11,378,896	11,561,901
Contractual Allowance											8,244,831	8,203,504
Total Accounts Receivable, Net of Allowance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,134,065	$ 3,358,397
Other Receivables											5,232,811	4,544,509
Inventory											390,217	390,678
Prepaid Expense											1,604,395	1,773,525
Total Current Assets	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,396,781	$33,957,526
Long Term Assets												
Fixed Assets											59,737,918	59,688,855
Accumulated Depreciation											26,825,778	26,524,130
Construction in Progress											74,832	60,801
Total Fixed Assets, Net of Depreciation											32,986,973	33,225,527
Total Long Term Assets	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 32,986,973	$33,225,527
New Hospital Loan											$ 2,259,469	$ 2,199,566
Total Assets	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 69,643,223	$ 69,382,618
Liabilities & Equity												
Current Liabilities												
Account Payable											788,154	1,006,653
Interest Payable											738,491	659,479
Accrued Taxes											54,951	49,716
Accrued Payroll and Related											1,155,442	1,052,124
Cost Report Settlement											150,000	150,000
Total Current Liabilities	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,887,038	$2,917,973
Long term Liabilities												
Long Term Notes Payable											26,264,885	26,307,824
Total Long Term Liabilities	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$26,264,885	$26,307,824
Capital Equipment Lease											249,548	256,297
Total Liabilites	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$29,401,471	$29,482,094
Retained Earnings											$39,458,675	$39,458,675
Net Income											$783,077	$441,849
Total Liabilities and Equity	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$69,643,223	$69,382,618

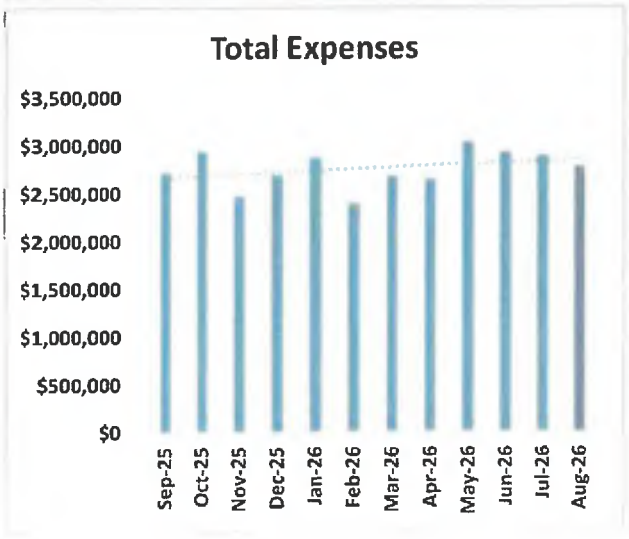
Financial Trends

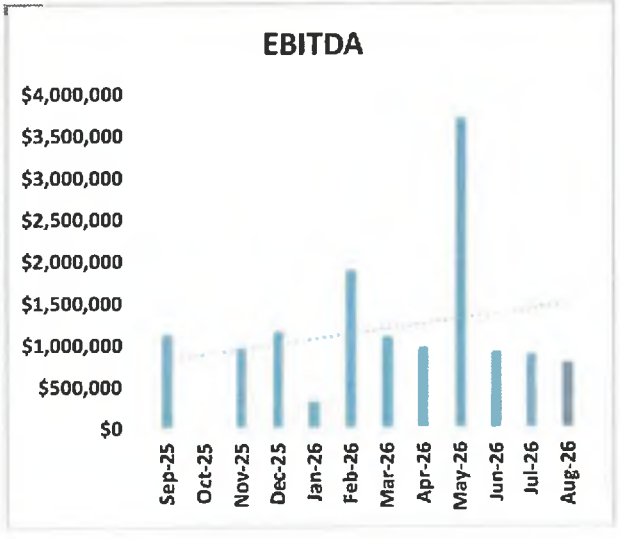












SIERRA VISTA HOSPITAL

POLICIES AND PROCEDURES

DEPARTMENT:	Nursing Administration	Original Policy Date:	February 25, 2026
SUBJECT:	Doula support within Sierra Vista Hospital and Clinics	Review:	**2026** _____ **2027** _____ **2028** _____
		Last Revised:	
APPROVED BY:		Manager:	Sheila F. Adams, RN, MHA, MSN

SCOPE: This policy applies to all Sierra Vista Hospital and Clinics departments, licensed practitioners, employees, contractors, and volunteers involved in obstetric, perinatal, postpartum, emergency, and inpatient services.

PURPOSE: To ensure patient-centered culturally responsive, maternity care by authorizing patients to be accompanied by a doula of their choice during pregnancy-related care, labor and delivery, and up to twelve (12) months postpartum in compliance with New Mexico House Bill 214 (Doula Credentialing and Access Act) and Center for Medicare & Medicaid Services (CMS) Conditions of Participation.

DEFINITIONS:

1. Doula: A trained, non-medical support person who provides services, including health education, advocacy or physical, emotional or social support, to a person during the pre-conception period, pregnancy, childbirth or the postpartum period to promote positive health outcomes.
2. Patient: Any individual receiving pre-conception, pregnancy, childbirth, or postpartum care.
3. Support Person: An individual selected by the patient to provide comfort and assistance during care.

POLICY:

1. Patients have the right to hire and designate a doula to accompany them during applicable care without discrimination based on certification, employment, or reimbursement status.
2. The presence of a doula supports CMS requirements for patient rights, informed decision-making, and culturally competent care.
3. Doula access shall not interfere with the hospital's obligation to provide safe, effective medical care.
4. This policy will be provided in writing to:
    - Health care providers providing services related to pregnancy, childbirth or the 12-month postpartum period at the facility
    - Patients receiving services related to pregnancy, childbirth or the 12-month postpartum period at the facility
    - Any other person, at the request of the patient
5. A notice of the policy and procedure will be posted:
    - In the admitted patient's room (for services related to pregnancy, childbirth, or the 12-month postpartum period
    - On the Sierra Vista Hospital and Clinics website.

ROLES AND RESPONSIBILITIES:

1. Doulas must:
    a. Provide proof of certification in the Doula role.
    b. Provide proof of immunization status including COVID immunization or proof of exemption.
    c. Complete HIPPA training, review infection control policies, and department orientation.
2. Doula provides non-clinical support and must not:
    a. Speak for the patient, interfere with provider/patient conversations and make decisions for the patient.
    b. Does not perform clinical or medical task, such as taking vital signs, perform fetal heart tone checks, adjusting fetal heart monitors, perform vaginal examinations, perform perineal massage or provide postpartum clinical care
    c. Does not diagnose or treat in any modality and will not diagnose medical conditions or present options for medical care.

3. Clinical staff retain full responsibility for medical decision-making and patient care.
4. Hospital leadership ensures staff education and policy enforcement and is responsible for:
    a. Presenting Doula Packet containing HIPPA training, infection control policies and department orientation.
    b. Obtaining proof of certification in the Doula role.
    c. Obtaining proof of immunizations and COVID immunization status.
    d. HIPPA training, infection control policies and department orientation.
    e. Maintaining the records.

PROCEDURE:

1. Patients may identify a doula during prenatal care, admission, or at any time during hospitalization.
2. The doula's presence will be documented in the electronic health record.
3. Doulas must comply with infection prevention, privacy, safety, and emergency procedures.
4. Doulas may remain with the patient unless their presence poses a documented safety risk.

PATIENT RIGHTS AND GRIEVANCE PROCESS: Patients may file a grievance if access to a doula is restricted. Grievances will be handled in accordance with Sierra Vista Hospital and Clinics Patient Bill of Rights and Responsibilities and Patient Complaint/Grievance Procedure, consistent with CMS standards.

STAFF TRAINING AND COMPLIANCE

Staff will receive education on this policy during orientation and annually thereafter.

QUALITY ASSURANCE AND REVIEW

Sierra Vista Hospital and Clinics will monitor compliance through audits, patient feedback, and incident review. This policy will be reviewed at least annually or upon regulatory change.

ASSOCIATED POLICIES:

Patient Bill of Rights and Responsibilities policy #850-01-055
Patient Complaint/Grievance Procedure policy #280-03-109

REFERENCES:

New Mexico House Bill 214 – Doula Credentialing and Access Act retrieved from https://www.nmlegis.gov/Sessions/25%20Regular/final/HB0214.pdf

CMS Conditions of Participation – Patient Rights (42 CFR §482.13) retrieved from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-B/section-482.13

Sierra Vista Hospital Doula support within Sierra Vista Hospital and Clinics policy
Employee Acknowledgement

I, _____, hereby acknowledge that I have received, read, and understood the Doula support within Sierra Vista Hospital and Clinic policy issued by Sierra Vista Hospital & Clinics, effective as of May 1, 2026.

I understand that it is my responsibility to comply with the standards and expectations outlined in the Doula support within Sierra Vista Hospital and Clinics policy. I agree to uphold these principles and understand that any violation may result in disciplinary action, up to and including termination of employment.

By signing below, I confirm my acceptance and understanding of the Doula support within Sierra Vista Hospital and Clinics policy.

_____

Date Employee's Signature

_____

Print Name

Sierra Vista Hospital Doula support within Sierra Vista Hospital and Clinics policy
Provider Acknowledgement

I, _____, hereby acknowledge that I have received, read, and understood the Doula support within Sierra Vista Hospital and Clinic policy issued by Sierra Vista Hospital & Clinics, effective as of May 1, 2026.

I understand that it is my responsibility to comply with the standards and expectations outlined in the Doula support within Sierra Vista Hospital and Clinics policy.

By signing below, I confirm my acceptance and understanding of the Doula support within Sierra Vista Hospital and Clinics policy.

_____ _____

Date Provider's Signature

_____

Print Name

SIERRA VISTA HOSPITAL AND CLINICS	POLICY # 690-05-104
	PAGE: 1 OF: 8
SUBJECT/TITLE: Employee Health Vaccine Standing Order	EFFECTIVE: September 2026
DEPARTMENT/SCOPE: Employee Health, Medical Staff, Pharmacy	OWNER: Bettina Fitzgerald RN, BSN

Purpose:

The purpose of the Employee Health Vaccine Standing Order is to establish a standardized process for assessing vaccination needs and administering recommended vaccines to eligible adult employees/volunteers. The standing orders authorize qualified Employee Health nurses and certified medical assistants, within their scope of practice, to provide vaccinations without an individual employee-specific order when established eligibility criteria are met.

This policy is intended to promote timely access to recommended immunizations, reduce the risk of vaccine-preventable diseases among Sierra Vista Hospital, support workplace health and safety, and ensure vaccination practices are consistent with current clinical recommendations, applicable laws and regulations, and organizational requirements.

Policy:

The Employee Health Standing Orders authorize qualified registered nurses, licensed practicing nurse, and certified medical assistants, acting within their scope of practice and organizational requirements, to assess adult employees/volunteers for vaccination needs and administer vaccines without an individual employee-specific order when the employee/volunteer meets one or more of the eligibility criteria established in the applicable standing order.

Employees/volunteers who do not meet the criteria of the standing order or who require individualized clinical evaluation will be referred to as an authorized healthcare provider for further assessment.

Procedure:

Screen for Contraindications and Precautions

I. Contraindications
   a. Do not give a vaccine to a person who has experienced a serious systemic or anaphylactic reaction to a prior dose of the vaccine or to any of its components.

II. Precautions
   a. Moderate or severe acute illness with or without fever

Provide Vaccine Information Statements

I. Provide all employees/volunteers with a copy of the most current federal Vaccine Information Statement (VIS).

Document Vaccination

I. Medical record: Document the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. You must also document, in the employee medical record, the publication date of the VIS and the date it was given to the employee/volunteer. If vaccine was not administered, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, employee refusal).

Vaccine Administration Preparation

I. Choose the needle gauge, needle length, and injection site according to the following chart:

Gender and Weight	Needle Gauge	Needle Length	Intramuscular Injection Site
Female or male less than 130 lbs	22-25	⅝" - 1"	Deltoid muscle of arm
Female or male 130- 152 lbs	22-25	1"	Deltoid muscle of arm
Female 153-200 lbs	22-25	1 - 1½"	Deltoid muscle of arm
Male 153- 260 lbs	22-25	1 - 1½"	Deltoid muscle of arm
Female 200+ lbs	22-25	1 - 1½"	Deltoid muscle of arm
Male 260 + lbs	22-25	1 - 1½"	Deltoid muscle of arm
Female or male, any weight	22-25	1 - 1½"	Deltoid muscle of arm

Hepatitis B Vaccine

I. Serologic testing

a. If the employee is found to be HBsAg-positive, appropriate medical follow-up should be provided; if the employee is anti-HBs-positive or shows evidence of immunity to HBV (qualitatively reported as "positive" or quantified at least 10 IU/mL), no further doses of hepatitis B vaccine are indicated.

II. Hepatitis B Vaccine Administration

Type of Vaccine	Age Group	Dose	Route
Adult formulation Engerix-B (GSK) or Recombivax HB (Merck)	20 yrs & older	1.0 mL	Intramuscular (IM)

III. Hepatitis B Vaccine Schedule

History of Previous Vaccine	Schedule for Engerix-B, Recombivax HB
None/ unknown/ non-immune	Give a 3-dose series at 0, 1, and 6 months
1 dose	Give dose #2 at least 4 wks after #1; then, give dose #3 at least 8 wks after dose #2 and at least 16 wks after dose #1.
2 doses	Give dose #3 at least 8 wks after dose #2 and at least 16 wks after dose #1

IV. Hepatitis B Vaccine Orders

☐ Hepatitis B adult vaccine 20 mcg/mL intramuscular suspension, 20 mcg = 1 mL, intramuscular

Tetanus, diphtheria, and pertussis (Tdap) Vaccine

I. Vaccination Assessment

a. Lack of documentation of ever receiving a dose of tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap) as an adolescent or adult
b. Lack of documentation of receiving at least 3 doses of tetanus- and diphtheria-containing toxoids
c. Completion of a 3-dose primary series of tetanus- and diphtheria-containing toxoids with no documentation of receiving a booster dose in the previous 10 years.

II. Tdap Vaccine Administration

Type of Vaccine	Age Group	Dose	Route
Tdap Boostrix (GSK) or Adacel (Sanofi)	10 years and older	0.5 mL	Intramuscular (IM)

III. Tdap Vaccine Schedule

Vaccine History	Dose and schedule for administration of Td and Tdap
None/Unknown/Undocumented	Give Tdap as dose #1. Give dose #2 (Td or Tdap) at least 4 weeks later, and dose #3 (Td or Tdap) 6–12 months after dose #2.
1 previous dose (not Tdap)	Give Tdap as dose #2 at least 4 weeks after dose #1. Give dose #3 (Td or Tdap) 6–12 months after dose #2.
1 previous dose (as Tdap)	Give Td or Tdap as dose #2 at least 4 weeks after dose #1. Give dose #3 (Td or Tdap) 6–12 months after dose #2.
2 previous doses (none Tdap)	Give Tdap as dose #3 at least 6 months after dose #2.
2 previous doses (including 1 Tdap)	Give dose #3 (Td or Tdap) at least 6 months after dose #2.
3 or more previous doses (none Tdap)	Give Tdap as soon as possible. (You do not need to wait 10 years from previous dose.)
3 or more previous doses (including 1 or more doses of Tdap)	Give Td or Tdap booster every 10 years

I. Tdap Order

☐ Tetanus/diphth/pertuss (Tdap) adult/adol, 0.5 mL, Intramuscular, Susp

Measles, Mumps, and Rebella (MMR) Vaccine

II. Vaccination Assessment

a. Identify adults in need of initial MMR vaccination who were born in 1957 or later, and either
   i. lack documentation of previous MMR vaccination, and lack laboratory evidence of immunity or disease to measles, mumps, and rubella,
   ii. Healthcare worker of any age, and who do not meet evidence of immunity by having met any of the following criteria:
      1. documentation of receiving at least 1 dose of MMR vaccine
      2. laboratory evidence of immunity or laboratory confirmation of disease to measles, mumps, and rubella

b. Identify adults who have been recommended to receive an additional dose of MMR because of their increased risk for mumps during a current mumps outbreak (resulting in either 2 or 3 total doses)

III. MMR Vaccine Administration

Type of Vaccine	Age Group	Dose	Route
Measles, Mumps, and Rubella Virus Vaccine Live MMR II	6 months and older	0.5 mL	Subcutaneous (SubQ) Use ⅝" Needle tissue over triceps
			Intramuscular (IM)

IV. MMR Vaccine Schedule

Vaccine History	Dose and Schedule for Administration
No documented/ None/ Unknown	Give 0.5 mL MMR as dose #1. If indicated, give dose #2 at least 4 weeks later.
1 previous dose of MMR	If indicated, give 0.5 mL MMR as dose #2 at least 4 weeks after dose #1.

V. MMR Vaccine Orders

- ☐ Measles/mumps/rubella virus vaccine, 0.5 mL, Subcutaneous
- ☐ Measles/mumps/rubella virus vaccine, 0.5 mL, Intramuscular

Influenza Vaccine

I. Vaccination Assessment

a. All adults are recommended to receive influenza vaccination each year.

b. Adults age 65 and older should preferentially receive any one of the following high dose or adjuvanted influenza vaccines: high-dose inactivated influenza vaccine (HD-IIV), recombinant influenza vaccine (RIV), or adjuvanted IIV (aIIV). If none of these three vaccines are available, then any other age-appropriate influenza vaccine should be used.

c. Adults who are or will be pregnant during the influenza season: administer any recommended, age-appropriate IIV or RIV to pregnant people in any trimester.

d. Adults who do not recall whether they received influenza vaccine in the current season should be vaccinated.

e. Do not consider egg allergy of any severity to be a contraindication or a precaution to administration of any influenza vaccine (egg-based or non-egg-based).

II. Influenza Vaccine Administration

Type of Vaccine	Age Group	Dose	Route
Inactivated influenza vaccine (IIV) (Fluzone)	6 months and older	0.5 mL	Intramuscular (IM)
High dose IIV (HD-IIV) (Fluzone High Dose)	65 years and older	0.5 mL	Intramuscular (IM)
Cell culture-based IIV (ccIV) (Flucelvax)	6 months and older	0.5 mL	Intramuscular (IM)

III. Influenza Vaccine Order

- ☐ Fluzone PF Prefilled Syringe 2026-2027, 0.5 mL, Intramuscular, Susp
- ☐ Flucelvax PF Prefilled Syringe 2026-2027, 0.5 mL, Intramuscular, Susp
- ☐ Fluzone High – Dose PF Prefilled Syringe 2026-2027, 0.5 mL Intramuscular, Susp

Adverse Reaction Reporting

I. All Adverse Events to VAERS Report all adverse events following the administration of hepatitis B vaccine to the federal Vaccine Adverse Event Reporting System (VAERS). To submit a VAERS report online (preferred) or to download a writable PDF form, go to http://vaers.hhs.gov/reportevent.html.

Manage Medical Emergencies

I. Administering any medicine, including vaccines, can cause an adverse reaction. Always verify container labels to ensure the correct product is being administered. To reduce the risk of an adverse reaction, screen employee/volunteer for vaccine contraindications and precautions before vaccination

Reaction	Signs and Symptoms	Management
Injection site	Soreness, redness, itching, or swelling	Apply a wet cloth to the injection site. Consider giving medication to reduce pain (e.g., Tylenol) or itching (e.g., Benadryl) if needed.
	Slight bleeding	Apply pressure and an adhesive compress over the injection site.
	Continuous bleeding	Place thick layer of gauze pads over site and maintain direct and firm pressure. Raise the bleeding injection site (e.g., arm) above the level of the employee's heart.
Psychological fright, presyncope, and syncope (fainting)	Anxiety before injection	Have employee sit or lie down for the vaccination.
	Employee feels "faint" (e.g., light-headed, dizzy, weak, nauseated, or has visual disturbance)	Have employee lie flat. Loosen any tight clothing and maintain open airway. Apply cool, damp cloth to employee's face and neck. Keep employee under close observation until full recovery.
	Fall, without loss of consciousness	Check the employee for injury before trying to move the employee. Place employee flat on back with feet elevated.
	Loss of consciousness	Check the employee for injury before trying to move the employee. Place employee flat on back with feet elevated. Call for assistance.
Anaphylaxis	Skin and mucosal symptoms such as generalized hives, itching, or flushing; swelling of lips, face, throat, or eyes. Respiratory symptoms such as nasal congestion, change in voice, sensation of throat closing, stridor, shortness of breath, wheeze, or cough. Gastrointestinal symptoms such as nausea, vomiting, diarrhea, cramping abdominal pain. Cardiovascular symptoms such as collapse, dizziness, tachycardia, hypotension.	See anaphylaxis protocol below.

II. Emergency medical protocol for managing anaphylaxis in adults

a. If itching and swelling are limited to the injection site, observe employee closely for the development of generalized symptoms.

b. If symptoms are generalized, call for a rapid alert. A healthcare professional should assess the airway, breathing, circulation, and level of consciousness of the employee. Monitor vital signs at 5-minute intervals.

c. Epinephrine Dosing information: The most important therapy in anaphylaxis is epinephrine. There are NO absolute contraindications to epinephrine in the setting of anaphylaxis.

   i. First-line treatment: epinephrine is the first-line treatment for anaphylaxis. Vaccine cart emergency box contains 2 (two) Epinephrine Injection single-dose auto injector 0.3 mg for adult use. Administer IM, preferably in the mid-outer thigh. Epinephrine doses may be repeated an additional time at 5–15-minute interval while waiting for the rapid response team.

d. Monitor blood pressure and pulse every 5 minutes. Perform cardiopulmonary resuscitation (CPR), if necessary, and maintain airway. Keep employee in recumbent position (flat on back) unless he or she is having difficulty breathing. If breathing is difficult, employee's head may be elevated, provided blood pressure is adequate to prevent loss of consciousness. If blood pressure is low, elevate legs.

e. Record the employee's reaction (e.g., hives, anaphylaxis) to the vaccine, all vital signs, medications administered to the employee, including the time, dosage, response, and the name of the medical personnel who administered the medication, and other relevant clinical information.
f. Report the incident to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov/reportevent.html.

III. Epinephrine order

☐ EPINEPHrine 0.3 mg injectable kit, 0.3 mg, Intramuscular, Once, Now

References:

Centers for Disease Control and Prevention. *Adult Immunization Schedule by Age: Addendum Updated July 2, 2025.*

Centers for Disease Control and Prevention. *Vaccine-Specific Recommendations: ACIP Recommendations*. Vaccine-Specific Recommendations | ACIP Recommendations

Immunize.org. *Using Standing Orders for Administering Vaccines: What You Should Know*. Updated October 2014.

Occupational Safety and Health Administration. *Bloodborne Pathogens, 29 CFR § 1910. 1030.*. 29 CFR 1910.1030—Bloodborne Pathogens

This policy and procedure shall remain in effect for all employees/volunteers of Sierra Vista Hospital effective _____ until rescinded or until _____.

Medical Director _____ / _____ _____
Name Signature Date

SIERRA VISTA HOSPITAL AND CLINICS	FORM: F-690-05-104-1
SUBJECT/TITLE: Employee Health Vaccine Order Sheet	

Employee/Volunteer Name: _____

Employee/Volunteer Date of Birth: _____ Age: _____

Date of Vaccine Administration: _____

- ☐ Annual Vaccine
- ☐ New Hire Vaccines
- ☐ Occupational Exposure Vaccine

Vaccine Orders:

Hepatitis B Vaccine:

- ☐ Hepatitis B adult vaccine 20 mcg/mL intramuscular suspension, 20 mcg = 1 mL, intramuscular

Measles, Mumps, and Rebella (MMR) Vaccine:

- ☐ Measles/mumps/rubella virus vaccine, 0.5 mL, Subcutaneous
- ☐ Measles/mumps/rubella virus vaccine, 0.5 mL, Intramuscular

Tetanus, diphtheria, and pertussis (Tdap) Vaccine:

- ☐ Tetanus/diphth/pertuss (Tdap) adult/adol, 0.5 mL, Intramuscular, Susp

Influenza Vaccine:

- ☐ Fluzone PF Prefilled Syringe 2026-2027, 0.5 mL, Intramuscular, Susp
- ☐ Flucelvax PF Prefilled Syringe 2026-2027, 0.5 mL, Intramuscular, Susp
- ☐ Fluzone High – Dose PF Prefilled Syringe 2026-2027, 0.5 mL Intramuscular, Susp

Medical Emergencies:

- ☐ EPINEPHrine 0.3 mg injectable kit, 0.3 mg, Intramuscular, Once, Now

This policy and procedure shall remain in effect for all employees/volunteers of Sierra Vista Hospital effective _____ until rescinded or until _____.

Medical Director _____ / _____ _____
Name Signature Date

SIERRA VISTA HOSPITAL AND CLINICS		POLICY # 513-02-015
		PAGE: 1 OF: 4
SUBJECT/TITLE: Emergency Cart Medications		EFFECTIVE: 1997
DEPARTMENT/SCOPE: Cardiopulmonary, Nursing, Medical Staff, Radiology, Rehab Center, Pharmacy	OWNER: Melissa Biemer Pharm.D., RPh	

Purpose:

To establish a standardized process for the control, security, inspection, restocking, documentation, and maintenance of medications contained in emergency carts ("crash carts") throughout patient care areas.

Policy:

Emergency cart medications shall be maintained in a manner that ensures medications are secure and readily accessible for emergency patient care. Emergency carts shall remain secured when not in use and shall be inspected, restocked, documented, and checked according to this policy.

Procedure:

Responsibilities:

I. Pharmacy staff is responsible for the medication-related components of emergency cart management, including:
   a. Inspection of returned medication trays.
   b. Medication inventory and charging.
   c. Medication tray restocking.
   d. Expiration-date monitoring.
   e. Documentation and filling of completed emergency cart medication forms.
   f. Application of medication drawer expiration labels.

II. The pharmacist is responsible for the final verification of the medication tray prior to placement in the emergency cart. The pharmacist shall verify that the medication tray has been accurately restocked according to the approved Emergency Cart Medication List and Layout Form and shall provide the required signature/sign-off documenting completion of the final verification.

Receipt and Inspection of Medication Trays:

I. The pharmacy technician or pharmacist receiving an emergency cart medication tray shall inspect the tray for obvious contamination before accepting it. All medications and fluids shall be removed from the emergency cart and returned to the Pharmacy for inspection, reconciliation, and restocking.

II. If contamination is identified, including blood, body fluids, or other visible contaminants, pharmacy personnel shall not accept the medication tray. The medication tray shall remain in the patient room until it has been properly decontaminated in accordance with infection prevention and environmental cleaning procedures.

III. The medication tray must be accompanied by the patient identification sticker for the patient for whom the medications were received/used.

Medication Inventory and Patient Charging:

I. Before restocking an emergency cart, pharmacy personnel shall use the Adult Emergency Cart Medication List and Layout Form to inventory medications used during the emergency.
II. The completed form shall be used to facilitate appropriate patient charging for medications utilized during the emergency.
III. Once charging has been completed, the pharmacy technician shall:
    a. Date the form.
    b. Write "CHARGED" on the form.
IV. Completed forms shall be filed in the designated pharmacy filing cabinet according to date.

Restocking Emergency Cart Medications:

I. A new Adult Emergency Cart Medication List and Layout Form shall be prepared for each emergency cart being restocked.
II. Emergency cart medications shall be restocked according to the approved Adult Emergency Cart Medication List and Layout Form.
III. Medications placed in emergency cart trays should have an expiration date of no sooner than three months from the date of restocking, unless the medication is subject to an approved shortage or other documented exception.
IV. If a medication drawer is soiled with dust, dirt, or other residue, the drawer shall be cleaned with a damp cloth and thoroughly dried before medications are restocked.

Expiration-Date Documentation:

I. When the medication tray is restocked, the earliest expiration date for each medication shall be recorded in the EXP box next to the applicable medication name on the Adult Emergency Cart Medication List and Layout Form.
II. The earliest expiration date of all medications contained in the completed tray shall be recorded next to Cart Expiration Date on the form.
III. Pharmacy personnel shall ensure that expiration dates are clearly documented and accurately reflect the medications contained in the tray.

Independent Double Check:

1. All medication trays shall be independently double-checked before being released for placement in an emergency cart.
2. The pharmacist or pharmacy technician who restocks the tray shall sign the designated space on the Adult Emergency Cart Medication List and Layout Form.
3. A pharmacist shall independently verify the completed tray and shall sign the designated pharmacist space.
4. The completed form shall then be placed in the Emergency Cart Binder located in the pharmacy.

Tamper Locks:

I. Each emergency medication tray will be sealed with two (2) blue safety seal. The number on each safety seal will be documented on the Adult Emergency Cart Medication List and Layout Form.
II. The emergency medication tray will be sealed with a security bag with a red border. An expiration date label will be placed on the exterior of the bag.
III. Each emergency cart shall be equipped with a security/tamper-evident lock and shall remain locked unless the cart is required for an emergency or authorized inspection/restocking.
IV. If the security lock is broken, missing, or otherwise not intact:
    a. The cart shall be checked for missing or used supplies and medications.
    b. Any medications or supplies that have been used or are missing shall be replaced as applicable.
    c. A new security lock shall be applied after the cart has been inspected and appropriately restocked.
V. Pharmacy personnel shall document the breaking of a security seal when medications are inventoried or restocked. Documentation shall be completed on the **Emergency Cart Daily Checklist** maintained with the emergency cart.

Emergency Cart Medication Drawer Labeling:

I. After the medication tray has been restocked and returned to the emergency cart, a label shall be placed on the exterior of the medication drawer.
II. The label shall include:
    a. The expiration date of the first medication to expire in the tray.
    b. The date the medication drawer was filled/checked.

Documentation:

The Adult Emergency Cart Medication List and Layout Form shall be used to document medications administered to the patient during the emergency. After the medication charges have been reviewed and verified, Pharmacy staff shall send a copy of the completed form to Health Information Management (HIM) for scanning into the patient's medical record.

References:

The Joint Commission. (2017, April). *Crash-cart preparedness* (Quick Safety Issue 32). The Joint Commission – Crash-cart preparedness

Adult Emergency Cart Medication List and Layout

Atropine Sulfate prefilled syringe (1mg/10mL)
Qty: 3 Used:
Exp:

Adenosine Vial (12mg/4mL)
****USE BAG & HIGH ALERT LABEL****
Qty: 4 Used:
Exp:

Sodium Chloride 0.9% Flush (10mL)
Qty: 6 Used:
Exp:

Dopamine premixed bag (400mg/250mL)
Qty: 1 Used:
Exp:

Flumazenil vial (0.5mg/5mL)
Qty: 1
Used:
Exp:

Epinephrine MDV (10mg/10mL)
Qty: 1
Used:
Exp:

Epinephrine ABBOJECT (1mg/10mL)
Qty: 3 Used:
Exp:

Lidocaine premixed bag (2gram/500mL)
Qty: 1 Used:
Exp:

Amiodarone vial (150mg/3mL)
Qty: 4 Used:
Exp:

Epinephrine ABBOJECT (1mg/10mL)
Qty: 3 Used:
Exp:

Calcium Chloride prefilled syringe (1g/10mL)
Qty: 2 Used:
Exp:

Magnesium Sulfate vial (1gram/2mL)
Qty: 1 Used:
Exp:

Lidocaine prefilled syringe (100mg/5mL)
Qty: 2 Used:
Exp:

Naloxone prefilled Syringe (2mg/2mL)
Qty: 2 Used:
Exp:

SIERRA VISTA HOSPITAL AND CLINICS

☐ Cart Expiration Date: _____

☐ Fill Date: _____

☐ Filled By: _____

☐ Checked By: _____

☐ Crash Cart: _____

Patient Identification

Blue Seal: _____
Blue Seal: _____
Yellow Seal: _____

Dextrose 50% ABBOJECT (25g/50mL)
Qty: 2 Used: Exp:
Sodium Bicarbonate 8.4% ABBOJECT (50mEq/50mL)
Qty: 2 Used: Exp:
Sodium Chloride 0.9% 1000mL
Qty: 2 Used: Exp:
Lactated Ringer 1000mL
Qty: 2 Used: Exp:
Sodium Chloride 0.9% 250mL
Qty: 1 Used: Exp:

SIERRA VISTA HOSPITAL AND CLINICS	POLICY # 690-04-025
	PAGE: 1 OF: 18
SUBJECT/TITLE: Occupation Exposure to Blood Borne Pathogens	EFFECTIVE: October 2026
DEPARTMENT/SCOPE: All Departments	OWNER: Bettina Fitzgerald RN, BSN

Purpose:

To establish a standardized process for the immediate reporting, evaluation, treatment, documentation, and follow-up of employees who experience occupational exposure to blood or other potentially infectious materials.

The facility will provide prompt and confidential medical evaluation and follow-up following an occupational exposure in accordance with the OSHA Bloodborne Pathogens Standard and current Centers for Disease Control and Prevention (CDC) guidance.

Policy:

Sierra Vista Hospital is committed to prevent occupational exposure to bloodborne pathogens, including hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

All occupational exposures shall be treated as potentially urgent medical events. Employees shall immediately report exposures and shall not delay medical evaluation while awaiting source-patient laboratory results.

When clinically indicated, HIV post-exposure prophylaxis (PEP) shall be initiated as soon as possible. PEP should not be delayed while awaiting laboratory results when exposure presents a substantial risk for HIV transmission.

Definitions:

Occupational Exposure: A reasonably anticipated skin, eye, mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious material that may result from an employee's duties.

Exposure Incident: A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious material that occurs during the performance of an employee's duties.

Source Individual/Patient: Any individual, living or deceased, whose blood or other potentially infectious material may have been the source of an occupational exposure.

Post-Exposure Prophylaxis (PEP): Antiretroviral therapy administered following potential HIV exposure to reduce the likelihood of HIV infection.

Procedure:

Responsibilities

I. Employee
   a. When safe to do so, immediately stop activity or exposure.
   b. Perform appropriate first aid to exposed area.
   c. Report exposure immediately to supervisor.
   d. Participate in the exposure evaluation and follow-up process.

II. Supervisor/Charge Nurse
   a. Provide first aid.
   b. Report exposure without delay.
   c. Notify Infection Prevention/Employee Health department.
   d. Ensure employee receives an immediate medical evaluation.
   e. Assist with source patient identification and testing.
   f. Complete all required incident documentation.

III. Employee Health/Infection Prevention
   a. Ensure employee receives an initial medical evaluation and appropriate follow-up.
   b. Verify employee Hepatitis B vaccination and immunity status.
   c. Coordinate source-patient testing.
   d. Coordinate follow-up laboratory testing.
   e. Provide counseling and education.
   f. Maintain employee health record.
   g. Review exposure incidents for trends and opportunities for prevention.

IV. Sierra Vista Hospital Provider
   a. Provide the initial medical evaluation.
   b. Assess the source patient, as appropriate.
   c. Order initial laboratory testing.
   d. Assess the need for HIV PEP treatment.
   e. Complete the Occupation Exposure to Blood Borne Pathogens – Medical Evaluation F-690-04-025-3.
   f. Provide counseling and education.

Immediate Management of a Needle Stick or Sharpes Injury

I. Skin or Puncture Exposure
   a. Wash the affected area immediately with soap and water.
   b. Do not squeeze, scrub aggressively, or use caustic agents on the wound.
   c. Remove contaminated clothing if necessary.
   d. Cover the wound with appropriate dressing after cleansing.

II. Eye Exposure
    a. Immediately flush the eye with water, saline, or an appropriate sterile irrigation.
III. Mouth or Mucous Membrane Exposure
    a. Immediately flush the affected area thoroughly with water.

Reporting

The employee shall report the exposure immediately to the supervisor or designated reporting individual. The employee and supervisor shall complete Occupation Exposure to Blood Borne Pathogens - Exposure Report F-690-04-025-2.

Source Evaluation

The source patient should be assessed clinically and epidemiologically by the provider to determine the likelihood of the presence of viral infection.

The source patient should be informed of the incident and requested to consent to hepatitis B, hepatitis C and HIV testing. Written informed consent from the source patient is required to perform the test. If the exposure was from a high-risk patient and the exposure was from a large bore needle that had been in the patient's vein or artery, the provider may allow testing of the patient's blood without the patient's consent if and only if the laboratory has the patient's blood sample on hand that was already drawn for another test (NM State Statute 24-2B-2). The source patient's refusal to be tested must be documented by the provider.

If the source patient has evidence of HIV infection or AIDS, the affected employee should have an HIV laboratory test. They should be evaluated clinically for the possibility of receiving the HIV post-exposure prophylaxis treatment. Written informed consent from the employee is required to receive this regimen of HIV Post Exposure Treatment Form F-690-04-025-7.

Initial Employee Medical Evaluation

The exposed employee shall receive a medical evaluation from Sierra Vista Hospital Emergency Department as soon as possible. The following shall be evaluated:

I. Route and type of exposure
II. Depth of injury
III. Source-patient HIV status, if known
IV. Source-patient HBV and HCV status, if known
V. Employee's HBV vaccination and immunity status
VI. Employee's medical history and current medications
VII. Pregnancy status when clinically appropriate
VIII. Potential drug interactions or contraindications to HIV prophylaxis

Baseline Laboratory Testing

After appropriate counseling and consent, baseline testing shall be obtained as clinically indicated.

Baseline Testing May Include:

- ☐ HIV baseline testing (HIV Screen TC)
- ☐ Hepatitis B testing (Hepatitis B Virus Profile TC)
- ☐ Hepatitis C testing (Hepatitis C Virus Antibodies TC)
- ☐ Serum creatinine
- ☐ Hepatic function testing
- ☐ Additional testing required based on the selected HIV PEP regimen

Baseline blood collection and testing shall occur as soon as possible. OSHA requires employers to offer baseline HIV and HBV testing available following an exposure.

Hepatitis B Management

Hepatitis B virus (HBV) is more readily transmitted through occupational exposure to infected blood than HIV because HBV may be present in high concentrations in the blood of infected individuals. As a result, an occupational exposure to HBV may carry a significant risk of infection, depending on the nature of the exposure and the source patient's infection status.

Many individuals infected with HBV are asymptomatic. When symptoms occur, they may include fatigue, flu-like symptoms, abdominal discomfort, loss of appetite, nausea, and jaundice. Both symptomatic and asymptomatic individuals may transmit HBV to others. Some individuals who become infected may develop chronic HBV infection and may unknowingly transmit the virus.

Following an occupational exposure to blood or other potentially infectious materials, the employee's hepatitis B vaccination and immunity status shall be reviewed promptly.

Management may include:

I. **No treatment:** No post-exposure prophylaxis may be necessary when the employee has documented adequate immunity to hepatitis B.
II. **Hepatitis B vaccination:** Hepatitis B vaccination shall be provided when indicated based on the employee's documented vaccination and serologic status.
III. **Hepatitis B immune globulin (HBIG):** HBIG may be administered when clinically indicated based on the source patient's HBV status and the employee's vaccination and immunity status.
IV. **Testing and follow-up:** Additional laboratory testing, counseling, and medical follow-up shall be provided when indicated.

All post-exposure evaluation and management shall be conducted in accordance with current guideline and the employee's documented hepatitis B vaccination and serologic status.

Hepatitis C Management

Hepatitis C virus (HCV) is a bloodborne pathogen that can be transmitted through occupational exposure to the blood of an infected individual. Healthcare workers may be at risk of HCV infection following an accidental occupational exposure to blood or other potentially infectious materials.

There is currently no recommended routine post-exposure prophylaxis medication for hepatitis C. Therefore, post-exposure management focuses on timely evaluation, laboratory testing, and follow-up to identify possible HCV infection as early as possible.

I. **Baseline testing:** Baseline hepatitis C testing shall be performed as soon as possible following the exposure, in accordance with current clinical recommendations.

II. **Follow-up testing:** Follow-up HCV testing shall be performed at the intervals recommended by current CDC guidance and based on the circumstances of the exposure.

If testing indicates evidence of HCV infection, the employee shall be referred promptly to an appropriately qualified healthcare provider for further medical evaluation and consideration of treatment.

HIV Post-Exposure Prophylaxis (PEP) Management

HIV infection may be asymptomatic for years, and clinical manifestations of HIV infection can vary considerably. HIV is transmitted through exposure to certain body fluids, including blood, semen, vaginal fluids, rectal fluids, and breast milk, when the fluid encounters mucous membranes, damaged tissue, or the bloodstream. HIV is not transmitted through casual contact or exposure to sweat, tears, or saliva when not contaminated with blood.

Employees evaluated for a potential occupational HIV exposure shall receive appropriate baseline clinical evaluation and laboratory testing. Follow-up HIV testing and other indicated laboratory monitoring shall be arranged by the employee health nurse based on the exposure, the PEP regimen, and current clinical guidance.

Exposure to HIV is a medical emergency. Occupational HIV post-exposure prophylaxis (PEP) should be evaluated and initiated as soon as possible when clinically indicated. PEP is most effective when started promptly, ideally within 24 hours of exposure, and should be initiated no later than 72 hours after exposure when indicated.

PEP should not be delayed solely because source-patient HIV testing or other laboratory results are pending when the exposure represents a substantial risk for HIV transmission. If the source patient is subsequently determined to be HIV-negative, PEP may be discontinued in consultation with the treating provider.

Determining whether PEP is indicated:

I. Exposure route
II. Type and quantity of body fluid
III. Severity of exposure
IV. HIV status of source patient
V. Source viral load, if known
VI. Likelihood of HIV Infection
VII. Employee-specific clinical factors
VIII. Potential drug interactions and contraindications

When HIV PEP is indicated, the employee shall receive the first dose as soon as possible. The first dose should not be delayed while awaiting laboratory results when the clinical assessment supports initiation of PEP.

The standard PEP course is generally 28 days, unless provider modifies treatment course based on patient-specific circumstances.

The specific antiretroviral regimen shall be selected by the treating physician in accordance with CDC HIV PEP Guidelines, taking into consideration renal function, hepatic function, pregnancy, concomitant medications, drug interactions, and potential resistance.

The employee shall be provided with appropriate counseling regarding PEP adherence, potential adverse effects, follow-up testing, and measures to reduce the risk of secondary HIV transmission during the follow-up period.

Sierra Vista Hospital will stock the following medications for PEP regimen. If the patient requires a different PEP regimen the desire regimen can be sent to their retail pharmacy of choice.

I. Truvada® - tenofovir disoproxil fumarate (TDF) 300 mg + emtricitabine (F) 200 mg once daily
II. Isentress® - raltegravir (RAL) 400 mg twice daily

Sierra Vista Hospital shall provide the employee with the initial 28-day PEP course when clinically indicated and prescribed. Because certain antiretroviral medications used for HIV PEP may not be appropriate for repackaging, the medication shall be dispensed from the Emergency Department in the manufacturer's original packaging, as applicable.

The Emergency Department shall provide the employee with the medication and appropriate instructions for administration as prescribed by the treating healthcare provider. The dispensing provider shall dispense the medication in accordance with applicable New Mexico Board of Pharmacy requirements and Sierra Vista Hospital Policy #513-04-004.

Documentation of medication dispensing, counseling, and follow-up shall be maintained in the patient's electronic health record.

References:

Occupational Safety and Health Administration. (n.d.). *Bloodborne pathogens and needlestick prevention—29 CFR 1910.1030.*

Centers for Disease Control and Prevention. (2025). *Clinical guidance for PEP.*

Centers for Disease Control and Prevention. (2025). *HIV occupational transmission.*

Centers for Disease Control and Prevention. (2025). *Antiretroviral postexposure prophylaxis after sexual, injection drug use, or other nonoccupational exposure to HIV—United States, 2025.*

Employee Information:

I. **Employee Name:** _____
II. **Date of Birth:** _____
III. **Phone Number:** _____
IV. **Date of Injury:** _____

Supervisor Notification:

- ☐ **Name of Supervisor Notified:** _____
- ☐ **Date of Notification:** _____
- ☐ **Time of Notification:** _____

HSC Risk Management Services Supervisor's Incident/Accident Investigation Report:

- ☐ **Incident/Accident Investigation Report Completed – F-855-01-042-2**
- ☐ **Date of Completion:** _____

Occupation Exposure to Blood Borne Pathogens – Exposure Report:

- ☐ **Exposure Report Completed – F-690-04-025-2**
- ☐ **Date of Completion:** _____

Occupation Exposure to Blood Borne Pathogens – Medical Evaluation:

- ☐ **Medical Evaluation Completed – F-690-04-025-3**
- ☐ **Date of Completion:** _____

Occupation Exposure to Blood Borne Pathogens – Sharpes Injury Log:

- ☐ **Sharpe Injury Log Completed – F-690-04-025-6**
- ☐ **Date of Completion:** _____

Occupation Exposure to Blood Borne Pathogens – Employee HIV Blood Draw Consent (if indicated):

- ☐ **Employee HIV Blood Draw Consent (If indicated) – F-690-04-025-4**
- ☐ **Date of Completion:** _____

Occupation Exposure to Blood Borne Pathogens – HIV PEP Treatment Form (if indicated):

- ☐ **Employee HIV PEP Treatment Form (if indicated) – F-690-04-025-7**
- ☐ **Date of Completion:** _____

Occupation Exposure to Blood Borne Pathogens – Follow-up Instruction Form:

- ☐ **Follow-up Instruction Form – F-690-04-025-8**
- ☐ **Date of Completion:** _____

REFUSAL OF TREATMENT:

Occupation Exposure to Blood Borne Pathogens – Refusal of Treatment Statement:

- ☐ **Refusal of Treatment Statement – F-690-04-025-5**
- ☐ **Date of Completion:** _____

Employee Information:

I. **Employee Name:** _____
II. **Date of Birth:** _____
III. **Phone Number:** _____
IV. **Date of Injury:** _____
V. **Department/Job Title:** _____
VI. **Patient's Medical Record:** _____
VII. **Date of Report:** _____
VIII. **Time of Report:** _____

Exposure Information:

I. **Date of Exposure:** _____
II. **Time of Exposure:** _____
III. **Location of Exposure:** _____
IV. **Body Site Exposed:** _____
V. **Type of Exposure:**
- ☐ Needlestick/sharps injury
- ☐ Blood contact with broken skin
- ☐ Blood contact with mucous membrane
- ☐ Human bite
- ☐ Other: _____

VI. **Type of Potentially Infectious Material:**
- ☐ Blood
- ☐ Blood-containing body fluid
- ☐ Vaginal secretions
- ☐ Seminal fluid
- ☐ Internal body fluids: _____
- ☐ Unknown

VII. **Exposure Category:**
- ☐ Non-Parenteral
- ☐ Possible Parenteral
- ☐ Doubtful Parenteral
- ☐ Definite Parenteral

VIII. **Exposure Severity:**
a. How much fluid: _____
b. How long was exposure: _____
c. How severe was the injury: _____

II. **Additional Information:**
_____
_____

Source Information:

I. Patient Name, if known: _____
II. Exact location exposure took place: _____

Describe Activity Leading to Exposure:

- ☐ Giving Injection
- ☐ Recapping Needles
- ☐ Discarding Needles
- ☐ Handling IV Lines
- ☐ Other: _____
- ☐ Handling Disposal Box
- ☐ Cleaning Blood Spills
- ☐ Handling Waste Products
- ☐ Handling Lab Specimens
- ☐ Controlling Bleeding
- ☐ Performing Invasive Procedure

Describe Situation Precisely:

_____

_____

I.	Describe the area	☐ Washed	☐ Flushed
II.	Did injury bleed freely?	☐ Washed	☐ Flushed
III.	Was antiseptic applied?	☐ Washed	☐ Flushed
IV.	Other: _____		

Employee Signature: _____ **Date/Time:** _____

Evaluation of Exposure by Employee Health Nurse or Infection Control Practitioner:
Brief Description of Events:

_____

_____

I.	Was this a bona fide exposure to blood or bloody fluids potentially infectious for bloodborne pathogens?	☐ Yes	☐ No
II.	Was site care rendered in a timely manner?	☐ Yes	☐ No
III.	Was the source resident identified and evaluated?	☐ Yes	☐ No
IV.	Was source positive for HBV?	☐ Yes	☐ No
V.	Was source positive for HIV?	☐ Yes	☐ No
VI.	Was HBV prophylaxis offered?	☐ Yes	☐ No
VII.	Treatment Regimen: _____		
VIII.	Was follow-up immunization provided for HBV?	☐ Yes	☐ No

Corrective measures taken to ensure prevention in the future:

_____

_____

Employee Health Nurse/Designee Name: _____ **Title:** _____

Employee Health Nurse/Designee Signature: _____ **Date/Time:** _____

Employee Information:

I. **Employee Name:** _____
II. **Date of Birth:** _____
III. **Date of Injury:** _____
IV. **Patient's Medical Record:** _____
V. **Date of Report:** _____
VI. **Time of Report:** _____

Exposure History:

Description of Exposure/Injury:

_____
_____
_____

Was the exposed area washed/flushed? ☐ Yes; _____ ☐ No

Source Information:

Source Known? ☐ Yes ☐ No

Source Patient Name/Identifier: _____

Source patient HIV status	☐ Positive	☐ Negative	☐ Unknown
Source patient Hepatitis B status	☐ Positive	☐ Negative	☐ Unknown
Source patient Hepatitis C status	☐ Positive	☐ Negative	☐ Unknown

Source testing ordered ☐ HIV(Consent) ☐ Hepatitis B ☐ Hepatitis C

Date/Time Source Testing Obtained: _____

Employee Medical History:

Previous known HIV infection?	☐ Yes	☐ No	☐ Unknown
Previous Hepatitis B infection?	☐ Yes	☐ No	☐ Unknown
Previous Hepatitis C infection?	☐ Yes	☐ No	☐ Unknown

Hepatitis B vaccination documentation available? ☐ Yes ☐ No

Hepatitis B vaccination history:

☐ Completed series	☐ Partial series	☐ Not vaccinated	☐ Unknown
Known Hepatitis B immunity/titer:	☐ Immune	☐ Non-immune	☐ Unknown

Tetanus vaccination history: ☐ Up to Date ☐ Past Due ☐ Unknown

Physical Examination:

Exposure/Injury Site Examination:

_____
_____
_____

Other Pertinent Findings:

_____

_____

_____

Baseline Laboratory Evaluation:
Testing should be ordered according to the exposure risk and clinical guidelines.

☐ HIV baseline testing (HIV Screen TC)
☐ Hepatitis B testing (Hepatitis B Virus Profile TC)
☐ Hepatitis C testing (Hepatitis C Virus Antibodies TC)
☐ Liver function testing, if clinically indicated
☐ Pregnancy testing, if clinically indicated
☐ Other: _____

Baseline testing obtained: ☐ Yes ☐ No ☐ Declined
Date/Time Testing Obtained: _____

Post-Exposure Management:
HIV Post-Exposure Prophylaxis Evaluation:
☐ Not Indicated ☐ Indicated/Offered ☐ Initiated ☐ Declined

Time PEP was offered: _____

Time first dose(s) administered/taken, if applicable: _____

Hepatitis B Post-Exposure Management:
☐ Not Indicated ☐ Vaccine indicated ☐ HBIG indicated ☐ Declined ☐ Status pending

Hepatitis C Follow-up:
☐ Baseline Testing Obtained ☐ Follow-up Testing Recommended ☐ Referred for follow-up

Medications/Treatments Provided:

_____

_____

_____

Diagnosis: _____
Disposition: _____

Provider's Signature: _____ **Date/Time:** _____

Employee Information:

I. **Employee Name:** _____
II. **Date of Birth:** _____
III. **Date of Injury:** _____
IV. **Patient's Medical Record:** _____
V. **Date of Report:** _____
VI. **Time of Report:** _____

Reason for Testing:

I have been informed that I may have been exposed to blood or another potentially infectious body fluid. HIV testing has been recommended as part of the medical evaluation of this exposure.

Testing:

I authorize the collection of a specimen for HIV testing as clinically indicated.
I understand that:

I. The purpose of the test is to determine whether HIV infection is present.
II. HIV testing may require appropriate follow-up or repeat testing depending on the timing of the exposure and the type of test performed.
III. A reactive/positive screening result dose not, by itself, establish a final diagnosis and requires confirmatory testing.
IV. A negative test result may not completely exclude a recent HIV infection because testing has limitations during the early period following infection.

Confidentiality:

I understand that HIV test results are confidential and that disclosure is subject to applicable state and federal laws. Except as permitted or required by law, my HIV test results will not be disclosed to people other than those involved in my medical care or otherwise authorized to receive such information without my specific written consent.
I understand that certain disclosures may be permitted or required by law, including disclosures to specified individuals or public health authorities under applicable circumstances. Information relating to HIV testing and results will be maintained in my medical record in accordance with applicable privacy requirements and facility policy.

Counseling and Follow-up:

I have been given an opportunity to ask questions about HIV testing, the potential meaning of the results, and recommended follow-up.
I understand that evaluation for HIV post-exposure prophylaxis (PEP) may be time-sensitive when indicated, and I have been advised regarding the need for prompt medical assessment.

Consent:

By signing below, I acknowledge that I have received an explanation of the HIV test, its purpose, and the potential implications of the results. I have had an opportunity to ask questions, and my questions have been answered.

☐ **I Consent to HIV Testing**

Employee Signature: _____ **Date/Time:** _____

Person Obtaining Consent Name: _____ **Title:** _____

Person Obtaining Consent Name Signature: _____ **Date/Time:** _____

Employee Information:

I. **Employee Name:** _____
II. **Date of Birth:** _____
III. **Date of Exposure:** _____
IV. **Time of Exposure:** _____

Recommended Evaluation:

I have been advised to undergo prompt medical evaluation following this potential blood-borne pathogen exposure. I understand that evaluation may include assessment and testing for HIV, hepatitis B, and hepatitis C, as clinically indicated.

I have also been informed that certain preventative measures or treatments may be time-sensitive, and that delaying evaluation may reduce available options.

Risk of Refusal:

The potential risks of declining evaluation include, but are not limited to:

I. Failure to identify an infection resulting from the exposure.
II. Missing an opportunity for time-sensitive preventive treatment when indicated.
III. Potential transmission of an infection to others if an infection is acquired.
IV. Other risks associated with delayed diagnosis or treatment.

Refusal

Despite the information provided to me, I decline medical evaluation and/or recommended testing or treatment related to this potential blood-borne pathogen exposure.

I have had an opportunity to ask questions, and my questions have been answered to my satisfaction.

Employee Signature: _____ **Date/Time:** _____

Witness Signature: _____ **Date/Time:** _____

Name/Title of Person Providing Information: _____

Signature: _____ **Date/Time:** _____

Please complete a log for each employee exposure incident involving a sharp.

Employee Information:

I. **Employee Name:** _____

II. **Department:** _____

III. **Date of Injury:** _____

IV. **Time of Injury:** _____

Complete this form and direct the employee to the Emergency Department or Walk-In Clinic for evaluation by a healthcare provider. The Sharps Injury Log must be submitted to the Infection Control/Employee Health Nurse or designee after the employee has been evaluated by a provider.

Description of the Exposure Incident:

_____
_____
_____
_____
_____
_____
_____
_____

Job Classification

- ☐ MD
- ☐ Nurse: RN LPN/LVN CNA/MA
- ☐ Tech: EMT RT RAD
- ☐ Phlebotomist/Lab Tech
- ☐ Housekeeper/Janitor
- ☐ Student: _____
- ☐ Other: _____

Department /Location

- ☐ Med/Surg
- ☐ Emergency Department
- ☐ Radiology
- ☐ Rural Health Clinic
- ☐ Laboratory
- ☐ Service/Utility Area
- ☐ Patient Room: _____
- ☐ Nurse's Station
- ☐ Other: _____

Procedure

- ☐ Draw venous blood
- ☐ Draw arterial blood
- ☐ Injection, though skin
- ☐ Start IV/set up saline lock
- ☐ Heparin Flush/Saline Flush
- ☐ Cutting
- ☐ Suturing
- ☐ Unknown/not applicable
- ☐ Other: _____

Did the exposure incident occur?

- ☐ During use of sharp
- ☐ Between steps of a multistep procedure
- ☐ After use and before disposal of sharp
- ☐ While putting sharp into disposal container
- ☐ Sharp left in inappropriate place (table, bed, etc)
- ☐ Disassembling
- ☐ Other: _____

Body Part
Check all that apply

- ☐ Finger
- ☐ Hand ☐ R ☐ L
- ☐ Arm ☐ R ☐ L
- ☐ Face/Head
- ☐ Torso
- ☐ Leg ☐ R ☐ L

Identify Sharp Involved
If known

Type: _____

Brand: _____

Model: _____

I.e. 18 G needle/ABCmedical/"NoStick" syringe

Did the device being used have engineered sharps injury protection?
☐ Yes ☐ No ☐ Unknown

Was the protective mechanism activated?
☐ Yes- Fully ☐ Yes – Partially ☐ No

Did the exposure incident occur?
☐ Before Activation ☐ During Activation ☐ After Activation

Exposed Employee:

If sharp had no engineered sharps injury protection, do you have an opinion that such a mechanism could have prevented the injury?
☐ Yes ☐ No
Explain: _____
_____

Do you have an opinion that any other engineering, administrative or work practices control could have prevented the injury?
☐ Yes ☐ No
Explain: _____
_____

Employee Information:

I. **Employee Name:** _____

II. **Date of Birth:** _____

III. **Date :** _____

IV. **Date of Exposure:** _____

HIV Post-Exposure Prophylaxis (PEP) Counseling:

The employee has been counseled regarding HIV Post-Exposure Prophylaxis (PEP) following an occupation exposure to blood or other potentially infectious materials.

The employee understands that PEP is intended to reduce the risk of HIV infection following a potential exposure and that medications should be taken exactly as prescribed.

Information Reviewed with Employee:

The following information has been reviewed and discussed with the employee:

- ☐ *Purpose of HIV PEP*: Reduces the risk of HIV infection following an occupation exposure.
- ☐ *Importance of Prompt Therapy*: Starting PEP therapy as soon as possible when recommended by a healthcare provider.
- ☐ *Medication Instructions*: How and when to take the prescribed medication(s), including when the duration of therapy.
- ☐ *Common Side Effects:* Which may include nausea, vomiting, diarrhea, headache, fatigue, dizziness, or other symptoms.
- ☐ *Potential Serious or Concerning Side Effects*: The employee has been advised to seek medical attention promptly if potentially life-threatening or severe symptoms develop, such as difficulty breathing, swelling of the face or throat, severe allergic reaction, severe rash, or other symptoms requiring immediate attention.
- ☐ *Pregnancy and Breastfeeding Considerations*: The employee was informed that pregnancy status and breastfeeding considerations may affect the selection and management of PEP medications. The employee was instructed to notify the healthcare provider if pregnant, planning to become pregnant, breastfeeding, or if pregnancy occurs while taking PEP.
- ☐ *Medication Interactions*: The employee was instructed to inform the healthcare provider and/or pharmacist of all prescription medications, over-the-counter medications, vitamins, supplements, and other substances being taken.
- ☐ *Follow-up is Required*: The employee understands that follow-up with Infection Control/Employee Health is required.
- ☐ *Follow-up Laboratory testing:* The employee understands that follow-up laboratory testing may be required as recommended by healthcare provider and /or Infection Control/Employee Health.
- ☐ *Adherence:* The employee understands the importance of taking PEP as prescribed and not stopping treatment without discussing with a healthcare provider.
- ☐ *Questions and Concerns:* The employee was given an opportunity to ask questions and received answers to the questions presented.

PEP Medication Information:

Medication(s) Prescribed: _____

Dose/Frequency: _____

Treatment Start Date: _____

Expected Completion Date: _____

Employee Consent and Acknowledgement:

I acknowledge that the purpose, benefits, risks, potential side effects, pregnancy considerations, medication instructions, and follow-up requirements associated with HIV Post-Exposure Prophylaxis (PEP) have been explained to me.

I understand that:

I. PEP is prescribed to reduce the risk of HIV infection following a potential occupational exposure.
II. I should take the medication(s) as prescribed and follow the instructions provided by my healthcare provider.
III. I have been informed of possible side effects and understand when I should contact a healthcare provider or seek emergency medical care.
IV. I have been advised to inform my healthcare provider if I am pregnant, planning pregnancy, breastfeeding, or become pregnant while taking PEP.
V. Follow-up with the appropriate healthcare provider and Infection Control/Employee Health is required.
VI. Additional testing and follow-up appointments may be necessary.
VII. I have had the opportunity to ask questions and have received answers to my questions.

☐ **I consent to taking HIV PEP as recommended by my healthcare provider.**

☐ **I decline HIV PEP after receiving counseling regarding the potential benefits, risks, and follow-up requirements.**

Employee Signature: _____ **Date/Time:** _____

Witness Signature: _____ **Date/Time:** _____

Name/Title of Person Providing Counseling: _____

Signature: _____ **Date/Time:** _____

SIERRA VISTA HOSPITAL AND CLINICS	FORM: F-690-04-025-8
SUBJECT/TITLE: Occupation Exposure to Blood Borne Pathogens – Follow-Up Instruction Sheet	PAGE: 18 OF: 18

The following information is available to personnel who have had exposure to body fluids.

I. You are encouraged to report and seek a medical evaluation for any acute febrile illness, particularly one that is characterized by swollen glands, fever, and/or rash that occurs within 12 weeks after exposure.

II. If a baseline HIV antibody test is requested, your written informed consent is necessary.

III. If your first HIV test results are negative, you are encouraged to retest in six (6) weeks, three (3) months, and six (6) months after exposure. The dates are as follows:

- ☐ **6 weeks date:** _____
- ☐ **3 months date:** _____
- ☐ **6 months date:** _____

IV. *An Employee HIV Blood Draw Consent Form must be signed prior to each HIV testing.*

V. If your first hepatitis C test results are negative, you are encouraged to retest for hepatitis C in six (6) months after exposure.

- ☐ **6 months date:** _____

VI. If you have never been vaccinated with hepatitis B vaccination, this series of vaccinations is available to you. Your written informed consent is necessary to administer or refuse the hepatitis B vaccination. The first injection may be received immediately, a second in one (1) month, and a third in six (6) months.

VII. The Emergency Department physician will decide if a tetanus booster is appropriate at this time.

VIII. You must return to Employee Health within 10 to 15 days for lab results and consultation.

- ☐ **Appointment date:** _____

IX. Post Exposure Follow-up Instruction Form given to the employee. Date: _____

I have received a copy of this information and have been provided with an explanation of my choices. I understand the material presented to me.

Employee Signature: _____ **Date/Time:** _____

Witness Signature: _____ **Date/Time:** _____

SIERRA VISTA HOSPITAL AND CLINICS	POLICY # 513-01-013
	PAGE: 1 OF: 2
SUBJECT/TITLE: Standing Orders	EFFECTIVE: 09/2026
DEPARTMENT/SCOPE: Clinic, Employee Health, Medical Staff, Nursing, Pharmacy	OWNER: Melissa Biemer PharmD., RPh

Purpose

The purpose of this policy is to establish standardized procedures for the development, approval, implementation, and use of standing orders within Sierra Vista Hospital. Standing orders are designed to facilitate timely and efficient patient care while ensuring compliance with regulatory and clinical standards.

Policy:

Standing orders will be permitted for well-defined clinical situations and shall be developed using evidence-based guidelines. All standing orders must be written in a clear, standardized format and be readily available at the point of care. Standing orders are intended to facilitate timely clinical interventions when predefined criteria are met and shall not replace independent clinical judgment. Clinicians are expected to exercise professional judgment and deviate from a standing order when the patient's clinical condition warrants an alternative course of action.

Each standing order shall include, at a minimum:

I. Defines clinical indications for use.
II. Specific inclusion and exclusion criteria.
III. Required patient assessments.
IV. Clearly defined interventions and actions to be taken.
V. Any required monitoring, documentation, and follow-up.

Standing orders shall be developed collaboratively by interdisciplinary teams, including physicians, nursing leadership, and pharmacy. All standing orders must be reviewed and approved by pharmacy and therapeutics and medical staff committees prior to implementation. Standing orders shall be reviewed at least annually and revised as necessary to ensure alignment with current evidence, regulatory requirements, and standards of practice.

Standing orders may only be implemented by qualified and competent personnel who have completed the required education, training, and competency validation. Their use must support timely, appropriate patient care while remaining within the scope of practices of the individual executing the order. Each standing order initiated shall be dated, time-stamped, and authenticated promptly by the responsible, licensed practitioner.

Sierra Vista Hospital shall monitor the use of standing orders through its quality improvement and compliance committees. Audits will assess adherence to policy, appropriateness of use, and documentation completeness.

Definitions:

Standing Orders: are pre-approved, written protocols that authorize qualified healthcare personnel to perform specific clinical tasks or interventions without a direct, patient specific order at the time of execution, provided that predefined criteria are met.

References:

Centers for Medicare & Medicaid Services. (2023). *State Operations Manual Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals*. U.S. Department of Health and Human Services.

Institute for Safe Medication Practices. (2022). *Guidelines for safe implementation and use of standing orders*. ISMP.

New Mexico Administrative Code. (2023). *Title 7, Chapter 7: Health Facility Licensing and Certification*. State of New Mexico.

New Mexico Board of Nursing. (2023). *Nurse Practice Act and Rules*. State of New Mexico

SIERRA VISTA HOSPITAL AND CLINICS	POLICY #
	PAGE: 1 OF: 7
SUBJECT/TITLE: Vancomycin Pharmacokinetic Dosing	EFFECTIVE: October 2026
DEPARTMENT/SCOPE: Medical Staff, Nursing, Pharmacy	OWNER: Melissa Biemer Pharm.D., RPh

Purpose:

To establish standardized, evidence-based practices for therapeutic and safe dosing, monitoring, and adjustment of vancomycin regimens to optimize clinical outcomes while minimizing the risk of toxicity.

Policy:

Vancomycin dosing will be individualized based on patient-specific factors, including weight, renal function, infection severity, and clinical status. Pharmacokinetic monitoring will be used to optimize vancomycin therapy.

Definitions:

AUC (Area Under the Curve): A measure of a patient's total exposure to vancomycin over a specified period, expressed as mg·h/L. For vancomycin, AUC is generally expressed as the 24-hour area under the concentration-time curve (AUC).

AUC/MIC: The ratio of the 24-hour vancomycin area under the concentration-time curve to the minimum inhibitory concentration (MIC) of the organism.

Creatinine Clearance (CrCl): An estimate of renal function used to assess vancomycin clearance and guide initial dosing and dosing intervals. CrCl may be estimated using the Cockcroft-Gualt Equation and patient-specific weight and serum creatinine. For patients 65 years of age or older with a serum creatinine less than 1 mg/dL, a serum creatinine of 1 mg/dL will be used for calculation of CrCl

Estimated Trough Concentration: The predicted or measured vancomycin serum concentration immediately before the next scheduled dose. When trough-based monitoring is used, the target concentration is determined according to the infection being treated and patient-specific factors.

MIC (Minimum Inhibitory Concentration): The lowest concentration of an antimicrobial that inhibits visible growth of a microorganism under standardized laboratory conditions. Vancomycin AUC targets are interpreted in relation to the MIC of the infecting organism.

Steady State: The condition in which the rate of vancomycin administration is approximately equal to the rate of elimination, resulting in relatively consistent drug exposure from one dosing interval to the next. Steady state may not be achieved in patients with rapidly changing renal function.

Vancomycin Trough: A vancomycin serum concentration obtained immediately before administration of the next scheduled dose. Trough concentrations may be used for therapeutic monitoring when AUC-based monitoring is not feasible or when clinically indicated.

Pharmacokinetics (PK): The study of how a drug is absorbed, distributed, metabolized, and eliminated by the body. For intravenous vancomycin, patient-specific pharmacokinetic parameters are used to estimate drug exposure and optimize dosing.

Procedure:

Pharmacist Responsibilities:

I. Review vancomycin therapy, indication, dose, dosing interval, and renal function.
II. Determine the need for therapeutic drug monitoring.
III. Order and appropriately time vancomycin serum concentrations.
IV. Calculate or estimate AUC when applicable.
V. Evaluate vancomycin exposure in relation to the treatment indication.
VI. Adjust the vancomycin dose and/or dosing interval as clinically appropriate.
VII. Monitor renal function and other relevant laboratory data.
VIII. Document interventions and dosing recommendations in Med-Manager Pharmacist Intervention Queue.
IX. Communicate pending or abnormal vancomycin results to the after-hours remote order pharmacy when appropriate.

Ordering:

The prescriber will order **"Vancomycin Pharmacy to Dose"** when pharmacokinetic dosing and monitoring by the pharmacy is desired.

If the prescriber enters a specific vancomycin dose or dosing regimen, the patient will be monitored and managed according to this policy, regardless of whether a formal pharmacokinetic pharmacy consult has been ordered. The pharmacist will evaluate the appropriateness of the prescribed regimen and intervene as clinically indicated.

Pharmacists are authorized, in accordance with this policy, to order vancomycin serum concentrations and comprehensive metabolic panels (CMP) as necessary to monitor renal function, assess vancomycin levels, and optimize therapy.

If no vancomycin dosing instructions are provided by the prescriber, the pharmacist will contact the prescriber to discuss and establish an appropriate dosing regimen before modifying vancomycin therapy.

Loading Dose:

A loading dose may be considered for patients with serious or life-threatening infections when rapid attainment of therapeutic exposure is desired.

Loading-dose selection should account for actual body weight, severity of infection, volume of distribution, and renal function.

Recommended Loading Dose:

I. 20 mg/kg based on actual body weight
II. Maximum dose: 2,000 mg
III. Obtain a random vancomycin level every 1-3 days, as clinically appropriate, to guide subsequent dosing and therapeutic drug monitoring.

Maintenance Dosing:

Initial maintenance dosing should be determined using actual body weight, renal function and estimated creatinine clearance, infection severity and location, patient-specific pharmacokinetics, presence of acute kidney injury or changing renal function, prior vancomycin exposure and serum concentrations, when available.

Guidelines for pharmacists for initial vancomycin dosing in adults (based on estimate CrCl):

Dose: 15 mg/kg/dose; maximum of 2,000 mg per dose

Estimated CrCl	Suggested Initial Dosing Interval
≥90 mL/min	15 mg/kg, IV, every 8 hours
60–89 mL/min	15 mg/kg, IV, every 12 hours
45–59 mL/min	15 mg/kg, IV, every 18 hours
30–44 mL/min	15 mg/kg, IV, every 24 hours
15–29 mL/min	15 mg/kg, IV, every 48 hours

These dosing intervals are intended as initial recommendations only. Subsequent dosing should be individualized using clinical response, renal function, vancomycin serum concentrations, and AUC-guided therapeutic drug monitoring when feasible.

Patients with unstable or rapidly changing renal function require more frequent reassessment and individualized vancomycin dosing. Standard dosing intervals may result in significant subtherapeutic or supratherapeutic drug levels in individual patients, particularly those with acute kidney injury (AKI), obesity, serious or life-threatening infections.

The pharmacist will enter the recommended vancomycin regimen into the patient's electronic health record (EHR) under the ordering provider who initiated the vancomycin pharmacy consult.

Monitoring:

The staff pharmacist scheduled for the shift will follow patients receiving vancomycin and document relevant clinical information and pharmacist interventions in the Med-Manager Pharmacist Intervention Queue.

If a vancomycin serum concentration is expected to result after regular pharmacy hours, the pharmacist will notify the after-hours remote order pharmacy to review the result and manage subsequent vancomycin dosing, as appropriate.

The pharmacist will order vancomycin serum concentrations at clinically appropriate intervals to guide subsequent dosing and therapeutic drug monitoring. The initial vancomycin concentration will typically be obtained prior to the third or fourth dose, depending on the patient's renal function, dosing regimen, clinical status, and anticipated time to steady state. Subsequent levels should generally be obtained every 1–3 days when clinically indicated, with more frequent monitoring for patients with unstable or rapidly changing renal function.

AUC-guided therapeutic drug monitoring should be used when feasible to individualize subsequent vancomycin dosing rather than relying solely on a predetermined dosing interval or trough concentration.

Recommended AUC/MIC: 400–600 mg·h/L, assuming an MIC of 1 mg/L.

The pharmacist will determine the vancomycin through goal based on the indication.

Estimated Trough	Indication
10-15 mg/L	☐ Cellulitis ☐ Diabetic Foot Infection without Osteomyelitis ☐ Urinary Tract Infection ☐ Empiric therapy for unknown infection ☐ Infections not caused by S. aureus
15-20 mg/L	☐ Serious infections caused by MRSA ☐ Bacteremia ☐ Endocarditis ☐ Osteomyelitis ☐ Meningitis ☐ Pneumonia

Note: Trough concentrations of 15–20 mg/L may result in AUC exposure above the desired range in some patients and may increase the risk of nephrotoxicity.

Discontinuation/De-escalation:

Vancomycin therapy should be reassessed as microbiology, clinical, and laboratory information becomes available. The pharmacist will evaluate the ongoing indication for vancomycin therapy and recommend to the prescriber that therapy be discontinued, de-escalated, narrowed, or transitioned to an appropriate alternative antimicrobial agent when vancomycin is no longer indicated or when an alternative therapy is more appropriate.

Recommendations should consider culture and susceptibility results, clinical response, infection source, duration of therapy, renal function, and antimicrobial stewardship.

Documentation

The pharmacist managing vancomycin therapy will document all dosing and therapeutic drug monitoring activities in the patient's electronic health record (EHR) through Med-Manager Pharmacist Intervention Queue.

Documentation should include, but is not limited to:

I. *Indication for* vancomycin therapy, including suspected or confirmed infection and microbiology results when available.
II. Patient-specific dosing information, including actual body weight, renal function, estimated creatinine clearance, current vancomycin dose, and dosing interval.
III. Loading dose, when administered, including dose and weight used for calculation.
IV. Maintenance dosing regimen, including dose, route, frequency, and any dose or interval adjustments.
V. Renal function assessment, including serum creatinine and changes in renal function that may affect vancomycin clearance.
VI. Vancomycin serum concentrations, including the concentration, date and time of collection, and relationship to the preceding vancomycin dose.
VII. AUC assessment, when applicable, including the estimated AUC24/MIC, pharmacokinetic method used, and target range.
VIII. Trough concentration and target, when trough-based monitoring is clinically indicated.
IX. Pharmacist assessment and dosing recommendation, including the rationale for initiating, continuing, holding, or modifying vancomycin therapy.
X. Timing of the next vancomycin dose and laboratory monitoring, when applicable.
XI. Communication with the ordering provider or clinical care team, when intervention or clarification is required.
XII. Follow-up plan, including the next planned vancomycin concentration, renal function assessment, or AUC evaluation.

Documentation should be completed in a timely manner to ensure continuity of care between pharmacists and shifts.

All vancomycin dose adjustments and therapeutic drug monitoring decisions should be documented with sufficient detail to allow subsequent pharmacists and other members of the healthcare team to understand the rationale for the treatment plan.

References:

Cockcroft, D. W., & Gault, M. H. (1976). Prediction of creatinine clearance from serum creatinine. *Nephron, 16*(1), 31–41. https://doi.org/10.1159/000180580

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SIERRA VISTA HOSPITAL

PROTOCOL

DEPARTMENT: Infection Prevention | Original Date: July 2022

SUBJECT: **MRSA and HAI Screening and Prevention** | Review: **2024** BF **2025** BF **2026** BF

Last Revised: · September 2, 2026

APPROVED BY: Infection Prevention Committee, Medical Staff | Manager: Bettina Fitzgearld, RN, BSN

SCOPE:
Nursing Staff of Sierra Vista Hospital.

REASON: PROTOCOL

Methicillin-resistant *Staphylococcus aureus* (MRSA) are strains of *Staphylococcus aureus*, or "staph," bacteria that are resistant to the antibiotic methicillin as well as to related beta-lactam antibiotics, such as oxacillin, penicillin, amoxicillin, and cephalosporins, that are used to treat ordinary staph infections. MRSA testing detects the presence of MRSA in a patient's sample.

Staphylococcus aureus frequently colonizes the human skin and is present in the nose of about a third of U.S. adults. It does not usually cause illness or symptoms. However, if there is a break in someone's skin from a wound or surgery, or if someone's immune system is weakened, then colonizing *S. aureus* can cause an infection.

Widespread use of antibiotics over the past several decades has led to the development of antibiotic-resistant strains of *S. aureus*. Infection with these strains can cause skin infections and potentially more severe, life-threatening infections such as pneumonia, bloodstream infections (septicemia), or infections at a surgical site. However, according to the Centers for Disease Control and Prevention (CDC), less than 2% of the population carries the type of staph bacteria known as MRSA. [For more on this, see the article Staph Infections and Methicillin-Resistant *Staphylococcus aureus*.]

MRSA can be spread in healthcare settings and in the community. Contaminated hands, medical equipment, and surfaces in places such as hospitals, clinics, or nursing homes allow the spread of MRSA from colonized or infected patients. In the community, anything that allows for skin-to-skin contact can spread MRSA. This includes sharing personal care items, participating in contact sports, or living or working in close contact with others.

In longitudinal studies it has been evidenced practice that doing the following can prevent MRSA or other HAIs from developing up to 37%. In other longitudinal studies that have identified that people that are colonized with MRSA (patients, staff, etc.) will have active MRSA infections from weeks to years later, avg on studies is 26 weeks.

BACTROBAN® nasal ointment is indicated for the eradication of nasal colonization with methicillin-resistant *Staphylococcus aureus* (MRSA) in adult and pediatric patients (aged 12 years and older) and healthcare workers as part of a comprehensive infection control program to reduce the risk of infection among patients at high risk of MRSA infection during institutional outbreaks of infections with this microorganism.

Daily CHG bathing generally lowers your risk of getting an infection in the hospital. You are less likely to get sick from a germ that is very hard to treat. One example is methicillin-resistant Staphylococcus aureus (MRSA). CHG bathing can also help prevent other types of infections, such as:

- Vancomycin-resistant Enterococcus (VRE)
- Infections from central venous catheters
- Infections at surgical sites
- Infections from ventilator use

MRSA screening PROCEDURE:

- Perform a MRSA screening swab on patients from long term care facilities or provider discretion (for patients with high hospital utilization) placed on the nursing unit.
- The nurse will apply Bactroban or Mupirocin intranasal to nursing unit MRSA screened patients BID until discharged (maximum of 5 days).

Chlorhexidine bath PROCEDURE: The nurse or PCT can perform the CHG procedure.
The CHG bathing is documented in Cerner on the MAR for the CHG and under Adult quick view under personal hygiene.

Use wipes or the liquid, NOT BOTH.

- **Chlorhexidine Gluconate 2%** (wipes) helps reduce bacteria, provides rapid bactericidal action, and rinse free. For external use only.
    - Always don gloves before bathing the patient.

Step-by-Step Application:

- **Zone 1 (Neck, chest, and abdomen):** Wipe the neck, shoulders, chest, and abdomen, including skin folds and creases.
- **Zone 2 and 3 (Arms and hands):** Use a new wipe for each arm, wiping from the shoulder down to the fingers, making sure to clean between the fingers and armpits.
- **Zone 4 and 5 (Legs and feet):** Use a fresh wipe for each leg, starting at the thigh and moving down to the toes, cleaning thoroughly between the toes.
- **Zone 6 (Back and posterior):** Use the final wipe to clean the back of the neck, entire back, and buttocks/posterior.

- **Allow to air dry:** Let the skin dry completely for about one minute. Do not rinse, wash off, or towel-dry the solution, as the lingering residue provides continuous antimicrobial protection.
    - Keep out of eyes, ears and mouth.
    - Do not use on skin that is compromised beyond superficial layers.
    - Do not flush.
    - **Stop using if skin irritation, sensation or allergic reaction occurs.**

Safety Precautions

- **Avoid sensitive areas:** Do not use CHG wipes above the jawline/neck (keep away from eyes, ears, mouth, and head).
- **Mucous membranes and wounds:** Avoid direct contact with deep open wounds, broken skin, or internal genital/anal cavities.
- **Remove heavy soilage first:** If a patient is soiled with feces, urine, or vomit, clean the area with soap and water first, pat dry, and then apply the CHG wipe. ***** (see below for showering times and minimum dry time prior to the CHG procedure)
- **No lotions or powders:** Do not apply standard non-compatible lotions, creams, deodorants, or powders after the bath, for at least 60 minutes as they can neutralize the antiseptic properties of the CHG residue

******Can be used 30 minutes after bathing (minimum dry time)** (for both types)

- **DYNA- HEX 4 (Chlorhexidine Gluconate) liquid 4% solution** (bottle) is an antiseptic for external use only. (can be diluted to 2% (see instructions below).
- Dyna-hex contains CHG, for skin disinfection
- When used repeatedly, Dyna-hex CHG leaves the hands/ body antiseptic for up to six hours
- Dyna-hex binds to the surfaces of the skin, creating a persistent effect not seen in alcohol, iodine or any other anti-bacterial products
- Dyna-hex continues to be effective in the presence of organic substances (blood) - unlike iodine
- Significantly reduces the number of microorganisms on the hands and forearms prior to surgery or patient care
- Helps reduce bacteria that potentially can cause disease.

    - Use 2-3 bottles of the liquid DYNA-Hex 4 Chlorhexidine Gluconate (depending on the size of your patient).
    - Pour the bottles of the liquid into a large basin.
    - Need 6 wash cloth's (more if needed for line, tubes, drains or larger patients).
    - Always don gloves before bathing the patient
    - Apply CHG to skin with a firm massage
    - Clean neck well even if not visibly soiled. Clean the chest, arms, groin, lets, back & buttocks. Use separate wash cloth for each area.
    - Avoid getting CHG in the eyes or into the ear canals.

- Do not use on skin that is compromised beyond superficial layers.
- Rinse thoroughly.

Step-by-Step Application:

- **Zone 1 (Neck, chest, and abdomen):** Wipe the neck, shoulders, chest, and abdomen, including skin folds and creases.
- **Zone 2 and 3 (Arms and hands):** Use a new wipe for each arm, wiping from the shoulder down to the fingers, making sure to clean between the fingers and armpits.
- **Zone 4 and 5 (Legs and feet):** Use a fresh wipe for each leg, starting at the thigh and moving down to the toes, cleaning thoroughly between the toes.
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Allow to air dry: Let the skin dry completely for about one minute. Do not rinse, wash off, or towel-dry the solution, as the lingering residue provides continuous antimicrobial protection

- Keep out of eyes, ears and mouth.
- Do not use on skin that is compromised beyond superficial layers.
- Do not flush.
- **Stop using if skin irritation, sensation or allergic reaction occurs.**

REFERENCE(S):

- Stryker REF 9602-ANZ: https://www.stryker.com/content/dam/stryker/sage/products/antiseptic-body-cleanser/resources/ca/Antiseptic%20Body%20Cleanser%20Spec%20Sheet_Bilingual.pdf
- DYNA-HEX 4 CHG liquid: https://www.guidelinecentral.com/drug/245c41e6-a0f6-0825-e054-00144ff8d46c/dyna-hex-4/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5253275/
- https://www.labcorp.com/help/patient-test-info/mrsa-screening
- https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/chg-bathing-to-prevent-healthcareassociated-infections#:~:text=Many%20experts%20now%20recommend%20daily,with%20simple%20soap%20and%20water
- https://www.cdc.gov/infectioncontrol/pdf/strive/MRSA202-508.pdf
- https://www.rxlist.com/bactroban-nasal-drug.htm#indications
- https://pmc.ncbi.nlm.nih.gov/articles/PMC12056876/

SIERRA VISTA HOSPITAL

POLICIES AND PROCEDURES

DEPARTMENT: Infection Prevention

Original Policy Date:6/30/22

Review: **2026** BF

SUBJECT: : Infection Prevention and Control Guidelines for Patients with Coronavirus Disease (COVID-19

Last Revised:8/10/2026

APPROVED BY: Infection Prevention Committee & Medical Board

Manager: Bettina Fitzgerald RN, BSN

SCOPE: A. To ensure early recognition of a patient or Healthcare Personnel (HCP) who may have COVID-19 upon arrival at any entry point to Sierra Vista Hospital and Clinics. B. To prompt the rapid institution of infection control measures and reporting to minimize potential transmission to staff, patients and/or visitors. C. Provide interim work exclusion for the healthcare personnel (HCW) with Covid or other respiratory illnesses.

AFFECTED AREAS Sierra Vista Hospital and Clinics

Guidelines: Sierra Vista Hospital and Clinics and its employees must comply with COVID-19 guidelines to protect HCPs (Health Care Personnel) from COVID-19.

Background Information: Infection control procedures including administrative rules and engineering controls, environmental hygiene, correct work practices, and appropriate use of personal protective equipment (PPE) are all necessary to prevent infections from spreading during healthcare delivery. Prompt detection and effective triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel, and visitors at the facility. This guidance is based on the information available about COVID-19 related to disease severity, transmission efficiency, and shedding duration. This will be refined and updated as additional information becomes available.

DEFINITIONS:

COVID-19: Coronavirus Disease

Close contact Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated while not wearing recommended PPE.

Healthcare Personnel (HCP) For the purposes of this document, HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

Airborne Infection Isolation Room (AHR) are single patient rooms at negative pressure relative to the surrounding areas, and with a minimum of six air changes per hour, (12 air changes per hour are recommended for new construction or renovation). Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter before recirculation.

Respiratory Hygiene/ Cough Etiquette consists of measures to contain respiratory secretions for all individuals with signs and symptoms of a respiratory infection. It includes covering nose and mouth when coughing or sneezing; using tissues and disposing of them in the nearest waste receptacle afteruse; and performing hand hygiene after having contact with respiratory secretions and contaminated objects or materials (CDC, 2005).

Patient Cohorting is defined as placing a group of two or more patients with the same infection/organism in the same room/area, which is physically separated from other patients (cohort area). Patient cohorting may be utilized as an alternative approach to isolation in circumstances where there are two or more patients with the same confirmed infection, but there are insufficient facilities to isolate them all or it is deemed unsafe to isolate due to the patient's condition.

PROCEDURE/Process:

I. Minimize Chance for Exposures

1. Before Arrival

A. Whenever possible, instruct patients and persons who accompany them to call ahead or inform HCP upon arrival if they have symptoms of any respiratory infection (e.g., cough, fever) and to take appropriate preventive actions (e.g., wear a facemask upon entry to contain cough, follow triage procedures).

B. If a patient is arriving via transport by emergency medical services (EMS), the driver should contact the receiving emergency department (ED). This will allow the healthcare facility to prepare for receipt of the patient.

C. Screen and triage all clients, patients, delivery people, visitors, and other non employees entering Sierra Vista facilities where direct patient care is provided for people who have symptoms of COVID-19.

2. Upon Arrival and During the Visit

A. Ensure all persons with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough) adhere to respiratory hygiene and cough etiquette, hand hygiene, and triage procedures throughout the duration of the visit.

B. Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCP with instructions about hand hygiene, respiratory hygiene, and cough etiquette.

Ensure that patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough) are not allowed to wait among other patients seeking care.

C. Ensure rapid triage and isolation of patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough): 1. Identify patients at risk for having COVJD-19 infection before or immediately upon arrival at the healthcare facility.

D. Follow triage procedures to detect patients suspected to have COVID-19 during or before patient triage or registration (e.g., at the time of patient check-in) and ensure that all patients are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of COVJD-19 or contact with possible COVID-19 as directed in the triage screening tool.

E. Implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient's nose and mouth if that has not already been done) and isolate the patient for COVID-19 in a single-person room or Airborne Infection Isolation Room (AIIR), if aerosol- generating procedure needs to be done.

F. Provide supplies for respiratory hygiene and cough etiquette, alcohol-based hand rub (ABHR), tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc.

3. Employee Self-Assessment

A. Employees must do a self- assessment before starting work using the tool determined by the administration for the following COVID-19 criteria:

i. Symptoms consistent with COVID-19; fever (at least 100.4) or chills, new unexplained cough, congestion, running nose, shortness of breath or difficulty breathing, new or unusual muscle or body aches, chills, new or unusual fatigue, sore throat, diarrhea, headache, and new loss of taste or smell with no other explanation.

ii. Employees who are COVID-19 positive or have been told by a licensed healthcare provider that they are suspected to have COVID-19, experiencing recent loss of taste and/or smell with no other explanation, experiencing both a fever of at least 100.4°F and new unexplained cough associated with shortness of breath must not start working, instead notify their supervisor and be tested.

iii. Employees must notify their supervisor when they are COVID-19 positive or have been told by a licensed healthcare provider that they are suspected of having COVID-19.

iv. Employees that test positive for COVID -19 need to stay at home, off work for a minimum of 3 days(from symptom onset or first positive test). The employee may return if there symptoms are better, they have have had no fever for 24 hrs .

The employee will need to wear a NIOSH Approved N95 mask or a well – fitting surgical mask or procedure mask through the end of day 7 (from symptomology) per NMDOH on 9.29.2025 via the New Mexico Health Alert Network (HAN). Testing is not required to return to work.

If an employee member misses 3 or more scheduled shifts, then the employee needs to see a provider to be released to return to work.

II. Adherence to Standard, Contact, and Droplet or Airborne Precautions, Including the Use of Eye Protection

1. Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. All HCP (see section III for measures for non-HCP visitors) who enter the room of a patient with suspected or confirmed COVID-19 should adhere to Standard, Contact, and Droplet or Airborne Precautions, including the following:

a. Patient Placement

1. Place a patient with known or suspected COVID-19 (i.e., PUI) in a single-person room. Patients undergoing aerosol-generating procedures should be placed in Airborne Infection Isolation Rooms (AIIRs).If AIIR is not available, place patient in a single room with door closed and use portable HEPA filter unit.

11. Patients with the same respiratory pathogen may be housed in a semiprivate room. A patient with COVID-19 should NOT be housed in the same room as a patient with an undiagnosed respiratory infection.

111. To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).

1v. Patient room doors should be kept closed as much as possible, patient safety takes precedence if door needs to remain open and HCPs will wear appropriate PPE in the area.

v. If possible, based on staffing and available vacant rooms, as a measure to limit HCP exposure and conserve PPE, consider entire units within the facility, with dedicated HCP, to care for known or suspectedCOVID-19 patients.

vi. Any suspected patients in the ambulatory setting should be placed in a private exam room with the door closed if felt to be safe to keep door closed- do not allow them to wait in the waiting room.

vu. Patients should wear a facemask to contain secretions during transport. vm. Limit transport and movement of the patient outside of the room to medically essential purposes. Consider providing portable x-ray equipment.

IX. Personnel entering the room should use PPE, including respiratory protection, as described below. x. Only essential personnel should enter the patient's room.

xi. Use dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs, thermometer). If equipment will be used for more than one patient (e.g., video remote interpreting device), clean and disinfect such equipment before use on another patient according to manufacturer's instructions.

xn. Once the in-patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated AIIR for one hour and non-AIIR for 2 hours. After this time has elapsed, the room should undergo terminal cleaning and surface disinfection before it is returned to routine use.

B. Hand Hygiene

1. HCP should perform hand hygiene using ABHR before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Hand hygiene can also be performed by washing with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.

11. Ensure that hand hygiene supplies are readily available to all personnel in every care location.

c. Personal Protective Equipment

1. Gloves a. Perform hand hygiene, then put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated.

b. Remove and discard gloves when leaving the patient room or in between procedure or patient care.

REFERENCE(S):

1. NEW MEXICO HEALTH ALERT NETWORK (HAN) ADVISORY 2025-2026 Interim Guidance for the Management of Healthcare Personnel with Acute Viral Respiratory

   https://www.nmhealth.org/publication/view/general/9368/

2. Interim Work Exclusion Guidance for Healthcare Personnel with Acute Respiratory Infections 2025-2026 Respiratory Virus Season

   https://www.nmhealth.org/about/erd/ideb/hai/publications/

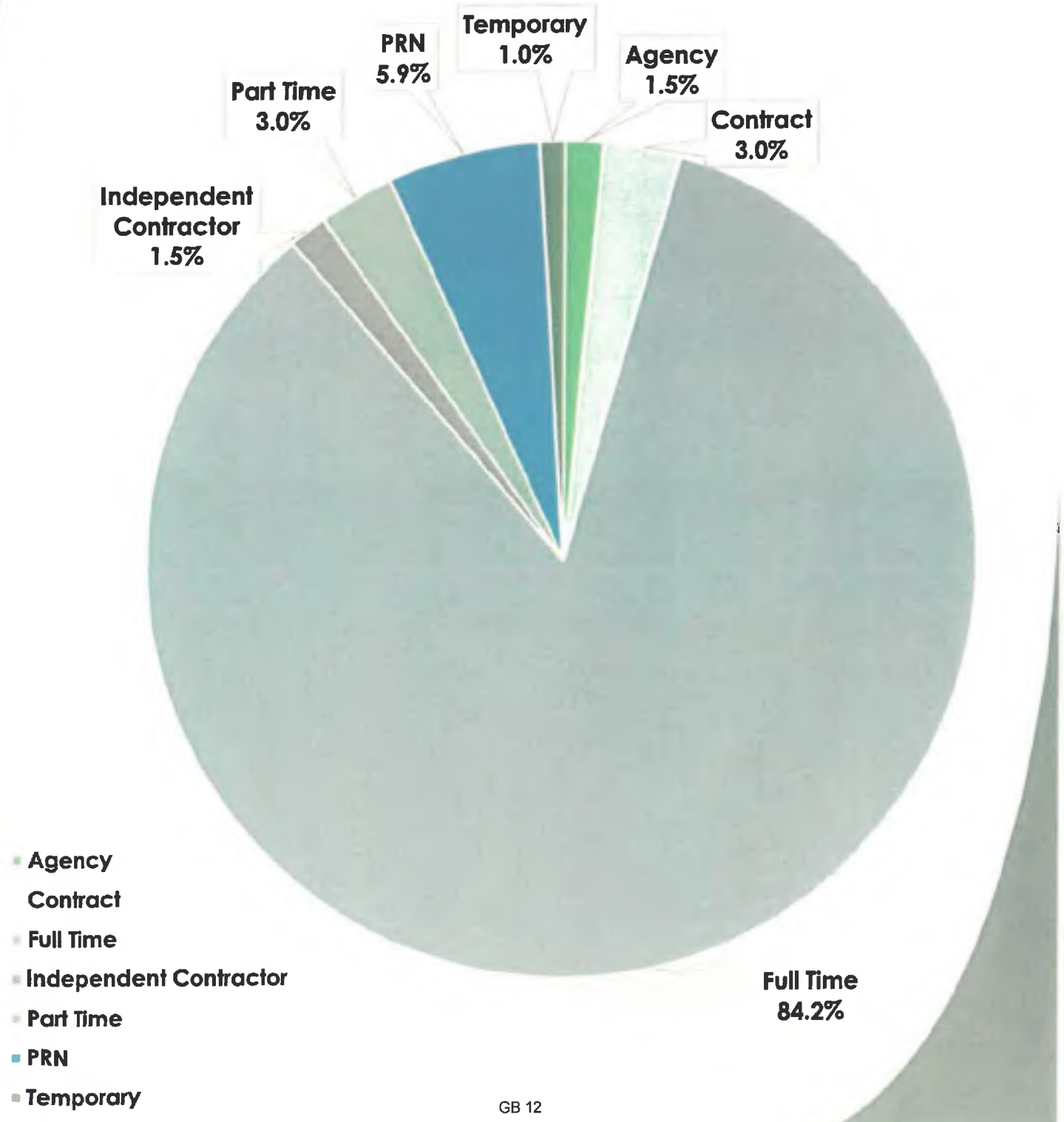
Form:

Interim Work Exclusion Guidance for Healthcare Personnel with Acute Respiratory Infections 2025-2026 Respiratory Virus Season

SIERRA VISTA HOSPITAL AND CLINICS

Human Resources Governing Board Report
August 2026

Staffing Matrix



SIERRA VISTA HOSPITAL AND CLINICS

Human Resources Governing Board Report August 2026

FTE Utilization



6 Month Trend By Category

	March'26	August '26	6 Month Trend Change
Agency	2.3%	1.5%	-0.8%
Contract	4.7%	3%	-1.7%
Full Time	82.2%	84.2%	2%
Independent Contractor	1.9%	1.5%	-0.4%
Part Time	1.9%	3%	1.1%
PRN	6.5%	5.9%	-0.6%
Temporary	0.5%	1%	0.5%
Utilized FTE	200.75	189.5	-5.6%

SIERRA VISTA HOSPITAL AND CLINICS

Human Resources Governing Board Report
August 2026

Vacancies (As of 09/18/2026)

FTE Count	Title	Status	Department
2	EVS Technician	FT	Housekeeping
1	Case Manager (RN)	FT	Social Services
1	House Supervisor, RN (Weekend)	FT	Nursing Administration
1	Respiratory Therapist	FT	Cardiopulmonary
3	Cook	FT	Dietary
1	Provider Services Director	FT	Clinic
2	LPN	FT	Clinic
1	Mammography Technician	FT	Imaging Services
1	Physical Therapist	FT	Rehab Services
3	Registered Nurse (ED)	FT	Emergency Department
1	Registered Nurse (Med/Surg)	FT	Med/Surg
1	CNA/Unit Clerk	FT	Med/Surg
1	Registration Clerk	FT	Business Office
1	Pharmacist	FT	Pharmacy
1	Paramedic	FT	Ambulance

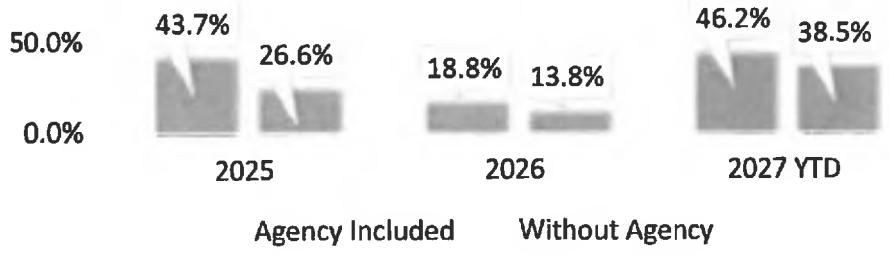
New Hires (August 2026)

FTE Count	Title	Status	Department
1	Cook	FT	Dietary
1	Certified Medical Assistant	FT	Clinic

Turnover (August 2026)

FTE Count	Title	Status	Department
1	Certified Nurse Practitioner	FT	Clinic
1	Pharmacist	PT	Pharmacy
1	Quality & Risk Director	FT	Quality
1	Certified Medical Assistant	FT	Clinic

First Year Turnover Rate (Fiscal Year)



SIERRA VISTA HOSPITAL AND CLINICS

Human Resources Governing Board Report August 2026

Current Projects

- Current Response & Action Plans from Employee Satisfaction Survey Feedback
  - Nursing Leadership Restructure: SVH continues to make progress in completing the Nursing Leadership restructure. The Med/Surg Manager assumed the role on August 23, 2026, and the Emergency Department Manager and Clinical Educator are scheduled to assume their new roles on September 27, 2026. With these positions in place, the Weekend House Supervisor is the only remaining position needed to complete the Nursing Leadership restructure.
  - Executive Leadership Recruitment: SVH is actively interviewing candidates for the permanent Chief Nursing Officer (CNO) position. The goal is to identify the right candidate with sufficient time to allow for a healthy transition and knowledge-transfer period with the Interim CNO before the conclusion of her tenure. SVH is also interviewing candidates for an Interim Director of Provider Services to support continued leadership and operational stability within the Rural Health Clinic.
  - SVH Leadership Training and Development Program: The first quarter of SVH's targeted leadership training program was successfully completed on September 17, 2026. The training provided focused education to strengthen leadership practices, workforce management, communication, accountability, and key human resources responsibilities.
  - Enhanced Onboarding and Orientation Initiative: The final touches are being completed on SVH's enhanced onboarding and orientation initiative, with the first orientation session scheduled for October 8, 2026. The enhanced program will provide standardized onboarding for new employees and ongoing education for current employees, helping ensure staff receive consistent and up-to-date information on organizational expectations, safety, compliance, patient care, and key operational processes.

Regulatory Compliance and Workforce Readiness

Evaluating current HR compliance with Joint Commission's 2026 National Performance Goals 11 & 12 and identifying areas for improvement.

- Goal 11: The critical access hospital maintains workplace and patient safety.
- Goal 12: The critical access hospital is staffed to meet the needs of the patients it serves, and staff are competent to provide safe, quality care.

CNO REPORT – September 24, 2026

- Med-Surg Manager - Selena Polanco
- ED Manager - Aaron Moore
- Clinical Educator - Amanda Moore
- Education for nurses

  Code Drills - On-going

  Skills Fair 10/17

  Just In Time - education as needed
- Animal Care for patients
- Disposable surgical instruments will no longer be required to run sterile processing
- Policies- CARA and Doula



SVH Boarding Process for Patients' Animals

FREE Services

TorC City Animal Shelter

- **Call Animal Control** through Dispatch at **575.894.7111** for safe keeoing of a patient's animal.
  - Animal Control will go to the patient's home and remove the pet from the yard.
  - **If the pet is inside the house**, someone must meet them for the hand over.
  - **Animal Control will take the pet to the animal shelter** where it can safely stay for **10 days at no cost.**
- **If a patient must be hospitalized for more than 10 days,** the Animal Shelter will continue to care for their pet providing the patient, caregiver, or case worker is in **daily contact** with the Animal Shelter.

PAID Services

Arenas Valley Animal Clinic of Sierra County

- Our local veterinary clinic wil board pets **by appointment only.**
  - **Call 575.894.6773**
    - Monday, Wednesday, Friday - 7:30am - 4:00pm
    - Tuesday & Thursday - 8:00am - 6:00pm
- The pets MUST be up-to-date on all vaccines, including Bordetella.
- Boarding costs depend on the size of the animals:
  - Large Dogs: $35/day | Large Cats: $31/day
  - Medium Dogs: $31/day | Medium cats: $27/day
  - Small Dogs: $25/day | Small cats: $25/day

"Last Resort" Services

Dog Shak

- Call Anissa, the Dog Shak owner, at **575.894.2017**
- Anissa is willing to help in a pinch if the above solutions do not work out.

CEO Report September 2026

- EMS Building Update
- Health Fair and Community Events
  1. Kingston 10/16/26
- VA Hospital Meeting
- 3 Crosses and Mt View meetings in Las Cruces 10/6/2026
- Ovation Clinic Assessment Update
- Phreesia Software Update
- New CT update
- Boiler update