July 18, 2024
Amended July 23, 2024[2]

TO: Legal Counsel

News Media
Salinas Californian
El Sol
Monterey County Herald
Monterey County Weekly
KION-TV
KSBW-TV/ABC Central Coast
KSMS/Entravision-TV

The next regular meeting of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **THURSDAY, JULY 25, 2024, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA** and via teleconference **1920 AUSTIN'S COLONY PKWY, BRYAN, TEXAS, 77802.** (V*isit* **SalinasValleyHealth.com/virtualboardmeeting** *for Public Access Information*).

Allen Radner, MD
President/Chief Executive Officer

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

[2]The amendment addresses the fact that one Board Member will be participating in the meeting remotely.

REGULAR MEETING OF THE BOARD OF DIRECTORS
SALINAS VALLEY HEALTH[1]

THURSDAY, JULY 25, 2024, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C

Salinas Valley Health Medical Center
450 E. Romie Lane, Salinas, California

AND

Via Teleconference
1920 Austin's Colony Pkwy
Bryan, TX, 77802

(Visit salinasvalleyhealth.com/virtualboardmeeting for Public Access Information)

AMENDED AGENDA — *Presented By*

1. CALL TO ORDER / ROLL CALL — *Victor Rey*

2. CLOSED SESSION *(See Attached Closed Session Sheet Information)* — *Joel Hernandez Laguna*

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION — *Joel Hernandez Laguna*
(Estimated time 4:30 pm)

4. AWARDS & RECOGNITION — *Allen Radner, MD*

5. PUBLIC COMMENT — *Joel Hernandez Laguna*

This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.

6. BOARD MEMBER COMMENTS AND REFERRALS — *Board Members*

7. CONSENT AGENDA - GENERAL BUSINESS — *Joel Hernandez Laguna*
(Board Member may pull an item from the Consent Agenda for discussion.)

A. Minutes of the Regular Meeting of the Board of Directors June 27, 2024
B. Financial Report
C. Statistical Report
D. Policies Requiring Approval
   1. Fecal Management System in the ICU Nursing Standardized Procedure
   2. Hyperbilirubinemia-Infant Management & Treatment
   3. Nipple Shields
E. Approved Projects
   1. Budget Augmentation for Nuclear Medicine Equipment Replacement Project.
   2. Budget Augmentation for CT Equipment Replacement Project.

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

- Board President Report
- Questions to Board President/Staff
- Public Comment
- Board Discussion/Deliberation
- Motion/Second
- Action by Board/Roll Call Vote

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE *Catherine Carson*

Minutes of the July 15, 2024 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. The following recommendation has been made to the Board.

1. Consider Recommendation for Board Approval of providing harm reduction services and education to hospitalized patients who use illicit substances in Monterey County and ensure the availability of equitable, safer drug-use supplies upon discharge.

    - Questions to Committee Chair/Staff
    - Motion/Second
    - Public Comment
    - Board Discussion/Deliberation
    - Action by Board/Roll Call Vote

B. PERSONNEL, PENSION AND INVESTMENT COMMITTEE *Juan Cabrera*

Minutes of the July 15, 2024 Personnel, Pension and Investment Committee meeting have been provided to the Board for their review. The following recommendation has been made to the Board.

1. Consider Recommendation for Board Approval of
    (i) The Findings Supporting Recruitment of Jamil Matthews, MD;
        - That the recruitment of a vascular surgeon to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
        - That the recruitment benefits and incentives the District proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;

    (ii) The Contract Terms of the Recruitment Agreement for Dr. Matthews; and

    (iii) The Contract Terms of the Vascular Surgery Professional Services Agreement for Dr. Matthews.

    - Questions to Committee Chair/Staff
    - Motion/Second
    - Public Comment
    - Board Discussion/Deliberation
    - Action by Board/Roll Call Vote

C. **FINANCE COMMITTEE** *Joel Hernandez Laguna*

Minutes of the July 22, 2024 Finance Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board.

1. Consider Recommendation for Board Approval of the Workday Financial and Supply Chain Management Solutions as Sole Source and Contract Award.
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote
2. Consider Recommendation for Board Approval of the Lease Agreement between Salinas Valley Memorial Healthcare System (SVMHS) and Mobile Modular Management Corporation for the Installation and Lease of Two (2) Modular Units.
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

9. TRANSFORMATION, STRATEGIC PLANNING & GOVERNANCE COMMITTEE *Rolando Cabrera, MD*

Minutes of the July 17, 2024 Transformation, Strategic Planning & Governance Committee meeting have been provided to the Board for their review. Additional Report from Committee Vice-Chair, if any.

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF JULY 11, 2024, AND RECOMMENDATIONS FOR BOARD APPROVAL OF THE FOLLOWING: *Rakesh Singh, MD*

A. Reports
   1. Credentials Committee Report (Including the following)
      - Anesthesiology Clinical Privileges Delineation Revision
      - Robotic Surgery Clinical Privileges Delineation Revision
   2. Interdisciplinary Practice Committee Report (Including the following)
      - Abdominal Pain Nursing Standardized Procedure
      - HCG Recheck Nursing Standardized Procedure
      - Intraosseous Infusion Nursing Standardized Procedure
      - Nausea and Vomiting Nursing Standardized Procedure
      - SEPSIS Management Nursing Standardized Procedure
      - Urinary Tract Infection Nursing Standardized Procedure
      - Vaginal Bleeding Nursing Standardized Procedure
      - APP Rules and Regulations

- CRNA Clinical Privilege Delineation – New

B. Policies/Procedures/Plans:

1. Care of the Patient with an IRRAflow Irrigation Catheter
2. Medical Cannabis for the Terminally Ill Patient
3. Medication Use
4. Restraints

- Questions to Committee Chair/Staff
- Motion/Second
- Public Comment
- Board Discussion/Deliberation
- Action by Board/Roll Call Vote

11. EXTENDED CLOSED SESSION *(if necessary)* — *Joel Hernandez Laguna*

12. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION — *Joel Hernandez Laguna*

13. ADJOURNMENT — *Joel Hernandez Laguna*

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, August 22, 2024, at 4:00 p.m.**

The complete Board packet including subsequently distributed materials and presentations is available at the Board Meeting and in the Human Resources Department of the District. All items appearing on the agenda are subject to action by the Board. Staff and Committee recommendations are subject to change by the Board.

Requests for a disability related modification or accommodation, including auxiliary aids or services, in order to attend or participate in a meeting should be made to the Board Clerk during regular business hours at 831-759-3050. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

SALINAS VALLEY HEALTH BOARD OF DIRECTORS
JULY 25, 2024
AGENDA FOR CLOSED SESSION

Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance with Section 54954.5 of the Government Code.

CLOSED SESSION AGENDA ITEMS

HEARINGS/REPORTS
(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

Subject matter: (Specify whether testimony/deliberation will concern staff privileges, report of medical audit committee, or report of quality assurance committee):

1. Medical Executive Committee
    - Report of the Medical Staff Credentials Committee (With Comments)
2. Report of the Medical Staff Quality and Safety Committee to Quality and Efficient Practices
    - Health Information Management Report
    - Quality and Safety Committee Consent Agenda
        - Emergency Department
        - Case Management/Social Work
        - Education Department
        - Clinical Informatics
        - Human Resources
        - Mammography
        - Radiology/Nuclear Medicine
        - Compassionate Marijuana Use, Ryan's Law

CONFERENCE WITH LABOR NEGOTIATOR
(Government Code §54957.6)

Agency designated representative: (Specify name of designated representatives attending the closed session): Allen Radner, MD

Employee organization: (Specify name of organization representing employee or employees in question): National Union of Healthcare Workers, California Nurses Association, Local 39, ESC Local 20, or

Unrepresented employee: (Specify position title of unrepresented employee who is the subject of the negotiations):

REPORT INVOLVING TRADE SECRET
(Government Code §37606 & Health and Safety Code § 32106)

Discussion will concern: (Specify whether discussion will concern proposed new service, program, or facility): Trade Secret, Strategic Planning, Proposed New Programs and Services

Estimated date of public disclosure: (Specify month and year): Unknown

CONFERENCE WITH LEGAL COUNSEL-EXISTING LITIGATION
(Government Code §54956.9(d)(1))

Name of case: (Specify by reference to claimant's name, names of parties, case or claim numbers): Araujo et al vs. Salinas Valley Memorial Healthcare System

CONFERENCE WITH LEGAL COUNSEL-ANTICIPATED LITIGATION
(Government Code §54956.9(d)(2))

Significant exposure to litigation pursuant to Section 54956.9(d)(2) or (3) (Number of potential cases): One (1)

Additional information required pursuant to Section 54956.9(e): Attorney General of California

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Joel Hernandez Laguna)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
CLOSED SESSION REPORT

(Joel Hernandez Laguna)

AWARDS AND RECOGNITION

(Verbal)

(DR. RADNER)

Awards & Recognition

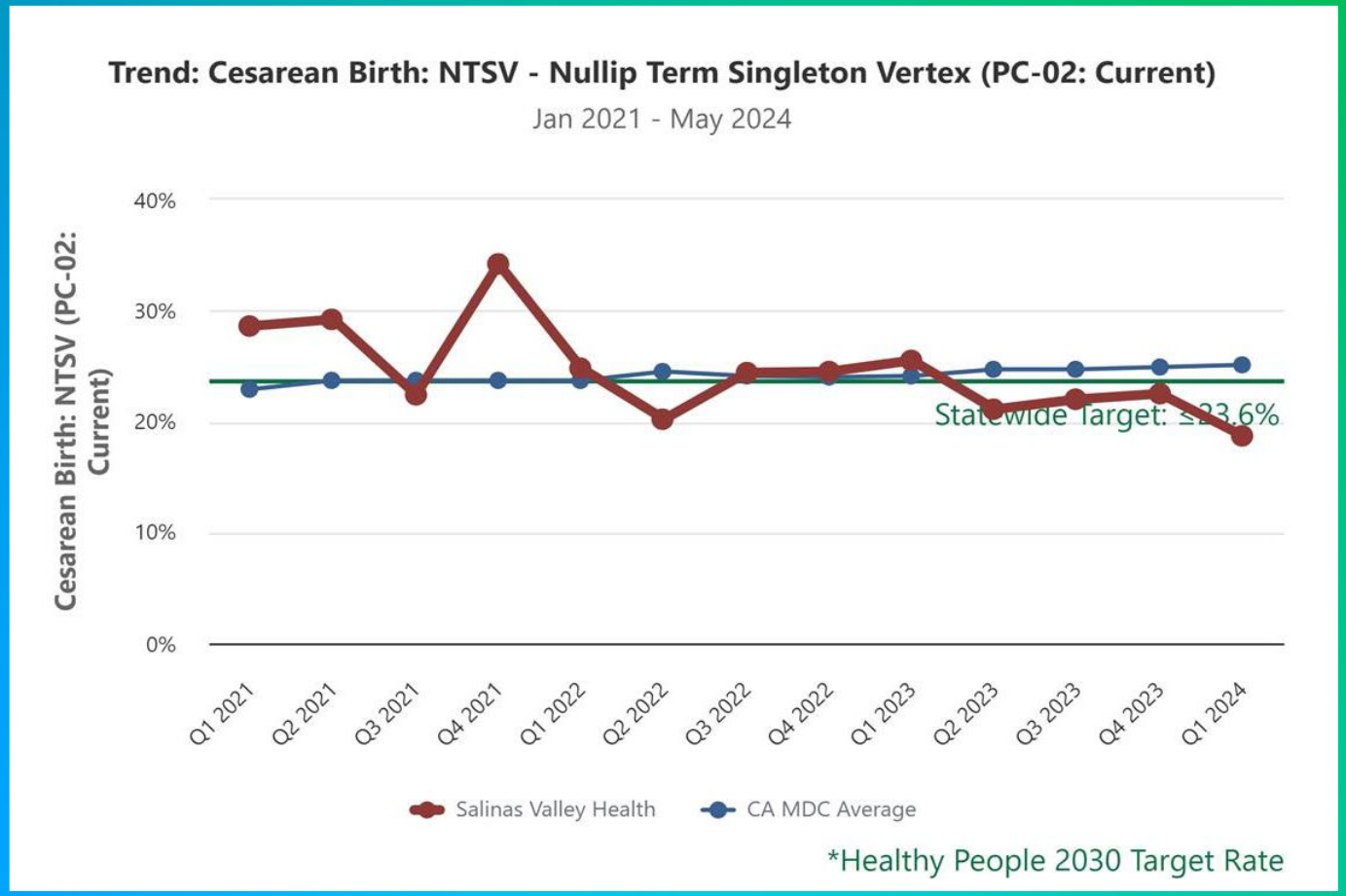
Board of Directors Meeting

July 25, 2024

STAR Award Honoree (March)
Holly Lombardi

2024 - 2025
U.S. NEWS & WORLD REPORT
High Performing Hospital

HIGH PERFORMING HOSPITALS
U.S.News & WORLD REPORT
2024
MATERNITY



BETA Healthcare Award
Quest for Zero: 14th Consecutive Year

Mother Baby

Labor & Delivery

BETA HEALTHCARE GROUP

Highest Designation Platinum Award Earned from the College of Cardiology: Chest Pain- MI Registry

AMERICAN COLLEGE of CARDIOLOGY

American Heart Association

GOLD PLUS Stroke

GOLD Coronary Artery Disease NSTEMI

2024 - 2025
U.S. NEWS & WORLD REPORT
BEST Regional Hospital and High Performing Hospital
#44 in California

Ranked as high-performing in 10 out of 20 procedures and conditions:

1. Spinal fusion
2. Congestive heart failure
3. Heart attack
4. Lymphoma and myeloma
5. Pneumonia and stroke
6. Kidney failure
7. Diabetes
8. Hip fracture
9. Leukemia
10. Maternity Care

2024 California Opioid Honor Roll from CalCompare

Salinas Valley Health Medical Center has been recognized as a California hospital who achieved an “Excellent” recognition in Cal Hospital Compare’s 2024 Opioid Care Honor Roll Program

- Recognized for excellent level for progress in creating care processes for opioid use disorder

Salinas Valley Health Shines with **Nine** Epic **Gold Stars**

Salinas Valley Health has achieved an outstanding feat. We've been awarded nine Gold Stars by Epic, surpassing industry averages.

- Commitment to excellence in healthcare technology utilization
- 86% completion rate of Gold Star Items demonstrates exceptional proficiency
- Dedication to optimizing patient care

Awards & Recognition

Board of Directors Meeting

July 25, 2024

PUBLIC COMMENT

BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

DRAFT SALINAS VALLEY HEALTH[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
JUNE 27, 2024

Board Members Present: President Victor Rey, Jr., Vice-President Joel Hernandez Laguna, Juan Cabrera, Rolando Cabrera, MD and Catherine Carson;
Absent: None.

Also Present:
Allen Radner, MD, President/Chief Executive Officer
Rakesh Singh, MD, Chief of Staff
Matthew Ottone, Esq., District Legal Counsel
Kathie Haines, Executive Support

Dr. Singh left at 4:07 p.m. during Closed Session.

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Victor Rey, Jr., called the meeting to order at 4:01 p.m. in the Downing Resource Center, Rooms A, B, and C.

2. CLOSED SESSION

President Rey announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Hearings and Reports, (2) Conference with Labor Negotiator-National Union of Healthcare Workers, California Nurses Association, Local 39, ESC Local 20, (3) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, and (4) Public Employee Appointment: President/Chief Executive Officer*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:03 p.m. The Board completed its business of the Closed Session at 4:20 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:34 p.m. President Rey reported that in Closed Session, the Board discussed *(1) Hearings and Reports, (2) Conference with Labor Negotiator-National Union of Healthcare Workers, California Nurses Association, Local 39, ESC Local 20, and (3) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services.* The Board received and accepted the reports listed on the Closed Session agenda.

President Rey announced there is a need for an extended closed session. The items to be discussed in Extended Closed Session will be *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, and (2) Public Employee Appointment: President/Chief Executive Officer*.

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

4. AWARDS AND RECOGNITION

Dr. Radner announced it was his pleasure to open the Awards and Recognition portion of the Board of Directors. The following was presented:

- Workday Implementation Team: The team consisted of staff from General Accounting, Human Resources and Information Technology. Michelle Childs, CHRO, Augustine Lopez, CFO and Audrey Parks, CIO, reported this team of payroll, human resources, and information technology professionals worked diligently and collaboratively for 9 months to bring Workday, a modern human capital management system, to Salinas Valley Health. Their dedication to accuracy, efficiency and timeliness resulted in on-time go-live with no interruption to operations. This group, under immense stress, worked tirelessly individually and as teams across departments, demonstrating Support, Teamwork, Accountability and Respect to each other as they navigated the transition of data and processes from a less flexible/manually driven system to a high tech, user friendly automated system of critical components including payroll, compensation, benefits, recruitment, performance management, leaves of absence and the associated system integrations. Collectively, these individuals and groups were accountable to each other, their departments, administration and all staff for a seamless transition, at which they succeeded. This group of talented individuals are our WorkDay Heroes.

  The following individuals were honored: Noel Grayson, Karen Haruta, Cyndie Mar, Nicole Shriner, Robert Andersen, Joe Chai, Genieve Fematt, Vaness Gutierrez, Lili Marquez-Garcia, Kate Martinez, Angelica Plascencia and Tim France.

- Lynette Fitzgerald, Director/Community Benefit reported that the Perinatal Department sponsored their 3rd annual diaper drive. On June 1st at the Salinas Sports Complex the Mobile Clinic and 5 perinatal nurses distributed diapers, and baby hats, baby booties and stuffies provided by the Service League. Another Community Health Day is scheduled for October 12th, Gonzales Central Park from 11 am to 2 p.m. The day will include diaper distribution through the SVH Mobile Clinic and a free flu clinic through the Monterey County Health Department. The event will include the opportunities for other organizations to participate. Contact Ms. Fitzgerald if there is interest in sponsoring a table at the event. Ms. Fitzgerald was thanked for bringing this event to South County.

5. EMERGENCY DEPARTMENT CONSTRUCTION UPDATE

Stephen Lyon, Project Manager/Bogart Construction, and David Thompson, Clinical Manager/ED, provided an Emergency Department (ED) Expansion Phase 1 Update including project history, current overflow conditions, and the need for modular building installation which complies with HCAi Policy Intent Notice (PIN) 34 allowing 'duplicate hospital services' described in Health & Safety Code Sec. 129730 and will be licensed through CDPH. Staff was engaged for input on patient flow and operational flow. The intent is to increases space, provide family comfort by allowing family members to be together, improve arrival process with a fast track area, provide privacy, provide better flow for patient satisfaction and better flow for staff.

BOARD MEMBER DISCUSSION: Explain the canopy over the modular buildings: The canopy over the walkway will provide a chance for families to be outside but the space cannot function as another room. Will there be proper air filtration? Yes, air filtration is required by CDPH for licensing. Will the modular buildings have the same communication capabilities? The construction team is working with IT to ensure communication between the modular buildings and the ED. The buildings will have full access

to the medical records system. What is the plan for security? The area will have cameras and will be tied to the main hospitals security system.

6. PUBLIC COMMENT

Evelyn, RN/1Main spoke about the current staffing matrix which was changed about a year ago. The matrix reduced staffing making rest breaks a challenge and is concerned about patient care.

Nina RN stated she is a patient advocate and spoke about the staffing matrix reducing staffing affecting nursing practice with lack of attention to patient acuity. She asked if the Board was aware that senior administration made this decision.

Natalie Ramirez, RN/Oncology spoke about the hospital's choice of legal counsel for collective bargaining. She requested the Board hold leadership accountable for the staffing matrix to support nurses.

Hugo Gutierrez, RN/4T stated he is a dedicated patient advocate. He stated the patient matrix enacted by senior administration affects patient care and did not include RN input. Nursing professional clinical judgment is not being considered.

Chrystal Cortez, RN/Float stated the matrix only accounts for budgeting. Patients are in the hospital with higher acuity, with less staffing and resources which is affecting patient care.

Rachel, RN/Heart Center stated patients have higher acuities and the staffing model is cut razor thin. Does the Board know about the matrix?

7. BOARD MEMBER COMMENTS AND REFERRALS

Vice President Joel Hernandez Laguna: Director Hernandez thanked Carla Spencer, CNO, for coordinating an ED tour July 2nd at 7:30 a.m. He thanked Marketing for promoting the hospital, new physicians and services. Director Hernandez has received calls over the past few weeks from patients stating they received great care from nurses and physicians; compassion and professionalism were shown by all staff. He thanked the Mobile Clinic leadership (Dr. Rodriguez and Ms. Fitzgerald) for their good work. He recommended the website include times when services stop rather than hours the Mobile Clinic will be on site.

Director Juan Cabrera: None

Director Rolando Cabrera, MD: Director Dr. Cabrera welcomed Carla Spencer as CNO and thanked her for being at her first Board Meeting in her new role.

Director Catherine Carson: Director Carson stated the search committee has completed their search for the new President/CEO. Marketing provided their performance improvement plan to the Medical Staff Quality and Safety Committee this morning which was excellent and will be provided again at Quality and Efficient Practices Committee in July if you care to join the meeting.

President Victor Rey, Jr.: Director Rey thanked Dr. Rodriguez and Ms. Fitzgerald for the Mobile Clinic focus on South County. There was great feedback on the Safety Fair in Soledad. He concurred with Director Carson's comments on the Marketing Plan; it is spectacular.

8. CONSENT AGENDA – GENERAL BUSINESS

Recommend Board Approval of the Following:

A. Minutes of the Regular Meeting of the Board of Directors May 23, 2024

B. Minutes of the Special Meeting of the Board of Directors May 20, 2024
C. Minutes of the Special Meeting of the Board of Directors May 28, 2024
D. Minutes of the Special Meeting of the Board of Directors June 6, 2024
E. Financial Report
F. Statistical Report
G. Policies Requiring Approval
    1. Administrative Executive Expenditure Reimbursement
    2. Annual Board Policy on Community Giving
    3. Capital Equipment
    4. Community Funding (Administrative Policy)
    5. Competitive Solicitation
    6. Continuing Education and Hospital Travel
    7. Contract Approval Matrix
    8. Expense Approval Matrix
    9. IT Purchase & Lifecycle Management
    10. Scope of Service: Administration
    11. Scope of Service: Clinical Research Program
    12. Work-Related and Non Work-Related Subpoenas

PUBLIC COMMENT:
None.

BOARD MEMBER DISCUSSION: Gary Ray, CLO, will be working on a policy on contract quality validation for operational and clinical contracts. Community Funding Policy: Are there percentages for community spending? Is there a report on community spending report vs. marketing and charitable support? Ms. Fitzgerald stated there are no percentages but there is a budget. There is a plan to reach out to organizations that have not applied. Requests must align with the Community Health Needs Assessment. Suggestions: Look at percentages in the future and track value measures for community benefit and report through the Community Advocacy Committee.

MOTION:

Upon motion by Director Hernandez Laguna, second by Director Dr. Cabrera, the Board of Directors approved the Consent Agenda, Items (A) through (G), as listed above.

ROLL CALL VOTE:

Ayes: Directors J. Cabrera, Dr. Cabrera, Carson, Hernandez Laguna and Rey;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

9. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Catherine Carson regarding the Quality and Efficient Practices Committee. The minutes were provided for Board review. There was an excellent presentation by the Procedural Unit Practice Council which consists of the Cath Lab, Cardiology, Cardiac Wellness and Diagnostic Imaging. There was a report on sepsis prevention which will now be included in value based purchasing. The CMS Star report will be published in July.

B. PERSONNEL, PENSION AND INVESTMENT COMMITTEE

A report was received from Director Juan Cabrera regarding the Personnel, Pension and Investment Committee. The following recommendations were made.

1. Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Erika Garcia, MD, (ii) Contract Terms for Dr. Garcia's Recruitment Agreement, and (iii) Contract Terms for Dr. Garcia's family medicine and obstetrics Professional Services Agreement.

PUBLIC COMMENT:
None.

BOARD MEMBER DISCUSSION:
Great job by the recruiting team. The Recruitment Agreement was clarified. Dr. Garcia will be privileged in the hospital for normal deliveries, not C-Sections.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Hernandez Laguna, the Board of Directors makes the following findings and approves the recommendations as follows:

(i) The Findings Supporting Recruitment of Erika Garcia, MD;

- That the recruitment of a family medicine and obstetrics physician to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
- That the recruitment benefits and incentives the District proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;

(ii) The Contract Terms of the Recruitment Agreement for Dr. Garcia; and

(iii) The Contract Terms of the Family Medicine and Obstetrics Professional Services Agreement for Dr. Garcia.

ROLL CALL VOTE:

Ayes: Directors J. Cabrera, Dr. Cabrera, Carson, Hernandez Laguna and Rey;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

2. Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Amber Grandison, MD, (ii) Contract Terms for Dr. Grandison's Recruitment Agreement, and (iii) Contract Terms for Dr. Grandison's family medicine and obstetrics Professional Services Agreement.

PUBLIC COMMENT:
None.

BOARD MEMBER DISCUSSION:
Dr. Grandison just finished her fellowship.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director J. Cabrera, the Board of Directors makes the following findings and approves the recommendations as follows:

(i) The Findings Supporting Recruitment of Amber Grandison, MD;

- That the recruitment of a family medicine and obstetrics physician to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
- That the recruitment benefits and incentives the District proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;

(ii) The Contract Terms of the Recruitment Agreement for Dr. Grandison; and

(iii) The Contract Terms of the Family Medicine and Obstetrics Professional Services Agreement for Dr. Grandison.

ROLL CALL VOTE:

Ayes: Directors J. Cabrera, Dr. Cabrera, Carson, Hernandez Laguna and Rey;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

3. Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Aurora Robledo, MD, (ii) Contract Terms for Dr. Robledo's Recruitment Agreement, and (iii) Contract Terms for Dr. Robledo's family medicine and obstetrics Professional Services Agreement.

PUBLIC COMMENT:
None.

BOARD MEMBER DISCUSSION:
Our physician retention is above the national level. Hiring female providers helps bridge cultural barriers.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director J. Cabrera, the Board of Directors makes the following findings and approves the recommendations as follows:

(i) The Findings Supporting Recruitment of Aurora Robledo, MD;

- That the recruitment of a family medicine and obstetrics physician to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
- That the recruitment benefits and incentives the District proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;

(ii) The Contract Terms of the Recruitment Agreement for Dr. Robledo; and

(iii) The Contract Terms of the Family Medicine and Obstetrics Professional Services Agreement for Dr. Robledo.

ROLL CALL VOTE:
Ayes: Directors J. Cabrera, Dr. Cabrera, Carson, Hernandez Laguna and Rey;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

4. Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Annette Janelle Rasi, MD, (ii) Contract Terms for Dr. Rasi's Recruitment Agreement, and (iii) Contract Terms for Dr. Rasi's mammography and diagnostic imaging Professional Services Agreement.

PUBLIC COMMENT:
None.

BOARD MEMBER DISCUSSION:
None.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director J. Cabrera, the Board of Directors makes the following findings and approves the recommendations as follows:

(i) The Findings Supporting Recruitment of Annette Janelle Rasi, MD;

- That the recruitment of a mammography and diagnostic imaging physician to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
- That the recruitment benefits and incentives the District proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;

(ii) The Contract Terms of the Recruitment Agreement for Dr. Rasi; and

(iii) The Contract Terms of the Mammography and Diagnostic Imaging Professional Services Agreement for Dr. Rasi.

ROLL CALL VOTE:

Ayes: Directors J. Cabrera, Dr. Cabrera, Carson, Hernandez Laguna and Rey;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

5. Consider Recommendation for Board Approval to fund the required minimum contribution to the Salinas Valley Memorial Healthcare District Employees' Pension Plan for Calendar Year 2024.

PUBLIC COMMENT:
None.

BOARD MEMBER DISCUSSION:
None.

MOTION:

Upon motion by Director Carson, and second by Director Hernandez Laguna, the Board of Directors approves funding the required minimum contribution of $12,742,860 to the Salinas Valley Memorial Healthcare District Employees' Pension Plan for Calendar Year 2024.

ROLL CALL VOTE:

Ayes: Directors J. Cabrera, Dr. Cabrera, Carson, Hernandez Laguna and Rey;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

C. FINANCE COMMITTEE

A report was received from Director Joel Hernandez Laguna regarding the Finance Committee. The minutes were provided for Board review. The following recommendations were made:

1. Consider Recommendation to the Board of Directors for Approval of the project budget for the Salinas Valley Health Clinics X-Ray Equipment Installation of 559 Abbott Street Imaging Center.

MOTION:

Upon motion by Director Carson, and seconded by Director Dr. Cabrera, the Board of Directors approves the total estimated Project Budget for the Salinas Valley Health Clinics X-Ray Equipment Installation at 559 Abbott Street Imaging Center in the budgeted amount of $450,000.

PUBLIC COMMENT:
None.

BOARD DISCUSSION:
None.

ROLL CALL VOTE:

Ayes: Directors J. Cabrera, Dr. Cabrera, Carson, Hernandez Laguna and Rey;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

2. Consider Recommendation for Board of Directors approval of Quest Diagnostics Reference Laboratory Agreement

MOTION:

Upon motion by Director Dr. Cabrera, and seconded by Director J. Cabrera, the Board of Directors approves the new agreement with Quest Diagnostics in the amount of $5,125,103 (annual cost of $1,708,338).

PUBLIC COMMENT:
None.

BOARD DISCUSSION:
It was noted this contract will provide a savings of over $850,000.

ROLL CALL VOTE:

Ayes: Directors J. Cabrera, Dr. Cabrera, Carson, Hernandez Laguna and Rey;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

10. REVIEW AND CONSIDERATION FOR APPROVAL OF FISCAL YEAR 2025 (FY2025) OPERATING AND CAPITAL BUDGET

Augustine Lopez, CFO, reported the FY2025 Operating and Capital Budget has been reviewed in depth by the members of the Board at the Special Meeting of the Board on June 6, 2024 and by the Finance Committee on June 24, 2024. The entire leadership is involved in preparing the budget. The budget supports the Salinas Valley Health Mission and Vision and promotes patient safety and quality care. The following was reviewed: Salinas Valley Health Medical Center (SVHMC) average daily census (ADC) trend FY2013 through FY2025 budget, key budget assumptions, proposed consolidated FY2025 Budget Compared to FY2024 projection, and FY2025 capital budget summary. A full report was included in the packet.

PUBLIC COMMENT:
None.

BOARD DISCUSSION: Director Hernandez Laguna, Chair of Finance Committee, commended the team and stated he is confident with budget. Dr. Cabrera thanked Mr. Lopez and the team and stated he appreciates the work and the presentation.

MOTION:

Upon motion by Director Dr. Cabrera, and seconded by Director Hernandez Laguna, the Board of Directors approves the Salinas Valley Health Operating & Capital Budget for Fiscal Year 2025 with a Budgeted Operating Margin Loss of <$12.8M> or <1.7%> and a Total Capital Budget of $101.3M.

ROLL CALL VOTE:

Ayes: Directors J. Cabrera, Dr. Cabrera, Carson, Hernandez Laguna and Rey;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

11. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON JUNE 13, 2024, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING:

Allen Radner, MD, President/CEO, reviewed the reports of the Medical Executive Committee (MEC) meeting of June 13, 2024, and Policies/Procedures/Plans revisions. Proposed Medical Staff Bylaws Amendments were included in the packet for review. Bylaw revision has been a long process. The Bylaws will be presented for approval to the medical staff at the next Annual Medical Staff Meeting. The full Bylaws will then be referred to the Board of Directors for final approval. A full report was provided in the Board packet.

Recommend Board Approval of the Following:

a. Reports
    1. Credentials Committee Report
    2. Interdisciplinary Practice Committee Report
b. Policies/Procedures/Plans:
    1. Code Stroke Policy

PUBLIC COMMENT:
None.

BOARD DISCUSSION:
None.

MOTION:

Upon motion by Director J. Cabrera, second by Dr. Cabrera, the Board of Directors receives and accepts the Medical Executive Committee Credentials Committee Report, and approves the Policies, Procedures, Plans, as follows:

a. Reports
    1. Credentials Committee Report
    2. Interdisciplinary Practice Committee Report
b. Policies/Procedures/Plans:
    1. Code Stroke Policy

ROLL CALL VOTE:
Ayes: Directors J. Cabrera, Dr. Cabrera, Carson, Hernandez Laguna and Rey;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

12. CONSIDER BOARD RESOLUTION NO. 2024-02 GENERAL ELECTION FOR SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM; REQUESTING THE COUNTY ELECTIONS DEPARTMENT TO CONDUCT THE ELECTION; REQUESTING CONSOLIDATION OF THE ELECTION WITH STATEWIDE GENERAL ELECTION; AND AUTHORIZING PUBLICATION OF THE NOTICE OF ELECTION

Matthew Ottone, Esq., District Legal Counsel, reported Resolution No. 2024-02 was included in the Board Packet for the Board's consideration. The resolution is necessary as it is a requirement by the County of

Monterey to conduct an election for the Zone 2 and Zone 3 vacancies effective December 6, 2024 and to consolidate with the November statewide election.

MOTION:

Upon motion by Director Hernandez Laguna, second by Dr. Cabrera, the Board of Directors adopts ***RESOLUTION NO. 2024-02*** *General Election for Salinas Valley Memorial Healthcare System; Requesting the County Elections Department to Conduct the Election; Requesting Consolidation of the Election with Statewide General Election; and Authorizing Publication of Notice of Election.*

PUBLIC COMMENT:
None.

BOARD DISCUSSION:
The question was raised about campaign contributions by Board member Dr. Cabrera. Matt Ottone, Esq., District Legal Counsel, will provide information and facilitate a discussion during the next Transformation, Strategic Planning and Governance Committee.

ROLL CALL VOTE:

Ayes: Directors J. Cabrera, Dr. Cabrera, Carson, Hernandez Laguna and Rey;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

13. EXTENDED CLOSED SESSION

President Rey announced items to be discussed in Extended Closed Session are *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, and (2) Public Employee Appointment: President/Chief Executive Officer*. The meeting recessed into Closed Session under the Closed Session Protocol at 6:15 p.m. The Board completed its business of the Closed Session at 7:54 p.m.

14. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 7:54 p.m. President Rey reported that in Extended Closed Session, the Board discussed *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, and (2) Public Employee Appointment: President/Chief Executive Officer*. No action was taken.

15. CONSIDER APPROVAL OF EMPLOYMENT AGREEMENT FOR PRESIDENT/CEO FOR SALINAS VALLEY HEALTH

President Rey announced Item 15 – Consider Approval of Employment Agreement for President/CEO for Salinas Valley Health. Prior to introducing the item, President Rey orally provided a summary of the recommended salary, compensation and benefits of the proposed Agreement with Dr. Radner pursuant to Government Code Section 54952.7(c)(3). Specifically, President Rey reported as follows:

Compensation:
- Base Salary: $840,000 Annualized
- Incentive: Participation in the Annual Incentive Plan

Benefits:

- Medical, RX, Dental, Vision insurance coverage consistent with offering to non-affiliated staff.
- Life insurance at the Executive Level ($400K)
- PTO Accrual - paid time off accrual throughout the year in accordance with SVMH's standard policy.
- Short Term Disability Benefits. Should the Employee become disabled and unable to work, Employee will continue to receive one hundred percent (100%) of base salary for up to six (6) months using combination of sick leave, state disability benefits and supplemental pay.
- Education: SVH agrees to pay for up to $2,500 in continuing medical education to maintain physician license.

Michelle Childs, CHRO, summarized the terms and conditions of the proposed Employment Agreement with Allen Radner, MD. Ms. Childs stated there was one edit necessary in the agreement in Section 2.3 where the word "other" should be eliminated.

MOTION:

Upon motion by Director Dr. Cabrera, second by Director J. Cabrera, the Board of Directors approves Employment Agreement, with the edit articulated by Ms. Childs, for the position of President/Chief Executive Officer.

PUBLIC COMMENT:
None.

BOARD DISCUSSION:
None.

ROLL CALL VOTE:

Ayes: J. Cabrera, Dr. Cabrera, Carson, and Rey
Noes: Hernandez Laguna;
Abstentions: None;
Absent: None.

Motion Carried

16. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, July 25, 2024, at 4:00 p.m.** There being no further business, the meeting was adjourned at 8:02 p.m.

_____

Rolando Cabrera, MD
Secretary, Board of Directors

Financial Performance Review

June 2024

Finance Committee – Open Session

Augustine Lopez

Chief Financial Officer

Consolidated Financial Summary
For the Month of June 2024

$ in Millions	For the Month of June 2024			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 84.1	$ 60.3	$ 23.8	39.5%
Operating Expense	$ 63.8	$ 60.3	$ (3.5)	-5.8%
Income from Operations *	**$ 20.3**	**$ -**	**$ 20.3**	**0.0%**
Operating Margin %	*24.1%*	*0.1%*	*24.0%*	*24000.00%*
Non Operating Income **	$ 7.0	$ 1.9	$ 5.1	268.4%
Net Income	**$ 27.3**	**$ 1.9**	**$ 25.4**	**1336.8%**
Net Income Margin %	*32.4%*	*3.2%*	*29.2%*	*912.5%*

(*)Normalizing Items Included above:

$1.0M CCAH Care Based incentive fee (CY 2023)
$1.5M CCAH Supplemental Outpatient Program (FY 2023)
$2.7M CCAH Rate Range Program (CY 2022)
$4.1M Medi-Cal – Population Health Program (FY 2023)
$4.6M Medi-Cal – HQAF Program (CY 2023)
$13.9M Total Normalizing Items

(*) Additionally, the above incorporates a $5M partial pickup of the original Anthem Reserves of $17 million due to progress made in collecting outstanding funds from Anthem for the out of network period (8/1/23 to 11/14/23).

****Non Operating Income favorable budget impact includes**

$2.5M Favorable Investment Income
$1.7M Higher than budget property tax revenue
$0.8M Higher than budget donations for the month

Consolidated Financial Summary
For the Month of June 2024 - Normalized

$ in Millions	For the Month of June 2024			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 70.2	$ 60.3	$ 9.9	16.4%
Operating Expense	$ 63.8	$ 60.3	$ (3.5)	-5.8%
Income from Operations *	**$ 6.4**	**$ -**	**$ 6.4**	**0.0%**
Operating Margin %	*9.1%*	*0.1%*	*9.0%*	*9000.00%*
Non Operating Income **	$ 7.0	$ 1.9	$ 5.1	268.4%
Net Income	**$ 13.4**	**$ 1.9**	**$ 11.5**	**605.3%**
Net Income Margin %	*19.1%*	*3.2%*	*15.9%*	*496.9%*

(*)Normalizing Items Excluded above:

$1.0M CCAH Care Based incentive fee (CY 2023)
$1.5M CCAH Supplemental Outpatient Program (FY 2023)
$2.7M CCAH Rate Range Program (CY 2022)
$4.1M Medi-Cal – Population Health Program (FY 2023)
$4.6M Medi-Cal – HQAF Program (CY 2023)
$13.9M Total Normalizing Items

(*) Additionally, the above incorporates a $5M partial pickup of the original Anthem Reserves of $17 million due to progress made in collecting outstanding funds from Anthem for the out of network period (8/1/23 to 11/14/23).

****Non Operating Income favorable budget impact includes**

$2.5M Favorable Investment Income
$1.7M Higher than budget property tax revenue
$0.8M Higher than budget donations for the month

Consolidated Financial Summary YTD June 2024

$ in Millions	FY 2024 June YTD			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 779.1	$ 724.8	$ 54.3	7.5%
Operating Expense	$ 746.8	$ 721.7	$ (25.1)	-3.5%
Income from Operations *	**$ 32.3**	**$ 3.1**	**$ 29.2**	**941.9%**
Operating Margin %	*4.1%*	*0.4%*	*3.7%*	*925.0%*
Non Operating Income **	$ 41.6	$ 22.9	$ 18.7	81.7%
Net Income	**$ 73.9**	**$ 26.0**	**$ 47.9**	**184.2%**
Net Income Margin %	*9.5%*	*3.6%*	*5.9%*	*163.9%*

(*)Normalizing Items Included above:

$1.2M Medicare/Medi-Cal PY favorable cost report settlements
$1.0M CCAH Care Based incentive fee (CY 2023)
$1.5M CCAH Supplemental Outpatient Program (FY 2023)
$2.7M CCAH Rate Range Program (CY 2022)
$4.8M DHCS Rate Range Program (CY 2023)
$4.2M NDPH Population Health (CY 2023)
$4.1M Medi-Cal – Population Health Program (FY 2023)
$9.7M Medi-Cal – HQAF Program (CY 2022-2023)
$25.0M Total Normalizing Items

(*) Additionally, the above incorporates a $5M partial pickup of the original Anthem Reserves of $17 million due to progress made in collecting outstanding funds from Anthem for the out of network period (8/1/23 to 11/14/23).

Consolidated Financial Summary
YTD June 2024 - Normalized

$ in Millions	FY 2024 June YTD			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 754.0	$ 724.8	$ 29.2	4.0%
Operating Expense	$ 746.8	$ 721.7	$ (25.1)	-3.5%
Income from Operations *	**$ 7.2**	**$ 3.1**	**$ 4.1**	**132.3%**
Operating Margin %	*1.0%*	*0.4%*	*0.6%*	*150.0%*
Non Operating Income	$ 41.6	$ 22.9	$ 18.7	81.7%
Net Income	**$ 48.8**	**$ 26.0**	**$ 22.8**	**87.7%**
Net Income Margin %	*6.5%*	*3.6%*	*2.9%*	*80.6%*

(*)Normalizing Items Excluded above:

$1.2M Medicare/Medi-Cal PY favorable cost report settlements
$1.0M CCAH Care Based incentive fee (CY 2023)
$1.5M CCAH Supplemental Outpatient Program (FY 2023)
$2.7M CCAH Rate Range Program (CY 2022)
$4.8M DHCS Rate Range Program (CY 2023)
$4.2M NDPH Population Health (CY 2023)
$4.1M Medi-Cal – Population Health Program (FY 2023)
$9.7M Medi-Cal – HQAF Program (CY 2022-2023)
$25.0M Total Normalizing Items

(*) Additionally, the above incorporates a $5M partial pickup of the original Anthem Reserves of $17 million due to progress made in collecting outstanding funds from Anthem for the out of network period (8/1/23 to 11/14/23).

Salinas Valley Health Key Financial Indicators
Without Normalizing Items

Statistic	YTD 06/30/24	SVH Target	+/-	S&P A+ Rated Hospitals	+/-	YTD 6/30/23	+/-
Operating Margin*	4.1%	5.0%		4.0%		3.3%	
Total Margin*	9.5%	6.0%		6.6%		7.6%	
EBITDA Margin**	8.7%	7.4%		13.6%		6.9%	
Days of Cash*	370	305		249		329	
Days of Accounts Payable*	51	45		-		40	
Days of Net Accounts Receivable***	55	45		49		49	
Supply Expense as % NPR	14.0%	14.0%		-		12.6%	
SWB Expense as % NPR	53.8%	53.0%		53.7%		51.4%	
Operating Expense per APD*	6,743	6,739		-		6,503	

All metrics above are consolidated for SVH except Operating Expense per APD
*These metrics have not been adjusted for normalizing items
**Metric based on Operating Income (consistent with industry standard)
***Metric based on 90 days average net revenue (consistent with industry standard)

Questions/Comments

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
June 30, 2024

	Month of June,		Twelve months ended June 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 72,566,937	$ 58,973,649	$ 649,188,244	$ 635,980,307
Other operating revenue	1,097,830	(323,920)	20,125,317	17,574,158
Total operating revenue	73,664,767	58,649,729	669,313,561	653,554,465
Total operating expenses	49,092,863	57,110,629	582,424,863	577,998,123
Total non-operating income	2,010,790	3,694,712	(15,098,859)	(13,033,398)
Operating and non-operating income	$ 26,582,694	$ 5,233,812	$ 71,789,839	$ 62,522,944

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
June 30, 2024

	Current year	Prior year
ASSETS:		
Current assets	$ 401,422,695	$ 434,416,907
Assets whose use is limited or restricted by board	166,413,835	157,874,523
Capital assets	250,302,997	246,418,049
Other assets	303,079,228	194,004,525
Deferred pension outflows	85,689,707	116,911,125
	$ 1,206,908,462	$ 1,149,625,130
LIABILITIES AND EQUITY:		
Current liabilities	101,325,037	85,928,225
Long term liabilities	21,314,004	22,722,645
Lease deferred inflows	2,171,322	2,856,606
Pension liability	90,982,672	118,792,064
Net assets	991,115,427	919,325,589
	$ 1,206,908,462	$ 1,149,625,130

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
June 30, 2024

	Month of June,		Twelve months ended June 30,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,829	1,762	21,385	23,632
Medi-Cal	1,032	981	12,532	13,871
Commercial insurance	577	659	6,913	8,720
Other patient	88	86	1,237	1,467
Total patient days	3,526	3,488	42,067	47,690
Gross revenue:				
Medicare	$ 121,703,177	$ 105,303,384	$ 1,395,446,138	$ 1,263,747,921
Medi-Cal	77,246,175	67,816,969	875,287,625	849,142,377
Commercial insurance	54,328,979	56,494,220	641,129,022	628,644,840
Other patient	10,052,648	8,840,971	110,305,478	105,684,890
Gross revenue	263,330,979	238,455,544	3,022,168,263	2,847,220,028
Deductions from revenue:				
Administrative adjustment	244,590	72,563	3,607,697	3,086,596
Charity care	349,225	824,076	7,410,211	7,724,323
Contractual adjustments:				
Medicare outpatient	39,430,344	33,599,796	442,800,772	370,792,647
Medicare inpatient	50,049,740	44,240,449	567,315,573	554,690,748
Medi-Cal traditional outpatient	1,796,203	2,647,523	28,467,619	38,876,838
Medi-Cal traditional inpatient	(2,249,601)	1,250,711	45,866,021	59,791,485
Medi-Cal managed care outpatient	36,088,642	29,702,102	395,136,856	341,338,709
Medi-Cal managed care inpatient	20,221,280	20,115,843	297,492,152	304,661,806
Commercial insurance outpatient	19,422,189	21,941,233	270,180,430	225,451,397
Commercial insurance inpatient	18,685,248	20,116,538	245,845,850	240,140,483
Uncollectible accounts expense	5,000,605	4,464,114	53,909,164	47,598,238
Other payors	1,725,577	506,947	14,947,674	17,086,451
Deductions from revenue	190,764,042	179,481,896	2,372,980,019	2,211,239,721
Net patient revenue	$ 72,566,937	$ 58,973,649	$ 649,188,244	$ 635,980,307
Gross billed charges by patient type:				
Inpatient	$ 129,076,916	$ 119,256,978	$ 1,505,395,393	$ 1,519,243,349
Outpatient	102,019,795	88,023,889	1,154,413,242	972,572,733
Emergency room	32,234,268	31,174,677	362,359,628	355,403,945
Total	$ 263,330,979	$ 238,455,544	$ 3,022,168,263	$ 2,847,220,028

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
June 30, 2024

	Month of June,		Twelve months ended June 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 72,566,937	$ 58,973,649	$ 649,188,244	$ 635,980,307
Other operating revenue	1,097,830	(323,920)	20,125,317	17,574,158
Total operating revenue	73,664,767	58,649,729	669,313,561	653,554,465
Operating expenses:				
Salaries and wages	16,985,600	15,338,476	201,289,712	200,797,483
Compensated absences	3,062,085	2,644,838	36,326,553	34,442,854
Employee benefits	6,179,115	18,318,477	99,148,801	105,232,116
Supplies, food, and linen	8,672,612	6,827,793	91,446,086	82,119,292
Purchased department functions	4,597,589	(387,921)	45,152,493	44,883,132
Medical fees	2,621,106	2,733,203	30,242,006	26,844,907
Other fees	2,083,674	2,987,068	27,191,426	35,119,574
Depreciation	2,771,436	5,334,051	29,727,888	27,508,356
All other expense	2,119,646	3,314,644	21,899,898	21,050,409
Total operating expenses	49,092,863	57,110,629	582,424,863	577,998,123
Income from operations	24,571,904	1,539,100	86,888,698	75,556,342
Non-operating income:				
Donations	1,196,627	6,648,598	3,890,720	16,406,938
Property taxes	2,013,568	2,053,906	5,680,235	5,720,572
Investment income	3,003,039	1,407,871	27,801,454	8,254,571
Taxes and licenses	0	0	0	0
Income from subsidiaries	(4,202,444)	(6,415,663)	(52,471,268)	(43,415,479)
Total non-operating income	2,010,790	3,694,712	(15,098,859)	(13,033,398)
Operating and non-operating income	26,582,694	5,233,812	71,789,839	62,522,944
Net assets to begin	964,532,733	914,091,777	919,325,587	856,802,644
Net assets to end	$ 991,115,427	$ 919,325,589	$ 991,115,427	$ 919,325,589
Net income excluding non-recurring items	$ 26,582,694	$ 5,233,812	$ 71,789,839	$ 62,522,944
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	0	0	0	0
Operating and non-operating income	$ 26,582,694	$ 5,233,812	$ 71,789,839	$ 62,522,944

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
June 30, 2024

	Month of June,		Twelve months ended June 30,	
	current year	prior year	current year	prior year
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	$ (209,448)	$ (205,490)	$ (2,407,117)	$ (2,049,389)
Neurological Clinic	(108,508)	(54,088)	(817,152)	(766,375)
Palliative Care Clinic	(114,394)	(102,021)	(1,094,454)	(868,678)
Surgery Clinic	(192,332)	(165,233)	(2,163,374)	(1,743,314)
Infectious Disease Clinic	(39,076)	(57,387)	(457,326)	(395,766)
Endocrinology Clinic	(194,916)	(148,938)	(2,667,748)	(2,047,230)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(527,727)	(566,907)	(6,750,097)	(5,868,064)
OB/GYN Clinic	(328,415)	(370,995)	(4,819,227)	(4,004,236)
PrimeCare Medical Group	(565,631)	(544,539)	(9,711,033)	(7,848,773)
Oncology Clinic	(372,851)	(295,432)	(4,209,599)	(3,372,919)
Cardiac Surgery	(376,859)	(361,566)	(3,902,381)	(3,668,865)
Sleep Center	(80,280)	(25,867)	(735,322)	(441,453)
Rheumatology	(72,022)	(71,591)	(877,205)	(754,269)
Precision Ortho MDs	(473,582)	(343,244)	(5,616,903)	(4,554,483)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(71,785)	(11,307)	(604,771)	(408,671)
Vaccine Clinic	0	0	16	(683)
Dermatology	(42,774)	(70,753)	(469,724)	(282,387)
Hospitalists	0	0	0	0
Behavioral Health	(54,437)	(34,834)	(604,274)	(413,214)
Pediatric Diabetes	(40,674)	(53,000)	(535,486)	(556,954)
Neurosurgery	(114,005)	(38,329)	(742,328)	(375,427)
Multi-Specialty-RR	30,924	10,277	70,750	91,011
Radiology	(354,160)	(1,582,324)	(3,075,420)	(2,079,819)
Salinas Family Practice	(107,723)	(92,393)	(1,490,868)	(1,237,679)
Urology	(170,151)	(287,378)	(1,995,313)	(1,262,931)
Total SVHC	(4,580,826)	(5,473,339)	(55,676,356)	(44,910,568)
Doctors on Duty	236,614	(269,933)	883,934	246,029
Vantage Surgery Center	0	0	0	0
LPCH NICU JV	0	(506,820)	0	(506,820)
Central Coast Health Connect	(102,308)	(106,009)	(102,308)	(106,009)
Monterey Peninsula Surgery Center	164,330	(82,599)	1,668,738	1,508,283
Coastal	(8,891)	6,058	118,894	37,941
Apex	0	0	0	0
21st Century Oncology	11,929	(35,789)	80,003	(140,774)
Monterey Bay Endoscopy Center	76,708	52,766	555,827	456,440
Total	$ (4,202,444)	$ (6,415,663)	$ (52,471,268)	$ (43,415,479)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
June 30, 2024

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 270,540,350	$ 328,752,213
Patient accounts receivable, net of estimated uncollectibles of $55,096,213	111,333,643	85,106,372
Supplies inventory at cost	7,862,358	8,016,154
Current portion of lease receivable	1,732,185	1,921,803
Other current assets	9,954,159	10,620,365
Total current assets	401,422,695	434,416,907
Assets whose use is limited or restricted by board	166,413,835	157,874,523
Capital assets:		
Land and construction in process	43,346,670	58,875,555
Other capital assets, net of depreciation	206,956,327	187,542,495
Total capital assets	250,302,997	246,418,049
Other assets:		
Right of use assets, net of amortization	7,284,598	5,681,859
Long term lease receivable	467,297	1,115,546
Subscription assets, net of amortization	10,207,128	10,754,599
Investment in Securities	257,603,817	145,498,387
Investment in SVMC	3,062,893	10,499,369
Investment in Coastal	1,800,535	1,681,641
Investment in other affiliates	22,120,787	18,240,951
Net pension asset	532,173	532,173
Total other assets	303,079,228	194,004,525
Deferred pension outflows	85,689,707	116,911,125
	$ 1,206,908,462	$ 1,149,625,130
L I A B I L I T I E S A N D N E T A S S E T S		
Current liabilities:		
Accounts payable and accrued expenses	$ 68,991,986	$ 57,123,763
Due to third party payers	3,675,118	5,404,186
Current portion of self-insurance liability	21,781,195	16,874,923
Current subscription liability	4,227,920	4,630,742
Current portion of lease liability	2,648,818	1,894,611
Total current liabilities	101,325,037	85,928,225
Long term portion of workers comp liability	12,752,056	13,027,333
Long term portion of lease liability	5,101,119	3,980,405
Long term subscription liability	3,460,829	5,714,907
Total liabilities	122,639,041	108,650,871
Lease deferred inflows	2,171,322	2,856,606
Pension liability	90,982,672	118,792,064
Net assets:		
Invested in capital assets, net of related debt	250,302,997	246,418,049
Unrestricted	740,812,430	672,907,540
Total net assets	991,115,427	919,325,589
	$ 1,206,908,462	$ 1,149,625,130

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
June 30, 2024

	Month of June,				Twelve months ended June 30,			
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:								
Gross billed charges	$ 263,330,979	$ 234,963,711	28,367,268	12.07%	$ 3,022,168,263	$ 2,824,756,792	197,411,471	6.99%
Dedutions from revenue	190,764,042	185,084,553	5,679,489	3.07%	2,372,980,019	2,225,100,017	147,880,002	6.65%
Net patient revenue	72,566,937	49,879,158	22,687,779	45.49%	649,188,244	599,656,775	49,531,469	8.26%
Other operating revenue	1,097,830	1,332,540	(234,710)	-17.61%	20,125,317	15,990,480	4,134,837	25.86%
Total operating revenue	**73,664,767**	**51,211,698**	**22,453,069**	**43.84%**	**669,313,561**	**615,647,255**	**53,666,306**	**8.72%**
Operating expenses:								
Salaries and wages	16,985,600	17,292,681	(307,081)	-1.78%	201,289,712	207,339,020	(6,049,308)	-2.92%
Compensated absences	3,062,085	3,052,417	9,668	0.32%	36,326,553	34,755,047	1,571,506	4.52%
Employee benefits	6,179,115	8,024,751	(1,845,636)	-23.00%	99,148,801	96,162,309	2,986,492	3.11%
Supplies, food, and linen	8,672,612	6,680,801	1,991,811	29.81%	91,446,086	81,476,548	9,969,538	12.24%
Purchased department functions	4,597,589	3,539,228	1,058,361	29.90%	45,152,493	42,470,750	2,681,743	6.31%
Medical fees	2,621,106	2,359,060	262,046	11.11%	30,242,006	28,308,722	1,933,284	6.83%
Other fees	2,083,674	2,222,815	(139,141)	-6.26%	27,191,426	26,972,924	218,502	0.81%
Depreciation	2,771,436	2,083,937	687,499	32.99%	29,727,888	25,622,216	4,105,672	16.02%
All other expense	2,119,646	1,801,863	317,783	17.64%	21,899,898	21,859,160	40,738	0.19%
Total operating expenses	**49,092,863**	**47,057,554**	**2,035,309**	**4.33%**	**582,424,863**	**564,966,695**	**17,458,168**	**3.09%**
Income from operations	**24,571,904**	**4,154,144**	**20,417,760**	**491.50%**	**86,888,698**	**50,680,559**	**36,208,139**	**71.44%**
Non-operating income:								
Donations	1,196,627	166,667	1,029,960	617.98%	3,890,720	2,000,000	1,890,720	94.54%
Property taxes	2,013,568	333,333	1,680,235	504.07%	5,680,235	4,000,000	1,680,235	42.01%
Investment income	3,003,039	1,185,806	1,817,234	153.25%	27,801,454	14,229,667	13,571,788	95.38%
Income from subsidiaries	(4,202,444)	(4,089,532)	(112,912)	2.76%	(52,471,268)	(47,194,522)	(5,276,746)	11.18%
Total non-operating income	**2,010,790**	**(2,403,726)**	**4,414,516**	**-183.65%**	**(15,098,859)**	**(26,964,855)**	**11,865,997**	**-44.01%**
Operating and non-operating income	**$ 26,582,694**	**$ 1,750,418**	**24,832,276**	**1418.65%**	**$ 71,789,839**	**$ 23,715,704**	**48,074,136**	**202.71%**

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of June and twelve months to date

	Month of June		Twelve months to date		
	2023	2024	2022-23	2023-24	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	44	54	457	444	(13)
Other Admissions	97	70	1,034	906	(128)
Total Admissions	141	124	1,491	1,350	(141)
Medi-Cal Patient Days	68	54	739	643	(96)
Other Patient Days	166	147	1,746	1,541	(205)
Total Patient Days of Care	234	201	2,485	2,184	(301)
Average Daily Census	7.5	6.5	6.8	6.0	(0.8)
Medi-Cal Average Days	1.7	1.5	1.7	1.7	(0.0)
Other Average Days	0.8	1.7	1.7	1.7	(0.1)
Total Average Days Stay	1.8	1.7	1.7	1.7	(0.0)
ADULTS & PEDIATRICS					
Medicare Admissions	373	384	4,709	4,474	(235)
Medi-Cal Admissions	309	258	3,477	3,211	(266)
Other Admissions	401	339	3,698	3,668	(30)
Total Admissions	1,083	981	11,884	11,353	(531)
Medicare Patient Days	1,520	1,569	19,967	18,036	(1,931)
Medi-Cal Patient Days	1,036	1,080	14,309	12,951	(1,358)
Other Patient Days	927	612	12,156	8,486	(3,670)
Total Patient Days of Care	3,483	3,261	46,432	39,473	(6,959)
Average Daily Census	112.4	105.2	126.9	107.8	(19.0)
Medicare Average Length of Stay	4.0	4.2	4.2	4.0	(0.2)
Medi-Cal AverageLength of Stay	3.3	3.5	3.6	3.5	(0.1)
Other Average Length of Stay	2.3	1.5	2.6	1.9	(0.8)
Total Average Length of Stay	3.2	3.0	3.5	3.1	(0.4)
Deaths	29	15	296	310	14
Total Patient Days	3,717	3,462	48,917	41,657	(7,260)
Medi-Cal Administrative Days	10	0	103	398	295
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	10	0	103	398	295
Percent Non-Acute	0.27%	0.00%	0.21%	0.96%	0.74%

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of June and twelve months to date

	Month of June		Twelve months to date		
	2023	2024	2022-23	2023-24	Variance
PATIENT DAYS BY LOCATION					
Level I	263	271	3,569	3,020	(549)
Heart Center	345	325	4,194	3,902	(292)
Monitored Beds	619	650	7,979	7,390	(589)
Single Room Maternity/Obstetrics	359	300	4,013	3,543	(470)
Med/Surg - Cardiovascular	732	864	10,754	10,077	(677)
Med/Surg - Oncology	289	180	3,381	3,234	(147)
Med/Surg - Rehab	443	499	6,025	5,541	(484)
Pediatrics	83	128	1,409	1,561	152
Nursery	234	201	2,485	2,184	(301)
Neonatal Intensive Care	60	44	1,531	1,205	(326)
PERCENTAGE OF OCCUPANCY					
Level I	67.44%	67.25%	75.22%	63.65%	
Heart Center	76.67%	69.89%	76.60%	71.27%	
Monitored Beds	76.42%	77.66%	80.96%	74.99%	
Single Room Maternity/Obstetrics	32.34%	26.16%	29.71%	26.23%	
Med/Surg - Cardiovascular	54.22%	61.94%	65.47%	61.35%	
Med/Surg - Oncology	74.10%	44.67%	71.25%	68.16%	
Med/Surg - Rehab	56.79%	61.91%	63.49%	58.39%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	15.37%	22.94%	21.45%	23.76%	
Nursery	47.27%	39.30%	20.63%	18.13%	
Neonatal Intensive Care	18.18%	12.90%	38.13%	30.01%	

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of June and twelve months to date

	Month of June		Twelve months to date		
	2023	2024	2022-23	2023-24	Variance
DELIVERY ROOM					
Total deliveries	136	99	1,436	1,266	(170)
C-Section deliveries	39	29	451	382	(69)
Percent of C-section deliveries	28.68%	29.29%	31.41%	30.17%	-1.23%
OPERATING ROOM					
In-Patient Operating Minutes	19,894	17,993	236,813	196,776	(40,037)
Out-Patient Operating Minutes	32,654	32,130	335,196	361,429	26,233
Total	52,548	50,123	572,009	558,205	(13,804)
Open Heart Surgeries	14	10	168	136	(32)
In-Patient Cases	138	126	1,615	1,380	(235)
Out-Patient Cases	307	320	3,396	3,581	185
EMERGENCY ROOM					
Immediate Life Saving	38	36	399	443	44
High Risk	653	856	7,633	9,470	1,837
More Than One Resource	2,944	2,758	35,378	33,671	(1,707)
One Resource	1,807	1,842	24,430	22,909	(1,521)
No Resources	88	81	1,168	1,052	(116)
Total	5,530	5,573	69,008	67,545	(1,463)

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of June and twelve months to date

	Month of June		Twelve months to date		
	2023	2024	2022-23	2023-24	Variance
CENTRAL SUPPLY					
In-patient requisitions	14,140	12,716	180,922	154,567	-26,355
Out-patient requisitions	11,263	10,300	117,046	126,556	9,510
Emergency room requisitions	771	645	9,051	8,252	-799
Interdepartmental requisitions	6,093	6,892	81,494	79,697	-1,797
Total requisitions	32,267	30,553	388,513	369,072	-19,441
LABORATORY					
In-patient procedures	35,383	36,157	468,241	433,828	-34,413
Out-patient procedures	11,202	41,060	126,815	377,306	250,491
Emergency room procedures	12,806	11,665	155,144	153,246	-1,898
Total patient procedures	59,391	88,882	750,200	964,380	214,180
BLOOD BANK					
Units processed	276	292	3,711	3,370	-341
ELECTROCARDIOLOGY					
In-patient procedures	1,042	1,117	13,466	13,338	-128
Out-patient procedures	446	388	4,503	4,742	239
Emergency room procedures	1,211	1,277	13,964	15,122	1,158
Total procedures	2,699	2,782	31,933	33,202	1,269
CATH LAB					
In-patient procedures	88	115	1,212	1,508	296
Out-patient procedures	118	155	1,024	1,520	496
Emergency room procedures	0	0	1	1	0
Total procedures	206	270	2,237	3,029	792
ECHO-CARDIOLOGY					
In-patient studies	380	403	4,765	4,618	-147
Out-patient studies	263	260	2,922	3,370	448
Emergency room studies	2	4	17	17	0
Total studies	645	667	7,704	8,005	301
NEURODIAGNOSTIC					
In-patient procedures	165	141	1,709	1,538	-171
Out-patient procedures	20	13	240	203	-37
Emergency room procedures	0	0	0	0	0
Total procedures	185	154	1,949	1,741	-208

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of June and twelve months to date

	Month of June		Twelve months to date		
	2023	2024	2022-23	2023-24	Variance
SLEEP CENTER					
In-patient procedures	0	0	2	0	-2
Out-patient procedures	208	259	1,795	3,031	1,236
Emergency room procedures	0	0	1	0	-1
Total procedures	208	259	1,798	3,031	1,233
RADIOLOGY					
In-patient procedures	1,173	1,267	17,017	15,651	-1,366
Out-patient procedures	441	456	4,884	4,953	69
Emergency room procedures	1,491	1,505	18,214	18,172	-42
Total patient procedures	3,105	3,228	40,115	38,776	-1,339
MAGNETIC RESONANCE IMAGING					
In-patient procedures	198	183	1,860	1,817	-43
Out-patient procedures	138	98	1,305	1,299	-6
Emergency room procedures	7	8	73	74	1
Total procedures	343	289	3,238	3,190	-48
MAMMOGRAPHY CENTER					
In-patient procedures	4,043	3,065	47,667	48,819	1,152
Out-patient procedures	3,987	3,045	47,225	48,356	1,131
Emergency room procedures	3	0	12	10	-2
Total procedures	8,033	6,110	94,904	97,185	2,281
NUCLEAR MEDICINE					
In-patient procedures	10	15	225	228	3
Out-patient procedures	71	137	1,089	1,421	332
Emergency room procedures	0	0	2	3	1
Total procedures	81	152	1,316	1,652	336
PHARMACY					
In-patient prescriptions	84,753	80,980	1,134,381	999,487	-134,894
Out-patient prescriptions	16,579	15,898	183,891	191,292	7,401
Emergency room prescriptions	9,049	9,743	105,838	114,678	8,840
Total prescriptions	110,381	106,621	1,424,110	1,305,457	-118,653
RESPIRATORY THERAPY					
In-patient treatments	16,391	15,192	213,968	191,679	-22,289
Out-patient treatments	894	348	13,317	12,400	-917
Emergency room treatments	290	637	4,796	6,246	1,450
Total patient treatments	17,575	16,177	232,081	210,325	-21,756
PHYSICAL THERAPY					
In-patient treatments	2,195	2,224	30,363	29,748	-615
Out-patient treatments	261	247	2,526	3,074	548
Emergency room treatments	0	0	2	0	-2
Total treatments	2,456	2,471	32,891	32,822	-69

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of June and twelve months to date

	Month of June		Twelve months to date		
	2023	2024	2022-23	2023-24	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,445	1,289	19,059	17,072	-1,987
Out-patient procedures	201	245	2,101	2,761	660
Emergency room procedures	0	0	0	0	0
Total procedures	1,646	1,534	21,160	19,833	-1,327
SPEECH THERAPY					
In-patient treatments	512	539	5,705	6,054	349
Out-patient treatments	43	36	325	447	122
Emergency room treatments	0	0	0	0	0
Total treatments	555	575	6,030	6,501	471
CARDIAC REHABILITATION					
In-patient treatments	2	0	3	12	9
Out-patient treatments	564	535	6,452	6,641	189
Emergency room treatments	0	0	0	3	3
Total treatments	566	535	6,455	6,656	201
CRITICAL DECISION UNIT					
Observation hours	326	349	4,975	3,792	-1,183
ENDOSCOPY					
In-patient procedures	73	75	996	934	-62
Out-patient procedures	72	72	719	708	-11
Emergency room procedures	0	0	0	0	0
Total procedures	145	147	1,715	1,642	-73
C.T. SCAN					
In-patient procedures	723	778	8,795	8,692	-103
Out-patient procedures	448	377	4,922	4,304	-618
Emergency room procedures	765	655	8,333	8,749	416
Total procedures	1,936	1,810	22,050	21,745	-305
DIETARY					
Routine patient diets	20,668	11,891	277,213	191,757	-85,456
Meals to personnel	28,233	31,578	303,414	358,577	55,163
Total diets and meals	48,901	43,469	580,627	550,334	-30,293
LAUNDRY AND LINEN					
Total pounds laundered	97,403	94,389	1,221,167	1,164,513	-56,654

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: July 16, 2024

Re: Policies Requiring Approval

As required under Title 22, CMS, and The Joint Commission (TJC), please find below a list of regulatory required policies with summary of changes that require your approval.

	Policy Title	Summary of Changes	Responsible VP
1.	Fecal Management System in the ICU Nursing Standardized Procedure	New Standardized Procedure for ICU only.	Carla Spencer, CNO
2.	Hyperbilirubinemia-Infant Management & Treatment	Updated per AP guidelines. Changed to procedure.	Carla Spencer, CNO
3.	Nipple Shields	Updated references, clarification of instructions - no content changes made.	Carla Spencer, CNO

Status Pending PolicyStat ID 15296351

Last Approved	N/A	Owner	Lacey Cone: Director Critical Care Services
Next Review	3 years after approval	Area	Nursing Standardized Procedures

Fecal Management System in the ICU Nursing Standardized Procedure

I. POLICY

A. This is a standardized procedure specific to the Intensive Care Unit (ICU).

II. DEFINITIONS

A. Director of Nursing – Nursing Director responsible for a nursing unit or cluster of units.
B. RN – Registered Nurse employed by SVHMC
C. SP – Standardized Procedure
D. ICU- Intensive Care Unit

III. PROCEDURE

A. Function(s)
    1. To provide care for bedridden patients experiencing episodes of liquid stool related to disease process and/or medication administration in the ICU.
B. Circumstances
    1. Setting: ICU only
    2. Supervision
        a. ICU RNs who qualify to perform this standardized procedure may independently order, and place, the fecal management system
        b. Physician supervision is not required.
    3. Patient Conditions

a. ICU patients who present with any of the following symptoms may have the procedure initiated:
    i. Frequent incontinence of liquid or semi liquid stool- greater than 3 times in a 24 hour period.
    ii. Medications ordered per rectum that need to be retained, such as lactulose enema.

b. Circumstances of change in patient condition when the RN is to immediately contact the physician:
    i. Rectal pain
    ii. Rectal bleeding
    iii. Abdominal symptoms, such as distention or pain

C. Database
1. Subjective- n/a
2. Objective
    a. Frequent incontinence of liquid or semi-liquid stool- greater than 3 times in a 24 hour period.
    b. Medications ordered per rectum that need to be retained, such as lactulose enema.

D. Diagnosis
1. Incontinent diarrhea

E. Plan
1. Treatment
    a. The order must be placed under the name of the attending ICU or Hospitalist physician with order source "per policy".
        i. If the patient is NOT being covered by one of these services, the RN must call the attending physician for an order to place a fecal management system.
2. Patient conditions requiring consultation/reportable conditions:
    a. Notify the patients physician immediately of the following:
        i. Rectal pain
        ii. Rectal bleeding
        iii. Abdominal symptoms, such as distention or pain
3. Education-Patient/Family
    a. Explain procedure to the patient and/or family.
    b. Review patients health history to ensure there are no contraindications to insertion of fecal management device

4. Follow-up
    a. As needed to maintain patency and continuity of care
5. Documentation of Patient Treatment
    a. Document patient procedure and care on the appropriate nursing documentation screen " Rectal Tube Assessment and Care".

F. Record Keeping
1. The facility will retain the patients' record according to the Record Retention procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education
1. A RN who has completed orientation and has demonstrated clinical competency may perform the procedures listed in this protocol.
2. Education will be provided upon hire with a RN preceptor/designee

B. Training
1. Clinical competency must be demonstrated and approved by supervising personnel

C. Experience
1. Current California RN license and designated to work in the ICU.

D. Evaluation
1. Initial: During the initial orientation process RNs are educated to this SP and complete a review with their preceptor. This is documented on the Department Specific Orientation Checklist and maintained in the office of Education
2. Ongoing: At least every 3 years competency will be re-assessed via annual skills assessment.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Review Schedule
1. Every 3 years or when practice changes are made.

B. Approval
1. The standardized procedure will go through Critical Care Committee every three (3) years for approval from the Intensivist and Hospitalist physician groups
2. The electronic policy and procedure system maintains tracking of initiation, review and approval of this SP including the Interdisciplinary Practice Committee, Medical Executive Committee and the Board of Directors.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. California Board of Registered Nursing,

B. Title 16, California Code of Regulations Section 1474

C. Medical Board of California. Title 16, Code of Regulations Section 1379

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	06/2024
IDPC	Katherine DeSalvo: Director Medical Staff Services	06/2024
Critical Care Committee	Katherine DeSalvo: Director Medical Staff Services	06/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024
Policy Owner	Lacey Cone: Director Critical Care Services	06/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **15061416**

Last Approved	N/A	Owner	Julie Johnson: Clinical Manager
Next Review	3 years after approval	Area	Women's and Children's Services

Hyperbilirubinemia-Infant Management & Treatment

I. POLICY STATEMENT

A. Total Serum Bilirubin (TSB) level(s) will be drawn on all newborns prior to discharge (preferably coordinated with newborn genetic screen) and PRN for visibly detected jaundice prior to 24 hours of age.

II. PURPOSE

A. To guide the registered nurse (RN) in identification of newborns at risk for significant hyperbilirubinemia and provide guidelines for the use of different treatment methods.

III. DEFINITIONS

A. TSB – total serum bilirubin

B. TcB – Transcutaneous bilirubin

C. G6PD – Glucose-6-phosphate dehydrogenase

IV. GENERAL INFORMATION

A. Newborns (less than 28 days of age) will be assessed for hyperbilirubinemia during hospitalization including:

1. Risk factors predisposing development of hyperbilirubinemia in conjunction with neurotoxicity risk factors.
2. Presence, level and intensity of jaundice

B. Newborns with TSB levels requiring treatment by phototherapy in Mother Baby or transferred to NICU for evaluation and treatment.

V. PROCEDURE

A. Identify newborns at risk for the development of hyperbilirubinemia.

1. Risk Factors for Developing Significant Hyperbilirubinemia

a. Lower gestational age (ie, risk increases with each additional week less than 40 wk)

b. Jaundice in first 24 hours after birth

c. Pre-discharge transcutaneous bilirubin (TcB) or total serum bilirubin (TSB) concentration close to the phototherapy threshold

d. Hemolysis from any cause, if known or suspected based on a rapid rate of increase in the TSB or TcB of >0.3 mg/dL per hour in the first 24 hours or >0.2 mg/dL per hour thereafter

e. Phototherapy before discharge

f. Parent or sibling requiring phototherapy or exchange transfusion

g. Family history or genetic ancestry suggestive of inherited red blood cell disorders, including G6PD deficiency

h. Exclusive breastfeeding with suboptimal intake

i. Scalp hematoma or significant bruising

j. Down syndrome

k. Macrosomic infant of a diabetic mother

2. Hyperbilirubinemia Neurotoxicity Risk Factors

a. Gestational age <38 weeks and this risk increases with the degree of prematurity

b. Albumin < 3.0 g/dL

c. Isoimmune hemolytic disease (ie, positive direct antiglobulin test), G6PD deficiency, or other hemolytic conditions

d. Sepsis

e. Significant clinical instability in the previous 24 hours

B. Promote and support successful breastfeeding (see BREASTFEEDING THE NEWBORN).

C. Interpret all TSB or TcB levels according to the newborn's gestational age, age in hours of sampling, and neurotoxicity risk factors utilizing:

1. The Bilitool through Data Repository in the electronic health record (at http://bilitool.org/).

2. The Bilitool website lists Hyperbilirubinemia Neurotoxicity Risk Factors and links to Nomograms (Hours-Specific, Phototherapy, Escalation of Care, and Exchange Transfusion Threholds) for newborns ≥35 week gestation.

a. When reporting results to physician, report neurotoxicity risk. TcB may be used at other times to screen newborns but it is not recommended to

assess infant if within 3mg/dl of phototherapy levels or following phototherapy (within 24 hours).

D. Visually assess all newborns for jaundice at least every 12 hours following delivery until discharge.
    1. In newborns, jaundice can be detected by blanching the skin with digital pressure, revealing the underlying color of the skin and subcutaneous tissue. The assessment of jaundice must be in a well-lit room.

E. If the newborn appears jaundiced in the first 24 hours of life, obtain TSB as per order set and notify physician of results and recommendations per Bilitool.

F. All Newborns with a TSB level within 1 mg/dl or exceeding the "Escalation of Care Threshold" level (See Nomogram on Bilitool) or with signs of Acute Bilirubin Encephalopathy (ABE), will be admitted into the NICU for evaluation and treatment. Infants with elevated TcB measurement or if within 3 mg/dl of phototherapy threshold should be confirmed with a TSB level.

G. On discharge, recommended follow-up TSB or TcB checks and appointments should consider age at time of discharge and follow up recommendations per the Bilitool.org instruction. If possible, serial TSB levels with ages of sampling can be entered into Bilitool.org to obtain further information (i.e., bilirubin trend) to determine the appropriate time for repeating the TSB as an outpatient. Infants with elevated TcB measurements or if within 3 mg/dl of phototherapy threshold should be confirmed with a TSB level.

H. Discharge Recommendations see Attachment A

I. Parent Education: Prior to discharge parents will receive education to include:
    1. Observing for signs and symptoms of jaundice including yellow discoloration of skin or eyes, lethargy, or poor feeding.
    2. Contacting the newborn's physician if signs and symptoms of jaundice are observed.
    3. Risks associated with untreated jaundice, including acute bilirubin encephalopathy and kernicterus.
    4. Scheduling any follow up laboratory studies or other health agency care/ appointments.

J. Documentation: Assessment, results and interventions are documented in the electronic health record.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed.

VII. REFERENCES

A. American Academy of Pediatrics.(2022). Clinical Practice Guideline Revision: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation. *Pediatrics,* 150, (3). https://doi.org/10.1542/peds.2022-058859

B. American Academy of Pediatrics and the American College of Obstetricians and

Gynecologists. (2017). *Guidelines for Perinatal Care.* (8th ed.). Author.

C. Creative Commons Attribution. (2022). Bilitool. Retrieved from www.bilitool.org.

Attachments

Post Discharge Hyperbilirubinemia Management Recommendations.docx

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Womens and Childrens Services Committee	Katherine DeSalvo: Director Medical Staff Services	07/2024
Director of WCS	Julie Vasher: Director Women's & Children's Services	05/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2024
Policy Owner	Julie Johnson: Clinical Manager	05/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **15644721**

Last Approved	N/A
Next Review	3 years after approval
Owner	Julie Vasher: Director Women's & Children's Services
Area	Women's and Children's Services

Nipple Shields

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the nurse in appropriately assessing the need for and use of a nipple shield.

III. DEFINITIONS

A. Nipple shield - Silicone shield to be worn over nipple and areola to permit the flow of breast milk while providing a larger surface for the baby to latch onto.

IV. GENERAL INFORMATION

A. Nipple shields should be used under the direction of Lactation Services. Lactation service referral should be placed.

B. Nipple shields can be used for mothers experiencing difficulty with latching baby onto flat/ inverted nipples, facilitate oral stimulation for the preterm infant, infants needing more oral stimulation to breastfeed effectively, infants with weak or disorganized suck, high or low tone infant or infant with nipple preference (transition from pacifier, bottles).

C. The nipple shield cannot correct milk transfer problems or weight gain if the mother has inadequate milk volume, fix damaged nipples if the cause is not discovered and remedied, replace skilled intervention and close follow-up.

V. PROCEDURE

A. **Equipment**

1. Obtain breast shield from Materials Management or the NICU. Choose appropriate size for mother. Sizes are 24mm, 20mm, and 16mm.
2. Wash hands prior to each use. A small amount of water on the underside of the flat surface of the nipple shield can prevent shield from curving up after infant has latched on.
3. Turn shield halfway inside out and center over nipple and areola.
4. Slowly roll the shield over the nipple and areola and smooth down edges.
5. Support the breast with a "C" hold. Place thumb on top of the breast with fingers below.
6. Baby should latch onto breast and shield, taking part of the areola in his/her mouth.
7. After the baby has latched on and begins to suckle, listen for audible swallowing during suck/swallow/pause phase. Nipple shield should not move around as infant suckles and mother should feel a comfortable tug at breast as infant suckles.
8. Some attempts can be made to feed the infant without the nipple shield; Infant latched on in a good suck/swallow/pause pattern, detach infant, remove shield, and quickly attempt to re-attach infant to breast (refer to Policy on Breastfeeding the Newborn). There is no set time limit for nipple shield use.
9. Shield is to be worn during breastfeeding session. Clean with warm, soapy water, rinse with clean water and air dry. The nipple shield is a long-term use item and can be stored in a denture cup container.
10. Provide mother/family with community lactation service phone numbers upon discharge and the infant should have a follow-up physician appointment in place within 2-3 days.

B. Documentation
    1. Nipple shield size.
    2. Reason for shield use.
    3. Maternal education and verbal consent for use.
    4. Infant response and feeding documented in Electronic Health Record (EHR) and nurses note.
    5. Community Breastfeeding Resource phone numbers
    6. Nipple Shield handout given

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Lawrence, R.A., and Lawrence, R.M. (2022). *Breastfeeding A guide for the medical professional*. 9th ed. Philadelphia: Elsevier Mosby.

B. Medela. (2021). Nipple shield instructions for use. Medela website. www.medelabreastfeedingus.com

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Women's & Children's Service Line	Katherine DeSalvo: Director Medical Staff Services	07/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2024
Policy Owner	Julie Vasher: Director Women's & Children's Services	04/2024

Standards

No standards are associated with this document

Board Paper—Approved Projects: Board of Directors

Agenda Item: **Consent Agenda for Approved Projects**

Responsible Executive(s): Clement Miller, COO

Board Meeting Date: **July 25, 2024**

Executive Summary:

Project Name:	Nuclear Medicine Equipment Replacement Project
Budget Code:	2020-078
Approved Project Cost:	$3,002,053

To be Ratified by Board:

C.I.P:	01.1250.3710
Contract Amount:	$352,021
Description:	Additional funding is for design, construction, inspections and testing measures, and mobile equipment rentals

Summary of Contract Terms & Conditions

Existing contract terms and conditions shall apply.

Recommendation

Consider recommendation for approval/ratification of the above-reference budget augmentation in the amount of $352,021.

Attachments

Board Paper: Finance Committee

Board Paper: Finance Committee

Agenda Item:	**Consider recommendation for approval of a budget augmentation in the amount of $352,021 to be funded in the Fiscal Year 2025 for the Nuclear Medicine Equipment Replacement Project.**
Executive Sponsor:	Clement Miller, COO
Date:	July 8, 2024

Executive Summary

Salinas Valley Health is pursuing Nuclear Medicine equipment upgrades to enhance the diagnostic capability of exams by offering new and emerging procedures such as improved small lesion detectability, reduced scan times, and decreased patient dose. In renovation of the nuc med suite with a new control room, restroom and hot lab, building improvements to architectural, controls, electrical, fire life safety, mechanical, nurse call, plumbing, and structural systems have been implemented to facilitate workflow and comply with current building codes. Throughout construction, mobile nuc med equipment rentals have also been procured ensuring continuous service to the community. The original budget was approved during the August 2022 Board during the early design phase of the project. Anticipated completion of the construction contract is Summer 2024.

Background/Situation/Rationale

The additional funding is for design, construction, inspections, and testing measures in compliance with current fire life safety and structural standards, and for mobile equipment rentals. The following direct and indirect construction improvements are included: (A) Corrections and repairs to existing conditions to meet building code requirements, (B) Additional upgrades to architectural, electrical, fire life safety, mechanical, nurse call, plumbing and structural systems, (C) Unforeseen condition demolition, monitoring and abatement measures, and (D) Mobile equipment rentals.

The portion of the additional funding attributed to vendor delivery-related adjustments of direct and indirect construction costs include the following and are noted herein: (A) Mobile equipment rentals and (B) Extended conditions coordinating project Certificate of Occupancy with vendor delivery and equipment implementation timelines. To recover the actual costs related to these changes, Salinas Valley Health shall pursue negotiations with Canon Medical Systems, Inc.

CANON-RELATED DELIVERY COST IMPACT ESTIMATES	
The Nuc Med project Milestone has been awarded Substantial Completion status by HCAI. However, the Nuc Med and CT project Certificate of Occupancy is still pending full completion of both Nuc Med and CT Milestones.	
Mobile Equipment Rentals, 2.3 months	$59,500
Total Estimated Cost Impacts on Nuc Med Project	$59,500

Significant project impacts are attributed to:
(A) Corrections and repairs to existing conditions building conditions including electrical, fire alarm, fire life
(B) Upgrades to architectural, electrical, fire alarm/fire life safety, mechanical, nurse call and plumbing systems
(C) Unforeseen condition demolition, monitoring, testing and abatement
(D) Mobile equipment rentals required throughout Nuclear Medicine department decommissioning through
(E) Extended conditions coordinating project Certificate of Occupancy with vendor delivery and equipment implementation timelines

Meeting our Mission, Vision, Goals

It is the mission of Salinas Valley Memorial Healthcare System to provide quality healthcare to our patients for the health and well-being of our community. The provision of a modernized, code-compliant Nuclear Medicine suite will support present and future needs of our patients.

Pillar/Goal Alignment

☒ Service ☒ People ☒Quality ☐ Finance ☒ Growth ☒ Community

Timeline

Summer 2024 – Construction contract completion, nuc med building licensing, and go-live with Applications training

Financial Implications

Budget: Fiscal Year 2024 capital budgeting allocated funding for planning, design, permitting, procurement, and mobile equipment rentals in the amount of $3,002,053 during the early design phase. Current planning estimates total direct and indirect construction improvements and mobile unit costs at $3,354,074.

Current capital budget forecast includes:
Fiscal Year 2023-2024 - $2,941,451
Fiscal Year 2025 - $412,623

Following completion of construction closeout, the budget will be reconciled to account for actual costs.

Recommendation

Consider recommendation for approval of a budget augmentation in the amount of $352,021 to be funded in the Fiscal Year 2025 for the Nuclear Medicine Equipment Replacement Project.

Attachments

Attachment 1: Budget Summary

Nuclear Medicine Equipment Replacement CIP 01.1250.3710
Architect: HMC Architects
Subject: Budget Control Report

Date Printed: *7/18/2024*
Approved Budget: $3,002,053
Anticipated Completion: FY25 Q1
Prepared by: Bogard Team

Budget Summary

			A	A1	B	C	D	E (C+D)	F	G	H (B-(E+F))		CASH FLOW SUMMARY	
Line Item		Description	Original Budget	Budget Revisions	Current Budget	Contracts	Executed Change Order Requests	Contracts to Date	Potential Change Orders / Anticipated Contracts	Invoice Payments	Available Budget	Notes	FY23-24	FY25
	1	**Construction**												
100		Construction												
		FTG Builders	*$1,328,779*	*$66,439*	*$1,395,218*	*$1,225,776*	*$50,377*	*$1,276,153*	*$149,096*	*$1,086,027*	*-$30,031*		*$1,276,153*	*$149,096*
	2	**Design**										Construction Contracts		
200		Professional Fees - HMC, JAMA	$275,000	$0	$275,000	$317,653	$0	$317,653	$0	$298,230	-$42,653		$317,653	$0
		Inspections and Consultation							$0			Architectural and Consulting Engineers		
300		Inspector of Record	$50,000	$0	$50,000	$41,655	$0	$41,655	$25,080	$41,655	-$16,735		$41,655	$25,080
		Special Inspections - Kleinfelder	$30,000	$0	$30,000	$18,223	$0	$18,223	$0	$18,223	$11,777	Inspector of Record	$18,223	$0
		Testing	$13,000	$0	$13,000	$36,731	$0	$36,731	$0	$15,000	-$23,731	Special Inspections - Kleinfelder	$36,731	$0
	4	**AHJ Fees**										Testing and Monitoring		
400		OSHPD Fees, Salinas Fire	$50,000	$0	$50,000	$37,464	$0	$37,464	$2,997	$40,267	$9,539		$37,464	$2,997
	5	**Soft Costs**										HCAI Inspections, City of Salinas Fire Department		
502		Construction Management	$348,000	$0	$348,000	$348,000	$0	$348,000	$0	$348,000	$0		$348,000	$0
	7	**FF&E**										PM, CM, Superintendence		
701		Equipment												
		NM equipment	*$713,335*	*$0*	*$713,335*	*$713,335*	*$0*	*$713,335*	*$18,000*	*$0*	*-$18,000*		*$731,335*	*$0*
		Mobile Rentals	*$127,500*	*$0*	*$127,500*	*$127,500*	*$0*	*$127,500*	*$235,450*	*$0*	*-$235,450*	Annual Service Agreement starts June 2025	*$127,500*	*$235,450*
703		Data & Phone Equipment, Furnishings, Signage										Mobile CT Rentals		
		Data & Low Voltage Package	*$0*	*$0*	*$0*	*$5,737*	*$0*	*$5,737*	*$0*	*$6,466*	*-$5,737*		*$5,737*	*$0*
		Signage, Furnishings	*$0*	*$0*	*$0*	*$1,000*	*$0*	*$1,000*	*$0*	*$3,177*	*-$1,000*	Nuc Med Data	*$1,000*	*$0*
			$0									Signage, Furnishings		
9900		Project Contingency	$66,439	-$66,439	$0	$0	$0	$0	$0	$0	$0		$0	
Totals			**$3,002,053**	**$0**	**$3,002,053**	**$2,872,074**	**$50,377**	**$2,923,451**	**$430,623**	**$1,853,868**	**-$352,021**		**$2,941,451**	**$412,623**

Board Paper—Approved Projects: Board of Directors

Agenda Item: **Consent Agenda for Approved Projects**

Responsible Executive(s): Clement Miller, COO

Board Meeting Date: **July 25, 2024**

Executive Summary:

Project Name:	CT Equipment Replacement Project
Budget Code:	2020-077
Approved Project Cost:	$3,139,051

To be Ratified by Board:

C.I.P:	01.1250.3705
Change Amount:	$485,383
Description:	Additional funding is for design, construction, inspections and testing measures, and mobile equipment rentals. A portion of this added cost is related to vendor delivery changes, and will be pursued in negotiation with the vendor as actual project costs are reconciled.

Summary of Contract Terms & Conditions

Existing contract terms and conditions shall apply.

Recommendation

Consider recommendation for approval/ratification of the above-referenced budget augmentation in the amount of $485,383.

Attachments

Board Paper: Finance Committee

Board Paper: Finance Committee

Agenda Item:	**Consider recommendation for approval of a budget augmentation to be funded in the Fiscal Year 2025 for the CT Equipment Replacement Project.**
Executive Sponsor:	Clement Miller, COO
Date:	July 8, 2024

Executive Summary

Salinas Valley Health is pursuing CT equipment replacement to upgrade system capabilities including AI image reconstruction, patient positioning aids, increased weight capacities, and high quality cardiac imaging resulting in fewer patient transfers to Ryan Ranch, lower radiation dose needs, reduced artifacts, and reduced exam times. In renovation of the CT equipment room and control room, building improvements to architectural, controls, electrical fire life safety, mechanical, nurse call, plumbing and structural systems have been implemented to facilitate workflow and comply with current building codes. Throughout construction, mobile CT equipment rentals have also been procured ensuring continuous service to the community. The original budget was approved during the August 2022 Board during the early design phase of the project. Anticipated completion of the construction contract is Summer 2024.

Background/Situation/Rationale

The additional funding is for design, construction, inspections, and testing measures in compliance with current fire life safety and structural standards, and mobile equipment rentals, with a portion of the costs relating to vendor delivery coordination. The following direct and indirect construction improvements and costs include: (A) Corrections and repairs to existing conditions to meet building code requirements, (B) Additional upgrades to architectural, electrical, fire life safety, mechanical, nurse call, plumbing and structural systems, (C) Unforeseen condition demolition, monitoring and abatement measures, (D) Mobile equipment rentals, and (E) Extended conditions and rental costs from coordinating the CT and Nuc Med projects' Certificate of Occupancy completion with vendor delivery and equipment implementation timelines.

The portion of the additional funding attributed to vendor delivery-related adjustments of direct and indirect construction costs include the following and are noted herein: (A) Extended conditions for construction, design, and inspections, and (B) Mobile equipment rentals. To recover the actual costs related to these changes, Salinas Valley Health shall pursue negotiations with Canon Medical Systems, Inc.

ESTIMATE OF VENDOR-RELATED DELIVERY COST IMPACTS	
Construction	**$52,780**
Design and Consultant Fees	$35,882
Construction Management and Inspections	$47,320
Mobile Equipment Rentals	$119,000
Total Estimated Cost Impacts of Changes to Canon Delivery	**$254,982**

Significant project impacts are attributed to:
(A) Corrections and repairs to existing conditions building conditions including electrical, fire alarm, fire life safety,
(B) Upgrades to architectural, electrical, fire alarm/fire life safety, mechanical, and nurse call systems
(C) Unforeseen condition demolition, monitoring, testing and abatement
(D) Mobile equipment rentals required throughout construction and licensing
(E) Extended conditions coordinating project Certificate of Occupancy completion with vendor delivery and equipment implementation timelines

Meeting our Mission, Vision, Goals

It is the mission of Salinas Valley Memorial Healthcare System to provide quality healthcare to our patients for the health and well-being of our community. The provision of a modernized, code-compliant Nuclear Medicine suite will support present and future needs of our patients.

Pillar/Goal Alignment

☒ Service ☒ People ☒Quality ☐ Finance ☒ Growth ☒ Community

Timeline

Summer 2024 – Construction contract completion, CT licensing, and go-live with Applications training

Financial Implications

Budget: Fiscal Year 2024 capital budgeting allocated funding for planning, design, permitting, procurement, and mobile equipment rentals in the amount of $3,139,051 during the early design phase. Current planning estimates total direct and indirect construction improvements and mobile unit costs at $3,624,434. The currently estimated portion of Canon-related costs approximates $250,000.

Current capital budget forecast includes:
Fiscal Year 2023-2024 - $2,422,873
Fiscal Year 2025 - $1,201,560

Following completion of construction closeout, the budget will be reconciled to account for actual costs.

Recommendation

Consider recommendation for approval of a budget augmentation in the amount of $485,383 to be funded in the Fiscal Year 2025 for the CT Equipment Replacement Project.

Attachments

Attachment 1: Budget Summary

Salinas Valley Memorial Healthcare System 10348
Salinas Valley Health CIP 01.1250.3705

CT Scanner Equipment Replacement
Architect: HMC Architects
Subject: Budget Control Report

Date Printed: *7/18/2024*
Approved Budget: $3,139,051
Anticipated Completion: FY25 Q1
Prepared by: Bogard Team

Budget Control Summary

			A	A1	B	C	D	E (C+D)	F	G	H (B-(E+F))	Notes	CASH FLOW SUMMARY	
Line Item		**Description**	**Original Budget**	**Budget Revisions**	**Current Budget**	**Contracts**	**Executed Change Order Requests**	**Contracts to Date**	**Potential Change Orders / Anticipated Contracts**	**Invoice Payments**	**Available Budget**		**FY23-24**	**FY25**
	1	**Construction**												
100		Construction												
		TG Builders	*$1,223,811*	*$61,191*	*$1,285,002*	*$1,225,776*	*$50,377*	*$1,276,153*	*$201,876*	*$1,086,027*	*-$193,027*	Construction Contracts	*$1,276,153*	*$201,876*
	2	**Design**												
200		Professional Fees - HMC	$275,000	$0	$275,000	$296,729	$0	$296,729	$35,882	$278,384	-$57,611	Architectural and Consulting Engineers	$296,729	$35,882
		Inspections and Consultation												
300		Inspector of Record	$50,000	$0	$50,000	$41,655	$0	$41,655	$12,320	$41,655	-$3,975	Inspector of Record	$41,655	$12,320
		Special Inspections - Kleinfelder	$25,000	$0	$25,000	$20,000	$0	$20,000	$5,000	$18,223	$0	Special Inspections - Kleinfelder	$20,000	$5,000
		Testing, Abatement and Monitoring	$10,000	$0	$10,000	$37,931	$0	$37,931	$0	$15,000	-$27,931	Testing and Monitoring	$37,931	$0
	4	**AHJ Fees**												
400		OSHPD Fees, Salinas Fire	$50,000	$0	$50,000	$37,464	$0	$37,464	$7,493	$32,661	$5,043	HCAI Inspections, City of Salinas Fire Department	$37,464	$7,493
	5	**Soft Costs**												
502		Construction Management	$348,000	$0	$348,000	$348,000	$0	$348,000	$25,000	$348,000	-$25,000	PM, CM, Superintendence	$348,000	$25,000
	7	**FF&E**												
701		Equipment												
		CT Equipment	*$939,549*	*$0*	*$939,549*	*$939,549*	*$0*	*$939,549*	*$0*	*$0*	*$0*	CT Equipment due June 2024	*$187,910*	*$751,639*
		Mobile Rentals	*$156,500*	*$0*	*$156,500*	*$156,500*	*$0*	*$156,500*	*$162,350*	*$0*	*-$162,350*	Mobile CT Rentals	*$156,500*	*$162,350*
703		Data & Phone Equipment, Furnishings, Signage												
		Data & Low Voltage Package	*$0*	*$0*	*$0*	*$5,737*	*$0*	*$5,737*	*$0*	*$4,355*	*-$5,737*	CT Mobile Unit Data	*$5,737*	*$0*
		Signage, Furnishings, CT Battery, TGC	*$0*	*$0*	*$0*	*$14,795*	*$0*	*$14,795*	*$0*	*$13,472*	*-$14,795*	CT Battery, Signage, Furnishings	*$14,795*	*$0*
			$0											
9900		Project Contingency	$61,191	-$61,191	$0	$0	$0	$0	$0	$0	$0		$0	$0
Totals			**$3,139,051**	**$0**	**$3,139,051**	**$3,109,340**	**$50,377**	**$3,174,512**	**$449,921**	**$1,837,777**	**-$485,383**		**$2,422,873**	**$1,201,560**

QUALITY AND EFFICIENT PRACTICES COMMITTEE

Minutes of the Quality and Efficient Practices Committee will be distributed at the Board Meeting

Background information supporting the proposed recommendation from the Committee is included in the Board Packet

(CATHERINE CARSON)

Committee of the Whole
Salinas Valley Memorial Healthcare System
July 15, 2024

QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING
RECOMMENDATION OF JULY 2024

1. **Consider approval to support coordinated care between multiple community resources for prevention of opioid overdoses and deaths, to support this patient population and to reduce the opioid crises.**

   RECOMMENDATION: The Quality and Efficient Practices Committee recommends Board approval of providing harm reduction services and education to hospitalized patients who use illicit substances in Monterey County and ensure the availability of equitable, safer drug-use supplies upon discharge.

PERSONNEL, PENSION AND INVESTMENT COMMITTEE

Minutes of the
Personnel, Pension and Investment Committee
will be distributed at the Board Meeting

Background information supporting the
proposed recommendation from the
Committee is included in the Board Packet

(JUAN CABRERA)

- *Committee Chair Report*
- *Board Questions to Committee Chair/Staff*
- *Motion/Second*
- *Public Comment*
- *Board Discussion/Deliberation*
- *Action by Board/Roll Call Vote*

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Jamil Matthews, MD, (ii) Contract Terms for Dr. Matthews's Recruitment Agreement, and (iii) Contract Terms for Dr. Matthews's Vascular Surgery Professional Services Agreement**

Executive Sponsor: Allen Radner, MD, President/CEO, Salinas Valley Health
Gary Ray, Chief Legal Officer, Salinas Valley Health
Orlando Rodriguez, MD, Interim CMO, Salinas Valley Health Clinics

Date: July 15, 2024

Executive Summary

In consultation with members of the medical staff, Salinas Valley Health (SVH) executive management has identified the recruitment of a physician specializing in **vascular surgery** as a recruiting priority for the medical center's service area. Currently, there is only one other vascular surgeon credentialed on SVH Medical Staff. Adding another vascular surgeon to SVH Clinics will increase patient access and provide additional coverage for the peripheral vascular emergency department on-call panel.

The recommended physician, **Jamil Matthews, MD**, received his Doctor of Medicine degree in 2006 from Virginia Commonwealth University School of Medicine in Richmond. Dr. Matthews completed his General Surgery residency at University of Maryland School of Medicine and in 2019 completed his Vascular Surgery Fellowship at University of Washington School of Medicine in Seattle, WA. Dr. Matthews is certified by the American Board of Surgery and is currently practicing at Sound Vascular and Vein in Washington State. He plans to relocate with his family and join SVH in December of 2024.

Terms and Conditions of Agreements

The proposed physician recruitment requires the execution of two types of agreements:

1. **Professional Services Agreement**. Essential Terms and Conditions:
   - Professional Services Agreement (PSA). Contracted physician under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics. Pursuant to California law, physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
   - Term: PSA is for a term of two years, with annual compensation reported on an IRS W-2 Form.
   - Base Compensation: $550,000 per year.
   - Productivity Compensation: To the extent it exceeds the base salary, physician is eligible for work Relative Value Units (wRVU) productivity compensation.
   - Benefits. Physician will be eligible for standard SVH Clinics physician benefits:
     - Access to SVH Health Plan for physician and qualified dependents. Premiums are projected based on 15% of SVH cost.
     - Access to SVH 403(b) and 457 retirement plans. Five percent base contribution to 403(b) plan that vests after three years. This contribution is capped at the limits set by Federal law.
     - Four weeks (20 days) of time off each calendar year.
     - Continuing Medical Education (CME) annual stipend in the amount of $2,400 paid directly to physician and reported as 1099 income.
   - Professional Liability Insurance. Professional liability is provided through BETA Healthcare Group.

2. **Recruitment Agreement** that provides a recruitment incentive of $60,000, which is structured as forgivable loan over two years of service.

Meeting our Mission, Vision, Goals
Strategic Plan Alignment:

The recruitment of Dr. Matthews is aligned with our strategic priorities for the quality, finance, and growth pillars. We continue to develop Salinas Valley Health Clinics infrastructure that engages our physicians in a meaningful way, promotes efficiencies in care delivery and creates opportunities for expansion of services. This investment provides a platform for growth that can be developed to better meet the needs of the residents of our District by improving access to care regardless of insurance coverage or ability to pay for services.

Pillar/Goal Alignment:

☐ **Service** ☐ **People** ☒ **Quality** ☒ **Finance** ☒ **Growth** ☐ **Community**

Financial/Quality/Safety/Regulatory Implications

The addition of Dr. Matthews to SVH Clinics has been identified as a need for recruitment while also providing additional resources and coverage for SVH Cardiothoracic & Vascular Surgery.

The compensation proposed in these agreements have been reviewed against published industry benchmarks to confirm that the terms contemplated are fair market value and commercially reasonable.

Recommendation

Salinas Valley Health Administration requests that the Personnel, Pension and Investment Committee recommend to the Salinas Valley Health Board of Directors approval of the following:

1. **The Findings Supporting Recruitment of Jamil Matthews, MD;**
   - That the recruitment of a vascular surgeon to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
   - That the recruitment benefits and incentives the District proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;
2. **The Contract Terms of the Recruitment Agreement for Dr. Matthews; and**
3. **The Contract Terms of the Vascular Surgery Professional Services Agreement for Dr. Matthews.**

Attachments

- Curriculum Vitae for Jamil Matthews, MD

CURRICULUM VITAE

Jamil Anthony Matthews, MD, MS, RPVI
Board Certified Vascular and Endovascular Surgeon

Citizenship: United States

Current Employment:
Sound Vascular and Vein
32014 32nd Avenue South
Federal Way, WA 98001
Specialties: Peripheral arterial disease, carotid disease, venous disease, vascular access, vascular trauma

Current Hospital Credentials:
Valley Medical Center, Renton, WA (active)

Certification

- The American Board of Surgery #103948 (active)
- Registered Physician in Vascular Interpretation ID: 248920 (active)
- Oregon State Medical Board MD 216933 (active)
- Washington State Medical Board 60683789 full licensure (active)
- Alaska State Medical Board 152620 full licensure (active)
- Alaska Prescription Drug Monitoring Program (active)
- Drug Enforcement Administration (DEA) (active, non-exempt)
- ACLS eCard Code 206502316497 (present)
- BLS eCard Code195508464415 (present)

Education and Training (in chronological order):

- **Predoctoral**
  1/1994-5/1997- Hampton University, Hampton Virginia
  Bachelor of Science
  Biology
- **Doctoral/graduate**
  8/1999-8/2001- Virginia Commonwealth University SOM, Richmond, Virginia
  Master of Science
  Physiology/Biomedical Engineering
  8/2002-5/2006-Virginia Commonwealth University SOM, Richmond, Virginia
  Doctor of Medicine
- **Postdoctoral**
  Preliminary Residency in General Surgery:
  6/2006-6/2008- University of Southern California/Keck SOM, Los Angeles, CA
  6/2011-6/2012- University of Maryland SOM, Baltimore, MD

  Burn Surgery Fellowship:
  6/2013-6/2014 Johns Hopkins University SOM, Baltimore, MD

Residency in Vascular Surgery:
6/2014-6/2019- University of Washington SOM, Seattle, WA

Surgery Research Fellowships:

6/2008-6/2011- University of Southern California/Keck SOM, Los Angeles, CA. Tissue Engineering
6/2012-6/2013- University of Maryland School of Medicine, Baltimore, MD. Plastic Surgery

Employment (in chronological order):
Alyeska Vascular Surgery, Anchorage AK 6/2020-11/2021
Providence Alaska Medical Center, Anchorage AK 6/2020-11/2021
Sound Vascular and Vein, Federal Way WA. 1/2022-present

MEMBERSHIPS

Vascular and Endovascular Surgical Society 10/2019-present
Society of Vascular Surgery 2014-present (converting to board certified member status)
American College of Surgeons- 10/2023- present Associate Fellow Member

HONORS AND AWARDS

2023	Top Doctors in Vascular Surgery-Best in Washington Magazine
2013	Reviewer- EPlasty Surgical Journal
2013	LifeCell Plastic and Reconstructive Surgery Research Grant
2011	Outstanding Resident Research Award-Academic Surgical Congress Association for Academic Surgery
2011	Best poster session-Society of Black Academic Surgeons
2010	California Institute for Regenerative Medicine (CIRM) Training Grant (TG2-01168)
2009	Best poster session-Society of Black Academic Surgeons
2002-2006	Student National Medical Association
2002-2003	Cirriculum Representative
2002	A.D. Williams Scholarship for Summer Research
2002	Virginia Academy of Sciences Best research in Biomedical Engineering
2002	"Alumni Profile". Article from the Hampton University Alumni magazine.
2001	"Bodybuilding". Article on tissue engineering from the Richmond Times Dispatch. Front page of Health section. January 18, 2001.

Inventions, Patents, Copyrights:

- United States Patent 7615373. Electroprocessed Collagen. File: 49122-0151 (49122-263821)
- United States Patent 7615373B2. Electroprocessed Collagen and Tissue Engineering.

PUBLICATIONS

1. Janes LE, Sabino J, **Matthews J.A.,** Papadimitriou JC, Strome SE, Singh DP. Surgical management of craniofacial neurofibromatosis type 1 associated tumors: A case report and literature review. Journal of Craniofacial Surgery. (accepted). 2013.

2. Singh DP, Forte AJ, Zahiri HR, Janes L, Sabino J, **Matthews J.A.,** Bell RL, Thomson JG. Prognostication for body contouring surgery after bariatric surgery. http://www.eplasty.com. 2012;12:e46. Epub 2012 Sep 12. PMID: 22993644. 2013.

3. Singh DP, Zahiri HR, Janes L, Sabino J, **Matthews J.A.,** Bell RL, Thomson JG. Mental and physical impact of body contouring procedures on post-bariatric surgery patients. http://www.eplasty.com. 2012;12:e47. Epub 2012 Sep 12. PMID: 22993644. 2013.

4. Pontarelli EM, **Matthews J.A.,** Goodhue CJ, Stein JE. "On-Q pain pump versus epidural for postoperative analgesia in children. Pediatr ic Surgery International. Jul 17 2013. [Epub ahead of print]

5. **Matthews, J.A.,** Sala, F.G., Speer, A.L., Grikscheit, T.C. "Vascular Endothelial Growth Factor Improves the Growth of Tissue-Engineered Colon". Journal of the American College of Surgeons. 213;3:S67. September 2011.

6. **Matthews, J.A.,** Sala, F.G., Speer, A.L., Grikscheit, T.C. "Overexpression of Vascular Endothelial Growth factor optimizes the formation of tissue-engineered intestine". Journal of Regenerative Medicine. 6;5: 559-567. September, 2011.

7. **Matthews, J.A.,** Sala, F.G., Speer, A.L., Li, Y., Grikscheit, T.C. "Mesenchymal Specific Inhibition of Vascular Endothelial Growth Factor (VEGF) Attenuates Growth in Neonatal Mice". Journal of Surgical Research. May, 2011.

8. Barthel, E.R., **Matthews, J.A.,** Sala, F.G., Speer, A.L., Torashima, Y., Grikscheit, T.C. "Postnatal Human Colon Organoid Units can be Grown in Culture and Form Full-Thickness Intestinal Tissue in a Murine Host". Journal of the American College of Surgeons. 213;3:S76. September, 2011.

9. Speer, A.L., Sala, F.G., **Matthews, J.A.,** Grikscheit, T.C. "Tissue-engineered Small Intestine Regenerates from Frozen Organoid Units: A Novel Long-Term Storage Method". Journal of the American College of Surgeons. 213;3:S67. September 2011.

10. Speer, A.L., Sala, F.G, **Matthews, J.A.,** Grikscheit, T.G. "Murine Tissue-Engineered Demonstrates Epithelial Differentiation". Journal of Surgical Research. 171;1: 6-14. November, 2011.

11. Sala, F.G., **Matthews, J.A.,** Speer, A.L., Torashima, Y., Barthel, E.R., Grikscheit, T.C. A multicellular approach forms a significant amount of tissue-engineered small intestine in the mouse. Tissue Engineering Part A. Epub ahead of print. March 12, 2011.

12. **Matthews, J.A.,** Sala, F.G., Speer, A.L., Grikscheit, T.C. "Mesenchymal Specific Inhibition of Vascular Endothelial Growth Factor (VEGF) Attenuates Growth in Neonatal Mice". Journal of Surgical Research 2010.

13. **Matthews, J.A.,** Sala, F.G., Speer, A.L., Grikscheit, T.C. "Mesenchymal Specific Inhibition of Vascular Endothelial Growth Factor (VEGF) Reduces Intestinal Development in Neonatal Mice" Journal of the American College of Surgeons 2010.

14. **Matthews, J.A.,** Sala, F.G., Speer, A.L., Grikscheit, T.C. "Ubiquitous Overexpression of Vascular Endothelial Growth Factor (VEGF) Optimizes the Development of Tissue-Engineered Intestine" Journal of the American College of Surgeons 2010.

15. Pierce, J., **Matthews, J.A.,** Stanley, P., Panossian, A., Anselmo, D.M. " Successful treatment of an Arteriovenous Malformation of the Rectum by Angioembolization and Low Anterior Resection." Journal of Pediatric Surgery. In press.

16. Bowlin, G.L., Barnes, C.P., Smith, M.J., Sell, S.A., Tang, T., **Matthews, J.A.,** Simpson, D.G., Nimtz, J.C. "Feasibility of electrospinning the globular proteins hemoglobin and myoglobin." Journal of Engineered Fibers and Fabrics.1;2:16-29, 2006.

17. Boland, E.D., **Matthews, J.A.,** Pawlowski, K.J., Simpson, D.G., Wnek, G.E., Bowlin, G.L. "Electrospinning of Collagen and Elastin: Preliminary Vascular Tissue Engineering." Frontiers of Bioscience, 1;9:1422-32, 2004.

18. **Matthews, J.A.,** Boland, E.D., Wnek, G.E., Simpson, D.G., and G.L. Bowlin. "Electrospinning of Collagen Type II: A Feasibility Study." J. Bioactive and Compatible Polymers, 18;2:125-34, 2003.

19. Kenawy, E., Layman, J., **Matthews, J.A.,** Bowlin, G.L., Simpson, D.G., and G.E. Wnek. "Electrospinning of Poly(Ethylene-co-Vinyl Alcohol) Fibers." Biomaterials, 24;6: 907-13, 2003.

20. **Matthews, J.A.,** Simpson, D.G., Wnek, G.E., and G.L. Bowlin. "Electrospinning of Collagen Nanofibers." Biomacromolecules, 3;2: 232-238, 2002.

ABSTRACTS & POSTER PRESENTATIONS:

1. **Matthews, J.A.,** Heneghan, R., Singh, N. , Starnes, B. A Mycotic Aortic Aneurysm Caused by Fusobacterium Nucleatum. Pacific Northwest Vascular Society Meeting, Seattle, WA, November 1-2, 2018.

2. **Matthews, J.A.,** Sweet, M.P. Determining Branch Angle Tolerances in Fenestrated-Branched TEVAR. Western Vascular Society Meeting. Blaine, WA. September 23-26, 2017.

3. Matthews, J.A., Azar, A. Bakthatvatsalam, R. Resection of an Obstructing Vena Cava Tumor from Leiomyosarcoma. Seattle Surgical Society Meeting. Seattle, WA. January 23, 2015

4. **Matthews, J.A.**, Sabino, J., Conde-Green, A., Singh, D. "Alloderm Reduces Capsule Formation in Two-Stage Breast Reconstruction Following Mastectomy". Northeastern Society of Plastic Surgeons 30th Annual Meeting. Washington, DC, September 19-22, 2013.

5. **Matthews, J.A.**, Sabino, J, Silverman, R, Singh, D. "Porcine Acellular Dermal Matrix (Strattice) reduces Morbidity in Ventral Hernia Repair in Renal and Pancreas Transplant Patients". Northeastern Society of Plastic Surgeons 30th Annual Meeting. Washington, DC, September 19-22, 2013.

6. **Matthews, J.A.**, Sala, F.G., Speer, A.L., Grikscheit, T.C. "Vascular Endothelial Growth Factor Improves the Formation of Tissue-Engineered Colon" American College of Surgeons 97th Annual Clinical Congress. San Francisco, CA, October 23-27, 2011.

7. Sala, F.G., **Matthews, J.A.**, Speer, A.L., Grikschiet, T.C. "Key Mesenchymal Components of Tissue-Engineered Small Intestine do not derive from Bone Marrow Stem Cells." ". American Pediatric Surgical Association 42nd Annual meeting. Palm Desert, CA, May 22-25, 2011.

8. **Matthews, J.A.**, Sala, F.G., Speer, A.L., Barthel, E.R., Grikscheit, T.C. "Inhibition of Vascular Endothelial Growth Factor Directs Absorptive Lineage Differentiation of the Intestinal Epithelium via Notch Activation". American Pediatric Surgical Association 42nd Annual meeting. Palm Desert, CA, May 22-25, 2011.

9. Speer, A.L., Sala, F.G., Barthel, E.R., **Matthews, J.A.**, Grikscheit, T.G. "Mesenchymal Expression of fibroblast growth factor-10 (FGF-10) may be essential for generation tissue-engineered intestine." Society of Black Academic Surgeons 21st Scientific Assembly. Boston, MA, April 28-30, 2011.

10. **Matthews, J.A.**, Sala, F.G., Speer, A.L., Grikscheit, T.C. “Vascular endothelial growth factor (VEGF) increases growth rate of tissue-engineered intestine and drives crypt epithelium proliferation.” Society of Black Academic Surgeons 21st Scientific Assembly. Boston, MA, April 28-30, 2011.

11. Barthel, E.R., Sala, F.G., **Matthews, J.A.**,, Speer, A.L., Torashima, Y., Grikscheit, T.C. “Murine Tissue-Engineered Small Intestine Can Be Grown from Organoid Units (OU) Cultured in vitro.” British Association of Paediatric Surgeons 2011 International Congress. Belfast, Ireland, July 19-22, 2011.

12. Barthel, E.R., Sala, F.G., **Matthews, J.A.**,, Speer, A.L., Torashima, Y., Grikscheit, T.C.. “Fibroblast Growth Factor-10 (FGF10) Is Expressed in the Mesenchyme of Mouse Tissue-Engineered Small Intestine.” Society of Black Academic Surgeons 21st Scientific Assembly. Boston, MA, April 28-30, 2011.

13. **Matthews, J.A.**, Sala, F.G., Speer, A.L., Grikscheit, T.C. “Mesenchymal Specific Inhibition of Vascular Endothelial Growth Factor (VEGF) Attenuates Growth in Neonatal Mice” AAS Plenary Session. Annual Academic Surgical Congress, Huntington Beach, CA, February 1-3, 2011.

14. Sala, F.G., **Matthews, J.A.**, Speer, A.L., Li, Y., Grikscheit, T.C. Lgr5 Positive stem Cells Contribute to the Formation of tissue-Engineered Small Intestine in the Mouse Model. Annual Academic Surgical Congress, Huntington Beach, CA, February 1-3, 2011.

15. Li, Y., Sala, F.G., **Matthews, J.A.**, Speer, A.L., Torashima, Y., Barthel, E.R., Grikscheit, T.C. Murine Intestinal Subepithelial Myofibroblast Cells (ISEMF) Provide Necessary Support for Lgr5-EGFP Positive and Negative Cells to Grow in a Matrigel Culture System. Annual Academic Surgical Congress, Huntington Beach, CA, February 1-3, 2011.

16. Speer, A.L., Sala, F.G., **Matthews, J.A.**, Li, Y., Grikscheit, T.C. Tissue-Engineered Stomach: A Useful Mecanistic in Vivo Model and Potential Replacement Option. Annual Academic Surgical Congress, Huntington Beach, CA, February 1-3, 2011.

17. Li, Y., **Matthews, J.A.**, Sala, F.G., Speer, A.L., Torashima, Y., Barthel, E.R., Grikscheit, T.C. Tissue-Engineered Small Intestine Forms from Multicellular Clusters Maintained in Vitro Without Growth Factors. Annual Academic Surgical Congress, Huntington Beach, CA, February 1-3, 2011.

18. **Matthews, J.A.**, Sala, F.G., Speer, A.L., Grikscheit, T.C. “Mesenchymal Specific Inhibition of Vascular Endothelial Growth Factor (VEGF) Reduces Intestinal Development in Neonatal Mice” American College of Surgeons 96th Annual Clinical Congress,Washington, DC, October 3-7, 2010.

19. **Matthews, J.A.**, Sala, F.G., Speer, A.L., Grikscheit, T.C. “Ubiquitous Overexpression of Vascular Endothelial Growth Factor (VEGF) Optimizes the Development of Tissue-Engineered Intestine” American College of Surgeons 96th Annual Clinical Congress, Washington, DC, October 3-7, 2010.

20. **Matthews, J.A.**, Sala, F.G., Speer, A.L., Grikscheit, T.C. “Mesenchymal Specific Inhibition of Vascular Endothelial Growth Factor (VEGF) Attenuates Intestinal Growth in Neonatal Mice”. USC Stem Cell Translational and Clinical Sciences Research Symposium. Los Angeles, CA September 22, 2010.

21. Sala, F.G., **Matthews, J.A.**, Speer, A.L. Grikscheit, T.C. “Tissue-engineered small intestine regenerated from an intact stem cell niche. USC Stem Cell Translational and Clinical Sciences Research Symposium”. Los Angeles, CA September 22, 2010.

22. Speer, A.L., Sala, F.G., **Matthews, J.A.**, Grikscheit, T.C. “Tissue-Engineered Esophagus: an In Vivo Mouse Model with Therapeutic Potential. USC Stem Cell Translational and Clinical Sciences Research Symposium”. Los Angeles, CA September 22, 2010.

23. **Matthews, J.A**, Sala, F.G., Speer, A.L., Grikscheit, T.C. “A Novel Model for Investigating the Effects of Vascular Endothelial Growth Factor (VEGF) in the Mouse Mesenchyme”. Childrens Hospital Los Angeles and The Saban Research Institute 15th Annual Poster Session. Los Angeles, CA, June 7, 2010.

24. Sala, F.G., **Matthews, J.A.**, Speer, A.L., Skelton, D.C., Grikscheit, T.C. “Cell Lineage Tracing of Tissue-Engineered Small Intestine in the Mouse Model Demonstrates Contributions to the Stem Cell Niche and the Entire Epithelium”. Childrens Hospital Los Angeles and The Saban Research Institute 15th Annual Poster Session. Los Angeles, CA, June 7, 2010.

25. **Matthews, J.A.**, Sala, F.G., Speer, A.L., Grikscheit, T.C. “A Novel Model for Investigating the Effects of Vascular Endothelial Growth Factor (VEGF) in the Mouse Mesenchyme”. American Pediatric Surgical Association 41st Annual Meeting. Orlando, FL, May 16, 2010.

26. Speer, A.L., Sala, F.G., **Matthews, J.A.**, Skelton D.C., Grikscheit, T.C. “Tissue-Engineered Esophagus is a Versatile In Vivo Mouse Model with Intact Architecture”. American Pediatric Surgical Association 41st Annual Meeting. Orlando, FL, May 16, 2010.

27. Sala, F.G., **Matthews J.A.**, Speer A.L., Skelton D.C., Grikscheit T.C. “Cell Lineage Tracing of Tissue-Engineered Small Intestine in the Mouse Model Demonstrates Contributions to the Stem Cell Niche and the Entire Epithelium”. American Pediatric Surgical Association 41st Annual Meeting. Orlando, FL, May 16, 2010.

28. **Matthews, J.A**., Sala, F.G., Speer, A.L., Li, Y.L., Skelton, D.C., Grikscheit, T.C. “Key Intestinal Stem Cell Niche Components are Identified in Bowel Resected for Nectotizing Enterocolitis” Society of Black Academic Surgeons, 20th Annual Meeting, Durham, North Carolina, April 29-May 2, 2010.

29. Pierce, J., **Matthews, J.A.**, Stanley, P., Panossian, A., Anselmo, D.M. “Successful Treatment of an Arteriovenous Malformation of the Rectum by Angioembolization and Low Anterior Resection” International Society for the Study of Vascular Anomalies, 18th Annual Meeting, Brussels, Belgium, April 21-24, 2010.

30. **Matthews, J.A.**, Grikscheit, T.C. “Key Intestinal Stem Cell Niche Components Are Identified in Human Intestine during Necrotizing Enterocolitis” Academic Surgical Congress”, 5th Annual Meeting, San Antonio, Texas, February 3-5, 2010.

31. Speer, A.L., Sala, F.G., **Matthews, J.A.**, Grikscheit, T.C.; “Intestinal Subepithelial Myofibroblasts Demonstrate Cox- 2 Expression in Early Stages of Epithelial Proliferation in Tissue Engineered Small Intestine” Academic Surgical Congress”, 5th Annual Meeting, San Antonio, Texas, February 3-5, 2010.

32. Sala, F.G., **Matthews, J.A.**, Speer, A.L., Grikscheit, T.C.; “Murine Tissue-Engineered Small Intestine Demonstrates Intact Tight and Adherens Junctions” Academic Surgical Congress”, 5th Annual Meeting, San Antonio, Texas, February 3-5, 2010.

33. Sala, F.G., **Matthews, J.A.**, Skelton, D.C., Grickscheit, T.C. “Generation of Tissue-engineered Gastrointestinal Tissues: A Novel Murine Model” Poster presentation for the FASEB summer research

conference: Gastrointestinal Tract XIII: Advances in the Molecular and Cell Biology of the Intestinal Epithelium: Development, Inflammation, Host Defense and Cancer" Snowmass, Colorado, August 9-14, 2009.

34. Tai, C.C., Magdo, H.S., **Matthews, J.A.**, Weinstein, J.E., Connelly, M.E., Harrison, B.;, Ford, H.R., Shaul, D.B. "Cloacal Exstrophy: A Single Institution's Experience over 20 years." Association of Pediatric Surgeons, 42nd Annual Meeting, Hong Kong, China, May 10-14, 2009.

35. **Matthews, J.A.**, Grikscheit, T.G. "Indentification of Organoids in Matrigel for Tissue Engineered Intestine in Patients Requiring Delayed Implantation." Poster Session for the Society of Black Academic Surgeons, Nineteenth Annual Meeting. Seattle, Washington, April 2-4, 2009.

36. **Matthews, J.A.**, Boland, E.D., Simpson, D.G., Wnek, G.E., and G.L. Bowlin. "Cellular Interaction with Electrospun Collagen Type I Scaffolds." International Society for Applied Cardiovascular Biology (ISACB), Ninth Biennial Meeting, Savannah, Georgia, March 10-13, 2004.

37. **Matthews, J.A.**, Boland, E.D., Simpson, D.G., Wnek, G.E., and G.L.Bowlin. "Electrospinning Collagen and Elastin: Preliminary Vascular Tissue Engineering." International Society for Applied Cardiovascular Biology (ISACB), Ninth Biennial Meeting, Savannah, Georgia, March 10-13, 2004.

Professional Research Experience

6/2013-6/2014	Johns Hopkins University School of Medicine, Baltimore, Maryland The effect of aquaporin expression on edema formation following fluid resuscitation in burn patients with inhalation injuries.
6/2012-6/2013	University of Maryland Medical Center, Baltimore, Maryland The effect of alloderm on capsule formation following staged breast Reconstruction and the use of strattice in abdominal closure in high-risk patients.
6/2008-6/2011	Childrens Hospital Los Angeles, Los Angeles, California The effect of VEGF on tissue-engineered small intestine and colon using a gain of function and loss of function approach.
6/2000-6/2007	Virginia Commonwealth University, Richmond, Virginia Electrospinning of Collagen and Elastin Nanofibers to construct small diameter vascular prosthetics and determination of human cellular activity within the fiber matrix.
8/1997-6/1999	California Institute of Technology, Pasadena, California In Vitro Synthesis of oligopeptides and nucleotides to determine extraction techniques of DNA and protein fragments from the surface of Mars.

Extramural Funding (current, pending, previous)

6/2012-6/2013	LifeCell Plastic and Reconstructive Surgery Research Grant. $125,000
6/2010-6/2011	California Institute for Regenerative Medicine (CIRM) Training Grant (TG2-01168). $75,000

Educational Program Building/Leadership

6/2013-6/2014 Johns Hopkins Center for Bioengineering Innovation and Design-Graduate Council

2/2013 Marcus Garvey Leadership Association, guest speaker.

6/2010-6/2012 Chantilly High (Fairfax, Virginia) School Science Symposium, guest speaker for the annual scientific symposium

Teaching

Graduate Council Member/Instructor

6/2013-6/2014 Johns Hopkins Center for Bioengineering Innovation and Design, Baltimore Maryland

Tutor

6/2000-6/2005 Virginia Commonwealth University School of Medicine (Physiology for Graduate, Medical and Dental students), Richmond, Virginia

7/2002 Health Careers Opportunity Program (Gross Anatomy), Richmond, Virginia

6/1997-6/1999 University of California at Los Angeles (Histology, The Biology of Cancer, The Biology of AIDS), Los Angeles, California

Editorial Activities

1/2013-6/2013 Reviewer- ePlasty

FINANCE COMMITTEE

Minutes of the Finance Committee
will be distributed at the Board Meeting

Background information supporting the
proposed recommendations from the
Committee is included in the Board Packet

(JOEL HERNANDEZ LAGUNA)

- *Committee Chair Report*
- *Board Questions to Committee Chair/Staff*
- *Motion/Second*
- *Public Comment*
- *Board Discussion/Deliberation*
- *Action by Board/Roll Call Vote*

Board Paper: Review and Approval by President/CEO

Agenda Item:	Consider Recommendation for Board Approval of the Workday Financial and Supply Chain Management Solutions as Sole Source and Contract Award
Executive Sponsor:	Augustine Lopez, Chief Financial Officer Scott Cleveland, Controller Rolf Norman, Director of Financial Planning & Decision Support Judi Melton, Director of Materials Management Audrey Parks, Chief Information Officer
Date:	July 17, 2024

Executive Summary

In April 2023, Salinas Valley Health pursued Workday Human Capital Management encompassing the human resources and payroll information systems solutions following a competitive solicitation process. The competitive evaluation took into consideration that the solution may also serve financial and supply chain management since the strategic vision to ultimately replace our electronic hospital information system would mean Salinas Valley Health would need to find an alternate financial and supply chain management solutions. Meditech is our current hospital information system **(including materials management, accounts payable system, and general ledger)** and acute care electronic medical record (EMR). Epic is expected to replace Meditech on October 1, 2025. Epic, our new inpatient EMR, does not offer comparable materials management, accounts payable, general ledger, budgeting/planning, or analytics solutions.

Salinas Valley Health successfully implemented the Workday Human Capital Management solution on April 1, 2024. This solution covers major human resources and payroll functions. The finance and materials management teams spent the recent five months evaluating Workday Financial and Supply Chain Management solutions for functionality, workflow, integration, efficiency, and innovation. In evaluating solutions, understanding and properly assessing partner, product, price and people are essential to achieving sustainable success, the team elected to proceed with Workday Financial and Supply Chain Management.

Some differentiating factors include Workday's service level agreement commitment, commitment to innovation such as use of artificial intelligence and machine learning, and their cloud architecture that lends itself to scalability, performance and updatability. The team has prepared a separate presentation that goes into detail about the Workday Financial and Supply Chain Management solutions, also known as Enterprise Resource Planning (ERP).

Key reasons why we seek a fully integrated platform solution are as follows.

- Centralized data and a single source of truth eliminates risks with managing data in separate systems. An integrated platform creates a single source of truth for employee and business information, improving accuracy and streamlining reporting across departments,

- Improved efficiency and reduced costs are achieved through streamlined workflows and process automation. This allows finance and supply chain teams to focus on more strategic initiatives while reducing operational costs.
- Enhanced decision-making is possible with real-time access to combined enterprise resource planning (ERP) and human capital management (HCM) data. Salinas Valley Health is better able to make data-driven decisions regarding everything from staffing and training to budgeting and resource allocation.
- Improved compliance and security through integrated systems strengthens compliance efforts by ensuring consistent data across the organization and simplifying the stack of application solutions to manage.
- An integrated platform fosters better communication and collaboration among departments by eliminating data silos and providing a unified view of the business.
- Overall, a fully integrated ERP and HCM platform can significantly improve operational efficiency, provide valuable insights for better decision-making, and empower your workforce.

The Workday Enterprise Resource Planning project budget is estimated at $10,011,108 over six years. Costs include the following over a six-year period:

- Workday subscription fees
- Workday professional services fees (year one)
- Training
- Staffing (SVH) & contracted labor
- Out-of-pocket/travel expenses
- Contingency
- Other vendor off-sets (savings from systems that are replaced)

The contracted labor and staffing costs are based on use of contracted labor during the implementation followed by long-term staff after year one. The project team is sensitive to labor costs and will seek to limit staffing what is minimally needed.

Other solutions replaced by Workday and cost savings are determined based on contract renewal dates and any applicable early termination fees based on an August 1, 2025 go live date for Workday Financial and Supply Chain Management solutions.

The total cost of Workday from August 1, 2024 through June 27, 2030, same end date as the Workday Human Capital Management solution, is estimated at $11.8M. With operational savings from other vendor systems off-sets estimated at $1.8M, the net total is $10.0M. The net-cost variance from the budgeted amount in the Epic program scope is $6.3M over six years. This is largely due to increases in pricing when adding the full scope of financials and supply chain management which were unknown at the time of the Epic total cost of ownership (TCO) effort. Additionally, the Workday budget includes contracted labor and staffing, travel, contingency and increases in pricing by Workday since the Epic TCO was performed.

After offsets totaling $1,791,245 from replacing other vendor systems, **the net total cost for Workday Financials and Supply Chain Management is estimated at $10,011,108**.

Key Contract Terms	Workday Financial and Supply Chain Management
1. Proposed contract signing date	July 26, 2024
2. Term of agreement	August 2, 2024 – June 27, 2030 (co-terminates with the Workday Human Capital Management agreement)
3. Renewal terms	Non-renewing
4. Termination provision(s)	30 days' written notice for uncured breach
5. Payment Terms	Invoiced annually, net 30
6. Annual cost(s)	Average Annual $566,667/year in subscription costs.
7. Cost over life of agreement	Estimated at $10,011,108 over six years.
8. Budgeted (yes or no)	The Workday project cost was increased from the $3.8M in the Epic total cost of ownership (TCO) budget to a net of $10.0M. The $3.8M was budgeted as part of the Epic TCO, however, we noted that this was without review, analysis or planning as a separate analysis for Workday would be required. The unbudgeted increase of $6.2M was due to the expansion of the scope, the staffing resources needed, added contingency, and price increases from last year.
9. Contract	1001.4754

Recommendation

Consider recommendation for Board approval of the Workday Enterprise Resource Planning project as sole source and contract award with a total budget over six years estimated at $10,011,108 (after offsets of $1,791,245), and approval of a six (6) year contract with Workday Inc. in the amount of $4,899,800 for software subscription, training and implementation services subject to final legal review.

Attachments Provided to the Board of Directors

- Sole Source Justification

Justification for Sole Source Form

To: Proposal Evaluation Panel

From: Augustine Lopez, Chief Financial Officer
Scott Cleveland, Controller
Rolf Norman, Director of Financial Planning & Decision Support
Judi Melton, Director of Materials Management
Audrey Parks, Chief Information Officer

Type of Purchase: (check one)

- ☐ Materials/Supplies
- ☒ Data Processing/Telecommunication Goods > $25,000
- ☐ Medical/Surgical – Supplies/Equipment > $25,000
- ☐ Purchased Services

Cost Estimate ($):	Estimated $8,229,970 with off-sets, inclusive of labor and contingency
Vendor Name:	Workday, Inc., contract labor vendor (TBD), out-of-pocket travel
Item Title:	Workday: Financial and Supply Chain Management, 2024 - 2030

Statement of Need: My department's recommendation for sole source is based upon an objective review of the product/service required and appears to be in the best interest of the SVMHS. I know of no conflict of interest on my part or personal involvement in any way with this request. No gratuities, favors or compromising action have taken place. Neither has my personal familiarity with particular brands, types of equipment, materials or firms been a deciding influence on my request to sole source this purchase when there are other known suppliers to exist.

Describe how this selection results in the best value to SVMHS. See typical examples below.

☐ Licensed or patented product or service. No other vendor provides this. Warranty or defect correction service obligations of the consultant. **Describe why it is mandatory to use this licensed or patented product or service:**

☒ Existing SVMHS equipment, inventory, custom-built information system, custom built data inventory system, or similar products or programs. **Describe. If product is off-the-shelf, list efforts to find other vendors (i.e. web site search, contacting the manufacturer to see if other dealers are available to service this region, etc.).**
In April 2023, Salinas Valley Health pursued Workday Human Capital Management (HCM) encompassing the human resources and payroll information systems solutions following a competitive solicitation process. The competitive evaluation took into consideration that the HCM solution may also serve financial and supply chain management since the strategic vision to ultimately replace our electronic hospital information system would mean Salinas Valley Health would need to find an alternate financial and supply chain management solutions. Epic, our new inpatient electronic medical record system, does not offer solutions for financial and supply chain management.

The finance and materials management teams spent the recent five months evaluating Workday Financial and Supply Chain Management solutions. Salinas Valley Health successfully implemented the Workday Human Capital Management solution on April 1, 2024. This solution covers major human resources and payroll functions. The interdisciplinary team evaluated Workday Financial and Supply Chain Management solutions for functionality, workflow, integration, efficiency, and innovation. In evaluating these additional solutions, understanding and properly assessing partner, product, price and people are essential to achieving sustainable success, the team elected to proceed with Workday Financial and Supply Chain Management.

☐ Uniqueness of the service. **Describe.**

☐ SVMHS has established a standard for this manufacturer, supplier or provider and there is only one vendor. **Attach documentation from manufacturer to confirm that only one dealer provides the product.**

Justification for Sole Source Form

- ☐ Factory-authorized warranty service available from only this single dealer. Sole availability at the location required. **Describe.**
- ☐ Used item with bargain price (describe what a new item would cost). **Describe.**
- ☐ Other -The above reasons are the most common and established causes for an eligible sole source. If you have a different reason, **Describe:**

By signing below, I am attesting to the accuracy and completeness of this form.

Submitter Signature: _____ Date: _____

Board Paper: Finance Committee

Agenda Item: Consider Recommendation for Board Approval of the Lease Agreement between Salinas Valley Memorial Healthcare System (SVMHS) and Mobile Modular Management Corporation for the construction and lease of two (2) modular units.

Executive Sponsor: Clement Miller, Chief Operating Officer
Carla Spencer, Chief Nursing Officer
David Thompson, Interim Emergency Department Director

Date: July 22, 2024

Executive Summary

As part of the strategy to provide an improved care setting for our growing Emergency Department population Salinas Valley Health Medical Center (SVHMC) is seeking to outfit and lease 2 24x60 modular units that will be configured to meet the needs of our Emergency Department. The placement of these modular units will allow the organization to eliminate the use of the ED tents in addition to returning the Whitney Waiting Room to its intended use, a surgical waiting area.

Background/Situation/Rationale

At the height of the pandemic SVHMC determined that it was necessary to provide expanded emergency department space to meet the growing demand for emergency services. To accomplish this quick expansion the organization settled on erecting temperature controlled tents that have remained in service for the better part of the last 3 years. As with any tent structure, our current emergency room tents are not made for long term use. The tents are not impervious to rain, they often flood and maintaining an optimal temperature has proven to be difficult.

Over the past year the organization has sought out viable options to vacate the tent for a more suitable environment and after reaching out to multiple vendors we were able to locate a California based vendor that can meet our needs. Transitioning from the tents to the prefabricated modular units will allow the organization to provide care in a structure that meet's the current code, that is impenetrable of rain and wind, and is outfitted with an HVAC system to ensure that our staff and patients are comfortable when providing and receiving care

Pillar/Goal Alignment:

☒ Service ☒ People ☒ Quality ☐ Finance ☒ Growth ☒ Community

Financial Implications

The essential terms of the proposed Lease are as follows:

Key Contract Terms	Mobile Modular Management Corporation
1. Proposed effective date	August 2024
2. Term of agreement	Three (3) years commencing September 2024.
3. Renewal terms	Market Rate
4. Cost	Lease - $4,151.74 per month ($49,820.88 annually, $149,462.64 for the 3 year term Construction & Delivery - $499,889.90 Pick up - $32,244
5. Budgeted (indicate y/n)	Yes

Schedule: December 2023 – Executive approval to move forward with modular plan
June 2024 – Board presentation
July 2024 – Quote received

Recommendation

Consider Recommendation for Board Approval of the Lease Agreement between Salinas Valley Memorial Healthcare System (SVMHS) and Mobile Modular Management Corporation for the construction and lease of two (2) modular units, pending final contract negotiations and legal counsel approval

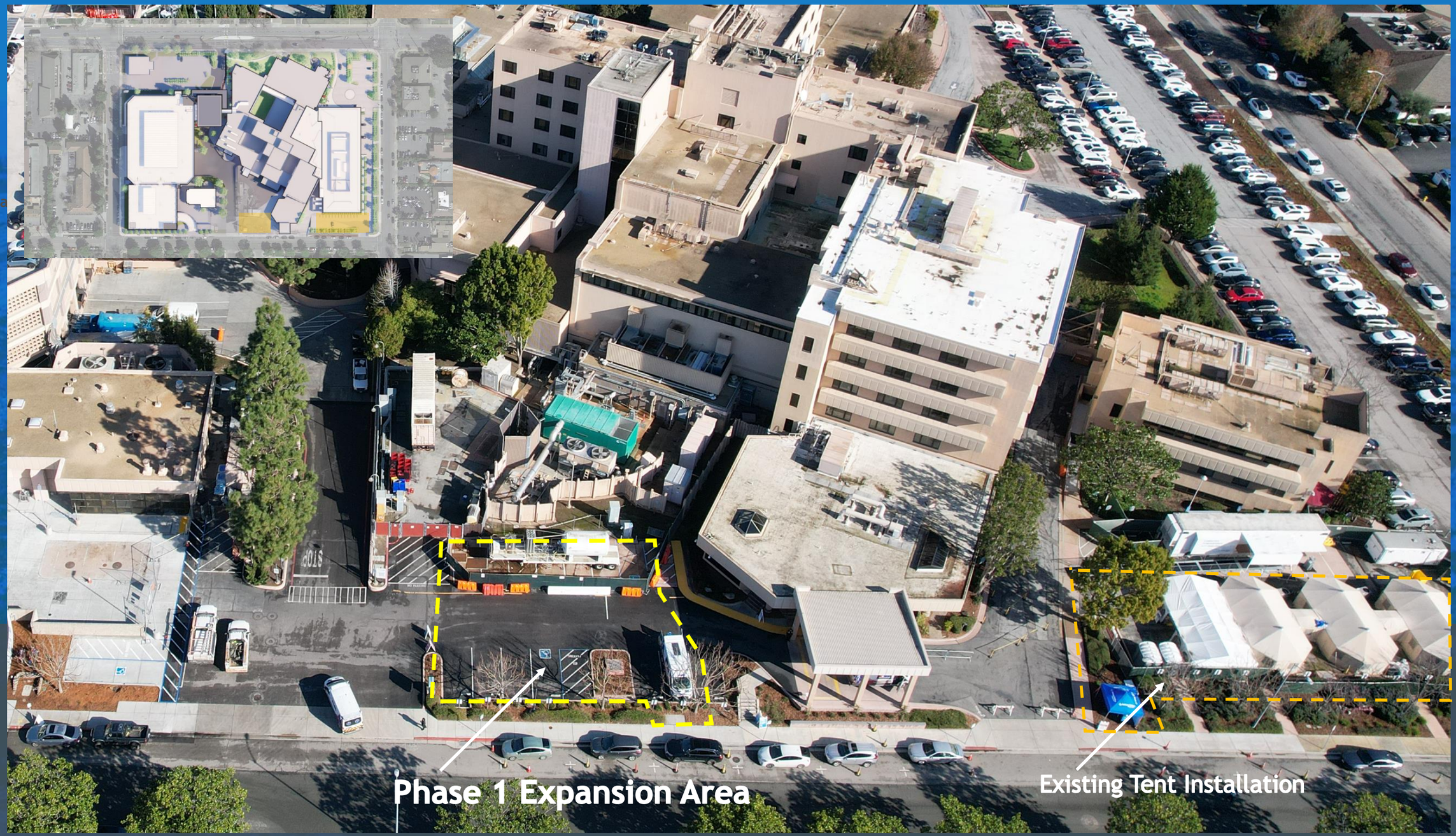
Attachments

- Attachment 1: June 2024 Board Presentation
- Attachment 2: Mobile Modular Lease Quote & Agreement – pending final contract review and approval
- Attachment 3: RFP Justification

Emergency Department Expansion - Phase 1 Update

JUNE 27, 2024

HOSPITAL CAMPUS – AFFECTED AREA

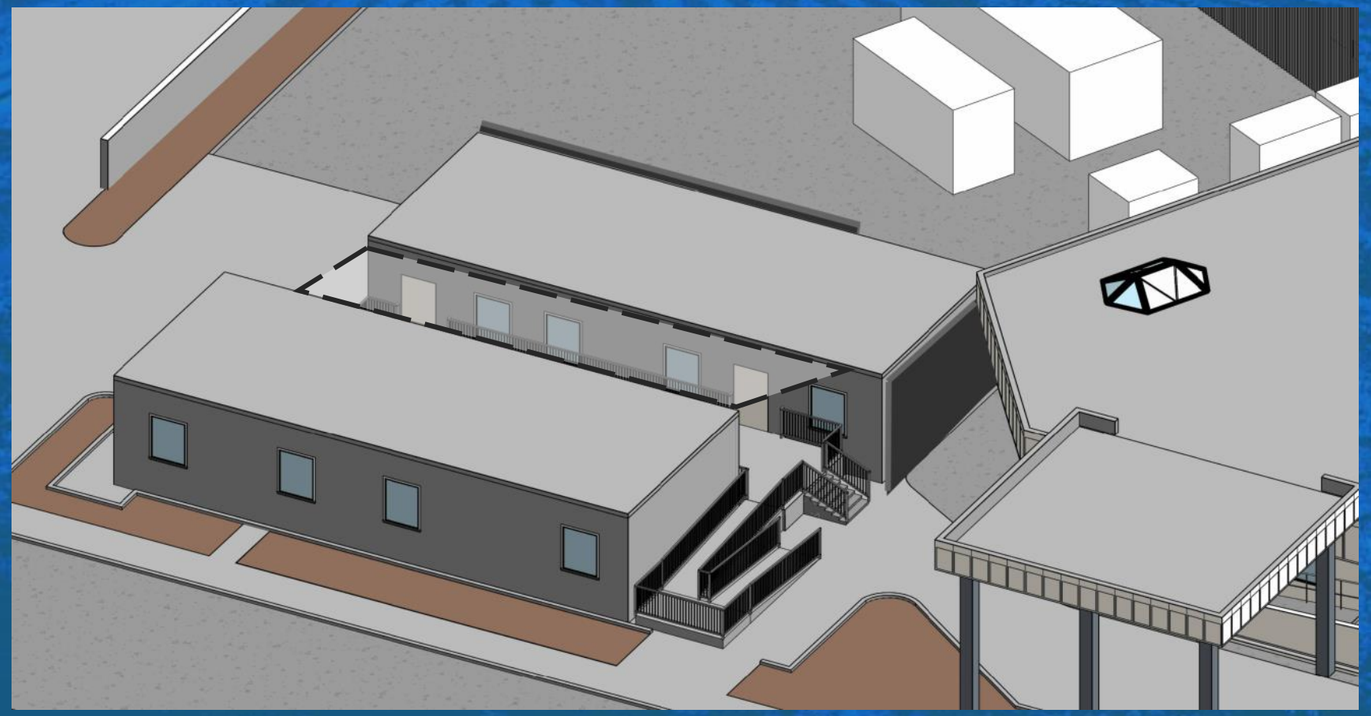


EXECUTIVE SUMMARY

Covid-Era approvals for the Tent installation, both City and State, have expired. The need to manage overflow census through the ED remains and is expected to remain until a permanent ED Expansion Project is accomplished, a process likely to take 3-5 years for programming/design/permitting/construction.

Phase-1: Modular Building Installation – Two 24' x 60' Modular Buildings (2,880 SF) with custom Interior Improvements, Access & Utility Upgrades

- Complies with HCAi Policy Intent Notice (PIN) 34 – Allows for 'duplicate hospital services' described in Health & Safety Code Sec. 129730
- Service areas to be licensed through CDPH



The Why:

1. **Increased space to support increased volumes**
2. **Discontinue utilization of tents**
3. **To better protect patients and staff from the elements**
4. **Improve arrival process for patient safety and experience**
5. **Increases waiting room space**
6. **Move the Fast Track area up front for improved flow**
7. **Increase treatment space in Fast Track**
8. **Provide for a more cohesive team and improve communication**
9. **Added bathrooms**

ED EXPANSION – RECENT PROJECT HISTORY

Feb-Sep 2023: initial ED Expansion Studies

September 2023: initial meeting with Huddy Consultants

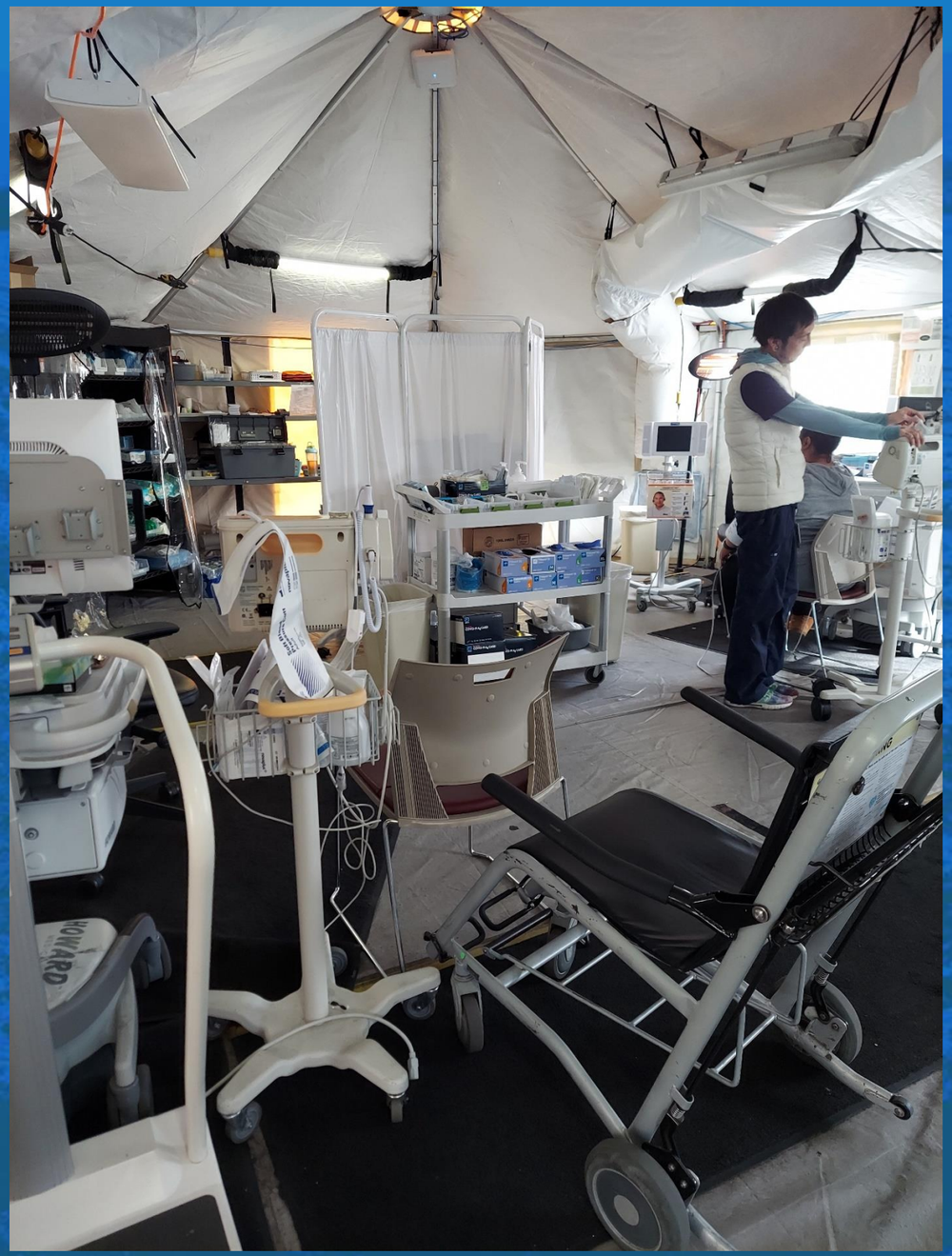
December 2023: modular location study to replace tents

January 2024: staff/Huddy interior use programming Kick-off

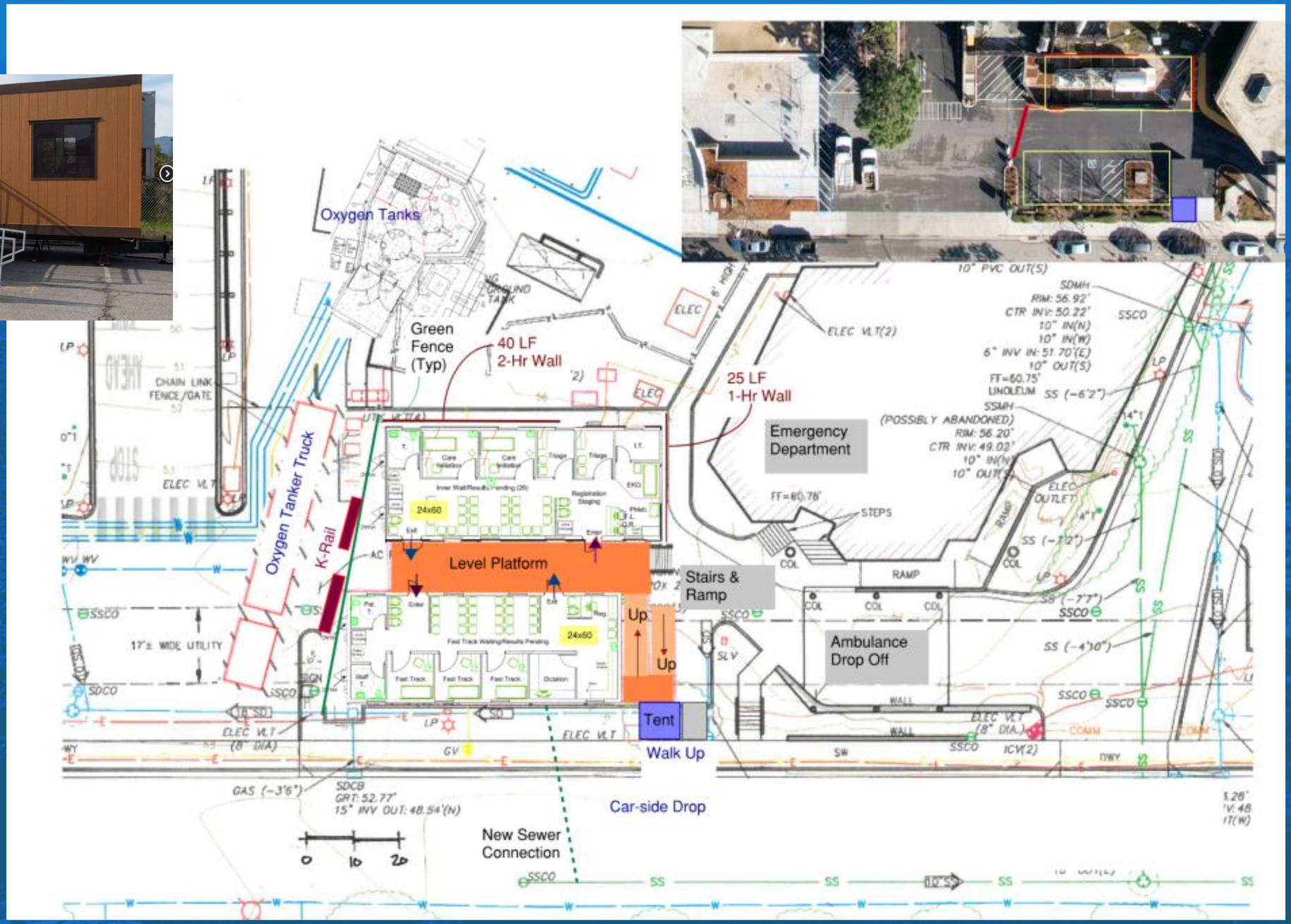
Jan-Mar 2024: staff outreach for programming feedback

Apr-June 2024: program refinement and design detailing

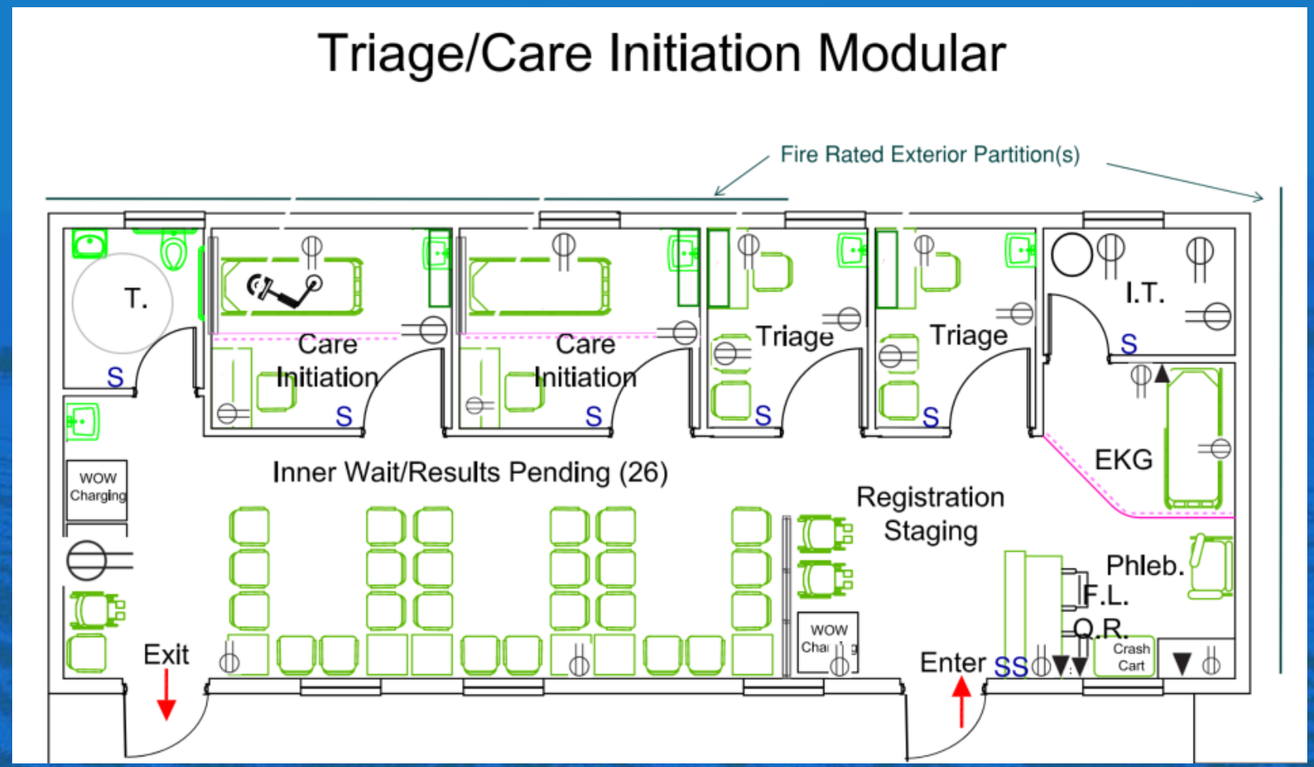
EXISTING OVERFLOW CONDITIONS

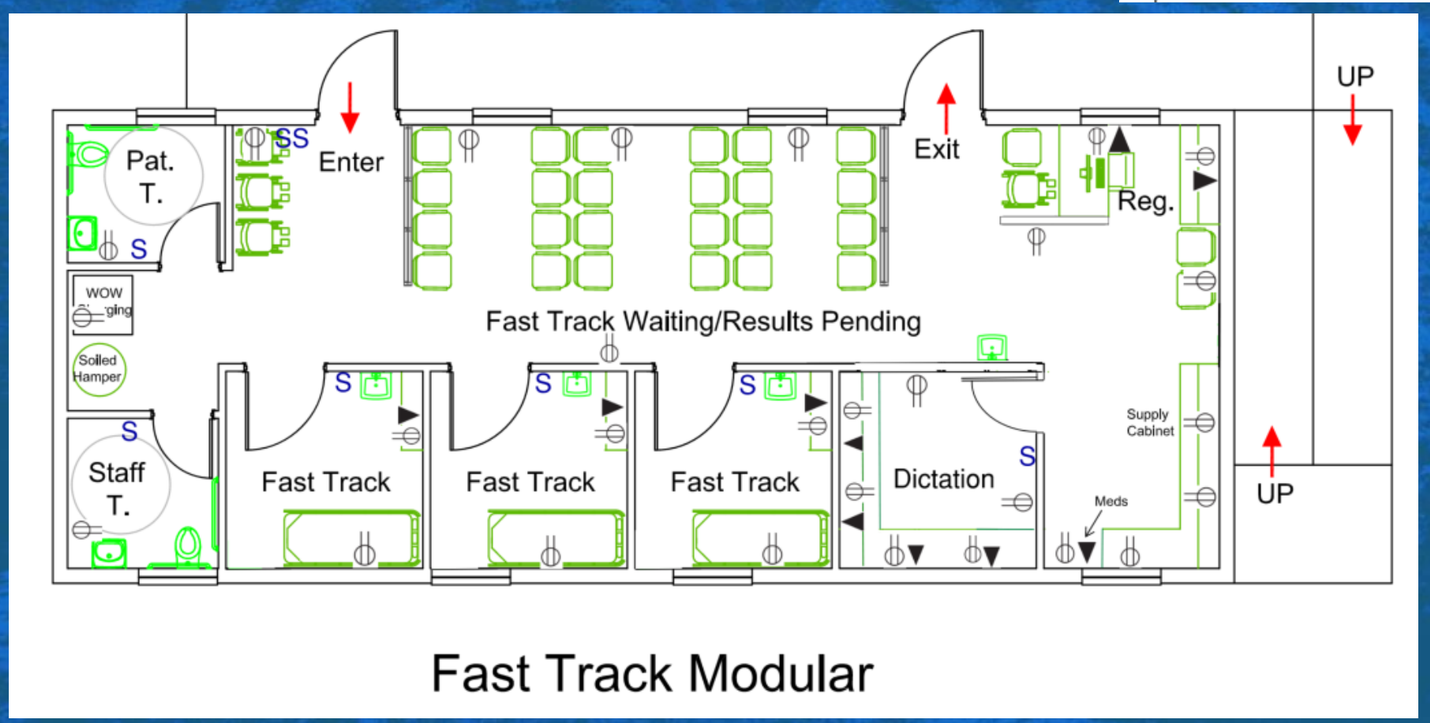


MODULAR SITE PLAN



INTERIOR LAYOUTS

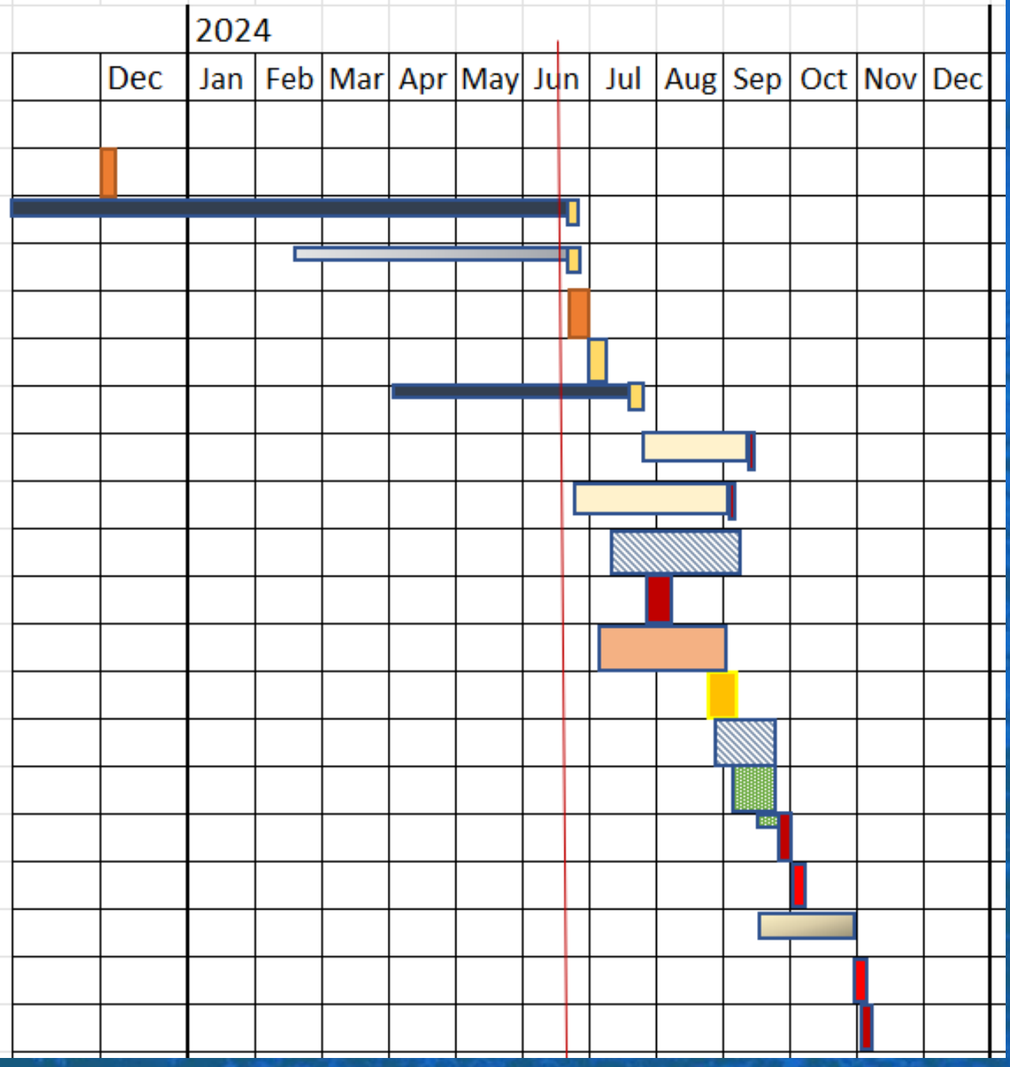




Fast Track Modular

DEVELOPMENT SCHEDULE

Modular Trailer Project Development
Executive Notice to Pursue Project
Design Option Development
Staff Review & Refinement
SVH Board Action to approve Project
Execute Lease/Order Long Lead Materials
Architect/Engineering Studies & HCAi Package Submittal
HCAi Plancheck & Permit Issuance
City of Salinas Planning & Fire Negotiation/Approvals
Encroachment Permit & Utility Make-Ready Work
Oxygen Project Completion & Temp Trailer Demobilization
Trailer Buildout (Offsite in NorCal)
Trailer Delivery & Setup
Utility Hookups/Ramp/Step/Deck/Canopy Installation
Equipment install, facility activation
Licensing & Commissioning
First Patient Visit - Best Case
Contigency Period to reflect jurisdictional approval uncertainty
First Patient Visit - Standard Case
Demo Tents



Mobile Modular Management Corporation
5700 Las Positas Rd
Livermore, CA 94551
925-606-9000
www.mgrc.com

Lease Quotation and Agreement

Quote # Q-452779
Date of Quote 12/18/2023
Quote Expiration Date:
Lease Term: 36 Months
Lessee PO#:

Lessee Name and Billing Address	Site Information	Lessor Name
Bogard Construction ("Lessee") 350 Coral Street Santa Cruz, CA 95060 Stephen Lyon Phone: 1 (831) 601-4718 slyon@bogardconstruction.com	Stephen Lyon 450 East Romie Lane Salinas, CA 93901 Cell: 1 (831) 601-4718 slyon@bogardconstruction.com	Mobile Modular Management Corporation a Division of McGrath RentCorp ("Lessor") **Questions?** Contact: Matt Benas Direct Phone: 1 (925) 453-3122 matt.benas@mobilemodular.com

SVH

Equipment and Accessories	Qty	Monthly Rent	Extended Rent	Taxable
Office, 24x60 HCD (NonStd) (Non-Standard Configuration.Size excludes 3' towbar.)	1	$1,597.00	$1,597.00	Y
Filter Replacement Program	2	$27.00	$54.00	Y
Damage Waiver	2	$75.00	$150.00	N
Office, 24x60 HCD (Item1274) (4 Offices.Size excludes 3' towbar.Vinyl wrap panel interior.)	1	$1,597.00	$1,597.00	Y
Filter Replacement Program	2	$27.00	$54.00	Y
Damage Waiver	2	$75.00	$150.00	N
		Equipment and Accessories Monthly Subtotal:		$3,602.00

Charges Upon Delivery	Qty	Charge Each	Total One Time	Taxable
Office, 24x60 HCD (NonStd) (Non-Standard Configuration.Size excludes 3' towbar.)				
Delivery	2	$1,247.00	$2,494.00	N
Delivery Pilot	2	$547.00	$1,094.00	N
Delivery Permit	2	$150.00	$300.00	N
Block and Level Building	1	$6,783.00	$6,783.00	N
Foundation, Installation	16	$261.00	$4,176.00	Y
Foundation, IC Provide Material	16	$224.00	$3,584.00	Y
Essential Material Handling Fee	2	$75.00	$150.00	N
Removal, Towbar/Hitch	2	$215.00	$430.00	N
Skirting, Install	168	$24.00	$4,032.00	Y
Modification (In House Labor) (Install sheet vinyl flooring)	1	$30,550.00	$30,550.00	Y
Drawings (Modification plans and foundation plans)	1	$5,130.00	$5,130.00	N
Service, Forklift On Delivery	1	$1,688.00	$1,688.00	N
Additional Labor, Rolling On Delivery	1	$878.00	$878.00	N
Office, 24x60 HCD (Item1274) (4 Offices.Size excludes 3' towbar.Vinyl wrap panel interior.)				
Delivery	2	$1,247.00	$2,494.00	N
Delivery Pilot	2	$547.00	$1,094.00	N

Mobile Modular Management Corporation
5700 Las Positas Rd
Livermore, CA 94551
925-606-9000
www.mgrc.com

Lease Quotation and Agreement

Quote #	Q-452779
Date of Quote	12/18/2023
Quote Expiration Date:	
Lease Term:	36 Months
Lessee PO#:	

Delivery Permit	2	$150.00	$300.00	N
Block and Level Building	1	$6,783.00	$6,783.00	N
Foundation, Installation	16	$261.00	$4,176.00	Y
Foundation, IC Provide Material	16	$42.00	$672.00	Y
Essential Material Handling Fee	2	$75.00	$150.00	N
Removal, Towbar/Hitch	2	$215.00	$430.00	N
Skirting, Install	168	$24.00	$4,032.00	Y
Drawings (Modification plans and foundation plans)	1	$5,130.00	$5,130.00	N
Modification (In House Labor) (Install sheet vinyl flooring)	1	$30,550.00	$30,550.00	Y
Modifications			$344,375.00	
		Charges Upon Delivery Subtotal:		$461,475.00

Charges Upon Return	Qty	Charge Each	Total One Time	Taxable
Office, 24x60 HCD (NonStd) (Non-Standard Configuration.Size excludes 3' towbar.)				
Return	2	$1,247.00	$2,494.00	N
Return Pilot	2	$547.00	$1,094.00	N
Return Permit	2	$150.00	$300.00	N
Prepare Equipment For Removal	1	$4,981.00	$4,981.00	N
Foundation, Removal	16	$80.00	$1,280.00	N
Cleaning Fee	2	$450.00	$900.00	N
Installation, Towbar/Hitch	2	$215.00	$430.00	N
Skirting, Removal	168	$20.00	$3,360.00	N
Service, Forklift On Return	1	$1,688.00	$1,688.00	N
Additional Labor, Rolling On Removal	1	$878.00	$878.00	N
Office, 24x60 HCD (Item1274) (4 Offices.Size excludes 3' towbar.Vinyl wrap panel interior.)				
Return	2	$1,247.00	$2,494.00	N
Return Pilot	2	$547.00	$1,094.00	N
Return Permit	2	$150.00	$300.00	N
Prepare Equipment For Removal	1	$4,981.00	$4,981.00	N
Foundation, Removal	16	$80.00	$1,280.00	N
Cleaning Fee	2	$450.00	$900.00	N
Installation, Towbar/Hitch	2	$215.00	$430.00	N
Skirting, Removal	168	$20.00	$3,360.00	N
		Estimated Charges Upon Return Subtotal:		$32,244.00

Mobile Modular Management Corporation
5700 Las Positas Rd
Livermore, CA 94551
925-606-9000
www.mgrc.com

Lease Quotation and Agreement

Quote #	Q-452779
Date of Quote	12/18/2023
Quote Expiration Date:	
Lease Term:	36 Months
Lessee PO#:	

Total Estimated Charges

Subtotal of Monthly Rent	$3,602.00
Personal Property Expense	$223.60
Taxes on Monthly Charges	$326.14
Total Charges per Month (including tax)	$4,151.74
Charges Upon Delivery (including tax)	$495,738.16
Estimated Charges Upon Return (including tax)*	$32,244.00
Estimated Initial Invoice*	$499,889.90

***Charges upon return will be charged at Lessor's then-current rates for lease terms greater than 12 months.**

Special Notes

Two 24x60 modular building with sheet vinyl flooring, custom layouts (per the provided drawings), custom windows and the exterior painted your choice of colors. The modification charges is the cost to create the custom layouts from the existing buildings and includes the cost to restore back to standard and HCD state inspections and approvals. Ramps, decks, stairs, fire rated walls, and cabinetry have not been included.

Fire Related Items: Unless noted, fire related items (alarms, sprinklers, smoke & heat detectors, and fire-rated walls, etc.) are not included.

General: Customer's site must be dry, compacted, level and accessible by normal truck delivery. Pricing does not include any clearing or grading of sites, obstruction removal, site or final building clean up , any asphalt transitions, dolly, crane, forklift, electrical or plumbing connections, window coverings, furniture, casework, appliances, doorstops, phone or data lines, gutters, downspouts or tie-in, temporary power, temporary fencing, traffic control, flagmen, soil and/or pull test, custom engineering, fees associated with inspections, city or county submittals and/or use permits, security screens, door bars and any item not specifically listed as being included.

Yes - Prevailing Wage: Pricing includes prevailing wage and certified payroll for installation and dismantle work performed on site.

Buildings containing a restroom(s): Restrooms are not self-contained. Where applicable, manifolds are shipped loose and assembled and connected by others. Water & sewer stub-out locations may vary. Paper & soap dispensers, sanitary and trash receptacles are not provided.

HVAC Filter Replacement Program: Customer has selected the HVAC Filter Replacement Program. This service is incidental to the Lease of the Equipment and not included with any limited warranties. The additional charge for this service is included in the monthly rental rate reflected above. For this additional monthly charge, MMMC will mail three (3) HVAC filters on a quarterly basis. Customer shall be solely responsible for installation of the filters each month. Customer shall be responsible for charges that may result if Customer fails to properly replace HVAC filters on a monthly basis.

Additional Information

Mobile Modular Management Corporation
5700 Las Positas Rd
Livermore, CA 94551
925-606-9000
www.mgrc.com

Lease Quotation and Agreement

Quote #	Q-452779
Date of Quote	12/18/2023
Quote Expiration Date:	
Lease Term:	36 Months
Lessee PO#:	

- Quote is valid for 30 days.
- Lessee's site must be dry, compacted, level and accessible by normal truck delivery. Costs to dolly, crane, forklift, etc. will be paid by Lessee. Unless noted, prices do not include permits, ramp removal, stairs, foundation systems, foundation system removal, temporary power, skirting, skirting removal, engineering, taxes or utility hookups.
- Subject to equipment availability. Unless noted, equipment and related furnishings, finishes, accessories and appliances provided are previously leased and materials, dimensions, and specifications vary. Detailed specifications may be available upon request.
- For lease transactions, Lessor reserves the right to substitute equal or better equipment prior to delivery without notice.
- This transaction is subject to prior credit approval. Security deposit and payment in advance may be required.
- **Sales Tax will be calculated based on the tax rate at the time of invoicing.**
- **Unless otherwise noted, prices do not include prevailing wages, Davis-Bacon wages, or other special or certified wages.**

Estimated Equipment Value

The Estimated Equipment Value is listed below. Lessee is solely responsible for complying with all insurance requirements set forth in the Lease Terms and Conditions attached hereto.

Equipment Description	Qty	Estimated Equipment Value (each)
Office, 24x60 HCD (NonStd)	1	$171,600.00
Office, 24x60 HCD (Item1274)	1	$172,400.00

Mobile Modular Management Corporation
5700 Las Positas Rd
Livermore, CA 94551
925-606-9000
www.mgrc.com

Lease Quotation and Agreement	
Quote #	Q-452779
Date of Quote	12/18/2023
Quote Expiration Date:	
Lease Term:	36 Months
Lessee PO#:	

This Lease Quotation and Agreement is entered into by and between Lessor and Lessee effective as of the date signed by Lessee. This Lease Quotation and Agreement includes the terms and conditions set forth in the following two documents (collectively, the "Agreement"), each of which is incorporated herein by this reference:

1. **Lease Terms and Conditions** attached hereto; and
2. **Supplemental Lease Terms and Conditions** located at (https://www.mobilemodular.com/contractterms), as the same may be updated from time to time in the sole and absolute discretion of Lessor.

IN THE EVENT THE LESSOR AND LESSEE HAVE ENTERED INTO A MASTER LEASE AGREEMENT, THE TERMS OF SUCH MASTER LEASE AGREEMENT ARE INCORPORATED HEREIN BY THIS REFERENCE, ARE DEEMED A PART OF THIS AGREEMENT, AND TAKE PRECEDENCE OVER ANY CONFLICTING TERMS IN THIS AGREEMENT.

By signing below, Lessee: (1) acknowledges and agrees that it has received, read and understands the terms of this Agreement and agrees to be bound by the terms of this Agreement, including prices and specifications, and (2) instructs Lessor to make appropriate arrangements for the preparation and delivery of the Equipment identified herein. This Agreement may be executed in one or more counterparts (including through the use of electronic signatures), each of which shall be deemed an original and all of which shall constitute one and the same Agreement. Upon execution of this Agreement, Lessor shall generate a Lease Agreement Number, which shall be referenced on all Lessor invoices.

No document provided by Lessee, including, without limitation, Lessee's purchase orders, work orders, bills of lading, or forms for receipt or acknowledgment or authorization ("**Lessee Forms**"), nor the terms and conditions associated with such Lessee Forms, shall amend, modify, supplement, waive, or release any term or condition of this Agreement (or the Master Lease Agreement, as applicable) even if such Lessee Forms are signed by an agent or representative of Lessor. The terms and conditions of this Agreement (or the Master Lease Agreement, as applicable) shall prevail over any Lessee Forms, and any inconsistent or additional terms and conditions in Lessee Forms shall be deemed void *ab initio* and of no force or effect.

The individuals signing this Agreement affirm that they are duly authorized to execute this Agreement by and on behalf of the parties hereto.

LESSOR:	**LESSEE:**
Mobile Modular Management Corporation	**Bogard Construction**
a Division of McGrath RentCorp	
Signature: _____	Signature: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Mobile Modular Management Corporation
5700 Las Positas Rd
Livermore, CA 94551
925-606-9000
www.mgrc.com

Lease Quotation and Agreement	
Quote #	Q-452779
Date of Quote	12/18/2023
Quote Expiration Date:	
Lease Term:	36 Months
Lessee PO#:	

LEASE TERMS AND CONDITIONS

1. **LEASE.** Lessor agrees to lease to Lessee, and Lessee agrees to lease from Lessor, the Equipment (as defined below). The lease of any Equipment is governed by the terms of this Agreement. The Equipment is and shall remain the personal property of Seller.

2. **TERMS.** All capitalized terms used and not otherwise defined herein, will have the meanings set forth in this Agreement. As used in this Agreement, the following definitions shall apply: "**Accessories**" shall mean any additions, attachments, or accessories to the modular buildings, or ancillary services, provided by Lessor to Lessee and identified in this Agreement; "**Equipment**" shall mean the modular buildings, Accessories, and/or Services identified in this Agreement, together with any replacements, repairs, additions, attachments or accessories hereafter rented to Lessee under this Agreement.

3. **PAYMENTS AND PRICE ADJUSTMENTS.** Lessee agrees to pay to Lessor each payment specified herein on a net invoice basis. Payment terms are net due upon receipt unless otherwise agreed upon in writing. All payments due from Lessee pursuant to this Agreement shall be made by Lessee without any abatement or setoff of any kind whatsoever arising from any cause whatsoever. Prices will be increased by Lessor for unknown circumstances or conditions, including, but not limited to, driver waiting time, special transport permits, difficult site conditions and/or increases in fuel prices.

4. **LEASE TERM; EARLY TERMINATION.** The Lease Term and Monthly Rent, each of which are specified in this Agreement, shall commence on the date the Equipment is delivered to the Site (the "Start Rent Date"), unless a different date is mutually agreed upon in writing, and shall continue thereafter for the number of months specified in this Agreement as the Lease Term. Lessee agrees to pay the Total Charges per Month specified in this Agreement (as may be adjusted pursuant to Section 5 below) for each month during the Lease Term and any extensions thereof. A month is defined as thirty (30) calendar days; rent will be billed monthly unless otherwise specified in this Agreement (but rent shall be due and owing even in the absence of actual receipt by Lessee of an invoice or bill). In the event that Lessee terminates this Agreement prior to the expiration of the Lease Term, Lessor shall be entitled to charge an early termination fee, even if such termination occurs prior to delivery of the Equipment. Such fee shall be determined by Lessor, in its sole discretion, following the receipt of the termination request. Such early termination fee may include, but shall not be limited to, charges related to the preparation of the Equipment for delivery and/or the rental value of this Agreement. In no event shall any such early termination fee exceed the total value of this Agreement. Lessor shall not be liable to Lessee for any failure or delay in obtaining, delivering or setting up the Equipment. If Lessee delays delivery of the Equipment for any reason for thirty (30) days or longer from the original delivery date mutually agreed upon between both parties, Lessor may, in Lessor's sole discretion, charge Lessee a monthly storage fee equal to the Monthly Rent starting on the original delivery date, and/or terminate this Agreement, subject to the early termination provisions set forth above.

5. **EXTENSION OF LEASE TERM.** Upon expiration of the initial Lease Term set forth in this Agreement, the lease of the Equipment shall automatically be extended on a month-to-month basis until the Equipment is returned to Lessor. This Agreement does not expire and the terms and conditions hereof shall remain in full force and effect for any extension of the Lease Term, unless otherwise agreed upon by Lessor and Lessee in writing. Lessor may periodically revise the Total Charges per Month from those reflected in this Agreement if the lease of the Equipment is extended beyond the initial Lease Term. If the lease of the Equipment is extended beyond the initial Lease Term, Lessor may revise the charges for the Charges Upon Return from those specified in this Agreement to reflect Lessor's then-current market rates for such services.

6. **PREPARATION FOR REMOVAL OF THE EQUIPMENT.** Prior to the scheduled removal of the Equipment, Lessee shall, at a minimum: (a) provide clear access to the Equipment for Lessor to dismantle and remove the Equipment from the Site by industry-standard trucking methods; (b) disconnect all utilities; (c) remove all personal property of Lessee's from the Equipment; and (d) in the case of Equipment that includes plumbing, flush the plumbing lines clean and ensure that no foreign matter remains in any fixtures. Plumbing must be properly disconnected by Lessee at its sole cost and expense. Lessee will be responsible for costs of repair required by improper plumbing disconnection to the extent that the Equipment is damaged. Any components, parts or accessories supplied by Lessor must be returned with the Equipment. In the event that Lessee fails to meet the requirements herein, additional charges may be incurred by Lessee for additional labor, waiting time, or dry-runs in the event that Lessor is unable to return the Equipment as scheduled.

7. **RETURN OF EQUIPMENT.** Lessee must provide a minimum of thirty (30) days prior, written notice to Lessor when requesting to return the Equipment. Lessee is responsible for complying with the requirements set forth in the "Preparation for Removal of the Equipment" section of these Lease Terms and Conditions. Unless otherwise agreed upon by Lessor in writing, Lessee shall continue to be responsible for payment of the Total Charges per Month set forth in this Agreement (as may be adjusted pursuant to Section 5 hereto) until return of the Equipment to Lessor is completed. The Total Charges per Month will be prorated in one-half (1/2) month increments only. If the Equipment is returned within the first fifteen (15) days of the billing period, Lessee shall be responsible for paying half of the Total Charges per Month; if Equipment is returned between the sixteenth (16th) and thirtieth (30th) days of the billing period, Lessee shall be responsible for paying the entire amount of the Total Charges per Month. The charges reflected in this Agreement for Charges Upon Return will be adjusted for any Lease Term longer than twelve (12) months or if the Lease is extended beyond the initial Lease Term, pursuant to Section 5.

8. **WARRANTIES; DISCLAIMER.** Lessor warrants to Lessee that the Equipment, when delivered and set up and under normal use and regular service and maintenance by Lessee, shall be free from major defects in materials and workmanship that prevent any normal use and operation. Accessories supplied by Lessor pursuant to this Agreement but not owned by Lessor shall not be subject to the foregoing warranty, but shall carry the applicable warranty of the Accessory owner, which Lessor hereby assigns to Lessee to the extent transferable. Lessor's liability under this warranty shall be limited to the replacement or repair of the defective Equipment (during Lessor's normal working hours), at Lessor's option; provided, however, that Lessee shall provide written notice of any failure or defect to Lessor within four (4) days after discovery, and within the applicable warranty period, and failure to provide such notice in a timely manner may result in a limitation of this warranty at Lessor's sole option. If Lessee does not grant clear, unobstructed access for any such repairs between 8:00 a.m. and 5:00 p.m., Monday through Friday, Lessee shall bear the cost of repair rates for labor at the applicable overtime rates. This warranty does not

extend to any Equipment subjected to improper application, damaged by accident or abuse, or repaired or altered outside of Lessor's facilities without prior written authorization from Lessor. **THE EXPRESS WARRANTIES CONTAINED IN THIS AGREEMENT ARE LESSOR'S SOLE AND EXCLUSIVE WARRANTIES WITH RESPECT TO THE EQUIPMENT AND SERVICES, AND ARE IN LIEU OF AND EXCLUDE ALL OTHER WARRANTIES, GUARANTEES, PROMISES, AFFIRMATION OR REPRESENTATIONS OF ANY KIND, EXPRESSED OR IMPLIED, WHICH MAY BE DEEMED APPLICABLE TO THE EQUIPMENT OR SERVICES, INCLUDING WITHOUT LIMITATION, THE CONDITION OF THE EQUIPMENT, ITS MERCHANTABILITY OR ITS FITNESS FOR ANY PARTICULAR PURPOSE, ANY WARRANTY AGAINST INFRINGEMENT OR AS TO TITLE, WARRANTIES ARISING FROM COURSE OF DEALING OR USAGE OR TRADE OR ANY OTHER MATTER. EXCEPT AS EXPRESSLY SET FORTH IN THIS SECTION, ALL EQUIPMENT AND SERVICES ARE BEING PROVIDED "AS IS", "WHERE IS, WITH ALL FAULTS". LESSOR SPECIFICALLY DISCLAIMS ANY WARRANTY, GUARANTY OR REPRESENTATION, ORAL OR WRITTEN, PAST OR PRESENT, THERETO. LESSEE HAS SELECTED ALL EQUIPMENT FOR LESSEE'S INTENDED USE AND RECOGNIZES THAT LESSOR IS NOT A DESIGNER OR MANUFACTURER OF ANY EQUIPMENT.**

9. **TAXES.** Lessee agrees to be responsible for all charges, fees and taxes (local, state and federal) levied or assessed upon Lessee or Lessor relating to the ownership, leasing, rental, sale, possession, use or operation of the Equipment (including, without limitation, sales, use and personal property taxes); provided, however, that the foregoing obligation shall not apply to any local, state or federal income tax assessed against the Lessor as a result of this Agreement which shall continue to be the obligation of Lessor. Lessee shall pay all such taxes for which it is responsible to the appropriate taxing authorities or, if directed or invoiced by Lessor, pay such amounts to Lessor for remittance by Lessor to the appropriate taxing authorities.

10. **LOSS OR DAMAGE.** Upon delivery and until the Equipment is removed from the Site by Lessor or its authorized agent, Lessee assumes all risk of loss or damage to the Equipment. Should any Equipment damaged be capable of repair, the Equipment shall be repaired and restored to its condition existing prior to such damage, at Lessee's sole cost and expense. In the event any of the Equipment is damaged beyond repair or is lost, stolen or wholly destroyed, this Agreement shall cease and terminate as to such Equipment as of the date of the event, accident or occurrence causing such loss or destruction, and Lessee shall pay Lessor within forty-five (45) days thereafter, an amount equal to the full replacement value of the Equipment, which payment obligation shall survive the termination of this Agreement.

11. **INSURANCE.** Lessee shall procure and maintain, at its sole expense (including all premiums, deductibles and self-insured retentions), (i) property insurance covering the loss, theft, destruction, or damage to the Equipment in an amount not less than the full replacement value thereof (and with a deductible no higher than $25,000), naming Lessor as loss payee of the proceeds, and (ii) commercial general liability insurance (minimum of $1,000,000 per occurrence and $2,000,000 in the aggregate) (and with a deductible no higher than $25,000), naming Lessor and its designees as additional named insureds. Lessee's insurance shall be primary and non-contributory to any insurance maintained by Lessor or any other additional insureds or additional named insureds. The liability insurance policy shall contain coverage for all contractual indemnity obligations of Lessee set forth in this Agreement, cross-liability and waiver of subrogation provisions in favor of Lessor and any other additional insureds. All evidence of all required insurance shall be in a form reasonably acceptable to Lessor and with a company having an A.M. Best rating of A- (VII) or better, and shall not be subject to cancellation without thirty (30) days' prior written notice to Lessor. Lessee shall provide to Lessor insurance certificates and endorsements (including without limitation, additional insured and loss payee endorsements) evidencing compliance with the insurance requirements of this Agreement (including without limitation, the deductible amounts and waiver of subrogation) prior to delivery of the Equipment and shall maintain all required insurance coverage until the Equipment is returned to Lessee. Lessor will not and does not provide insurance for any of Lessee's personal property that may be in or on any Equipment.

12. **INDEMNIFICATION AND LIMITATION OF LIABILITY.**

(a) **LESSEE ON BEHALF OF ITSELF, ITS SUCCESSORS, ASSIGNS, PARENTS, SUBSIDIARIES, VENDORS, SUBCONTRACTORS, AND AFFILIATES, AND THEIR RESPECTIVE REPRESENTATIVES, DIRECTORS, OFFICERS, MANAGERS, VENDORS, MEMBERS, SHAREHOLDERS, PARTNERS, CONTRACTORS, EMPLOYEES, AGENTS, AND ASSIGNS (EACH, A "LESSEE PARTY," AND COLLECTIVELY, THE "LESSEE PARTIES") SHALL INDEMNIFY, DEFEND, RELEASE, AND HOLD HARMLESS LESSOR, ITS SUCCESSORS, ASSIGNS, PARENTS, SUBSIDIARIES, VENDORS, CONTRACTORS, AND AFFILIATES, AND THEIR RESPECTIVE REPRESENTATIVES, DIRECTORS, OFFICERS, MANAGERS, VENDORS, MEMBERS, SHAREHOLDERS, PARTNERS, CONTRACTORS, EMPLOYEES, AGENTS, AND ASSIGNS (EACH A "LESSOR INDEMNIFIED PARTY," AND COLLECTIVELY, THE "LESSOR INDEMNIFIED PARTIES") FROM AND AGAINST ANY AND ALL LOSSES, FEES, COSTS, EXPENSES, CLAIMS, LIABILITIES, DAMAGES, PENALTIES, FINES, FORFEITURES, AND SUITS (INCLUDING COSTS OF DEFENSE, SETTLEMENT AND REASONABLE ATTORNEYS' FEES, ENVIRONMENTAL CONSULTANTS AND EXPERT WITNESS FEES AT TRIAL AND ON APPEAL) (COLLECTIVELY, "LOSSES") RELATING TO, ARISING OUT OF OR IN CONNECTION WITH: (1) ANY BREACH OR NON-FULFILLMENT OF ANY COVENANT, AGREEMENT, OR OBLIGATION TO BE PERFORMED BY LESSEE PURSUANT TO THIS AGREEMENT, OR ANY INACCURACY IN OR BREACH OF ANY OF THE REPRESENTATIONS OF LESSEE SET FORTH IN THIS AGREEMENT; (2) THE OCCURRENCE OF ANY EVENT SET FORTH IN SECTION 13; (3) THE SELECTION, USE, POSSESSION, DELIVERY, RENTING, LEASING, SUBLEASING, OPERATION, TRANSPORT, MAINTENANCE, CONDITION, REPAIR, REPLACEMENT, REPOSSESSION, RETURN OR STORAGE OF ANY EQUIPMENT OR ANY SERVICES; (4) ANY FAILURE BY ANY LESSEE PARTY TO COMPLY WITH ANY APPLICABLE LAW IN CONNECTION WITH ANY EQUIPMENT OR THE SERVICES OR THIS AGREEMENT; (5) ANY DEATH OR BODILY INJURY TO ANY PERSON OR DESTRUCTION OR DAMAGE TO ANY PROPERTY TO WHICH THE ACTS OR OMISSIONS OF A LESSEE PARTY CONTRIBUTED; OR (6) ANY NEGLIGENT OR INTENTIONAL ACT OR OMISSION OF ANY LESSEE PARTY FOR ANY ACTION RELATED TO OR ANY USE OF ANY EQUIPMENT. THIS INDEMNITY SHALL APPLY EVEN IF SAID LOSSES ARE OCCASIONED, BROUGHT ABOUT OR CAUSED BY THE CONCURRENT NEGLIGENCE OF ANY LESSOR INDEMNIFIED PARTY, UNLESS A COURT OF COMPETENT JURISDICTION SHOULD DETERMINE THAT THE LOSSES WERE PROXIMATELY CAUSED BY THE SOLE NEGLIGENCE OR WILLFUL ACTS OR OMISSIONS OF A LESSOR INDEMNIFIED PARTY. IF THE FOREGOING**

OBLIGATIONS ARE NOT ENFORCEABLE AGAINST LESSEE UNDER APPLICABLE LAW, LESSEE AGREES TO INDEMNIFY, DEFEND, RELEASE AND HOLD HARMLESS LESSOR INDEMNIFIED PARTIES FROM AND AGAINST ANY AND ALL LOSSES TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, INCLUDING, WITHOUT LIMITATION, TO THE EXTENT OF THE ACTS OR OMISSIONS OF THE LESSEE PARTIES' NEGLIGENT OR WORSE CONDUCT. THIS INDEMNIFICATION SHALL SURVIVE THE EXPIRATION OR EARLIER TERMINATION OF THIS AGREEMENT.

(b) **TO THE FULLEST EXTENT NOT PROHIBITED BY LAW, LESSOR'S LIABILITY, IF ANY, SHALL BE LIMITED TO THE VALUE OF RENTAL FEES AND ALL OTHER AMOUNTS PAID BY LESSEE AND RECEIVED BY LESSOR UNDER THIS AGREEMENT FOR THE EQUIPMENT AND/OR SERVICES, AND LESSOR SHALL HAVE NO LIABILITY TO LESSEE OR ANY THIRD-PARTY FOR ANY INDIRECT, SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES WHETHER BASED ON CONTRACT, TORT (INCLUDING NEGLIGENCE), STRICT LIABILITY OR OTHERWISE.**

13. **EVENTS OF DEFAULT; REMEDIES.** Each of the following shall constitute an "Event of Default": (1) failure by Lessee to make any payment within ten (10) days after its due date; (2) failure by Lessee to perform any other obligation under this Agreement, and the continuance of such default for ten (10) days after written notice thereof by Lessor to Lessee; (3) any material misrepresentation or false statement of fact by Lessee; (4) the loss, theft, damage, destruction or the attempted sale or encumbrance by Lessee of any of the Equipment; or (5) Lessee's dissolution, termination of existence, discontinuance of business, insolvency, or the commencement of any bankruptcy proceedings by or against, Lessee. Lessee acknowledges that any Event of Default will substantially impair the lease value of the Equipment hereof. Upon the occurrence of any Event of Default, Lessor may, without notice, exercise one or more of the following remedies: (1) declare all unpaid payments under this Agreement to be immediately due and payable; (2) terminate this Agreement as to any or all items of the Equipment; (3) take possession of the Equipment wherever found, and for this purpose enter upon any premises of Lessee and remove the Equipment, without any liability to Lessee; (4) direct Lessee at its expense to promptly prepare the Equipment for pickup by Lessor; (5) proceed by appropriate action either in law or in equity to enforce performance by Lessee of the terms of this Agreement or to recover damages for the breach hereof, including attorneys' fees and any other expenses paid or incurred by Lessor in connection with the repossession of the Equipment; (6) apply the security deposit specified in this Agreement ("Security Deposit") to payment of Lessor's costs, expenses and attorney fees in enforcing the terms of this Agreement and to indemnify Lessor against any damages sustained by Lessor; and/or (7) recover the replacement cost of any Equipment which Lessor is unable to repossess.. Lessor's waiver of any Event of Default shall not constitute a waiver of any other Event of Default or of any term or condition of this Agreement. No right or remedy referred to herein is intended to be exclusive and each may be exercised concurrently or separately and from time to time. In the event of repossession, Lessee waives any bond posting requirement.

Lease Terms and Conditions, Rev. 07/01/2022

Mobile Modular Management Corporation
5700 Las Positas Rd
Livermore, CA 94551
925-606-9000
www.mgrc.com

Lease Quotation and Agreement	
Quote #	Q-452779
Date of Quote	12/18/2023
Quote Expiration Date:	
Lease Term:	36 Months
Lessee PO#:	

DAMAGE AND DESTRUCTION WAIVER

This Damage and Destruction Waiver is an agreement between Bogard Construction ("Lessee") and Mobile Modular Management Corporation, a division of McGrath RentCorp ("Lessor"), dated as of 12/18/2023 (the "Waiver"). This Waiver is hereby incorporated into and made a part of Lease Quotation and Agreement number Q-452779 (the "Lease Agreement").

Lessee and Lessor agree as follows:

Section 1. Defined Terms.

All terms that are capitalized in this Waiver shall have the meanings ascribed to such terms in the Lease Agreement unless otherwise defined in this Waiver.

Section 2. Modification to Lease Terms and Conditions (Attachment A).

This Waiver relates to and modifies certain provisions of the Lease Terms and Conditions (the "Lease Agreement") under which Lessee is leasing certain modular building(s) from Lessor (the "Equipment").

Section 3. Waiver.

(a) For and in consideration of the payment of a fee described in Section 4 (the "Waiver Fee"), and subject to payment of any applicable deductible as required in Section 5, and the limitations on coverage in Section 6, (i) Lessee is relieved of any obligation or liability for any loss or damage to the Equipment as required by Section 7 of the Lease Agreement, in the event of loss or damage to the Equipment by any of the causes in Section 3(b) and (ii) Lessee is relieved from the duty to maintain certain insurance insuri ng for loss, damage or destruction of the Equipment ("Property Insurance") as required by Section 8 of the Lease Agreement.

(b) Subject to the provisions of Section 3(a), this Waiver relieves Lessee of any obligation or liability for loss or damage to the Equipment in the event the Equipment is damaged by any of the following causes:

i. Fire and smoke damage
ii. Lightning
iii. Windstorm/Tornado
iv. Flood
v. Hail
vi. Earthquake
vii. Explosions
viii. Collision with a vehicle

Section 4. Waiver Fee.

(a) The Waiver Fee specified in the Lease Agreement shall be payable monthly during each month of the Lease Term and any extensions thereof.

(b) This Waiver is effective upon payment of the Waiver Fee.

(c) The failure to make payment of the Waiver Fee each month shall cause this Waiver to be terminated immediately as of the date that such Waiver Fee was payable without further action or notice by Lessor ("Waiver Termination").

(d) In the event of a Waiver Termination, the obligations of the Lessee pursuant to Sections 10 and 11 of the Lease Agreement shall be immediately reinstated and applicable. Within five (5) days of such reinstatement of Section 11, Lessee shall provide proof of Property Insurance in which Lessee is named as an additional insured.

Section 5. Deductible.

Lessee shall pay a deductible on any damage to the Equipment per occurrence ("Deductible"). The applicable deductible amount shall be as set forth in the table below, based on the Estimated Insurance Value of the Equipment specified in the Lease Agreement. Provided that the cause of the damage to the Equipment results from a cause listed in Section 3(b) of the Waiver, Lessee shall not be liable for damage to the Equipment beyond the Deductible.

Estimated Insurance Value	Deductible
Less than $50,000.00	$2,500.00
Between $50,001.00 and $100,000.00	$5,000.00
Between $100,001.00 and $250,000.00	$10,000.00

Above $250,000.00	$50,000.00

0

Section 6. Limitations on Waiver.

Notwithstanding the waiver for losses and damages enumerated in Section 3 of this Waiver, Lessee shall be liable for loss or damage to the Equipment as follows:

(a) damage caused by the gross negligence or intentional acts of Lessee or its agents and employees;
(b) damage to Equipment that is located within 15 miles of an ocean, gulf or bay, due to windstorms and floods, including but not limited to hurricanes;
(c) damage to Equipment caused by a windstorm, not including a tornado, resulting from Lessee failing to secure or tie down the Equipment as recommended by Lessor;
(d) damage to contents of the Equipment or any real or personal property attached to or adjacent to the Equipment;
(e) theft or disappearance of the Equipment;
(f) damages to the Equipment from Lessee's failure to limit or mitigate the continuation of damage to the Equipment;
(g) liability for death or injury to any person;
(h) damages for Lessee's unauthorized improvements or modifications or additions to the Equipment;
(i) damages from graffiti, or other paint contamination or paint damage by any means;
(j) damage to the Equipment caused by any condition or event not enumerated in Section 3(b) of this Waiver

Section 7. Liability Insurance.

This Waiver does not affect the obligation of Lessee to maintain General Liability insurance as specified in Section 8 of the Lease Agreement for any liability arising out of or relating to Lessee's Lease of the Equipment.

Section 8. Nature of Waiver.

This Waiver is not insurance. It is a contractual agreement that relieves Lessee from certain duties and liabilities upon the payment of the Waiver Fee. The Waiver does not extend to or relate to any damage or loss of property in, on or about the Equipment. The Waiver does not extend to any loss or damage to the Equipment caused by the intentional acts of Lessee. Lessee shall be responsible for and will pay to Lessor amounts equal to the loss or damage caused to or sustained by the Equipment as a result of the intentional acts of Lessee. The Waiver does not relieve or affect any liability that Lessee may have as a result of the use of the Equipment.

Section 9. Other Terms and Conditions of the Lease Agreement.

Except for the waiver of the provisions of Section 7 and Section 8 of the Lease Agreement, all other terms and conditions of the Lease Agreement remain in full force and effect and shall not be modified by this Waiver.

Section 10. Notice of Loss, Damage or Destruction of Equipment.

Lessee will promptly advise Lessor in writing of any loss, damage, or destruction of the Equipment. Such notice of loss must be made within one (1) business day of the day on which Lessee knows of or has reason to believe that the Equipment is the subject of any loss, damage or destruction.

Section 11. Termination of the Waiver.

Lessee and Lessor may each terminate this Waiver upon thirty (30) days prior written notice. The Waiver may also be terminated by Lessor upon the default of Lessee to pay the required Waiver Payment as provided by Section 2(b) and 2(c) of this Waiver.

Section 12. Counterparts.

This Waiver may be executed in two (2) or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Counterparts may be delivered via facsimile, electronic mail (including pdf or with any electronic signature complying with the U.S. federal ESIGN Act of 2000, (e.g. execution of this Waiver may be through an e-sign service www.docusign.com) or other transmission method and any counterpart so delivered shall be deemed to have been duly and validly delivered and be valid and effective for all purposes.

Mobile Modular Management Corporation
5700 Las Positas Rd
Livermore, CA 94551
925-606-9000
www.mgrc.com

Lease Quotation and Agreement	
Quote #	Q-452779
Date of Quote	12/18/2023
Quote Expiration Date:	
Lease Term:	36 Months
Lessee PO#:	

This Waiver is executed as of the day and year first above written.

LESSOR:
Mobile Modular Management Corporation
a Division of McGrath RentCorp

LESSEE:
Bogard Construction

Signature: _____ Signature: _____

Name: _____ Name: _____

Title: _____ Title: _____

Date: _____ Date: _____

SVHMC ED Modular RFP Justification

The Salinas Valley Health construction team reached out to 3 vendors to seek their support with the development of a modular structure to offset the tent space and surgical waiting room currently utilized to support the emergency department volume.

Company 1: Scotsman – Based out of state and was unable to provide us with a workable and compliant option.

Company 2: Did not respond to requests for proposal

Company 3: Mobile Modular – California based company chosen based on their ability to meet our needs.

Company 3: Forts-Fold out shelters – The modular this vendor would supply did not meet the HCAI standards required for our purposes.

TRANSFORMATION, STRATEGIC PLANNING AND GOVERNANCE COMMITTEE

Minutes of the
Transformation, Strategic Planning,
and Governance Committee
will be distributed at the Board Meeting

(ROLANDO CABRERA, MD)

Salinas Valley HEALTH

Medical Executive Committee Summary – July 11, 2024

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Erickson, Jay MD	Neurology	Medicine	Tele-Neurology
Garcia, Erika, MD	Family Medicine	Family Medicine	Adult Family Medicine Family Medicine Pediatric & Well Newborn. Family Medicine Category I Obstetrics Salinas Valley Health Taylor Farms Family Health & Wellness Center (TFFHWC)
Gootnick, Susan, MD	Radiology	Surgery	Remote Radiology Salinas Valley Health Advanced Imaging-Non-Cardiac Diagnostic Radiology
Jackson, Amanda, MD	Pediatrics	Pediatrics	Salinas Valley Health Taylor Farms Family Health & Wellness Center
Jafery, Syed, MD	Radiology	Surgery	Remote Radiology Salinas Valley Health Advanced Imaging-Non-Cardiac Diagnostic Radiology
Kerwin, Lewis, MD	Psychiatry	Medicine	Tele-Psychiatry
Korenis, Panagiota, MD	Psychiatry	Medicine	Tele-Psychiatry
Kramer, Erik, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Kulik, Tobias, MD	Neurology	Medicine	Tele-Neurology
Mahendrarajah, Sulahshan, MD	Neurology	Medicine	Tele-Neurology
Morvarid, Babak, MD	Neurology	Medicine	Tele-Neurology
Parsons, David, MD	Gastroenterology	Medicine	Gastroenterology
Rainville, Christopher, MD	Psychiatry	Medicine	Tele-Psychiatry
Sachar, Pawani, MD	Neurology	Medicine	Tele-Neurology
Sangha, Maheep, MD	Gastroenterology	Medicine	Gastroenterology
Tanoura, Tad, MD	Radiology	Surgery	Remote Radiology Salinas Valley Health Advanced Imaging-Non-Cardiac Diagnostic Radiology
Zolyan, Anna, MD	Neurology	Medicine	Tele-Neurology

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Capron, Kelsey, MD	Family Medicine	Family Medicine	Family Medicine Adult, Pediatrics & Well Newborn Family Medicine Category 1 & II Obstetrics

Chamsuddin, Abbas MD	Radiology	Surgery	Remote Radiology Salinas Valley Health Advanced Imaging- Non-Cardiac Diagnostic Radiology
Chung, Natalie, MD	Ophthalmology	Surgery	Ophthalmology
Falkoff, Gary, MD	Radiology	Surgery	Radiology
Moulton, Kimberly, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Mrelashville, Davit, MD	Neurology	Medicine	Tele-Neurology
Mukai, Kanae MD	Cardiology	Medicine	Cardiology Salinas Valley Health Advanced Imaging – Cardiac Imaging Salinas Valley Health Cardiovascular Diagnostics Cardiac Diagnostics
Nakao, Zachary, DO	Emergency Medicine	Emergency Medicine	Emergency Medicine:
Page, Jon, MD	Ophthalmology	Surgery	Ophthalmology
Patel, Vikram, MD	Gastroenterology	Medicine	Gastroenterology
Poudel, Mahendra, MD	Infectious Disease	Medicine	Infectious Disease
Sanghi, Amit, DO	Radiology	Surgery	Remote Radiology Salinas Valley Health Advanced Imaging- Non-Cardiac Diagnostic Radiology
Stehmeier, Ian, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Sunde, Douglas, MD	Plastic Surgery	Surgery	Surgery – Active Community
Tammany, Alison, MD	General Surgery	Surgery	General and Colorectal Surgery General Surgery and Colorectal Robotic Surgery
Uchtmann, Nathaniel, MD	Internal Medicine	Medicine	Hospitalist- Adult
Wong, William Wai-Yip, MD	Anesthesiology	Anesthesiology	Anesthesiology

Modification of Privileges:

NAME	SPECIALTY	PRIVILEGE	RECOMMENDATION
Becerra, Maura, MD	Family Medicine	TFFH&WC	Temporary privileges effective 7/1/2024 while awaiting Board approval.
Rangel Ventura, Francis, MD	Family Medicine	TFFH&WC	Temporary privileges effective 7/1/2024 while awaiting Board approval.

Staff Status Modifications:

NAME	SPECIALTY	STATUS	RECOMMENDATION
Adams, Rebecca, MD	Family Medicine-Hospitalist	Provisional	Advance Active Staff
De Guzman, Liane, DO	Family Medicine-Hospitalist	Provisional	Provisional requirements including FPPE/Proctoring for Adult Hospitalist privileges have been met. Recommend advancement to Active Staff.
Dickey, James W., MD	General Surgery	Leave of Absence	Return from Leave of Absence effective 7/15/2024 pending Board approval
Fauconier, Ian, MD	Urology	Provisional	Advance Active Staff
Lee, Elaine, DO	Family Medicine-Hospitalist	Provisional	Advance Active Staff
Lee, Sherry, DO	Pediatrics	Leave of Absence	Return from Leave of Absence effective 7/22/2024 pending Board approval

Silva, Natali, MD	Family Medicine-Hospitalist	Provisional	Provisional requirements including FPPE/Proctoring for Adult Hospitalist privileges have been met. Recommend advancement to Active Staff.
Al-Hariri, Amr, MD	Neurology	Telemedicine	Resignation effective 6/20/2024
Black, Evan, MD	Neurology	Telemedicine	Resignation effective 6/23/2024
Flores, Mario, DO	Internal Medicine	Active	Resignation effective 7/20/2024
Hoke, Eileen, MD	Neonatologist	Active	Resignation effective 7/31/2024
McCorvey, V. Monique	Radiology	Provisional	Resignation effective 7/28/2024
Moussaoui, Asma, MD	Neurology	Telemedicine	Resignation effective 6/27/2024
Sandhu, Surinder, MD	Internal Medicine	Provisional	Resignation effective 6/4/2024
Tait, Lauren, MD	Radiation Oncology	Consulting	Resignation effective 7/31/2024

Other Items: (Attached)

ITEM	RECOMMENDATION
Anesthesiology Clinical Privileges Delineation Revision	Approve revisions to Reappointment Criteria
Robotic Surgery Clinical Privileges Delineation Revision	Approve addition of privileges for new Robots.

Interdisciplinary Practice Committee

Applicants:

APPLICANT	PRIVILEGES	DEPT	SUPERVISING PHYSICIAN(S)
Calero Bellorin, Eyda, NP	Nurse Practitioner TFFHWC	Family Medicine	Guadalupe Arreola, MD Miguel Dorantes, MD

Reappointments:

APPLICANT	PRIVILEGES	DEPT	SUPERVISING PHYSICIAN(S)
De La Cruz, Cindy, FNP	Nurse Practitioner	Medicine	Jeffrey Fiorenza, MD Richard Hell, MD
Wharram, Jennifer, PA-C	Physician Assistant	Medicine	Hong Zhao, MD Shehzad Aziz, MD Yang Liu, MD

Other Items: (Attached)

Abdominal Pain Nursing Standardized Procedure	Recommend approval
HCG Recheck Nursing Standardize Procedure	Recommend approval
Intraosseous Infusion Nursing Standardized Procedure	Recommend approval
Nausea and Vomiting Nursing Standardized Procedure	Recommend approval
SEPSIS Management Nursing Standardized Procedure	Recommend approval
Urinary Tract Infection Nursing Standardized Procedure	Recommend approval
Vaginal Bleeding Nursing Standardized Procedure	Recommend approval
APP Rules and Regulations	Recommend approval
CRNA Clinical Privilege Delineation - New	Recommend approval

Policies/Plans and Privilege Forms Recommended for Approval: (Attached)

1. Care of the Patient with an IRRAflow Irrigation Catheter
2. Medical Cannabis for the Terminally Ill Patient
3. Medication Use
4. Restraints

Informational Items:

I. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Medical Staff Excellence Committee
d. Quality and Safety Committee Reports:
   - Emergency Department
   - Health Information Management
   - Marketing and Communications
   - Case Management/Social Work
   - Education Department
   - Clinical Informatics
   - Human Resources
   - Mammography
   - Radiology/Nuclear Medicine

II. Order Sets Approved:

1	Temperature Goal
2	IRRA Flow/Device
3	Lab Utilization Order Sets
4	Anesthesia Local Block
5	Hypertriglyceridemia Protocol
6	Neonatal TPN Order Set
7	OM Joint Fluid
8	OM Diarrhea
9	OM CAP
10	OM STD Lab Panel
11	OM Vaginitis/Cervicitis Panel
12	OM Arthrocentesis
13	LAB Pleural Fluid
14	OM Lumbar Puncture
15	OM Hepatitis Lab Panel
16	OM Bone Marrow Lab Panel
17	Comfort Care

III. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings
c. Medical Staff Treasury Report July 3, 2024
d. Medical Staff Statistics Year to Date
e. Health Information Management (HIM) Update
f. Budget/Financial Update
g. HCAHPS Update July 2, 2024

Clinical Privileges Delineation
Anesthesiology

Applicant Name: _____

Qualifications:

To be eligible to apply for core privileges in anesthesiology, the applicant must meet the following qualifications:

1. Current certification or active participation in the examination process leading to certification in anesthesiology by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology.

OR

2. Successful completion of an ACGME or AOA accredited post-graduate training program in anesthesiology.

AND

Documentation of the provision of 400 hospital/surgery center anesthesiology cases performed within the past 24 months or demonstrate successful participation in a hospital-affiliated formalized residency or special clinical fellowship.

New applicants will be ~~requested~~ required to provide documentation of the number and types of hospital/surgery center cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

General Privilege Statement

Clinically privileged individuals who have been determined to meet criteria within their practice specialty are permitted to admit, evaluate, diagnose, treat and provide consultation independent of patient age, and where applicable, provide surgical and therapeutic treatment within the scope of those clinical privileges and to perform other procedures that are extensions of those same techniques and skills. In the event of an emergency, any credentialed individual is permitted to do everything reasonably possible regardless of department, staff status or clinical privileges, to save the life of a patient or to save a patient from serious harm as is outlined in the Medical Staff Bylaws.

General Anesthesiology core privileges

Management of patients, rendered unconscious or insensible to pain and emotional stress during surgical, obstetrical and certain other medical procedures; including preoperative, intraoperative and postoperative evaluation and treatment; the support of life functions and vital organs under the stress of anesthetic, surgical and other medical procedures; medical management and consultation in pain management; direct resuscitation in the care of patients with cardiac or respiratory emergencies, including the need for artificial ventilation, pulmonary care, and supervision of patients in post-anesthesia care units.

Core Proctoring Requirements:

Core proctoring requirements include direct observation or concurrent and/or retrospective review as per proctoring policy contained in the Medical Staff General Rules and Regulations.

Reappointment Criteria for Core Privileges:

Applicant must provide ~~reasonable evidence~~documentation of current ability to perform requested privileges; those physicians who have fewer than 150 patient ~~contacts~~ cases per year in the hospital/surgery center, and cannot provide documentation of current competence from another facility~~, will have all of their in-house patient contacts reviewed by the department wherein they are granted privileges until such time as current competence is affirmed.~~will not qualify for reappointment.

Special Procedures/Privileges

Qualifications: To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth below.

Proctoring of Special Procedure Privileges: These special procedure-proctoring requirements must be met in addition to the core proctoring requirements described on page one of this privilege form.

Applicant: Place a check mark in the (R) column for each privilege requested. New applicants must provide documentation of the number and types of hospital cases during the past 24 months.

(R)=Requested **(A)**=Recommended as Requested **(C)**=Recommended w/Conditions **(N)**=Not Recommended

Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Comprehensive Pain Management	Additional residency or fellowship program in pain management **OR** subspecialty certification for Pain Management (PM), eligibility for participation in the examination process for PM **OR** documentation of equivalent experience **OR** Core privileges plus documentation of current training and/or experience in the management of chronic pain	1 case	Five (5) cases within the past 24 months

(R)=Requested (A)=Recommended as Requested (C)=Recommended w/Conditions (N)=Not Recommended

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				TEE-Basic	1. Documentation of inclusion in Residency or Fellowship training completed within the past 24 months **OR** 2. Completion of a 20-hour didactic TEE course within the past 24 months. **Previous Experience** Documentation of 20 TEEs performed hands-on within the past 24 months	Option 1: 1 Case Option 2: 5 cases 1 case	5 TEE cases within the past 24 months
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	None	Current California State X-Ray S&O Fluoroscopy Certification

Salinas Valley Health Medical Center - Department of Anesthesiology

Definition - Comprehensive Pain Management: Comprehensive management of acute, chronic and/or cancer pain utilizing a broad range of peripheral nerve block procedures, epidural and subarachnoid injections, joint and bursal sac injections, cryotherapeutic techniques, epidural, subarachnoid, or peripheral neurolysis, electrical stimulation techniques, implanted epidural and intrathecal catheters, ports, and infusion pumps; acupuncture and acupressure, hypnosis, stress management, and relaxation techniques, trigeminal ganglionectomy, peripheral neurectomy and neurolysis, sympathectomy techniques, alternative pain therapies and management of local anesthetic overdose including airway management and resuscitation; management of therapies, side effects and complications of pharmacologic agents used in pain management.

Core Procedure List for Anesthesiology: The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Chief Medical Officer and/or the Chief of Staff.

1. Airway management
2. Anesthesia for laser surgery of the airway
3. Arterial and central venous cannulation
4. Cardiac anesthesia
5. Central neuraxial blockade (spinal, epidural)
6. Diagnostic and therapeutic management of acute and chronic pain
7. General anesthesia including invasive monitoring; respiratory therapy, including long-term ventilatory support; and airway management, including cricothyroidotomy
8. Intravenous conscious sedation
9. Local and regional anesthesia with and without sedation, including topical, and infiltration, minor and major nerve blocks. intravenous blocks, spinal, epidural, and major plexus blocks
10. Management of common intraoperative problems
11. Management of common PACU problems
12. Management of acute perioperative pain
13. Management of fluid, electrolyte. and metabolic parameters
14. Management of hypovolemia from any cause
15. Management of malignant hyperthermia
16. Manipulation of body temperature
17. Manipulation of cardiovascular parameters
18. Obstetric anesthesia
19. Peripheral nerve block
20. Preoperative evaluation/anesthetic
21. Pulmonary artery catheter insertion and management consultation
22. Resuscitation of patients of all ages
23. Sedation/monitored anesthetic care
24. Sedation and analgesia
26. Single lung anesthesia

Applicant: Complete this section only if you do not wish to apply for any of the specific core procedures listed above:

Please indicate any privilege on this list you would like to ***delete or change*** by writing them in the space provided below. Requests for deletions or changes will be reviewed and considered by the Department Chair, Credentials Committee and Medical Executive Committee. Deletion of any specific core procedure does not preclude mandatory requirement for Emergency Room call.

_____ _____

_____ _____

_____ _____

Signature: Date:

Acknowledgment of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Health Medical Center. I further submit that I have no health problems that could affect my ability to perform the privileges I am request. I also understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation,

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Applicant Signature Date

*****Department Chair's Recommendation*****

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend all requested privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
4.	
Notes:	

Department Chair Signature Date

Salinas Valley HEALTH

Clinical Privileges Delineation
Robotic Surgery
Primary Surgeon

Definition:

~~Computerized~~ Robotic assisted surgery using advanced technology coupled with high resolution imaging to remotely control surgical arms. Surgical intervention is accomplished by manipulation of the device under 3-D imaging which reproduces motions that affect patient tissue.

Approved Specialties (check those being requested)

- ☐ Cardiovascular Surgery
- ☐ Colon and Rectal Surgery
- ☐ General Surgery
- ☐ Gynecology
- ☐ Orthopedic Surgery
- ☐ Otolaryngology
- ☐ Thoracic Surgery
- ☐ Urogynecology
- ☐ Urology

Robot Type (check those being requested)

- ☐ daVinci ☐
- ROSA
  - ☐ Knee
  - Other (please specify): _____
- Mako
  - ☐ Partial Knee
  - ☐ Total Knee
  - ☐ Total Hip

Other (please specify):

_____

Initial Appointment Criteria for Primary Surgeon:

Current unrestricted privileges in one of the approved specialties at Salinas Valley Health Medical Center.

Experienced Non Residency/Fellowship Trained Applicants

Documentation of current privileges to perform both open and laparoscopic or endoscopic surgery

AND

Documentation of successful completion of the ~~"Intuitive"~~manufacurer's training course ~~(A hands-on training practicum in the use of the daVinci Surgical Platform of at least eight (8) hours duration with experience in a laboratory setting which included a minimum of three (3) hours of personal time on the system using animal or cadaver models.)~~

AND

Documentation of the successful proctoring of two cases conducted by a certified ~~"Intuitive"~~ proctor at the institution where cases were performed

AND

Documentation of the successful completion of twenty (20) cases as primary operator for robotic surgery within the past two (2) years.

Experienced Residency/Fellowship Trained Applicants

Documentation of appropriate training from their Residency/Fellowship program director
AND
Documentation of the successful completion of twenty (20) cases as primary operator for robotic surgery during training

Newly Trained Applicants

Documentation of current privileges to perform both open and laparoscopic or endoscopic surgery
AND
Documentation of successful completion of the ~~"Intuitive"~~manufacturer's training course ~~(A hands-on training practicum in the use of the daVinci Surgical Platform of at least eight (8) hours duration with experience in a laboratory setting which included a minimum of three (3) hours of personal time on the system using animal or cadaver models.)~~
AND
Documentation of the successful proctoring of two cases conducted by a certified ~~"Intuitive"~~ proctor at the institution where cases were performed.

For a newly trained robotic surgeon, the first three cases must be proctored by an Expert Proctor ~~from Intuitive Surgical, Inc~~provided by the manufacturer. The proctor will be approved by the Chair of the applicant's Department prior to scheduling. The need for additional proctoring, if any, to be recommended by the proctor or corresponding Department Chair.

Reappointment Criteria:
Documentation of the successful completion of at least twenty (20) robotic procedures during the past 24 months.

Proctoring: All applicants will be required to have the first three (3) cases proctored regardless of experience. It is the responsibility of the applicant to arrange proctorship by another practitioner within the primary practicing specialty. Written documentation must be received from the proctor stating requirements have been met and proctored surgeon is competent to perform the requested robotic assisted procedures before full privileges are granted.

Proctor Qualifications: Proctoring physician must practice in the primary specialty and have minimum experience of twenty (20) cases as a primary surgeon.

Proctor Expectations: Proctor must be present in the OR for positioning and procedure. Completion of proctoring form based on objective assessment of physician skills and insuring proctor form is forwarded to the Medical Staff Services Department.

Performance Review:
Outcomes for each surgeon will be monitored and reviewed on an ongoing process. These include but are not limited to: OR time, blood loss, conversion to open, complications, length of stay.

Acknowledgment of applicant:

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Health Medical Center. I further submit that I have no health problems that could affect my ability to perform the privileges I am request. I also understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation,

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Applicant Signature _____ Date _____

*****Department Chair's Recommendation*****

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend requested privileges
☐ Recommend requested privileges with the following conditions/modifications:
☐ Do not recommend the requested privileges for the following reasons:

Department Chair Signature _____ Date _____

Status **Pending** PolicyStat ID **14740336**

Last Approved	N/A	Owner	David Thompson: Clinical Manager
Next Review	3 years after approval	Area	Nursing Standardized Procedures

Abdominal Pain Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. CBC : Complete Blood Count

B. CMP: Comprehensive Metabolic Panel

C. HCG: Quantitative Serum Pregnancy Test

D. Draw Extra: Extra serum tubes collected in anticipation of blood test being added on at a later time.

E. ED: Emergency Department

F. INT: Intravenous Therapy (saline lock) with intermittent flushes

G. UA: Urinalysis

H. ODT: Oral Disintegrating Tablet

III. PROCEDURE

A. Function

- To expedite care for patients who present to the Emergency Department with a chief complaint of abdominal pain

B. Circumstances

- Setting

1. Registered nurses in the ED may order the following labs:

a. For patient's eighteen (18) years of age and over with a complaint of abdominal pain order: CBC, CMP, POC I-stats as

needed, serum HCG (non-menopause females only), Lipase, DRAW EXTRA, UA and culture if needed, Zofran 4 mg ODT (oral disintegrating tablet) X1 dose may be given.

b. For patient's ten (10) years of age to eighteen (18) years of age Zofran 4 mg ODT (oral disintegrating tablet) X1 dose may be given if continuing to feel sick. UA and culture if needed.

c. For patient's less than ten (10) years of age follow the age and weight based Zofran protocol:

    i. One (1) year to ten (10) years: 0.1mg/kg liquid PO max 4 mg x1. If weight based dose is 4 mg can give the ODT instead. For patients, only if continuing to vomit. On patients over three (3) years of age and older obtain UA and culture if needed.

d. If patient 40 years of age or older and complaining of epigastric/ upper abdominal pain, TROPONIN should be ordered and an EKG done

e. Place INT if vital signs unstable, persistent vomiting, sever pain/ distress and concern of life threating condition

- Supervision

1. Registered Nurses who are qualified to perform this standardized procedure may independently order blood work on patients who present with a chief complaint of abdominal pain, and for whom meet the criteria above. Physician supervision is not required.

- Patient Conditions

1. Emergency Department patients who meet the following criteria:

    a. If the patient has not been seen in the ED within the previous 24 hours for the same complaint and/or the need for blood testing and IV therapy is questionable/concerning.

    b. Chief complaint of abdominal pain

    c. Patients not signed up by a physician or will not see within 30 min or a timely manner

C. Database

- Subjective:

1. Prioritization and Severity of Illness

    a. Patients eighteen years of age and older with the chief complaint of abdominal pain will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating other medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see TRIAGE ASSESSMENT)

b. History of present illness/injury/chief complaint
c. Have patient point with one finger to most painful location
d. Consider conditions related to gastrointestinal, genitourinary, or reproductive systems.
    i. Female: determine last normal menstrual period
    ii. Male: assess for possible testicular torsion.
e. History of abdominal surgeries/illnesses
f. History of diarrhea, constipation, nausea, or vomiting
g. Pain description

- Objective:
    1. Chief complaint of abdominal pain
        a. Signs of hypovolemia
        b. Signs of peritoneal irritation
        c. Inability to ambulate or sit
        d. Color of skin/sclera
        e. Odors
        f. Objective signs of pain

D. Diagnosis
- Abdominal pain

E. Plan
- Treatment
    1. If the ED physician is not signed up or will see the patient within 30 min or a timely manner the order set should be placed under 'Physician, Emergency'
    2. The blood and urine specimens must be labeled accurately with the patient's name and account number. The accuracy of the label must be verified by using the hospital approved patient identification process (see PATIENT IDENTIFICATION POLICY). The labeling of specimens must occur AT THE PATIENT'S BEDSIDE. (see PATIENT IDENTIFICATION POLICY)
    3. Specimens collected by the ED nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hazard specimen bag
    4. Specimens collected in the ED will be handed to a phlebotomist or transported in person or by the pneumatic tube system to the lab.
- Patient conditions requiring consultation/reportable conditions
    1. **Immediately notify an Emergency Department physician of the following:**

a. Changes in airway, breathing, circulation or altered level of consciousness.

b. Change in triage acuity.

Note: if the patient appears unstable and/or a life threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY Conditions requiring immediate treatment include: Expanding or acute aortic abdominal aneurysm, suspected mesenteric ischemia, Ruptured appendix/peritonitis, ruptured ectopic, ovarian/ tsticular torsion, incarcerated hernia, DKA, severe pain or severe dehydration or c/o ACS.

- Education - Patient/Family
    1. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy
- Follow Up
    1. As needed to maintain continuity of care
- Documentation of Patient Treatment
    1. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.
    2. The ED RN initiating the standardized procedure will document the following: "CBC, CMP, LIPASE, DRAW EXTRA, UA, HCG Qualitative, urine HCG (if appropriate) ordered per "standardized procedure" in the patient record. EKG and TROPONIN if over forty (40) years of age with upper abdominal pain.
    3. Enters "supervising ED physician as ordering provider per policy.
    4. Navigates to ER Nursing Orders.
    5. Selects "ABD Pain-Standardized Procedure" order set.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education and Training

- The RN completes an initial review of the Standardized Procedure with an evaluation of knowledge.

B. Experience

- Current California RN license and designated to work in ED

C. Evaluation

- Initial: at 3 months, 6 months, and 12 months by the nurse manager through

feedback from colleagues, physicians, and chart review during performance period being evaluated.

- Routine: annually after the first year by the nurse manager through feedback from colleagues, physicians and chart review.
- Follow up: areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.
- Demonstrates knowledge of procedure through clinical performance.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method

- Policy goes through the Emergency Department Physician Group every three (3) years.
- Policy goes through the interdepartmental policy committee (IDPC) upon creation of policy and when changes are made.
- Chief Nursing Officer (Vice President of Patient Care Services) upon creation of policy and with significant changes.

B. Review schedule

- Review of policy occurs every three (3) years

C. Signatures of authorized personnel approving the standardized procedure and dates:

- Approval of the standardized procedure is outlined in the electronic policy and procedure system.
    1. Director of Emergency Department, Medical Director of Emergency Department, Chair of Interdisciplinary Practice Committee, and Chief Nursing Officer.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department and available upon request.

VII. REFERENCES

A. Board of Registered Nursing, Title 16, California Code of Regulations (CCR) Section 1474; Medical Board of California, Title 16 CCR, Section 1379.

B. Emergency Nurses Association: Emergency Nursing Core Curriculum (2007), 6th Edition- Emergency management involving assessment of the abdomen 47, 159-186

C. Marx, J., Hockberger, R.WS., & Walls, R. M. (Eds). (2002). Rosen's emergency medicine:

Concepts and clinical practice (5th ed). St Louis, MO: Mosby

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	07/2024
IDPC	Katherine DeSalvo: Director Medical Staff Services	06/2024
EM Dept.	Cristina Martinez: PHYSICIAN	06/2024
EM Dept.	David Thompson: Clinical Manager	06/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024
Policy Owner	David Thompson: Clinical Manager	05/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **15379801**

Last Approved	N/A	Owner	David Thompson: Clinical Manager
Next Review	3 years after approval	Area	Emergency Department

HCG Recheck Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Director of Nursing – Nursing Director responsible for a nursing unit or cluster of units.

B. ED: Emergency Department

C. HCG: Quantitative Serum Pregnancy Test

D. RN – Registered Nurse employed by SVHMC

E. SP – Standardized Procedure

III. PROCEDURE

A. Function(s)

1. To expedite care for patients who present to the Medical Emergency Department with a chief complaint of pregnancy recheck with continued bleeding.

B. Circumstances

1. Setting

a. Registered nurses in the Medical ED may order a pregnancy HCG for a chief complaint of HCG Recheck.

2. Supervision

a. Registered nurses who are qualified to perform this standardized procedure may independently order blood for a patients presenting with a complaint of HCG recheck and for whom meet the criteria. Physician supervision is not required.

3. Patient Conditions
    a. Medical Emergency Department patients who meet the following criteria:
        i. If the patient has been seen in the our ED within the previous 48-72 hours for the same complaint and/or the need for blood testing and IV therapy is questionable/concerning.
        ii. If patient has not been seen in our ED draw extra tubes and HCG
        iii. Chief complaint of HCG Recheck
        iv. If the ED Physician is not signed up or will see the patient within 30 min or a timely manner.

C. Database
    1. Subjective:
        a. Prioritization and Severity of Illness
            i. Patients with the chief complaint of HCG recheck will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating other medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see TRIAGE ASSESSMENT)
    2. Objective:
        a. Chief complaint of HCG Recheck
            i. Continued vaginal bleeding

D. Diagnosis
    1. HCG Recheck

E. Plan
    a. Treatment
        a. The order must be placed under the name 'Physician, Emergency'
        b. The blood and urine specimens must be labeled accurately with the patient's name and account number. at the patient's bedside. The accuracy of the label must be verified by using the hospital approved patient identification process (see PATIENT IDENTIFICATION POLICY).
        c. Specimens collected must be timed and initialed by the person drawing the specimen and placed in a bio-hazard specimen bag.
        d. Specimens collected will be handed to a phlebotomist or transported in person or by the pneumatic tube system to the lab.

    b. Patient conditions requiring consultation/reportable conditions:
        a. Immediately notify an Emergency Department physician of the following:
            i. Changes in airway, breathing, circulation or altered level of consciousness.

ii. Change in triage acuity.

iii. **NOTE**: If the patient appears unstable and/or a live threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY. Conditions requiring immediate treatment include: Ruptured appendix/peritonitis, ruptured Ectopic, ovarian syst rupture/torsion, severe pain, sever dehydration.

c. Education-Patient/Family

    a. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy

d. Follow-up

    a. As needed to maintain continuity of care

e. Documentation of Patient Treatment

    a. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.

    b. The ED RN initiating the standardized procedure will document the following: "HCG Quantitative"

    c. Enters 'Physician, Emergency' as ordering provider per policy.

    d. Navigates to ED Nursing Orders

    e. Selects "HCG ReCheck" order set

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education

    1. In accordance with the SVHMC RN job description

B. Training

    1. The RN completes an initial review of the Standardized Procedure with an evaluation of knowledge during the orientation period,

C. Experience

    1. In accordance with the established SVHMC job description and designated to work in the medical ED.

D. Evaluation

    1. Initial: During the initial orientation process RNs are educated to this SP and complete a review with their preceptor. This is documented on the Department Specific Orientation Checklist and maintained in the office of the Director of Nursing. The RN is required to implement this SP two (2) times prior to be deemed competent.

2. Ongoing: At least every 3 years competency will be re-assessed via annual skills assessment.
3. During the annual RN performance appraisal process any areas of this SP not meeting requirements will be reviewed with the RN and a plan will be defined if necessary,

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Review Schedule
    1. Every 3 years or when practice changes are made.

B. Approval
    1. The electronic policy and procedure system maintains tracking of initiation, review and approval of this SP including the Interdisciplinary Practice Committee, Medical Executive Committee and the Board of Directors.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. California Board of Registered Nursing
B. Title 16, California Code of Regulations Section 1474
C. Medical Board of California. Title 16, Code of Regulations Section 1379
D. Rooney, K., & Schilling, M. U. (2014). Point-of care testing in the overcrowded emergency department- Can it make a difference? *Critical Care*, 18:692. http:ccforum.com/content/18/6/692

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending

Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	07/2024
IDPC	Katherine DeSalvo: Director Medical Staff Services	07/2024
EM Dept.	Cristina Martinez: PHYSICIAN	07/2024
EM Dept.	David Thompson: Clinical Manager	06/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024
Policy Owner	David Thompson: Clinical Manager	06/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **15634818**

Last Approved	N/A	Owner	David Thompson: Clinical Manager
Next Review	3 years after approval	Area	Nursing Standardized Procedures

Intraosseous Infusion Standardized Procedure

I. POLICY

A. N/A

B. Circumstances:

- Setting:
  - A. Adult and pediatric patients where at least two attempts at IV access have been unsuccessful or it is determined that an IV attempt would be unsuccessful, and one of the following:
    - I. Cardiac arrest or impending arrest
    - II. Shock or evolving shock. This is a patient considered in Extremis.
  - B. Discuss placement of IO with Emergency Department Physician before insertion
- Supervision:
  - A. Intraosseous access and infusion may be performed in the emergency department by Registered Nurses who have successfully completed approved training within the past 12 months.
- Patient Condition:
  - A. Recent fracture of the involved bone.
  - B. Infection at the site selected for insertion
  - C. Inability to locate anatomical landmarks for insertion.
  - D. Those patients who have a patent IV or in whom an IV may be established in a timely manner.
  - E. Second attempt on the same bone.

- *Indications*

    A. Intraosseous access and infusion is approved for adult and pediatric patients.

    B. Intraosseous access and infusion will never be performed to establish prophylactic vascular access

    C. Intraosseous access and infusion is approved only in the proximal tibia for children. The patient must weigh 3kg or more in order to use the EZ-IO

    D. Intraosseous access and infusion is approved only in the proximal tibia and the proximal humerus for patients age 8 and older. Sternal placement is prohibited

Discuss placement of IO with Emergency Department Physician before insertion

- *Contraindications*

II. DEFINITIONS

A. Director of Nursing – Nursing Director responsible for a nursing unit or cluster of units.

B. Intraosseous access and infusion: provide an alternate means of vascular access when the IV route is not available or IV access attempts were unsuccessful and the patient would benefit from the timely administration of medications or fluids

C. In Extremis: A profound state where death appears imminent

D. EZ-IO- Type of Drill Intraosseous

E. RN – Registered Nurse employed by SVHMC

F. SP – Standardized Procedure

III. PROCEDURE

A. Functions:

1. Intraosseous access and infusion may be performed in the emergency department by Registered Nurses who have successfully completed approved training within the past 12 months

B. Circumstances:

1. Setting:

    a. Medical Emergency Department

2. Supervision:

    a. Registered Nurses who are qualified to perform this standardized procedure may do so, after consultation with physician.

3. Patient Condition:

    a. Adult and pediatric patients where at least two attempts at IV access have

been unsuccessful or it is determined that an IV attempt would be unsuccessful.

b. *Indications*

i. Intraosseous access and infusion will never be performed to establish prophylactic vascular access

ii. Intraosseous access and infusion is approved only in the proximal tibia for children.

iii. The patient must weigh 3kg or more in order to use the EZ-IO

iv. Intraosseous access and infusion is approved only in the proximal tibia and the proximal humerus for patients age 8 and older.

v. Sternal placement is prohibited

c. *Contraindications*

i. Recent fracture of the involved bone.

ii. Infection at the site selected for insertion

iii. Inability to locate anatomical landmarks for insertion.

iv. Those patients who have a patent IV or in whom an IV may be established in a timely manner.

v. Second attempt on the same bone.

C. Database

- Subjective

1. Assure that indications for use have been met.

a. At least two attempts at IV access have been unsuccessful or it is determined that an IV attempt would be unsuccessful, and one of the following:

i. Cardiac arrest or impending arrest

ii. Shock or evolving shock. This is the patient in extremis.

2. Assure that contra-indications for use are not present.

a. Recent fracture of the involved bone

b. Infection at the insertion site

c. Inability to locate anatomical landmarks for insertion

d. Patients who have a patent IV or in whom an IV may be established in a timely manner.

e. Second attempt in the same bone.

- Objective

1. Determine patient age and weight to select the appropriate IO insertion

device.

a. For a patient 3kg and under use a manual IO device

b. For a patient over 3kg and under 40kg and under age 8 use the Pediatric EZ-IO or manual device.

c. For a patient over age 8 or a weight over 40kg, use the Adult EZ-IO.

2. Approved insertion sites:

a. Proximal Tibia for pediatric patients. This is less than 8 year of age or less than 40kg.

b. Proximal Tibia or proximal humerus for adult patients. This is age 8 or older and 40kg or more.

D. Diagnosis:

a. Cardiac Arrest

b. Shock or evolving shock.

E. Plan

- Treatment

1. Process for Insertion

a. Use body substance isolation precautions

b. Obtain age/weight appropriate supplies

c. Rule out contra-indications

d. Locate appropriate insertion site

e. Prepare insertion site using aseptic technique

f. Prepare the Intraosseous device

g. Stabilize the site and insert the needle at a 90 degree angle to the bone

h. Remove the stylet for the catheter

i. Confirm placement of the catheters by flushing the catheter with 10cc normal saline

j. Consider the administration of Lidocaine 2% solution, 20 mg for the adult or 0.5mg/kg (up to 20mg) for the pediatric patient who is conscious and complains of pain.

k. Dress insertion site, stabilize and secure the catheter

- Patient conditions requiring consultation/reportable conditions:

a. Signs of infiltration of fluids

b. Redness or swelling at the site of insertion

c. Duration of access approaching 24 hours

- Education-Patient/Family
    a. Instruct patient or care provider to alert staff if site becomes painful or if the catheter becomes dislodged
    b. Necessity of intravenous therapy
- Follow-up
    a. As needed to maintain continuity of care
- Documentation of Patient Treatment
    a. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient response from the interventions

Record Keeping

- The facility will retain the patients' record according to the Record Retention procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education
    - In accordance with the SVHMC RN job description

B. Training
    - Clinical competency must be demonstrated and approved by supervising personnel or preceptor.

C. Experience
    - In accordance with the established SVHMC job description.

D. Evaluation
    - Initial: During the initial orientation process RNs are educated to this SP and complete a review with their preceptor. This is documented on the Department Specific Orientation Checklist and maintained in the office of the Director of Nursing. The RN is required to implement this SP two (2) times prior to be deemed competent.
    - Ongoing: At least every 3 years competency will be re-assessed via annual skills assessment.
    - During the annual RN performance appraisal process any areas of this SP not meeting requirements will be reviewed with the RN and a plan will be defined if necessary

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. eview Schedule

- Every 3 years or when practice changes are made.

B. Approval

1. The electronic policy and procedure system maintains tracking of initiation, review and approval of this SP including the Interdisciplinary Practice Committee, Medical Executive Committee and the Board of Directors.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. California Board of Registered Nursing,

B. Title 16, California Code of Regulations Section 1474

C. Medical Board of California. Title 16, Code of Regulations Section 1379

D. Maffei, Frank A. "Intraosseous Cannulation." Medscape, 11 October 2019, https://emedicine.medscape.com/article/908610-overview?form=fpf

E. "Vascular access, made versatile." (n.d.) Teleflex, https://www.teleflex.com/usa/en/product-areas/emergency-medicine/intraosseous-access/arrow-ez-io-system/use-and-application/index.html

F. Guenezan, J. Mimoz, O. Oriot, D. Petitpas, R. Scepi, M. Vendeuvre, T. "Use of intra-osseous access in adults: a systematic review." PubMed Central, 14 April 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4831096/

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending

Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	07/2024
IDPC	Katherine DeSalvo: Director Medical Staff Services	07/2024
EM Dept.	Cristina Martinez: PHYSICIAN	06/2024
EM Dept.	David Thompson: Clinical Manager	06/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024
Policy Owner	David Thompson: Clinical Manager	05/2024

Standards

No standards are associated with this document

Status Pending PolicyStat ID 15380356

Last Approved	N/A	Owner	David Thompson: Clinical Manager
Next Review	3 years after approval	Area	Emergency Department

Nausea and Vomiting Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. CBC: Complete Blood Count
B. CMP: Comprehensive Metabolic Panel
C. Director of Nursing: Nursing Director responsible for a nursing unit or cluster of units.
D. Draw Extra: Extra serum tubes collected in anticipation of blood test being added on at a later time.
E. ED: Emergency Department
F. HCG: Qualitative Serum Pregnancy Test
G. IV: Intravenous
H. ODT: Oral Disintegrating Tablet
I. POC: Point of Care
J. RN: Registered Nurse
K. UA: Urinalysis
L. EKG: Electrocardiogram
M. INT: Intravenous therapy (saline lock) with intermittent flushes

III. PROCEDURE

A. Function
    1. To expedite care for patients who present to the Emergency Department with a chief complaint of nausea and vomiting:

B. Circumstances

1. Setting

    a. Registered nurses in the ED may order the following labs for patient's eighteen (18) years of age and over with a complaint of nausea and vomiting: CBC, CMP, POC I-stats as needed, serum Qualitative HCG (non-menopause females only), Lipase, Draw EXTRA, UA and urine culture. If over forty (40) years of age, order an EKG and if having upper abdominal pain order a TROPONIN

    b. Registered nurses in the ED may order Zofran based on the following age and weight based protocol:

        i. One (1) year to ten (10) years: 0.1mg/kg liquid PO max 4 mg X1. If weight based dose is 4 mg can give the ODT instead. For patients, only if continuing to vomit.

        ii. Over ten (10) years old to adult: 4 mg ODT PO X1

2. Precautions:

    a. Cardiovascular:

        i. QT prolongation and Torsade De Pointes have been reported; monitoring recommended in patients with electrolyte abnormalities (eg., hypokalemia or hypomagnesemia), congestive heart failure, bradyarrhythmias, and concomitant use of QT prolonging medications.

    b. Gastrointestinal:

        i. Use caution following abdominal surgery or chemotherapy-induced nausea and vomiting as it may mask progressive ileus, gastric distension, or both

3. Contraindications:

    a. Cardiovascular:

        i. Congenital long QT syndrome: Do NOT ADMINISTER

        ii. Known allergy: DO NOT ADMINISTER

4. Supervision

    a. Registered nurses who are qualified to perform this standardized procedure may independently order blood work and initiate IV therapy to patients who present with a chief complaint of nausea and vomiting, and for whom meet the above criteria. Physician supervision is not required.

    b. Physician supervision is not required.

5. Patient Conditions

    a. Emergency Department patients who meet the following criteria:

        i. If the patient has not been seen in the ED within the previous 24 hours for the same complaint and/or the need for blood testing

and IV therapy is questionable/concerning.

ii. Patients one (1) year of age and over follow age and weight based Zofran protocol above.

iii. Chief complaint of nausea and vomiting

iv. Will not be seen by physician within 30 min or in a timely manner and a physician is not already signed up for them.

a. Change in triage acuity

C. Database

1. Subjective

a. Prioritization and Severity of Illness

i. Patients One (1) year of age and older with the chief complaint of nausea and vomiting will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating their medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see Triage Assessment)

ii. History of present illness/injury/chief complaint

iii. Have patient point with one finger to most painful location if applicable

iv. Consider conditions related to gastrointestinal, genitourinary, or reproductive systems.

a. Female: determine last normal menstrual period.

v. History of ingestions or poisoning

vi. Last meal eaten

vii. Fever

2. Objective

a. Chief complaint of nausea and vomiting

i. Signs of hypovolemia

ii. Signs of peritoneal irritation

iii. Inability to ambulate or sit

iv. Color of skin/sclera

v. Odors

vi. Objective signs of pain

D. Diagnosis

1. Nausea and Vomiting

E. Plan

1. Treatment

    a. The order must be placed under the name 'Physician, Emergency'

    b. The blood and urine specimens must be labeled accurately with the patient's name and account number, at the patient's bedside in accordance with the patient identification process (see PATIENT IDENTIFICATION POLICY).

    c. Specimens collected by the ED nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hzard specimen bag

    d. Specimens collected by the ED will be handed to a phlebotomist or transported in person or by the pneumatic tube system to the lab.

2. Patient conditions requiring consultation/reportable conditions:

    a. Immediately notify an Emergency Department physician of the following:

        i. Changes in airway, breathing, circulation or altered level of consciousness

        ii. Change in triage acuity

        iii. If the patient appears unstable and/or a life threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY. Conditions requiring immediate treatment include: Expanding or acute aortic abdominal aneurysm, suspected mesenteric ischemia, Ruptured appendix/peritonitis, ruptured ectopic, incarcerated hernia, severe dehydration, severe pain, and DKA.

3. Education-Patient/Family

    a. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy if applicable.

4. Follow-up

    a. As needed to maintain continuity of care

5. Documentation of Patient Treatment

    a. The order must be placed under the name of the supervising ED physician. If a different provider is later assigned to the patient, the orders will be transferred to the provider assigned.

    b. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.

    c. The ED RN initiating the standardized procedure will document the following: "CBC, CMP, LIPASE, DRAW EXTRA, UA, serum Qualitative HCG, urine HCG (if appropriate), IV and EKG if appropiate per "standardized procedure" in the patient record

d. Enters 'Physician, Emergency as ordering provider per policy
e. Navigates to ED Nursing Orders
f. Selects "Nausea and Vomiting" order set

6. Record Keeping
    a. The facility will retain the patients' record according to the Record Retention procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education
    1. The RN completes an intial review of the Standardized Procedure with an evaluation of knowledge

B. Training
    1. The RN completes an initial review of the Standardized Procedure with an evaluation of knowledge.

C. Experience
    1. Current California RN license and designated to work in the ED.

D. Evaluation
    1. Initial: During the initial orientation process RNs are educated to this Standardized Procedure and complete a review with their preceptor. This is documented on the Department Specific Orientation Checklist and maintained in the office of the Director of Nursing. The RN is required to implement this Standardized Procedure two (2) times prior to be deemed competent.
    2. Ongoing: At least every 3 years competency will be re-assessed via annual skills assessment.
    3. During the annual RN performance appraisal process any areas of this Standardized Procedure not meeting requirements will be reviewed with the RN and a plan will be defined if necessary

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method
    1. Policy goes through ED Physician Group every three (3) years.
    2. Policy goes through the interdepartmental policy committee (IDPC) upon creation of policy and when changes are made.
    3. Chief Nursing Officer (Vice President of Patient Services) upon creation of policy and with significant changes.

B. Review Schedule

1. Review of policy occurs every three (3) years

C. Signatures of authorized personnel approving the standardized procedure and dates:

1. Approval of the standardized procedure is outlined in the electronic policy and procedure system.

a. Director Emergency Department, Medical Director of Emergency Department, Chair of Interdisciplinary Practice Committee, and Chief Nursing Officer.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. Adams, M., & Urban, C. Q. (2013). Pharmacology: Connections to Nursing Practice. Prentice Hall. 479, 1019, 1104-1105

B. California Board of Registered Nursing,Title 16, California Code of Regulations Section 1474; Medical Board of California. Title 16, Code of Regulations Section 1379

C. Emergency Nurses Association: Emergency Nursing Core Curriculum (2007), 6th Edition- Emergency management involving assessment of the abdomen 47, 159-186

D. Marx, J., Hockbergner, R. WS., & Walls, R. M. (Eds). (2002). Rosen's Emergency Medicine: Concepts and Clinical Practice (5th ed). St Louis, MO: Mosby

E. Reeves, J.J; Shannon, M.W.; & Fleisher, G. R.: Ondansetron Decreases Vomiting Associated with Acute Gastroenteritis: a randomized, controlled trial. Pediatrics (2002) 109:e62.

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	07/2024

IDPC	Katherine DeSalvo: Director Medical Staff Services	07/2024
EM Dept.	Cristina Martinez: PHYSICIAN	07/2024
EM Dept.	David Thompson: Clinical Manager	06/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024
Policy Owner	David Thompson: Clinical Manager	06/2024

Standards

No standards are associated with this document

Status Pending PolicyStat ID 15674721

Last Approved	N/A	Owner	David Thompson: Clinical Manager
Next Review	3 years after approval	Area	Nursing Standardized Procedures

SEPSIS Management Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Director of Nursing – Nursing Director responsible for a nursing unit or cluster of units.

B. ED- Emergency Department

C. RN- Registered Nurse

D. SIRS- Systemic Inflammatory Response Syndrome

E. SP – Standardized Procedure

III. PROCEDURE

A. Function (s)

1. This Standardized Procedure outlines circumstances for which the Emergency Department RN, prior to the patient being examined by a Physician, may complete te orders on the Sepsis Management order set as below.

B. Circumstances

1. Setting

a. Medical Emergency Department

i. Patients 18 years of age or older presenting to the ED that meet screening criteria for Systemic Inflammatory Response Syndrome prior to Physician evaluation IF: the ED Physician is not signed up or will see the patient within 30 min or a timely manner and patient is not in extremis.

ii. Emergency Department patients 18 years or older that meet the

following criteria may receive acetaminophen:

a. Have not received acetaminophen within the past four (4) hours prior to arrival in the Emergency Department, with exceptions discussed below.

b. Patients with no known contraindications to acetaminophen

c. Contraindications to acetaminophen administration include:

i. Patients with G6PD deficiency

ii. Patients with severe liver impairment

iii. Emergency Department patients who are 18 years and older that meet the following criteria may receive ondansetron:

a. Have not received ondansetron within the past six (6) hours prior to arrival in the Emergency Department, with exceptions discussed below.

b. Patients with prolonged QT

c. Patients with no known contraindications to ondansetron.

2. Supervision

a. Registered Nurses who have successfully completed the following competencies are qualified to perform this standardized procedure for patients who meet the above criteria IF: the ED Physician is not immediately available.

i. Ordering IV Insertion using the Sepsis (ED RN) order set

ii. Ordering specimens using the Sepsis (ED RN) order set

iii. Ordering a chest x-ray using the Sepsis (ED RN) order set

iv. Ordering medications using the Sepsis (ED RN) order set

3. Patient Condition

a. **If the patient appears unstable and/or a life threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY**

C. Database

- Subjective

1. Prioritization and Severity of Illness

a. Patients 18 years or older that meet SIRS criteria will be triaged (prioritized) according to accepted triage policy based on the severity of their condition and incorporating other medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (See TRIAGE ASSESSMENT)

b. History of present illness/injury/chief complaint

- Objective
    1. Physical Examination: ED RN's assessment will consist of the following:
        a. Vital signs, chief complaint, suspicion of infection, assessment for altered mental status

D. Diagnosis
- Meets SIRS criteria and suspicion of infection

E. Plan
- Treatment
    1. IV Insertion x2
    2. Specimens to obtain
        a. Patients 18 years of age or older presenting to the ED that meet screening criteria for Systemic Inflammatory Response Syndrome prior to Physician evaluation IF: the ED Physician is not immediately available.
        b. UA and Culture if indicated
        c. CBC, with Automated Diff
        d. Comprehensive Metabolic Panel
        e. Lipase
        f. Prothrombin Time
        g. Partial Thromboplastin Time
        h. Lactate and reflex repeat
        i. Qualitative HCG for females under 50 years
        j. Blood cultures X 2
        k. Procalcitonin
        l. POC I-stat as needed
        m. Chest X-ray
        n. For females (possible pregnancy) use abdominal shields when getting the chest x-rays.
    3. Medication Administration
        a. Acetaminophen administration/dosing:
            i. Acetaminophen 650mg PO or PR once if temperature is > 38.3C°
            ii. Ondansetron 4mg ODT once if over 18 and vomiting
        b. Exclusion criteria:

i. Allergy to ondansetron, Acetaminophen

ii. Liver or Renal disease, GI bleeding or bleeding abnormality

iii. Prolonged QT

- Patient conditions requiring consultation/reportable conditions:
    1. **Immediately notify an Emergency Department physicians of the following:**
        a. Changes in airway, breathing, circulation or altered level of consciousness, unstable vital signs.
        b. Changes in triage acuity

- Education-Patient/Family
    1. Educate patient family on medications including side effects
    2. Explain procedure to patient of x-ray ordered, awaiting transport will take patient to Diagnostic Imaging at earliest opportunity, or will be done in the room.
    3. Explain specimens to be collected from patient.
    4. Instruct patient and family to remain NPO until ED physician discontinues NPO status.
    5. Instruct patient and family to notify nurse of any changes in the patient condition.

- Follow-up
    1. Reassessment and reevaluation of the patient's clinical status, vital signs and response to treatment in accordance with the Emergency Department Policy and Procedure on Assessment/Reassessment Policy (see STANDARDS OF CARE- EMERGENCY DEPARTMENT)

- Documentation of Patient Treatment
    1. The ED RN initiating this standardized procedure will select the Sepsis (ED RN) Order Set, using the name Physician, Emergency.
    2. The ED RN initiating the standardized procedure will document the following:
        a. Enters "Physician, Emergency" as ordering provider per policy.
        b. Navigates to Emergency Department Nursing Order Sets.
        c. Selects "Sepsis (ED RN)" order set.
        d. Documentation of care in MAR/Patient Note as applicable
        e. Document any interventions and outcomes in the electronic health care record.

F. Record Keeping

- The facility will retain the patients' record according to the Record Retention procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education
   - In accordance with the SVHMC RN job description

B. Training
   - Clinical Competency must be demonstrated and approved by supervising personnel or preceptor.

C. Experience
   - In accordance with the established SVHMC job description and designated to work in ED

D. Evaluation
   - Initial: During the initial orientation process RNs are educated to this SP and complete a review with their preceptor. This is documented on the Department Specific Orientation Checklist and maintained in the office of the Director of Nursing. The RN is required to implement this SP two (2) times prior to be deemed competent.
   - Ongoing: At least every 3 years competency will be re-assessed via annual skills assessment.
   - During the annual RN performance appraisal process any areas of this SP not meeting requirements will be reviewed with the RN and a plan will be defined if necessary

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Review Schedule
   1. Every 3 years or when practice changes are made.

B. Approval
   1. The electronic policy and procedure system maintains tracking of initiation, review and approval of this SP including the Interdisciplinary Practice Committee, Medical Executive Committee and the Board of Directors.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in

the department / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. California Board of Registered Nursing,

B. Title 16, California Code of Regulations Section 1474

C. Medical Board of California. Title 16, Code of Regulations Section 1379

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	07/2024
IDPC	Katherine DeSalvo: Director Medical Staff Services	07/2024
EM Dept.	Cristina Martinez: PHYSICIAN	07/2024
EM Dept.	David Thompson: Clinical Manager	06/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024
Policy Owner	David Thompson: Clinical Manager	06/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **15326295**

Last Approved	N/A	Owner	David Thompson: Clinical Manager
Next Review	3 years after approval	Area	Emergency Department

Urinary Tract Infection Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Director of Nursing - Nursing Director responsible for as nursing unit or cluster of units
B. RN - Registered Nurse employed by SVHMC
C. SP - Standardized Procedure
D. MSE: Medical Screening Exam
E. UTI: Urinary tract infection
F. U preg: Urine Pregnancy Test
G. UA: Urinalysis

III. PROCEDURE

A. Functions
    1. To expedite care for patients who present with a chief complaint of UTI symptoms:that will not receive a MSE by a provider within 30 minutes
        a. Registered nurses in the ED may order the following labs for patient's with a complaint of abdominal pain:
            i. Urinalysis and culture if indicated, order a UA with culture if indicated on any adult and also on any child with UTI symptoms that can void on their own starting age three (3) years old and up
            ii. Urine Pregnancy for females <50 years old

B. Circumstances

1. Setting
    a. Emergency Department
        i. May be completed in the triage area or once the patient is in the room.
2. Supervision
    a. Registered Nurses who are qualified to perform this standardized procedure may independently order urine sample. Physician supervision is not required.
3. Patient Conditions
    a. Patients who meet the following criteria:
        i. If the patient has not been seen in the ED within the previous 24 hours for the same complaint
        ii. Patients twelve years of age and over order the urine pregnancy
        iii. Chief complaint of UTI symptoms (suprapubic/groin pain, lower back pain, dysuria, frequent urination, bloody urine, flank pain, chills and/or feverr)
        iv. If no physician is signed up or the patient will not be seen by a physician within 30 minutes or a timely manner.

C. Database
1. Subjective:
    a. Prioritization and Severity of Illness
        i. Patient will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating other medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see TRIAGE ASSESSMENT)
        ii. History of present illness/injury/chief complaint
        iii. Have patient point with one finger to most painful location
        iv. Consider conditions related to gastrointestinal, genitourinary, or reproductive systems.
            a. Female: determine last normal menstrual period
            b. Male: assess for possible testicular torsion.
        v. History of abdominal surgeries/illnesses
        vi. History of UTIs, kidney stones, diarrhea, constipation, nausea, or vomiting
        vii. Pain description
2. Objective:

a. Chief complaint of UTI symptoms
b. Dysuria
c. Frequent urination
d. Flank pain
e. Bloody urine
f. Chills
g. Fever without cause
h. Odors
i. Objective signs of pain

D. Diagnosis
    1. Suspected UTI

E. Plan
    1. Treatment
        a. The order must be placed under the name 'Physician, Emergency'
        b. The ED RN initiating the standardized procedure will document the following: UA and culture if indicated, Urine Pregnancy ordered per "standardized procedure" in the patient record
            i. Navigates to ER Nursing Orders.
            ii. Selects "UTI Order Set" order set.
        c. The specimens must be labeled accurately with the patient's name and account number. The accuracy of the label must be verified by using the hospital approved patient identification process (PATIENT IDENTIFICATION POLICY).
        d. The labeling of specimens must occur AT THE PATIENT'S BEDSIDE. (PATIENT IDENTIFICATION POLICY)
        e. Specimens collected by the nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hazard specimen bag
        f. Specimens collected will be handed to a phlebotomist or transported in person or by the pneumatic tube system to the Laboratory.
    2. Patient conditions requiring consultation/reprotable conditions:
        a. Immediately notify an Emergency Department physician of the following:
            i. Changes in airway, breathing, circulation or altered level of consciousness.
            ii. Change in triage acuity.
        b. if the patient appears unstable and/or a life threatening condition is identified, the RN will notify the physician IMMEDIATELY.

3. Education - Patient/Family
    a. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy
4. Follow-up
    a. As needed to maintain continuity of care
5. Documentation of Patient Treatment
    a. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.

F. Record Keeping
    1. The facility will retain the patients record according to the Record Retention procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education
    1. In accordance with the SVHMC RN job description

B. Training
    1. The RN completes an initial review of the standardized procedure with an evaluation of knowledge.

C. Experience
    1. In accordance with the established SVHMC job description. (Add if there is unit specific experience required)

D. Evaluation
    1. Initial: During the initial orientation process RNs are educated to this SP and complete a review with their preceptor. This is documented on the Department Specific Orientation Checklist and maintained in the office of the Director of Nursing. The RN is required to implement this SP two (2) times prior to be deemed competent.
    2. Ongoing: At least every 3 years competency will be re-assessed via annual skills assessment.
    3. During the annual RN performance appraisal process any areas of this SP not meeting requirements will be reviewed with the RN and a plan will be defined if necessary

V. DEVELOPMENT AND APPROVAL OF THE

STANDARDIZED PROCEDURE

A. Review Schedule

1. Every 3 years or when practice changes are made.

B. Approval

1. The electronic policy and procedure system maintains tracking of initiation, review and approval of this SP including the Interdisciplinary Practice Committee, Medical Executive Committee and the Board of Directors.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. California Board of Registered Nursing,

B. Title 16, California Code of Regulations Section 1474

C. Medical Board of California. Title 16, Code of Regulations Section 1379

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	07/2024
IDPC	Katherine DeSalvo: Director Medical Staff Services	07/2024
EM Dept.	David Thompson: Clinical Manager	06/2024
EM Dept.	Cristina Martinez: PHYSICIAN	06/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024

Policy Owner	David Thompson: Clinical Manager	06/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **15422841**

Last Approved	N/A	Owner	David Thompson: Clinical Manager
Next Review	3 years after approval	Area	Nursing Standardized Procedures

Vaginal Bleeding Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Blood Type and Rh factor (Type and Rh)
B. CBC: Complete Blood Count
C. CMP: Comprehensive Metabolic Panel
D. Director of Nursing – Nursing Director responsible for a nursing unit or cluster of units.
E. HCG: Qualitative Serum Human Chorionic Gonadotropin
F. SP – Standardized Procedure
G. UA: Urinalysis
H. ED: Emergency Department

III. PROCEDURE

A. Function
    1. A registered nurse may start an IV and order blood work prior to a patient examination by a physician for Chief Complaint of vaginal bleeding.

B. Circumstances
    1. Setting
        a. Registered Nurses (RNs) assigned to the Emergency Department (ED) may initiate orders for patients presenting with vaginal bleeding prior to physician evaluation IF: the ED physician is not immediately available. The RN will ensure blood is drawn, order approved laboratory tests, and an INT

with routine flushes will be placed if the patient is unstable. This will apply to patients with symptoms listed in the PATIENT CONDITIONS section below.

2. Supervision
    a. Registered Nurses, who are employed in the Emergency Department and have successfully completed the Patient's with Vaginal Bleeding competency, are qualified to perform this standardized procedure and may order CBC, sHCG, Type and Rh, when vital signs are within normal limits initiate IV resuscitation if vital signs are abnormal, to the patients presenting with the chief complaint of vaginal bleeding and whom meet criteria.
    b. Registered nurses in the ED may order the following labs for patient's eighteen (18) years of age and over with a complaint of vaginal bleeding: CBC, CMP, serum HCG (non-menopause females only), Draw EXTRA, Type (ABO/RH Profile), UA and culture if needed, INT placement if patient unstable.
    c. If patient is under eighteen (18) years of age and confirms she is pregnant, then order above labs.
    d. If patient under eighteen (18) years of age and denies pregnancy than order UA with reflex culture and urine pregnancy
3. Patient Conditions
    a. Orders may be initiated prior to physician evaluation IF:
    the ED physician is not immediately available.
    Registered nurses in the ED may order the following labs for patient's thirteen years of age and over: CBC, CMP, HCG (non-menopause females only), DRAW EXTRA, Type (ABO/RH Profile), UA and culture if needed, and place INT.
    b. If the patient has not been seen in the ED within the previous 24 hours for the same complaint and/or the need for blood testing and IV therapy is questionable/concerning.

C. Database

- Subjective
    1. Patients with the chief complaint of vaginal bleeding will be triaged and prioritized according to accepted triage policy based on the severity of their vaginal bleeding using the Emergency Severity Index (ESI) 5 Level Triage. (See TRIAGE ASSESSMENT)
        a. Spontaneous abortion (miscarriage) is the loss of a pregnancy before viability of the fetus defined as 20 weeks gestation. Spontaneous abortion should be considered in any woman of childbearing age who presents to the emergency department with vaginal bleeding. Spontaneous abortions are commonly categorized as threatened, inevitable, incomplete, missed, or

septic.

b. An ectopic pregnancy (EP) could cause vaginal bleeding in pregnant women. EP intrudes into the tubal wall too deeply or grows too large, it can rupture the tube and can be life-threatening due to risk of hemorrhage.

c. Menopausal or women of a geriatric age, malignant disease should always be considered. Postmenopausal hormonal changes may be responsible for dysfunctional uterine bleeding (DUB). Patients in this age group with vaginal bleeding are at increased risk for uterine cancer.

d. Young females less than typical age of menarche (11 years of age to 12 years of age) with vaginal bleeding and severe pain/ distress consider assault, keep in clothes and get a physician immediately.

2. All patients presenting with chief complaint of vaginal bleeding and characteristics using numerical or Wong Baker pain scale.

    a. Onset of vaginal bleeding and potential cause (what happened)

    b. Last normal menstrual period (LNMP) and location of pain, if present.

    c. Duration of vaginal bleeding

    d. Characteristics of vaginal bleeding: amount, color, presence of clots/tissue. Number of full pads/tampons used (each holds approximately 30 ml of blood).

    e. Alleviating or aggravating factors

    f. Radiation of pain

    g. Treatment before arriving to the Emergency Department.

    h. Positive pregnancy test: date and method (serum or urine).

    i. Fatigue, dizziness, lightheadedness, syncope

    j. Contraceptive history

    k. Reproductive history, total number of pregnancies, live births spontaneous/therapeutic abortion(s) (gravida, para, SAB/TAB)

    l. Recent trauma or surgery

    m. Recent sexual intercourse

    n. Fever, recent birth-vaginal/c-section?

- Objective

    1. Patients with vaginal bleeding will be assessed for the following

        a. Level of consciousness, behavior, affect

        b. Abnormal vital signs

c. Skin, color; moist or dry

d. Gait

e. Quality and Quantity of vaginal bleeding, color, amount, passage of clots or tissue

f. Presence or absence of pain/cramping and location of pain

g. Palpation of abdomen for tenderness

h. Auscultation for Fetal Heart Tones

D. Diagnosis

- Vaginal bleeding caused by: Differential diagnosis:
    1. Spontaneous abortion from a nonviable fetus
    2. Ectopic pregnancy invading the tubal wall
    3. Uterine dysfunction
    4. Endocrine imbalance
    5. Sexual assault/abuse or maltreatment
    6. Malignant disease
- Assess fro the following:
    1. Deficient fluid volume
    2. Anticipatory grieving
- Plan
    1. Treatment
        a. Patient must have an accurate name-band in place before blood work is drawn.
        b. When initiating an IV infusion the RN will label the blood tubes accurately by using the hospital approved patient identification process (see PATIENT IDENTIFICATION POLICY). The labeling of specimens must occur AT THE PATIENT'S BEDSIDE.
        c. Specimens collected by the ED nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hazard specimen bag.
        d. Specimens will be handed to a phlebotomist or transported to lab in person or through the pneumatic tube system
        e. If no supervising ED physician has signed up for patient or not seen in 30 min or timely manner, order sets should be placed under "Physician, Emergency".
        f. The ED RN will assess the patient presenting with vaginal bleeding according the standardized policy and procedure of Vaginal Bleeding.

i. The ED RN will initiate IV therapy when the following is present:
    1. Moderate to heavy vaginal bleeding present
    2. Skin signs are cool, pale, and moist
    3. Systolic blood pressure (SPB) of 100 or less and/or heart rate of greater than 100.
    4. If specimens are obtained patient label must be taken to the bedside and verified with the patient using the two (2) Patient Identifiers (patient name and medical record number).

2. Patient conditions requiring consultation:
    a. If the patient appears unstable and/or life threatening condition is identified: the ED RN will notify the ED physician **IMMEDIATELY**.
    b. Heavy bleeding present with skin signs of cool, pale and moist.
    c. Vital signs critical less than 100 SBP and heart rate greater than 100.
    d. Changes in airway, breathing, circulation, or altered level of consciousness
    e. Change in triage acuity

3. Education-Patient/Family
    a. Educate on processes of the Emergency Department
        i. Why patient must remain NPO status until results
        ii. Explain the need for blood work and initiation of blood work
        iii. Explain the procedure of vaginal exam
        iv. Explain what medication given and why
        v. Education that patient did not do anything wrong, that miscarriage or threatened miscarriage it is not the patient's fault
        vi. Educate on receiving RhoGAM, if woman is Rh-negative
    b. Educating for threatened abortion
        i. Maintain bed rest for 24 to 48 hours or until bleeding subsides
        ii. Educate on the need for bed rest and pelvic rest (no sexual intercourse, do not place anything inside the vagina) until bleeding and cramping stop

iii. Use sanitary pads only; avoid tampons

iv. Return to the Emergency Department if bleeding or pain increases or you develop a fever

v. Save any clots or tissue that passes and bring to the emergency department or follow-up physician

vi. Ensure appropriate follow-up care with obstetrician/ gynecologist.

c. Education for complete abortion

i. Mild abdominal pain/cramping is common for several days

ii. Use sanitary pads only; avoid tampons

iii. Take temperature four times a day

iv. Pelvic rest

v. Ensure follow-up care with obstetrician/gynecologist.

vi. Activity as tolerated

vii. Return to the emergency department if temperature is higher than 100.6 F, bleeding, pain, or foul-smelling discharge occurs or increases

d. Follow up

i. Reassessment and reevaluation of vaginal bleeding every two (2) hours or more frequently according to the patient severity and amount of vaginal bleeding and accordance with the Emergency Department Policy and Procedure: Assessment/Reassessment (see STANDARDS OF CARE- EMERGENCY DEPARTMENT)

e. Documentation of Patient Treatment

i. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.

1. The ED RN initiating the standardized procedure will document the following: CBC, CMP, UA, sHCG, Type and Rh, and IV therapy ordered per "standardized procedure" in the electronic medical record.

2. Enters "Physician, Emergency' per policy.

3. Navigates to New Sets.

4. Selects "ER Nursing Orders" order set

5. Selects appropriate order.

- Record Keeping
    1. The facility will retain the patients' record according to the Record Retention procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education
    1. In accordance with the SVHMC RN job description

B. Training
    1. Competency assessed during orientation.

C. Experience
    - In accordance with the established SVHMC job description

D. Evaluation
    - Initial: During the initial orientation process RNs are educated to this SP and complete a review with their preceptor. This is documented on the Department Specific Orientation Checklist and maintained in the office of the Director of Nursing. The RN is required to implement this SP two (2) times prior to be deemed competent.
    - Ongoing: At least every 3 years competency will be re-assessed via annual skills assessment.
    - During the annual RN performance appraisal process any areas of this SP not meeting requirements will be reviewed with the RN and a plan will be defined if necessary

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Review Schedule
    1. Every 3 years or when practice changes are made.

B. Approval
    1. The electronic policy and procedure system maintains tracking of initiation, review and approval of this SP including the Interdisciplinary Practice Committee, Medical Executive Committee and the Board of Directors.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in

the department / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. California Board of Registered Nursing,
B. Title 16, California Code of Regulations Section 1474
C. Medical Board of California. Title 16, Code of Regulations Section 1379
D. Emergency Nurses Association: Emergency Nursing Core Curriculum (2000)

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	07/2024
IDPC	Katherine DeSalvo: Director Medical Staff Services	07/2024
EM Dept.	Cristina Martinez: PHYSICIAN	07/2024
EM Dept.	David Thompson: Clinical Manager	06/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024
Policy Owner	David Thompson: Clinical Manager	06/2024

Standards

No standards are associated with this document

Salinas Valley HEALTH

Advanced Practice Provider Rules and Regulations

~~January 27, 2022~~

June 27, 2024

ARTICLE I
PREAMBLE

The Medical Staff of ~~Salinas Valley Memorial Healthcare System~~Salinas Valley Health has adopted these Advanced Practice Provider (APP) Rules and Regulations for the governance of the APP Staff that provide services at ~~Salinas Valley Memorial Healthcare System~~Salinas Valley Health. Adherence to these rules and regulations is required by all members of the APP Staff holding privileges or working under clinical privileges.

ARTICLE II
GENERAL ORGANIZATION

The APP Staff shall include those practitioners who are not members of the Medical Staff but provide clinical services to hospital patients as described in this document. The APP Staff shall be composed of Dependent Practitioners.

ARTICLE III
NATURE OF MEMBERSHIP

No APP shall provide patient care services unless they have been granted clinical privileges. Appointment to the APP Staff shall permit the exercise of only those privileges that are granted in accordance with the ~~Salinas Valley Memorial Healthcare System~~Salinas Valley Health Medical Staff Bylaws and these Rules and Regulations. The criteria for APP clinical privileges shall be developed in consultation with and subject to oversight of the Medical Staff Department in which said privileges will be exercised.

ARTICLE IV
APPOINTMENT AND REAPPOINTMENT

4.1 DURATION OF ALLIED PRACTITIONER STAFF APPOINTMENT

All appointments and reappointments to the APP Staff will be for a period of no more than two (2) years.

4.2 MECHANISM FOR APPOINTMENT OR REAPPOINTMENT

4.2-1 APPLICATION

Every applicant for appointment or reappointment to the APP Staff at ~~Salinas Valley Memorial Healthcare System~~Salinas Valley Health will make application on the approved APP application form.

4.2-2 GENERAL PROVISIONS

The process for granting APP Staff appointment or reappointment and clinical privileges shall be the same as the process described in Article IV of the ~~Salinas Valley Memorial Healthcare System~~Salinas Valley Health Medical Staff Bylaws with the exception that the

Interdisciplinary Practice Committee (IDPC) of the Medical Staff shall carry out the credentialing processes as described in Section 4.6.

4.2-3 CREDENTIALS FILE

The credentials file will contain credentialing information and clinical privileges for APP Staff. The credential file shall be maintained by Medical Staff Services.

4.2-4 CLINICAL PRIVILEGES

a. The activities that the APP Staff will perform are defined as "clinical privileges".

b. All APP Staff clinical privilege forms shall be reviewed by the IDPC.

c. The privileges which may be granted to specific APP Staff members shall be defined in these Rules and Regulations. Clinical privilege forms shall be reviewed at minimum every two years. Privileges may include:

i. The provision of specific patient care services under the supervision or direction of a physician member of the Medical Staff consistent with the APP Staff member's licensure or certification;

ii. Participation, by request, on Medical Staff and/or administrative committees or teams;

iii. Attendance by request at Medical Staff and/or administrative meetings.

d. Dependent Practitioners may only provide clinical services to a patient under the supervision of a Medical Staff member holding appropriate clinical privileges relevant to the service to be provided.

ARTICLE V
HEARING AND APPEAL RIGHTS

Nothing in the Medical Staff Bylaws or these Rules and Regulations shall be interpreted to entitle APP Staff members to the fair hearing rights as described in Articles VI and VII of the Medical Staff Bylaws. An APP Staff member shall, however, have the right to challenge any action that would, a) constitute grounds for a hearing under Section 7.2 of the Medical Staff Bylaws, or b) may otherwise adversely affect the APP's ability to provide patient care services. Under such circumstances, the affected APP may file a written grievance with the Medical Executive Committee. The Medical Executive Committee shall, through a mechanism determined by the Medical Executive Committee, conduct a review of the issues and afford the APP Staff member an opportunity for an interview concerning the grievance. The interview shall not be considered a hearing as established in Article VII of the Medical Staff Bylaws and need not be conducted according to the procedural rules applicable to hearings.

Before the interview, the APP shall be informed of the general nature of the circumstances giving rise to the action and the APP Staff member may present relevant

information at the interview. A record of the interview shall be made and the Medical Executive Committee shall determine a decision on the action. This decision shall be forwarded to the Board of Directors. If, following review of the grievance, the Medical Executive Committee recommends withdrawing action against the APP, then the Board of Directors shall affirm the decision if it is supported by substantive evidence. If the Medical Executive Committee recommends upholding the action against the APP, then the APP shall be so notified and may appeal the decision to the Board of Directors prior to the Board of Directors rendering a final decision. This appeal process shall follow a format as may be developed by the Board of Directors.

ARTICLE VI
AUTOMATIC SUSPENSION OF PRACTICE RIGHTS

6.1 SUPERVISING/COLLABORATING PHYSICIAN

6.1.1 If the supervising/collaborating physician's membership or privileges are terminated, whether voluntarily or involuntarily, then the APP's ability to perform clinical services shall also terminate. In addition, the APP cannot be supervised by physicians whose privileges have been restricted through Medical Staff action based on quality of care issues.

6.1.2 APP Staff who do not have a supervising/collaborating physician on the Medical Staff at ~~SVMH~~SVH shall have their privileges automatically suspended. This shall not be deemed an adverse action and shall not entitle the APP to hearing and appeal rights as outlined in Article V of these Rules & Regulations.

6.2 LOSS OF LICENSURE OR CERTIFICATION

The APP's ability to provide clinical services shall terminate if the APP Staff member's licensure or certification is suspended, expired or revoked.

6.3 FAILURE TO BE ADEQUATELY INSURED

If at any time an APP's professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the APP's clinical privileges shall be suspended automatically as of that date until the Medical Staff determines that it has received acceptable documentation of adequate professional liability insurance coverage. If acceptable proof of such coverage is not provided to the Medical Staff within ninety (90) days of such lapse, then the practitioner's clinical privileges and allied health staff membership shall automatically terminate.

6.4 ACTION BY GOVERNMENT FUNDED HEALTH PROGRAM

Whenever an APP is excluded from any federally funded health care program, the APP's clinical privileges shall be automatically suspended as of the effective date of such exclusion.

6.5 FAILURE TO RESPOND OR APPEAR

APP Staff are expected to cooperate with Medical Staff committees and representatives in the discharge of their official functions. This includes responding promptly and appropriately to correspondence, providing requested information, and appearing at appropriately announced meetings regarding quality of care issues, utilization management issues, Medical Staff administrative issues, and other issues that may arise in the conduct of Medical Staff affairs. It also includes submitting to mental or physical examinations, as requested by the Chief of Staff or the Medical Executive Committee, for the purpose of resolving issues of fitness to perform mental or physical functions associated with the practitioner's privileges / prerogatives or any related issues of reasonable accommodation. Failure to comply shall constitute grounds for the Chief of Staff or a Department Chair to suspend the Member's privileges / prerogatives or take other appropriate action until a response is provided which is satisfactory to the requesting party. Any such suspension or action shall remain in effect until the APP is expressly notified that it is rescinded.

6.6 CRIMINAL ACTIVITY

Conviction of any felony or of any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, Medicare, Medicaid, or insurance fraud or abuse, or a plea of guilty or nolo contendere to charges pertaining to the same shall result in automatic relinquishment of APP membership and privileges / prerogatives.

6.7 MEDICAL EXECUTIVE COMMITTEE DELIBERATIONS AND ACTION

As soon as practicable after action is taken or warranted as described elsewhere in this Article, with the exception of routine suspensions for failure to complete medical records, the Medical Executive Committee shall review and consider the facts, and may take or recommend such additional action as it deems appropriate.

6.8 MEMBER OBLIGATIONS

An APP Staff member shall immediately provide written notice to the Medical Staff Services Department of any of the above described actions or events. The member shall also promptly provide the Medical Staff Services Department with a written explanation of the basis for such actions, including copies of relevant documents. The limitations described above shall take effect automatically as of the date of the underlying action or event, regardless of whether the member provides notice thereof to the Medical Staff Services Department. The Medical Executive Committee may request the member to provide additional information concerning the above described actions or events, and a failure of the member to provide such information may extend the special actions listed above, even though the underlying limitation may have been removed.

ARTICLE VII
RESPONSIBILITIES

APP Staff members' responsibilities shall include:

a. Maintain all applicable licensure or certification requirements;

b. Comply with any applicable requirements of the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and hospital administrative policies;

c. Retain appropriate responsibility within their area of professional competence for the care of each patient in the hospital for whom they are providing services;

d. Participate in quality assessment and performance improvement activities as requested by the Interdisciplinary Practice Committee, a Medical Staff Department, or any committee of the Medical Staff or the Board of Directors. Failure of an APP Staff member to participate in quality assessment or performance improvement activities when requested by the Medical Executive Committee shall result in responsive action including the possible revocation or suspension of all privileges.

e. Provide only those services, which are contained and approved in the practitioner's clinical privileges.

f. Not admit patients or assume primary patient care responsibilities unless otherwise specified in their clinical privileges.

g. Only provide clinical services to a patient pursuant to the order of a Medical Staff member unless otherwise specified in their clinical privileges.

h. Complete all proctoring requirements as may be established by the Interdisciplinary Practice Committee or the Medical Executive Committee.

i. Maintain certification (BLS, ACLS, NRP, etc.) as required by these APP Rules and Regulations or other organizational/Medical Staff policies and procedures.

j. Maintain continuing education as required by licensure and/or certification and ~~Salinas Valley Memorial Healthcare System~~Salinas Valley Health Medical Staff policies.

k. Complete all medical records in accordance with requirements established by the Medical Staff Bylaws and organizational policies.

l. Participate as appropriate in performance improvement and peer review activities as requested by the applicable Quality and Safety Committee, Medical Staff Excellence Committee or other Medical Staff or administrative committees.

m. Meet any additional requirements as may be described in these APP Rules and Regulations or as described in their respective approved /clinical privileges.

n. Abide by the Medical Staff Code of Conduct as outlined in the General Medical Staff Rules and Regulations

o. Demonstrate a willingness and capability, based on current behavior and evidence of performance, to work with and relate to other staff members, members of other health disciplines, administration and employees, visitors and the community in general in a cooperative, professional, non-disruptive manner that is essential for maintaining a health care environment appropriate to quality and efficient patient care.

ARTICLE VIII
DEPENDENT PRACTITIONERS

8.1 DEFINITION

Dependent Practitioners are licensed or certified in the State of California and are not authorized the independent exercise of clinical privileges at ~~Salinas Valley Memorial Healthcare System~~Salinas Valley Health. Dependent Practitioners may only provide patient care services as defined in the APP specific clinical privileges.

8.2 CATEGORIES

The following categories of Dependent Practitioners authorized to provide patient care at ~~Salinas Valley Memorial Healthcare System~~Salinas Valley Health are:

a. Nurse Practitioner (NP)
b. Physician Assistant (PA)

8.3 RESPONSIBILITIES/ PREROGATIVES

The Dependent Practitioner:

a. Must meet and abide by all requirements of these APP Rules and Regulations, Medical Staff Bylaws, Medical Staff Rules and Regulations, and Hospital policies.

b. Must provide a written supervising physician agreement that is signed and dated by both the APP and the supervising physician.

8.4 SUPERVISION

a. No physician shall supervise more than four (4) APP's.

b. The APP must function in a reasonable proximity to the supervising physician and the supervising physician or designee must be available either in person or by electronic communication. A supervising physician shall delegate to an APP only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice.

c. The physician must physically see each admitted patient prior to admission and prior to discharge. Thereafter, the supervising physician shall examine the patient the same day (or within 24 hours) as care is given by the APP to an in-patient.

d. In the case of a patient proceeding to the Operating Room, physician review and countersignature of an H&P completed by an APP must be completed prior to surgery. A note must be made by the supervising physician and must include a summary of the pertinent details of the history, important physical findings, the planned surgery, the rationale for the surgery, and documentation that the procedure has been explained to the patient by the supervising physician. The duty to obtain informed consent cannot be delegated to an APP.

e. Dictation: The APP may dictate the H&P or discharge summary only if they have participated in the patient's care.

8.5 MECHANISM OF SUPERVISION

8.5.1 **Physician Assistants**: Defined in the Practice Agreement/Clinical Privileges

8.5.2 **Nurse Practitioners**: Defined in the Clinical Privileges
The Nursing Practice Act (NPA) does not require physician countersignature of Nurse practitioner charts.

8.7 PATIENT CARE CLINICAL SERVICES

Locations of Services:
a. Salinas Valley ~~Memorial Hospital~~Health Medical Center
b. Ambulatory Care/Taylor Farms Family Health & Wellness Center
c. Cardiovascular Outpatient Diagnostic Center (CDOC)
d. Center for Advanced Cardiac Imaging (CADI)
e. Regional Wound Care Center
f. Outpatient Infusion Center

The APP Staff member may provide patient care clinical services through an approved practice agreement/clinical privileges

ARTICLE IX
APP INDEPENDENT PRACTITIONERS

8.6 DEFINITION

APP Independent Practitioners are licensed or certified in the State of California and are authorized the independent exercise of clinical privileges at ~~Salinas Valley Memorial Healthcare System~~Salinas Valley Health. APP Independent Practitioners may only provide patient care services as defined in the APP specific clinical privileges.

8.7 CATEGORIES

The following category of APP Independent Practitioner is authorized to provide patient care at ~~Salinas Valley Memorial Healthcare System~~Salinas Valley Health:

Certified Registered Nurse Anesthetist (CRNA)

8.8 RESPONSIBILITIES/ PREROGATIVES

c. Must meet and abide by all requirements of these APP Rules and Regulations, Medical Staff Bylaws, Medical Staff Rules and Regulations, and Hospital policies.

8.8 PATIENT CARE CLINICAL SERVICES

Locations of Services:
Salinas Valley Memorial Hospital

The APP Staff member provides patient care clinical services through an approved practice agreement/clinical privileges

ARTICLE X

AMENDMENTS TO THE APP RULES AND REGULATIONS

Suggested amendments to the APP Rules and Regulations shall be submitted to the Interdisciplinary Practice Committee and Medical Executive Committee for review and recommendation prior to approval by the Board of Directors. Amendments shall become effective when approved by the Board of Directors.

Clinical Privilege Delineation Form
Certified Registered Nurse Anesthetist (CRNA)

Applicant Name: _____

To be eligible to apply for core privileges as a CRNA, the applicant must meet the following qualifications:

New applicants will be required to provide documentation of the number and types of cases they were involved with during the past 24 months. Applicants have the burden of producing information deemed adequate by the Medical Staff and Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

Basic education and minimum formal training:
Successful completion of a nationally accredited CRNA training program

Certifications and Licensure:
In addition, applicants must provide documentation of the following:

Current California CRNA licensure required
Current DEA Certificate with all schedules
Current CRNA Certification as a Nurse Anesthetist by the National Board of Certification & Recertification of Nurse Anesthetists (NBCRNA)

Required Previous Experience:

- Provide documentation of 100 patient care activities, reflective of the scope of practice requested, performed within the past twenty-four (24) months at an accredited hospital or ambulatory surgery center
  OR
- Demonstrate successful completion of an accredited Nurse Anesthesia program within the past twenty-four (24) months
  AND
- Provide evidence of 40 hours of CE credits completed within the past twenty-four (24) months related to the practice prerogatives requested

Core Proctoring Requirements:
Proctoring required for first five (5) patient care activities. Core proctoring requirements include direct observation or concurrent review as per proctoring policy contained in the Medical Staff General Rules and Regulations.

Reappointment Criteria for Core Privileges:
Maintenance of all initial appointment criteria and documentation of successful completion of a minimum one hundred (100) core cases within the past twenty-four (24) months.

Core Privileges

Management of patients of all ages except as specifically excluded from practice, rendered unconscious or insensible to pain and emotional stress during surgical, obstetrical and certain other medical procedures. This would include preoperative, intraoperative and postoperative evaluation and treatment; the support of life functions and vital organs under the stress of anesthetic, surgical and other medical procedures; medical management and consultation in pain management; direct resuscitation in the care of patients with cardiac or respiratory emergencies, including the need for artificial ventilation, pulmonary care, and supervision of patients in post-anesthesia care units.

Core Procedures:

The core privileges in this specialty include the procedures on the following list and such other procedures that are extensions of the same techniques and skills. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Chief Medical Officer and/or the Chief of Staff.

1. Airway management
2. Arterial and central venous cannulation
3. Diagnostic and therapeutic management of acute and chronic pain
4. General anesthesia including invasive monitoring; respiratory therapy, including long-term ventilatory support; and airway management, including cricothyroidotomy
5. Local and regional anesthesia with and without sedation, including topical, and infiltration, minor and major nerve blocks. intravenous blocks, spinal, epidural, and major plexus blocks
6. Management of common intraoperative problems and common PACU problems
7. Management of fluid, electrolyte. and metabolic parameters as well as hypovolemia from any cause
8. Management of malignant hyperthermia and manipulation of body temperature
9. Manipulation of cardiovascular parameters
10. Obstetric anesthesia
11. Preoperative evaluation/anesthetic
12. Sedation/monitored anesthetic care

Acknowledgment of Practitioner:

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Health, and I understand that:

1. In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation

2. Any restriction on the clinical privileges granted to me is waived in an emergency and in such a situation; my actions are governed by the applicable section of the medical staff bylaws or related documents.

Applicant Signature _____ Date _____

*****Department Chair's Recommendation*****

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend all requested privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
4.	
Notes:	

Department Chair Signature _____ Date _____

Status **Pending** PolicyStat ID **15385357**

Last Approved	N/A	Owner	Kelly Flower: Clinical Manager
Next Review	3 years after approval	Area	Patient Care

Care of the patient with an IRRAflow Irrigation Catheter

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide ICU/CCU RNs guidance for insertion (assist), use and discontinuation of IRRAflow irrigating catheter.

III. DEFINITIONS

A. Ventriculostomy – an intraventricular catheter placed in the lateral ventricle that is used to measure and continuously monitor ICP, and provide sterile access for CSF

B. CSF- Cerebrospinal Fluid

C. ICP – (Intracranial Pressure) represents the fluid pressure of CSF in the intraventricular, sub-arachnoid, intra-parenchymal (brain tissue), epidural, or subdural spaces

D. EVD- External Ventricular Drain

E. Ventricular catheters provide a system for aseptically instilling intracranial and/or intrathecal medication therapy done by the neurosurgeon.

IV. GENERAL INFORMATION

A. A STAT CT must be performed prior to initiating irrigation function.

B. RN's will manage the closed ventricular irrigation/drainage system and obtain accurate ICP readings.

C. Neurosurgeons may irrigate and/or administer medication therapy, or obtain a CSF sample through an intraventricular catheter.

D. Patient with external ventricular drainage/irrigation and ICP monitoring system are monitored and cared for in the ICU/CCU

E. Height of the flow chamber is always specified with an MD order. Positioning the system too high may increase ICP and positioning too low may cause excessive CSF drainage and ventricular collapse.

V. PROCEDURE

A. **Set-up and maintenance** of intracranial pressure (ICP) monitor and ventricular drainage system for the irrigating external ventricular drain (EVD) module. The goal of treatment is to be in irrigation as long as possible.

1. **Equipment**:
    a. Drill Kit
    b. Sterile gloves/gowns/hats
    c. IRRAflow catheter
    d. Normal saline vials for priming
    e. IRRAflow Control Unit attached to IV pole
    f. IRRAflow cassette and tubing
    g. IRRAflow drainage collection system
    h. High flow stopcock (obtain from IR)
    i. Normal saline 0.9% NaCl 1000ml or fluids ordered

2. **Implementation/Set-up (in OR or ICU):**
    a. Neurosurgery provider (MD) will perform ventriculostomy procedure with IRRAS irrigating EVD catheter.
    b. RN will turn IRRAflow control unit on by pressing the power button and level IRRAflow control unit to the patient.
    c. The irrigating/drainage tubing set will be prepared by nursing staff in a sterile fashion and tubing will be primed per manufacture instruction. The tubing will remain a closed system until the neurosurgery resident has secured the IRRAflow catheter to the head.
    d. Once catheter is secured the nurse will hand the tubing to the provider to connect to the IRRAflow catheter.
    e. The neurosurgery provider will set the ICP high and low settings, drainage and irrigation rates, and communicate these to the nurse, both by verbal and written order.
    f. A STAT head CT scan will be ordered prior to starting irrigation
    g. Control unit may be put into drain mode until CT scan is confirmed.

B. **Common Settings**
Active Fluid Exchange- cmH20

High ICP: 28	Irrigation Rate: 90mls/hr (3mls-180mls)
Low ICP: 0	Irrigation Fluid: NS/LR or other
Bag Height: 0-10 (Max 15)	Treat Above: N/A

***Cycle time is 1 second to deliver 1 ml of irrigation solution, 9 seconds to monitor ICP and the rest of the time is dedicated to drainage. Irrigation rate changes the amount of time the device is in drain mode. Higher irrigation rate = less time in drainage.*

C. **Drain Only- cmH20**

High ICP: 28	Bag Height: (Max 15)
Low ICP: 0	Treat Above: N/A

Monitor Only- cm H20

High ICP: 28	Bag Height: (Max 15)
Low ICP: 0	

***Remember confirm that the drainage line is CLAMPED otherwise whenever the monitor hits the high limit the device will start draining until the ICP is less than the high limit.*

D. **Maintenance**

1. Once per hour, the IRRAflow computer module should be assessed for ICP measurements.
2. Calibrate module every 24 hours or when the cassette is removed to go to CT
3. ICP readings – High ICP
    a. During Drainage/Monitor modes: Confirm alert, perform routine ICP lowering techniques and alert provider if sustained for 5 minutes
    b. During Irrigation mode:
        i. *Irrigation will stop until ICP is below high limit*
        ii. Confirm alert
        iii. Perform routine ICP lowering techniques
        iv. If High Alert continues for 5 minutes after trouble shooting, change mode to DRAIN mode until the top of the next hour. Notify MD
        v. At the beginning of the next hour resume IRRIGATION at original order.
        **Goal is to be in irrigation mode as long as possible and return to irrigation mode as soon as possible.
        **If HIGH ICPs are still encountered, the neurosurgery provider can change the irrigation rate order to 60mls/hr to allow for more time in drainage.
4. ICP readings- Negative ICP
    a. Confirm the monitor is level to the tragus
    b. Recalibrate the monitor - remember when you recalibrate you must wait to

see "success" on the module before you turn the dial back.

c. If in irrigation mode no irrigation will occur until ICP is above the low valued.

d. Notify neurosurgery provider.

e. Drainage

   i. Drainage must be monitored and recorded in the EHR (electronic health record) hourly.

   ii. NET output is the drainage in drainage bag MINUS irrigation volume (cleared on control unit)

      a. Ex. 100 mls from drainage bag - 80 cleared on control unit = 20 mls of NET output for that hour

   iii. Net drainage per hour is patient dependent, if NET is greater than 20mls/hr alert Neurosurgeon to determine appropriate amount per patient condition

f. Traveling

   i. CT Scan: IRRAflow tubing and cassette will be removed from control unit to travel unless directed otherwise by the neurosurgeon.

      a. All connections must be clamped while traveling and cassette must be placed in a glove and wrapped in a washcloth to prevent damage. Lay tubing on chest and near head.

   ii. Interventional Radiology: IRRAflow control unit must be brought down to IR suite. RN can travel with tubing/cassette out of control unit or inside control unit.

      a. If tubing/cassette is removed from control unit, after patient is transferred to angio table the tubing and cassette will be re-inserted into control unit and ICP measurements started. Control unit must be level with the patient and previous settings started unless otherwise ordered by provider.

   iii. MRI: **The IRRAflow cassette and control unit are not MRI compatible, however the catheter itself is compatible.**

      a. If MRI is clinically needed the Neurosurgery MD will disconnect the catheter from the tubing and attach sterile IV caps to the tubing and catheter. The patient can then undergo MRI with the ventricular catheter in place.

      b. Once returned from MRI, the patient will be reattached to the IRRAflow system in a sterile fashion by the Neurosurgeon. All connections must be cleaned with

CHG prep.

c. Once re-connected the IRRAflow system will require recalibration

g. Changing Irrigation solution bag

i. RNs may spike new bag of fluids for the machine. If Normal Saline is utilized, change bag as soon as alert is noticed to prevent bag running dry. If medicated solution is utilized change when 50-100 mls are left.

h. Air in Line

i. **Air between irrigation fluid bag and cassette: RN or MD**

a. Two RNs are needed

b. Don Mask

c. PAUSE treatment.

d. Close the roller clamp on the irrigation tubing below the irrigation fluid.

e. Clamp the blue clamp on the irrigation tubing, prior to the cassette

f. Remove the empty bag of irrigation fluid and spike new bag, filling drip chamber ¾ full.

g. Remove irrigation tubing from air bubble sensor.

h. Clean the connection at the check valve with CHG prep

i. First RN will disconnect the connection at the leurlock, maintaining sterility while holding disconnected tubing.

j. Second RN will open the roller clamp to prime this section of tubing.

k. Once all air is removed, roll the roller clamp shut and connect the tube at the leurlock after ensuring all cleaning agent is dry.

l. Replace irrigation tubing into the air bubble sensor, open blue clamp and roller clamp

m. Restart treatment.

ii. **Air between cassette and patient. MD ONLY**

a. Pause Treatment

b. Turn the stopcock on the irrigation line off to the patient.

c. Clean open port on the stopcock with CHG, maintaining sterility.

d. Remove the cap.
e. Place sterile towels under open port (so the patients' bed does not get wet)
f. Open setting drop-down menu on Control Unit and select "Prime."
g. Choose "Manual Prime"
h. Prime, ensuring all large air bubbles cleared from the line.
i. Place sterile cap on the stopcock when completed.
j. Open the stopcock to patient.
k. Restart treatment.

i. Obtaining CSF sample- **MD ONLY**
   i. RN or MD will set the Control Unit to "Drain" Mode for 15 minutes.
   ii. After 15 minutes select "start/stop" on control unit to pause machine and close both irrigation and drainage tubing roller clamps to protect the cassette.
   iii. Remove leurlock on drainage lumen stopcock, clean with CHG prep
   iv. Connect the specimen syringe to the drainage lumen stop cock
   v. Release the white pinch clamp on the catheter.
   vi. Withdraw a CSF sample
   vii. Re-clamp white pinch clamp on the catheter and disconnect the CSF sample syringe.
   viii. Attach new leurlock to drainage catheter
   ix. Open the roller clamps on both the drainage and irrigation tubing lines and open the white pinch clamp on the catheter.
   x. Restart the prescribed treatment

j. Flushing the Tubing – **MD ONLY**
   i. Select Start/Stop to Pause therapy
   ii. Close the white pinch clamp on the drainage tubing connected to the catheter.

   iii. Ensure cassette protection by closing the roller clamps on the irrigation tubing to prevent flow of fluid and REMOVE the cassette from the control unit (it can it can rest in the white holder)
   iv. Attach a syringe, filled with normal saline, to the drainage line stopcock on the tube set and open roller clamp.

v. Gently flush the drainage tubing into the drainage collection bag
vi. Once drainage tubing is re-primed, close the roller clamp and remove syringe.
vii. Place cassette back into control unit and zero machine.
viii. Open all roller clamps and unclamp white pinch clamp.
ix. Resume previous settings as ordered.
x. Restart the prescribed treatment.

k. tPA administration via bolus- **MD ONLY**
i. Select "Start/Stop" to pause treatment
ii. Clamp both irrigation and drainage line
iii. Remove leurlock on stop cock on DRAINAGE line
iv. Clean site with CHG
v. Attach tPA syringe to the stop cock on DRAINAGE line, turn stop cock off to drain and open to patient
vi. Instill tPA through drainage line, once instilled, clamp line with white clamp and apply a new leurlock on stop cock.
vii. Open irrigation line *this reads the ICP
viii. Change procedure to "MONITOR only" for one hour.
ix. After hour has completed RN will unclamp drainage line and change procedure back to previous settings.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed.

VII. REFERENCES

A. Fargen KM, Hoh BL, Neal D, O'Connor T, Rivera-Zengotita M, Murad GJ. The burden and risk factors of ventriculostomy occlusion in a high-volume cerebrovascular practice: results of an ongoing prospective database. *Journal of Neurosurgery*. 2015:1-8

B. Hess RM, OConnor TE, Khan A, Siddiqui AH, Davies J. Cureus. Minimally invasive approach to subdural hematoma treatment using IRRAflow catheter and middle meningeal artery embolization. 2021;13:0.

C. Luyt K, Jary SL, Lea CL, et al. Drainage, irrigation and fibrinolytic therapy (DRIFT) for posthaemorrhagic ventricular dilatation: 10-year follow-up of a randomised controlled trial. Arch Dis Child Fetal Neonatal Ed. 2020;105:466–473.

D. Rajjoub K, Hess RM, O'Connor TE, Khan A, Siddiqui AH, Levy EI. Drainage, Irrigation, and Fibrinolytic Therapy (DRIFT) for Adult Intraventricular Hemorrhage Using IRRAflow® Self-Irrigating Catheter. Cureus. 2021 May 22;13(5):e15167. doi: 10.7759/cureus.15167. PMID: 34168930; PMCID: PMC8216022.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	07/2024
P&T Committee	Genevieve delos Santos: Director Pharmacy	07/2024
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	07/2024
Critical Care Committee	Katherine DeSalvo: Director Medical Staff Services	06/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2024
Critical Care Director	Lacey Cone: Director Critical Care Services	04/2024
Policy Owner	Kelly Flower: Clinical Manager	03/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **15666045**

Last Approved	N/A	Owner	Genevieve delos Santos: Director Pharmacy
Next Review	2 years after approval	Area	Pharmacy

Medical Cannabis for the Terminally Ill Patient

I. POLICY STATEMENT

A. In accordance with Health and Safety Code (HSC) 1649, terminally ill patients have the right to use medical cannabis while hospitalized at Salinas Valley Health Medical Center (SVHMC). This policy only applies to inpatient admissions. The permission to use medical cannabis does not apply to a patient receiving emergency care and does not apply to care provided in the SVHMC Emergency Department. The law requires health care facilities to allow the use of medical cannabis on their premises for terminally ill qualified patients who have a valid Medical Marijuana Identification Card (MMIC) or recommendation from an attending physician.

II. PURPOSE

A. To formalize a policy that provides guidance for:
1) Terminally ill patients requesting to utilize their own medical cannabis (marijuana) during an inpatient admission and;
2) Hospital personnel to implement and comply with requirements set forth in the Compassionate Access to Medical Cannabis Act or Ryan's Law as described by HSC 1649.

III. DEFINITIONS

A. **Terminally ill** - A patient with a medical condition resulting in a prognosis of life of one year or less if the disease follows its natural course.

B. **Medical cannabis** - Marijuana or products containing tetrahydrocannabinol (THC) that are derived from the cannabis plant including extracts, resins, oils, pills, lotions, or edibles and used in compliance with the CA Medical Marijuana program (HSC 11362.7).

C. **Medical Marijuana Identification Card (MMIC)** - A photo identification issued by the California Department of Public Health (CDPH) per HSC 11362.71 that verifies the validity and expiration date of the Qualified Patient's letter of recommendation for the medical use of cannabis.

D. **Health care facility** - A licensed general acute care hospital, special hospital, skilled nursing facility, congregate living health facility, or hospice provider while excluding a chemical dependency recovery hospital or a state hospital per California SB 311.

E. **Qualified Patient** - An individual who possesses or cultivates cannabis for personal medicinal purposes upon the written or oral recommendation or approval of a physician licensed to practice medicine in California (HSC 11362.5(d)).

F. **Primary Caregiver** - A person designated by a qualified patient, who has consistently assumed responsibility for the housing, health, or safety of that patient (HSC 11362.7(d)).

G. **Attending Physician** - An individual who possesses a license in good standing to practice medicine, podiatry, or osteopathy issued by the Medical Board of California, the California Board of Podiatric Medicine, or the Osteopathic Medical Board of California and who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a
patient and who has conducted a medical examination of that patient before recording in the patient's medical record the physician's assessment of whether the patient has a serious medical condition and whether the medical use of cannabis is appropriate (HSC 11362.7(a)).

IV. GENERAL INFORMATION

A. If a patient or primary caregiver requests to use medical cannabis during the patient's admission, SVHMC will determine eligibility according to this policy:
    1. The patient must be terminally ill.
    2. The patient must possess a valid CA Medical Marijuana Identification Card (MMIC) or documentation by the attending physician recommending use according to HSC 11362.7.

B. Smoking, vaping, or inhalation of medical cannabis is prohibited. Only formulations that can be self-administered by the patient or caregiver are allowed (oral, sublingual, rectal, vaginal, topical, etc.).

C. The patient or primary caregiver must complete a Compassionate Access to Medical Cannabis Act consent form.

D. SVHMC is not required to provide or furnish a patient with a recommendation to use medical cannabis in compliance with the Compassionate Use Act or include medical cannabis in a patient's discharge plan.

E. Hospital personnel shall not administer medical cannabis.

F. The patient or primary caregiver is responsible for acquiring, retrieving, administering, and removing medical cannabis.

V. PROCEDURE

A. Verification of MMIC
    1. Examine the MMIC card by comparing it to the sample card below. The MMIC should be unexpired and all valid MMIC cards will conform to the sample shown here:

2. The MMIC should be compared against the patient's valid, unexpired government identification (e.g. passport, DMV license, etc.).
3. Verify the MMIC online at https://mmic.cdph.ca.gov/MMIC_Search.aspx.
4. Document the results of the verification in the patient's medical record.

B. Qualification by the Attending Physician

1. If the patient or caregiver is unable to produce a valid MMIC, the attending physician may qualify the patient for use by providing written documentation in accordance with HSC 11362.715.
2. The attending physician must document in the patient's medical record that the patient is terminally ill and that the use of medical cannabis is appropriate.

C. Compassionate Access to Medical Cannabis Act Consent Form

1. The patient or primary caregiver must read, complete, and sign the Medical Cannabis consent form (Appendix A).
2. The completed consent form is included in the patient's medical record as well as scanned into the patient's electronic medical record.

D. Contraindications

1. Medical cannabis requires vaping or smoking.
2. Patient is unwilling to store their medical cannabis in a locked container in their room.
3. Patient is no longer qualified to use medical cannabis per the attending physician's determination.

E. Storage

1. SVHMC Pharmacy shall not store nor dispense medical cannabis.
2. Medical cannabis is considered the personal property of the patient and is not considered a medication as defined by SVHMC policy.
3. The manner in which a patient stores and uses medical cannabis will be reasonably restricted to ensure the safety of other patients, guests, and employees of the health care facility, compliance with State and Federal laws/regulations, and the safe

operations of the health care facility.

4. The patient's medical cannabis must be stored securely at all times in a locked container in the patient's room or with the patient's primary caregiver.
5. Hospital personnel are prohibited from placing medical cannabis into storage and/or retrieving medical cannabis from storage.

F. Medical Record Documentation

1. Documentation in the patient's medical record must include the use of medical cannabis.
2. Documentation shall include that the patient is able to self-administer the medical cannabis or that the primary caregiver will administer.
3. The attending physician will enter an order for medical cannabis in the patient's medical record.

G. Disposition

1. Upon discharge, the patient or primary caregiver must remove the medical cannabis from SVHMC.
2. Environmental services staff shall clean the storage container as appropriate.
3. If the patient expires, or the patient or primary caregiver are unable to remove the medical cannabis from SVHMC, the medical cannabis will be handled and disposed of according to SVHMC policy for illicit/illegal substances.

H. Federal Regulatory Compliance

1. If a federal regulatory agency, the United States Department of Justice (US DOJ), or the federal Centers for Medicare and Medicaid Services takes one of the following actions, SVHMC may suspend compliance with HSC 1649 until the federal regulatory agency notifies SVHMC that it may resume permitting the medical cannabis within the facility:
    a. A federal regulatory agency, the US DOJ, or CMS initiates enforcement action against a health care facility related to the facility's compliance with a state-regulated medical marijuana program.
    b. A federal regulatory agency, the US DOJ, or CMS issues a rule or otherwise provides notification to the health care facility that expressly prohibits the use of medical marijuana in health care facilities or otherwise prohibits compliance with a state-regulated medical marijuana program.

VI. EDUCATION

A. Education and/or training is provided as needed.

VII. REFERENCES

A. California Health and Safety Code Chapter 4.9. Compassionate Access to Medical Cannabis Act or Ryan's Law [Sections 1649 – 1649.6]

B. California Health and Safety Code Chapter 6, Article 2.5. Medical Marijuana Program [Sections 11362.7 – 11362.85].

C. Senate Bill No. 311, published 9/29/2021. Compassionate Access to Medical Cannabis Act or Ryan's Law.

D. Senate Bill No. 988, published 9/2/2022. Compassionate Access to Medical Cannabis Act or Ryan's Law.

E. Senate Bill No. 302, published 10/8/2023. Compassionate Access to Medical Cannabis Act or Ryan's Law.

F. California Department of Public Health Medical Marijuana Identification Card Program (MMICP). https://www.cdph.ca.gov/Programs/CHSI/Pages/MMICP.aspx. Accessed 2/1/2023.

Attachments

Appendix A: Compassionate Access to Medical Cannabis Act Consent Form.pdf

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	07/2024
MEC	Katherine DeSalvo: Director Medical Staff Services	07/2024
P&T	Kiri Golleher: Pharmacy Clinical Coordinator	07/2024
P&T	Genevieve delos Santos: Director Pharmacy	07/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2024
Policy Owner	Genevieve delos Santos: Director Pharmacy	07/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **15798603**

Last Approved	N/A	Owner	Genevieve delos Santos: Director Pharmacy
Next Review	3 years after approval	Area	Patient Care

Medication Use

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the clinicians in safely and accurately prescribing, administering and monitoring for medication therapeutic effects.

III. DEFINITIONS

A. Order Entry: The process of entering the medication order into the computerized patient drug profile.

B. Acknowledge: Process by which RN reviews medication order for appropriateness of clinical situation.

C. Reject Order: The electronic message sent to pharmacy when a medication order entered into the patient's profile is not appropriate for the clinical situation or does not match the original medication order written by the physician.

D. Pending: A MAR order status that requires further action.

E. Unverified: Medication orders entered by a Non-pharmacist that require pharmacist verification.

F. D/C: Discontinue medications

G. MAR (Medication Administration Record) - The Medication Administration Record (MAR) is a real time medication record that is designed to provide online documentation of medication administration.

H. BMV – Bedside Medication Verification

I. DNUA – Do Not Use Abbreviation

J. Verbal Order – orders dictated to a licensed person by a licensed independent practitioner (LIP)

IV. GENERAL INFORMATION

A. Medications are prepared and administered in accordance with the orders of a licensed independent practitioner or other practitioner responsible for the patient's care, and in accordance with hospital policies; medical staff bylaws, rules, and regulations; and law and regulation.

B. Only persons authorized via their licensure/certification/scope of practice may order, dispense and/or administer medications. Medications brought in by an outside practitioner will not be authorized for use. Medication management will be a collaborative effort among all disciplines involved in medication use to ensure safe practices.

C. Medication administration will follow the bedside medication verification (MAR/BMV) process to include scanning of the patient armband and the medication bar-code prior to administration.

D. Medications are not dispensed without acknowledge of the patient's allergy status. In the event of an emergency and allergy status cannot be obtained, Pharmacy will dispense medication as appropriate.

E. Control of medications between receipt by an individual health care provider and administration of the medication, including safe storage, handling, security, disposition and return to storage will be in accordance with state and federal guidelines of medication control.

V. PROCEDURE

A. Patient Specific Information

1. **Pharmacy Essentials of Patient Information**

a. The following information is accessible to licensed independent practitioners and staff who participate in the management of the patient's medications.

1. Age
2. Sex
3. Diagnosis
4. Allergies
5. Sensitivities
6. Current Medications
7. Height (when applicable)
8. Weight (when applicable)
9. Pregnancy and lactation information (when applicable)
10. Laboratory results (when necessary)
11. Other information required by the organization

2. **Inpatient Medication Profile**

    a. All medications ordered for a patient will be entered into the hospital's computer drug profiling system, reviewed and verified by a pharmacist. The following are exceptions:

        1. Emergencies (e.g., Code Blue)
        2. Any situation in which the patient would be harmed if the medication were not given immediately.
        3. Medications administered directly by or under the supervision of a licensed independent practitioner (LIP).

    b. Pharmacist review of medication orders includes the following:

        1. Patient allergies or potential sensitivities
        2. Existing or potential interactions between the medication ordered and food and medications the patient is currently taking
        3. The appropriateness of the medication, dose, frequency and route of administration
        4. Therapeutic duplication
        5. Current or potential impact as indicated by laboratory values
        6. Other contraindications
        7. Variation from criteria for use
        8. Other relevant medication related issues or concerns

    c. After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.

    d. Each patient drug profile will include the following patient specific information:

        1. Patient's name
        2. Room location
        3. Admitting physician
        4. Primary diagnosis
        5. Age
        6. Sex
        7. Height
        8. Weight
        9. Estimated creatinine clearance if creatinine ordered/available and other recent laboratory data
        10. Body surface area
        11. Fluid restriction status when ordered
        12. Drug allergies

13. Pregnancy and lactation information
14. Dialysis or end stage renal disease information
15. Updated information regarding each of the above will be entered on the patient drug profile.
16. Each medication entered into the drug profile must include the following:
    i. Drug name
    ii. Strength
    iii. Frequency of use
    iv. PRN orders must have an indication
    v. Route of administration
    vi. Start and stop dates, if applicable
17. Important notes (i.e., allergy clarifications, patient history) pertinent to the patient may be recorded on the Pharmacy profile
18. The MAR is a real time medication record that is designed to provide online documentation of medication administration.

B. **Medication Ordering/Prescribing**

1. All medications require an order from a person lawfully authorized to prescribe.
    a. The following IV fluids may be ordered per hospital approved policy when associated treatments are prescribed by the physician. Nurse will indicate per policy order.
        1. Blood transfusions – Administer Normal Saline per BLOOD AND BLOOD PRODUCT ADMINISTRATION POLICY
        2. Flushes with saline or heparinized saline solution for IV lines, central venous access lines will follow policy: CENTRAL VASCULAR ACCESS DEVICES
        3. Chemotherapy tubing flushed with normal saline per CHEMOTHERAPY ADMINISTRATION OF PARENTERAL AND ORAL ANTINEOPLASTIC AGENTS
        4. Flush tubing of medications as indicated by pharmacy
        5. Nurse may hang a Normal Saline IV at max rate of 10ml/hr to facilitate IV access patency for low volume infusions (when no primary solution exists).
           E.g. PCA's, titratable drips, insulin
        6. Nurse may order solutions used to maintain pressure line monitoring devices, such as Arterial lines, CVP's and Swan Ganz catheters. (either Normal Saline or Heparinized saline -2unit/ml) per policy. CENTRAL VASCULAR ACCESS DEVICES
        7. For topical anesthetic cream and intradermal injection of

lidocaine for IV site preparation, refer to. I.V. THERAPY - PERIPHERAL

2. PRN orders must be written to include the symptom or indication for use.
    a. If the order is missing the indication or symptom, the nurse or pharmacist will contact the physician for clarification.

3. **Therapeutic Duplication**
    a. Therapeutic Duplication is the practice of prescribing multiple medications for the same indication or purpose without clear distinction of when one medication should be given in preference over another.
        1. In the event that an approved duplication in prescribing has occurred, the nurse administering the medication will give in reference to the route PO first, IV/IM second, and PR (per rectum) third.

4. **Pharmacy drug protocols**
    a. The Pharmacy and Therapeutics Committee will authorize pharmacists to manage and monitor the therapy of approved drugs according to protocol. Therapy is modified based on monitoring the patient's response as evaluated by the pharmacist per protocol.
    b. The Pharmacist is authorized to use the protocols only after demonstrating competency

5. **Do not use abbreviations**
    a. To be acceptable, only those symbols and abbreviations approved by the Pharmacy and Therapeutics (P&T) and Medical Executive (MEC) Committees may be used. Per P&T approval, those abbreviations on the "Do Not Use" list may not be used when writing medication orders nor can DNUA appear in any pre-printed order forms, MARs, H&Ps, and all other computerized documentation regarding medications. In an effort to reduce medication errors, the following abbreviations **MAY NO LONGER BE USED.** (Refer to: ATTACHMENT C)

6. **Verbal/Telephone Orders** (Refer to: Article X111 SVHMCS Medical Staff General Rules and Regulations)
    a. Orders dictated to a licensed person by an M.D., D.O., D.D.S., D.P.M., P.A., (authorized LIP) are known as verbal orders.
    b. Verbal orders can be given in emergency situations or situations when the authorized LIP is involved in a procedure and physically unable to enter the orders.
    c. Verbal orders or telephone orders for medications may be received by other physicians, licensed nurses, pharmacists, dietitians, respiratory care practitioners, speech therapists and physical therapists within the scope of their practice.
    d. Physician assistants may also receive and give verbal orders (including

medications and IV fluids) on a patient-specific basis from the supervising provider or pursuant to an approved protocol and as dictated by their scope of practice and clinical privileging.

e. The person receiving the verbal order must read back and verify the order to the ordering party for verification.

f. The verbal / telephone order must:

1. Be authenticated, dated, timed, and subsequently signed by the ordering authorized LIP or by another authorized LIP responsible for the care of the patient within forty-eight (48) hours.
2. The physician must remain on the line until the Telephone orders are read back and verified.
3. Telephone orders should be limited to short order sets, protocols .or a minimal number of individual orders necessary to initiate care

7. **Therapeutic Interchange**

a. Therapeutic interchange may occur when approved by the Pharmacy and Therapeutics Committee. If a medication is interchanged, the medication as ordered by the physician and the therapeutic interchange medication will be indicated on the Medication Administration Record.

8. **Order Clarification/Legibility**

a. To be acceptable, the order must include the name of the drug, the dosage and frequency of administration, indication for PRNs, the route of administration, and the date, time, and signature of the prescriber.

b. To be acceptable, the order must be legible. An illegible medication order is defined as when two nurses/pharmacists cannot interpret the order with 100% certainty. If an order is deemed illegible, the nurse or pharmacist will contact the physician for clarification and re-write the clarified order.

9. **Range Orders**

a. Medication orders containing a range in dose or a range in frequency are accepted with defined parameters.

10. **PRN Orders**

a. PRN or "as needed" medication orders are acceptable based on the following criteria:

1. The diagnosis, condition or indication for use of a PRN medication is documented in the medical record
2. The order contains all of the elements of a complete medication order. (i.e., dose, route, frequency, etc)
3. PRN orders for multiple medications or doses to treat the same indication or symptoms include, as part of the order, specific parameters or criteria for the use of each medication/dose that

clearly communicates and delineates when each medication is to be administered.

4. Medication orders with more than one route of administration (i.e. IV/PO) clearly define, as part of the order, the parameters for selecting the route of administration. (i.e. may give IV if unable to take po)

11. **Herbal Products**
    a. Herbal products which are not FDA approved are not included on the hospital formulary and will not be procured by the pharmacy.
    b. Patient **cannot** use their own Herbal products while in the hospital
    c. Orders for herbal products that may be appended to the patient's medication list during medication reconciliation will be discontinued by the pharmacist.
    d. The Pharmacy Department serves as a resource for potential drug/drug and food/drug interactions, and/or any other questions regarding these products.

12. **Titration/Tapering of Medications**
    a. **Titration**: A specific physician order is required for medications that are to be titrated. The medication may be increased or decreased to achieve the desired clinical response. The physician order must have parameters for titration. For standard IV compound concentrations, refer to PHARMACY: STERILE COMPOUNDING. The nurse will use the IV Medication Titration Guidelines. Refer to: Attachment F
        1. The following are required elements for titration orders:
            i. Drug name
            ii. Dose
            iii. Maximum and minimum dose
            iv. Route
            v. Frequency
            vi. Dose calculation requirements (if applicable)
            vii. Exact strength of concentration (if applicable)
            viii. Duration (if applicable)
            ix. Special instructions (if applicable)

    b. For titratable drips with specific vital sign parameters ordered, the RN may change the bedside monitor settings to align with the MD ordered parameter.
    c. **Taper orders**: A specific physician order is required for medications that are to be tapered.
    d. Medication orders are written with a starting dose and instructions to

adjust the dose and/or frequency.

13. **Pediatric Dosing of Medications**
    a. All neonatal and pediatric medications dosages for pediatric patients below 50 kg are to be ordered by the prescriber as a weight based dosing parameter and then the calculated dose.
    b. The prescriber must order a complete pediatric medication order including:
        1. The name of the medication
        2. Indication, if applicable
        3. The dose, weight-based or dosage parameter utilized to calculate the dosage regimen, if applicable, such as dose per weight (mg/kg, mcg/kg, etc.)
        4. Upon receipt of the order, the pharmacists will confirm the dose ordered by utilizing SVHMC pediatric medications list, accepted neonatal or pediatric references. Any dose that falls outside a normal dosages range by more than 10% will be confirmed with the Prescriber.
        5. The following drug classes are exempted from this requirement:
            i. Vitamins orally
            ii. Iron preparations orally
            iii. Topical preparations
            iv. Vaccines
    c. A list of pediatric medications available for use is developed for the most commonly used pediatric medications at SVHMC. (Refer to: ATTACHMENT D).

C. **Medication Transcription/Verification**

1. **Medication Administration**- Medications that are STAT and must be given prior to the medication entry on the MAR, will automatically populate the MAR upon removal from the automated dispensing cabinet. **Medication Administration (See** AUTOMATED DISPENSING MACHINE DRUG DISTRIBUTION SYSTEM)
2. **Medication Resources**
    a. The nurse will only administer medications for which he/she has basic knowledge.
    b. Appropriate resources for drug information include the physician, drug books, pharmacist, drug specific policy/procedure, online drug database(s).

3. **Persons Authorized To Administer Medications**
    a. Medications must be prepared and administered by licensed or lawfully authorized personnel within the scope of their practice and their job

description. These include:

b. Registered Nurses (RNs) who have passed the hospital medication examination.

c. Licensed Vocational Nurses (LVNs) who have passed the hospital medication examination.

d. Clinical Nurse Specialist (CNS)

e. Speech Therapists

f. Physicians

g. Physician Assistants (PAs)

h. Respiratory Care Practitioners (RCPs) (drugs related specifically to respiratory therapy)

i. Physical Therapists (PTs) (certain topical medications)

j. Certified Radiologic Technologists (CRTs) (all radiologic contrast media)

k. Pharmacists

l. Perfusionist

m. Student nurses who have passed the hospital medication examination and other allied healthcare provider students (note: may administer medications within their scope of practice when done under the direct supervision of their instructor or SVHMC preceptor).

n. Medical assistants

4. **Preparation of Medications**

a. Only medications obtained by the SVHMC Pharmacy will be used; practitioners may not use medications brought in from sources other than the hospital with the exception of :

1. the patient's own FDA approved medications if not available from the hospital pharmacy

2. Staff preparing medications must comply with all applicable medication policies/procedures.

3. Medications should be prepared, using aseptic technique in an environment where there is adequate light, free from distractions, an uncluttered, clean work surface, and with clean hands.

b. It is recommended that a separate work area be used for preparation to minimize the risk of contamination

c. A filtering device (e.g., filter straw, filter needle) must be used when drawing up the contents of an ampule, to ensure that all glass particles are removed from the medication before administration to the patient.

d. When medications are mixed in the same syringe or container, observe the mixed solutions to ensure that no precipitate or other evidence of

incompatibility has occurred.

e. When preparing/administering medications from multi dose vials the following applies:
    1. All multi-dose vials **expire** 28 days from the day the vial is opened, or per the manufacturer's recommendation, whichever is shorter.
        i. The date written on the multi-dose vial indicates the last day the medication is allowed for use.
    2. Exceptions:
        i. The expiration dates for multi dose ointments, inhalers, and liquids are assigned by the manufacturer; therefore the 28 day expiration date does not apply.
        ii. Insulin vials will be dispensed with a 28 day expiration label when dispensed from the pharmacy.
        iii. If a MDV is entered in a patient room, then the vial, per CDC guidelines becomes a single dose vial.
        iv. For Taylor Farms Family Health & Wellness Center vaccine management- all multi-dose vials of vaccines will be labeled with both the date of opening and the 28 day expiration date.
f. The nurse will calculate and document the expiration date for any multi dose vial opened on the nursing unit.
g. Single dose vials are used only **ONCE and then discarded immediately after use.**
h. Information on medication labels is displayed in a standardized format, in accordance with law and regulation and standards of practice.
i. Any time one or more medications are prepared but not administered immediately, the medication container must be appropriately labeled with the following:
    1. Drug name, strength and amount (if not apparent from the container)
    2. Expiration date when not used within 24 hours
    3. Expiration time when expiration occurs in less than 24 hours
    4. For all compounded IV admixtures and parenteral nutrition formulas, the date prepared and the diluent.

j. When the person preparing the medications is not the person administering the medication, the label **also includes** the following:
    1. Patient name
    2. Content

3. Beyond use date, if applicable
4. Patient location where the medication is to be delivered
5. Directions for use and any applicable accessory and cautionary statements
6. Additional information regarding medication preparation is located in *the IV Admixture* section.

k. Administration Procedure
    1. The person who opens or prepares the medication should normally administer and record the administration of the medication.
    2. Medication given by a physician:
        i. If an RN prepares a dose for the physician to administer, show the physician the container and verify the dosage. The physician, or RN charts the medication.
        ii. If recording a medication administered by a physician, the RN documents as GIVEN with an administration comment of Administered by Physician.

l. Before administering any medication the licensed person administering the medication will:
    1. Discuss any unresolved, significant concerns about the medication with the patient's physician or prescriber (if different from the physician).
    2. Examine and administer medications only from clearly labeled containers. If the integrity of a drug or drug package has been compromised or the labeling/packaging is confusing, it should not be used.
    3. Confirm that the medication order has been acknowledged prior to administering the medication.
    4. Verifies that there is no contraindication for administering the medication.
    5. When a patient is NPO for test purposes or surgery, determine if medications should be given with a sip of water or held. Contact the physician for direction and orders and document accordingly.

    6. Before administering PRN medications, the MAR must be checked to be sure the proper time interval has elapsed.
    7. Explain what the medication is for and advise the patient or patient's family of any potential clinically significant adverse reaction, side effects or other concerns. All medications will be considered "new" to the patient.

8. Provide a copy of the medication information sheet from an approved hospital source (i.e., Care Notes or Micromedex) as appropriate (i.e., patient/caregiver is ready/able to learn, has not already received printed materials, etc.).
9. Instruct the patient to inform the nurse immediately of any unusual responses.

m. Administer medication as follows:

1. Verify that the medication selected matches the medication and product label
2. Check the manufacturer's information printed on the medication vial, IV bag, etc. and ensures that it matches the pharmacy label for correct drug, solution, expiration date, etc.
3. Verify that the medication is stable based on visual examination for particulates, discoloration, or other loss of integrity.
4. Verify the medication is not expired.
5. Verify that no contraindications exist.
6. Verify that the correct medication is being administered to the correct patient at the proper time, in the prescribed dose, and by the correct route.
7. Discuss any unresolved concerns about the medication with the patient's licensed independent practitioner, prescriber (if different from the licensed independent practitioner), and/or staff involved with the patient's care, treatment and services.
8. Access the MAR to view the patient's medication profile.
9. Wash hands or use hand sanitizer upon entry into patient's room
10. Identify patient using 2 patient identifiers per hospital policy. PATIENT IDENTIFICATION POLICY
11. Check for patient allergies and alert armband. Verify patient by scanning armband.
12. Scan medications to be administered, complete documentation screens, submit to obtain the list of medications to be given
13. Administer medications
14. File documentation
15. Stay with patient until oral medication is taken. Do NOT leave medication at the bedside.
16. Wash or use hand sanitizer upon exit of the patient's room
17. Monitor the patient's response to the medication during the course of the ongoing reassessments and treatments, Monitoring should include the patient's own perception about side effects and efficacy.

18. If an adverse drug event occurs, follow the "Adverse Drug Reaction Program", report incident using on-line occurrence reporting program ADVERSE DRUG REACTION PROGRAM

n. For a patient in isolation:
    1. Per policy, wash hands or use hand sanitizer upon entry into patient's room.
    2. Apply personnel protective equipment as per policy. ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS
    3. Administer medications as outlined above.
    4. File documentation
    5. Remove personal protective equipment and wash or use hand sanitizer upon exit of the patient's room
    6. Use another set of gloves and sanitize WOW surface and scanner
    7. Sanitize hands again

o. Documentation of Medications Administered
    1. Medication administration is documented on the MAR. In departments where medication administration is not documented in the EMR, documentation will occur on procedural forms or department specific software. Medications not given (e.g. refused by patient, held due to vomiting), document as "Not Given" with a selected reason. Notify the physician if indicated.

p. Document PRN medication indications and response in the electronic record.

q. Medication orders for "HOLD"
    1. Must include the amount of time the medication is to held (e.g. number of doses or number of days). If this information is not included with the "hold" order, the medication will be discontinued from the patient's medication profile.

5. **Standardized Times Of Administration for Inpatients:**
    a. Medications shall be administered in a timely manner. Depending on a variety of factors, including but not limited to, the pharmacokinetics of the prescribed medication; specific clinical applications; and patient risk factors, medications – unless otherwise noted – shall be administered at scheduled time. In order to decrease unnecessary variability in the medication administration process, medications will be administered using established standard times as approved by P&T. Refer to: **Attachment A.**
    b. The following are considered appropriate reasons for deviating from standardized times of administration:

1. Physician order for specific times. If appropriate, the pharmacist will contact the physician for clarification.
2. Clinical indication, such as intolerance to multiple vasoactive agents thus requiring "staggered times" or when specific regimens or guidelines require deviations from standardized times.
3. Medications which are dependent on the timing of meals, nursing staff may adjust medication administration times as appropriate.

c. **Time-critical scheduled medications**:

1. Time-critical scheduled medications are those for which an early or late administration of greater than thirty minutes might cause harm or have significant, negative impact on the intended therapeutic or pharmacological effect. Accordingly, scheduled medications identified under the hospital's policies and procedures as time-critical must be administered within thirty minutes before or after their scheduled dosing time, for a total window of 1 hour.
2. It is possible for a given medication to be time- critical for some patients, due to diagnosis, clinical situation, various risk factors, or therapeutic intent, but not time-critical for other patients.
3. Time-critical scheduled medications/medication types include:
    i. Antibiotics;
    ii. Anticoagulants;
    iii. Insulin;
    iv. Anticonvulsants;
    v. Immunosuppressive agents;
    vi. Pain medication;
    vii. Medications prescribed for administration within a specified period of time of the medication order;
    viii. Medications that must be administered apart from other medications for optimal therapeutic effect; or
    ix. Medications prescribed more frequently than every 4 hours.

d. **Non-time-critical scheduled medications:**

1. Non-time critical scheduled medications are those for which a longer or shorter interval of time since the prior dose does not significantly change the medication's therapeutic effect or otherwise cause harm. For such medications greater flexibility in the timing of their administration is permissible. Specifically:

i. Medications prescribed for daily, weekly or monthly administration may be within 2 hours before or after the scheduled dosing time, for a total window that does not exceed 4 hours.

ii. Medications prescribed more frequently than daily but no more frequently than every 4 hours may be administered within 1 hour before or after the scheduled dosing time, for a total window that does not exceed 2 hours

e. **Evaluation of medication administration timing policies:**

1. Medication Safety Committee should periodically evaluate their medication administration timing policies, including staff adherence to the policies, to determine whether they assure safe and effective medication administration.

f. The first doses of medications will be administered as soon as possible after pharmacist review and entry into the patient's medication profile, and allowing adequate time for delivery (if required). Subsequent doses will be adjusted to standard times as soon as possible.

g. When a medication order is written, the pharmacist assigns the administration schedule based on the following schedule:

1. When there are two standardized scheduling options (indicated above as **EITHER**), the administration time will be scheduled based on the time *closest to the original order time*, or in order to stagger multiple IVPB medications due to the increased time required for administration of these medications.

2. When a medication is ordered in between a standardized time, the pharmacist and nurse will consult the "Catch up chart" to determine whether a dose should be given or not, and when the next dose is due. Refer to: **Attachment C**

3. When it is necessary for the medication to deviate from the standardized times of administration, the nurse may send an electronic pharmacy communication in the EMR system indicating the reason for the deviation. If the reason for deviating from the standardized time is not valid, the Pharmacy will not change the standardized administration times.

h. The last dose of **diuretics** should be administered no later than **1730** unless otherwise ordered by physician, or patient has a urinary catheter in place.

i. Medications ordered **"STAT"** receive priority and are dispensed to the patient within twenty (20) minutes. Medications ordered **"NOW"** are dispensed within one (1) hour. New routine orders are dispensed within four (4) hours. Initial antibiotics should be given within one (1) hour. Chemotherapy and TPN medications are never considered "STAT".

j. Missed or Late Administration of Medications

1. If a medication is not administered or is not administered within its permitted window of time, the following actions shall be taken:

i. Staff shall re-time administration of the next scheduled dose of medication based on the recommendations established in this policy.

ii. Pharmacy and/or the prescribing physician shall be contacted if staff have any concerns around re-timing of the medication.

iii. If the missed or late administration of a medication dose results in a significant medication error, then the attending physician is to be notified and an occurrence report generated.

k. Use of Professional Judgment

1. Staff are expected to use their professional judgment in organizing and prioritizing patient care work-loads to assure that medications are delivered in a safe and timely manner. In exercising such judgment staff must take into account the complex nature and variability among medications; the indications for which they are prescribed; the clinical situations in which they are administered; and the needs of the patients receiving them.

6. **Hazardous Medications:** Refer to HAZARDOUS DRUG HANDLING

7. **Look Alike Sound Alike Medications:**

a. Look Alike, Sound Alike are those medications that have brand or generic names or packaging that is similar enough to make errors possible or probable. LOOK ALIKE, SOUND ALIKE MEDICATION MANAGEMENT

8. **IV Medications:**

a. Use of an infusion pump is required for all medications, when possible.

1. NICU patients require use of a soluset.

b. When an infusion pump is used, the Guardrails® function should be implemented. Basic Infusion may be used when the medication is not available in Alaris Guardrails.

c. Certain IV push and IV infusion medications have restricted areas of usage. IV Push & IV Infusion Medication List. Refer to: **Attachment E**

9. **IV Admixtures:**

a. **Approved Departments For Admixing: Emergency Only**

IV admixtures should only be prepared in the pharmacy, except in

emergencies or when it is not feasible (for example, short product stability). If it is necessary to admix medications outside of the Pharmacy, only the following clinical departments may admix : Emergency Department, NICU (all ampicillin doses), Pediatrics (all ampicillin doses), and Surgery.

- (SUBPOINT OF 9.a): Note: The assembly of sterile products with the use of adapters (i.e., mini-bag-plus, ADD-vantage, VIAL-MATE, etc.) is not considered compounding, and is thus permitted on the nursing floors for immediate use, and the should be hung within one hour of assembly.

b. The nurse is required to pass a competency and should contact a Pharmacist if they have any questions about the medication, dilution, rate, dose or admix procedure.

10. **Pharmacy Procedures for Sterile Compounding** (See PHARMACY: STERILE COMPOUNDING: GENERAL PROCEDURES

11. **Self -Administration by Patient/Caregiver in Inpatient Departments**

a. Self-administration of medications (e.g., subcutaneous insulin injections, patients with insulin pumps refer to "**CARE OF PATIENT, CONTINUOUS SUBCUTANEOUS INSULIN PUMP** ") by patients is allowed under specified circumstances, but not encouraged. The competency of the patient is assessed prior to allowing patients to self-administer medications. A patient felt to be mentally or physically incompetent or incapacitated will not be allowed to self-administer medications.

b. Specific orders for self-administration of medication by the patient must be ordered by the physician.

c. The medication shall be clearly labeled by the Pharmacy Department.

d. The medication shall, unless otherwise ordered, be locked in the patient's cassette.

e. Proper administration techniques including frequency, route and dose will be reviewed with the patient by the physician, nurse or appropriate healthcare provider within their scope of practice. The patient will also be educated on how the medication is expected to perform, any side effects that may occur from taking the medication and how the patient can monitor the effects of the medications.

f. Non-staff members who wish to administer medications, such as parents, family members or patients, must be determined competent in administration prior to the granting of approval for medication administration.

1. Competency will be assessed by the Registered Nurse.
2. Competency assessment will consist of verification by the staff member of the patient's knowledge base related to the medication and educational concepts outlined above and

documented in the medical record.

3. If the non-staff member requesting to administer medications is not deemed competent to administer medications, he or she will not be allowed to do so until further education results in approval of competency.

12. **Responsible Person:**
    a. Attending Physician - Order for self-administration shall appear in the medical record.
    b. Attending Physician & RN - Patient shall be thoroughly instructed on how to take medication, including amount and time expected actions, side effects and results of medication, and demonstrates knowledge and understanding of same.
    c. RN - Patient education for self-administration of medication shall be documented in the medical record.
    d. An appropriate patient care provider licensed to administer medications will supervise the patient/caregiver's administration of medications and document the medication administration in the medical record and on the MAR as appropriate.
    e. **Bedside Medications for Self Administration: Inpatient Departments**
    No medications may be left at the patient's bedside, with the following exceptions:
        1. Continuous infusions containing medications.
        2. The patient's physician determines that it is in the patient's best interest to arrange for the medication to be readily available in the patient's room in order to alleviate distress associated with acute or chronic exacerbations of a medical condition that the patient recognizes and usually self-medicates. An example would be a rescue inhaler for the treatment of asthma, or an inhaler used for the chronic management of chronic obstructive pulmonary disease. In such cases, a written order by the physician must be obtained and documented in the electronic medical record for reference by nursing staff. This exception does not negate that, if available, an appropriate patient care provider licensed to administer medications supervise the administration of the medication and record the administration in the medical record.

    f. **Medications Administered by Respiratory Care Practitioners (RCPs)**
        1. All medications (MedNebs and MDIs) administered by RCP's will be reviewed by a Pharmacist prior to administration. The following are exceptions: STAT, emergencies (Code Blue), any situation in which the patient would be harmed if the medication were not given immediately, medications administered directly by or under the supervision of a physician.

2. MedNebs: For inpatients, the order will be entered onto the patient's medication profile, with a comment indicating that the medication is to be administered by the RCP. The doses are documented on the MAR.

g. **Metered Dose Inhalers (MDIs) - Inpatient Procedure:**

1. Respiratory Care Practitioners (RCPs) is notified of the new order.
2. The RCP will educate the patient in the proper use of the MDI while administering the first dose. It is recommended that the nurse attend the initial patient educational session. The RCP will record the dose administered on the patient's MAR and document the education provided.
3. If the patient is unable to use the inhaler properly, the RCP and nurse will collaborate to ensure that the patient is provided additional instruction.
4. All subsequent doses of MDIs will be administered by the nurse and recorded on the MAR.

h. **Medicated Patches (includes controlled substances):**

1. Initial Patch Application:
    i. When applying a medicated patch:
    ii. Remove "old" patch and cleanse the area to remove residual medication.
    iii. Date/Time/Initial the "new" patch.
    iv. Apply patch to the approved site as recommended by the manufacturer. (Most patches should not be applied directly over the heart).
    v. Document on the MAR
2. Follow-up Monitoring of Patch:
    i. Every shift: the nurse will check for patch placement.
    ii. Document and verify type of patch, location, and integrity.
3. Discontinuation or removal of non-controlled substance patches may be documented on a separate MAR entry called "Patch Removal" that allows the nurse to document the removal
4. Topical Controlled Substance patches removed from the patient must be properly disposed of and **not** simply discarded in a trash receptacle or Sharps container.
    i. For handling/disposal of fentanyl patches, refer to TRANSDERMAL FENTANYL PATCH CLINICAL PROCEDURE

ii. Removal/change of patch:

a. Using gloves, remove the topical controlled substance patch from the patient.

b. Fold the patch into itself (i.e., adhesive to adhesive) and discard in a pharmaceutical waste container.

c. Wasted patch requires a co-signature, documented on the MAR. Two (2) nurses, or one (1) nurse and a Pharmacist. The wastage must be observed by both persons.

d. Follow documentation for routine change using the "Patch Removal" MAR entry as described above

5. If a controlled substance patch is to be "wasted" due to contamination or other reasons, the same process above is to be followed

13. **Patient/Medication Monitoring:**

a. **General Requirements**

1. The effects of medications on patients are monitored to assess the:
2. Effectiveness.
3. Minimize the occurrence of adverse events.
4. Each patient's response relative to his or her clinical needs.

b. The patient care provider (nurse, respiratory therapist, physical therapist, etc.) will collaborate with members of the health care team to monitor and assess the effect of medications on the patient to include but not limited to the following:

1. Physical assessment to include the patient's physiologic responses (e.g., vital signs, intake, output, etc.).
2. Laboratory results.
    i. Lab values displayed on medication administration are reviewed by the nurse.
3. Diagnostic study results.
4. Relevant clinical documentation (i.e., progress notes, medication administration record, etc.).
5. Patient's perception about the side effects & perceived efficacy as appropriate.

c. New medications added to the hospital formulary:

1. Pharmacy will add the following information to the electronic

drug entry, if appropriate:

2. Indication
3. Common side effects
4. Monitoring parameters if needed
5. Protocol, guidelines, and staff education may be necessary for new formulary medications as determined by the Pharmacy and Therapeutics Committee.

d. Certain specific medication monitoring requirements may include, but is not limited to:

1. **Insulin**
    i. The latest MBG will display on the MAR screen upon scanning the insulin.
    ii. If no insulin dose is required, document "not given" and select no coverage from the drop down menu.
    iii. For patients receiving insulin who are scheduled to be NPO for a procedure, contact the physician for appropriate orders **before** the procedure.
2. **Antihypertensive Medications**
    i. Check the patient's blood pressure before administration. Record the blood pressure on the MAR
3. **Digoxin**
    i. Check the patient's apical pulse for one minute before administration. Record the patient's pulse on the MAR. Hold for pulse of less than 50 or bradycardia associated symptoms, or as ordered by the physician. Notify physician within 4 hours of holding Digoxin.
4. **Electrolytes**
    i. Check the patient's most recent laboratory data before administration. The most current electrolyte results will display on the MAR.
5. **Warfarin**
    i. The patient's most recent PT/INR will display on the MAR.

14. **Adverse Drug Events:**
    a. **Adverse Drug Reactions (ADR). "ADVERSE DRUG REACTION PROGRAM** -- Refer to : # 261"
    b. Reported via Electronic Occurrence reporting process
15. **Medication Errors**

a. "MEDICATION ERROR REDUCTION PROGRAM – Refer to : # 2248"

b. Reported via Electronic Occurrence reporting process

16. **Chart Check: Inpatient Departments:**

    a. In an effort to ensure orders, including medications, have been processed and reviewed for appropriateness of clinical condition, nurses should perform chart checks every shift.

        1. Chart checks are performed each shift, shifts are defined as either 8 or 12 hours.

    b. If a discrepancy is encountered and/or medication orders are deemed inappropriate for the patient's clinical condition, the nurse will reject the medication order and contact the physician to clarify the order.

    c. When medication order or related orders have not processed, the nurse will take the appropriate measures to ensure the processing of the order.

17. **Medications Brought To Hospital: Inpatient Departments:** (Note: This policy excludes the medication use process in the out-patient Sleep Disorders Center and the Cardiac Rehabilitation Center at SVHMC. See policy MEDICATION RECONCILIATION

    a. **Storage and Destruction**

        1. When nursing personnel receive patient medications that are not required for the patient while they are hospitalized, yet cannot be sent home the following procedure will be implemented:

            i. Medications will be placed in a tamper-evident security bag, and sealed with the patient acting as a witness. The receipt should be noted and logged in the charting system.

                a. In the event that the patient is an unreliable witness, the bag should be filled and sealed in the presence of two nursing personnel.

            ii. The sealed bag should be brought to pharmacy, where the bag number is tracked and logged by pharmacy personnel, and stored in a secure manner.

            iii. Upon discharge, the nurse retrieves the sealed medication bag from pharmacy and returns to the patient/family member

                a. Medications not picked up from the pharmacy will be discarded 30 days post discharge.

        2. When home medications are administered in the pharmacy

            i. Medications are presented and stored in pharmacy in a white manila envelope, or similar storage container.

i. In the event that a medication must be retrieved from a sealed bag (noted above), the bag will be opened in the presence of two pharmacy personnel, the medication retrieved, and resealed using tamper-evident technology. This entry and removal will be documented and tracked by pharmacy.

ii. Pharmacy counts and logs the medication for patient use, and dispenses the appropriate quantity to the floor for the patient's use.

iii. Upon Discharge, the nurse obtains the remaining quantity from pharmacy and returns to the patient.

3. **Use of Patient's Own Medications: refer to** PATIENT'S OWN MEDICATION USAGE

18. **Patient Education: Inpatient Departments**

a. **Medication Safety Education**
Whenever possible, patients should participate in ensuring medication safety. The patient should be educated to question the nurse if the medications being given do not look familiar. Instruct the patient to speak up, and ask the nurse to check and make sure the medication is correct.

b. **Medication Education**

1. Patients, families and/or significant others, as identified by the patient, will receive information about the medications being administered throughout the course of treatment. Individual medication information is available through the CareNotes system.

2. The patient will be instructed to report any problems with the medication as well as their perception of the effectiveness of the medication.

3. In non-inpatient departments, the nurse administering the medication will verbally educate the patient regarding the name of the medication, indications and any side effects that the patient may experience.

c. **Discharge Medications**
Patients will receive written and when appropriate, verbal education about the medications they will be receiving upon discharge from the hospital. Written information is available through the CareNotes system.

19. **Disposition of Medications**

a. **Unused/Discontinued medications**

1. The nurses will return any unused and expired medications to the pharmacy by the end of their shift.

2. See DRUG PROCUREMENT / INVENTORY CONTROL for outside destruction procedure.

b. **Transfer of Patient: Disposition of Medications**

1. Medications stored in patient's cassette will be placed in a plastic bag with patient's name and transferred **WITH** the patient.
2. The nurse will check the refrigerator for any IV's, piggybacks and TPN's and transfer **WITH** the patient.
3. The nurse will return any discontinued **non-controlled** medications to the pharmacy by placing the medications in a plastic bag labeled with patient's name, account number and clearly marked "discontinued."
4. The discontinued medications may be placed in the secured pharmacy return bin.

c. **Discharge of Patient: Disposition of Medications**

1. Most commonly prescribed medications, including scheduled drugs, are stored in the Pyxis. Upon discharge of the patient, the patient's medication profile becomes inactive.
2. Patient specific medications that are not available in Pyxis will be stored in a locked medication cassette on the nursing unit. Upon discharge of the patient, these medications will be returned to the Pharmacy by the nurse responsible for discharging the patient.
    i. The nurse will place the medications in a plastic bag and remove the cassette patient label on the outside of the cassette, and mark "patient discharged". (Patient name & account number are required for crediting information)
        a. The nurse will then place the plastic bag in the secured pharmacy return bin.
    ii. Medications that are unused and intact will be credited to the patient and re-used if appropriate.
    iii. Partially used bottles or vials of medications will be disposed of consistent with current hospital policy on pharmaceutical and other waste.

20. **Medication Processes in Non-Inpatient Departments**
Unless specified as "inpatient units only", procedures within this policy apply to both inpatient and non-inpatient departments. Additionally, this policy excludes the medication use process in the out-patient Sleep Disorders Center and Cardiovascular Diagnostic Outpatient Center at SVHMC.

    a. **Non-inpatient Departments**:

Diagnostic Imaging, Endoscopy, Cardiac Cath Lab, Taylor Farms Family Health and Wellness Center, Outpatient Infusion, Ryan Ranch CVDC, Mammography and the Emergency Department.

b. **Pharmacist Oversight**:
Pharmacy oversight for prescribed medications is required for patients that are in a non-inpatient department *waiting for admission or transfer to an inpatient department greater than 2 hours*. In all other instances, oversight for medication prescribing is the responsibility of the physician. The following are exceptions:

1. STAT or now orders
2. Emergencies (e.g., Code Blue)
3. Any situation in which the patient would be harmed if the medication were not given immediately
4. Medications administered directly by or under the supervision of a physician

c. **Patient Verification/Identification:**
Prior to medication administration, patient verification occurs when the patient is placed in the procedure room. The procedure for use of two identifiers, per Section "Administration Procedure" PATIENT IDENTIFICATION POLICY is required. During the procedure, verbal orders from the physician are transcribed by the nurse on to the procedural form or unit specific procedural computer program. Medication administration follows inpatient process for scanning of armband and medication where the MAR/BMV system is utilized.

d. **Documentation of Medications:**

1. The following units may require the documentation of medications in two different computer systems. In the event discrepancies in medication documentation times arise, the procedural computer program will be the official time of record.
    i. Diagnostic Imaging: Conscious Sedation Record , MAR
    ii. Endoscopy: Conscious Sedation Record/Provation
    iii. OPS: PICIS Pre-op Manager, MAR
    iv. PACU: PICIS PACU Manager
    v. Cardiac Cath Lab: Conscious Sedation Record
    vi. Emergency Department: MAR

e. **Medications Brought to Hospital**:
Medications brought to the hospital: by patients who are non-inpatients will remain in the possession of the patient.

f. **Patient Education:**
The nurse administering the medication will verbally educate the patient regarding the name of the medication, indications and any side effects

that the patient may experience.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as necessary..

VII. REFERENCES

A. ISMP

B. TJC Medication Management Standards

C. Tarascon Pocket Pharmacopoeia 2008 Deluxe Edition

D. Tarascon Internal Medicine & Critical Care Pocketbook 4th Edition

E. AHFS Drug Information 2012

F. Lexi-Comp Online – Accessed 2/13

G. Drug Information Handbook, 15th Edition, Lexi-comp

H. MicroMedex Online – Accessed 2/13

Attachments

A: Standardized Medication Times

B: Medication Catch Up Chart

C: Unapproved Abbreviations

D: Commonly Used Pediatric Weight-Based Formulary

E - IV PUSH & IV INFUSION MEDICATION LIST FINAL 3.2024.pdf

F - Adult Titration Continuous Infusions FINAL-3.2024.pdf

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
P&TC	Genevieve delos Santos: Director Pharmacy	07/2024

P&TC	Kiri Golleher: Pharmacy Clinical Coordinator	07/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024
Policy Owner	Genevieve delos Santos: Director Pharmacy	05/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **15934754**

Last Approved	N/A	Owner	Anna Linn: Clinical Manager
Next Review	1 year after approval	Area	Patient Care

Restraints

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide staff in the appropriate use of restraints for patients who exhibit behaviors that interfere with medical healing, or exhibit violent or self-destructive behaviors.

B. To describe and differentiate documentation and monitoring requirements when restraints are used for any behavior.

III. DEFINITIONS

A. Adaptive support: Will be provided in response to assessed patient need. Examples are: postural support, orthopedic appliances, tabletop chairs that can be removed by the patient.

B. Alternative Interventions: Interventions used to prevent escalation of behavior in order to prevent the use of restraints. Alternatives include, but are not limited to, environmental modification and/or use of family/patient safety attendant.

C. Forensic restraint: Handcuffs, manacles or shackles applied by law enforcement for custody, detention and public safety. Forensic restraints are not covered by this policy.

D. Combination of soft/hard restraint: A unique combination of both hard and soft restraint consisting of Kevlar material to be used in the Emergency Department only.

E. LIP: Licensed independent practitioner (physician)

F. Restraint:

1. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

2. A drug or medication (chemical restraint) used as a restriction to manage a patients behavior and is not a standard treatment/dosage for the patient condition.
    a. Types of restraints used at SVHMC include:
        i. Mittens (pinned or tied to the bed)
        ii. Soft wrist & ankle restraints
        iii. 4 side rails (to prevent a patient from voluntarily getting out of bed)
        iv. Combination Soft/Hard Restraints for use in Emergency Department only

G. Non-Violent/Non-Self-Destructive Restraint (NV/NSD): Restraint used to prevent the patient from removing vital equipment or therapies, and/or when a patient demonstrates lack of understanding or ability to comply with safety directions or needed precautions.

H. Violent/Self-Destructive Restraint (V/SD): Restraint used when a patient exhibits behavior that is unpredictable, intentional, and threatens the immediate physical safety of the patient, staff or others.

I. "Trial release" constitutes a PRN order and therefore, is not permitted. (Note: a temporary, directly-supervised release that occurs for the purpose of caring for the patient's needs is not considered a "trial release").

IV. GENERAL INFORMATION

A. SVHMC strives to be a restraint-free facility. Chemical restraint and seclusion are not used at SVHMC.

B. Alternative therapies should be attempted prior to the use of a restraint. If alternatives are not attempted due to the emergent nature of the situation the reasons alternatives were not attempted will be recorded in the EHR.

C. If restraints are used the least restrictive restraint is used. Mittens and soft restraints are considered to be the least restrictive form of restraints.

1. Physical restraint of a patient shall be used only if patient exhibits behaviors that interfere with medical healing, threatens the safety of the patient, staff or others and when less restrictive methods have failed. The type of restraint used must be the least restrictive method possible to protect the patient, staff members or others from harm, or to protect the healing process.
    a. RNs' assess and monitors need for continued restraint.
    b. Restraints may be discontinued by the RN as soon as is safely possible when the patient's behavior ceases to interfere with medical healing, or the violent or self-destructive behavior ceases.
    c. An order from a Licensed Independent Practitioner (LIP) is required for the use of restraints. In the event of emergency application of restraints, the physician must be notified following the application.
    d. Any LIP who is privileged to write orders at SVHMC can write restraint orders.

e. PRN or standing orders for restraints are not permitted.

f. The patient (or family if the patient is unable to participate) will be informed of the hospital's process for restraints and the reason for the current restraint.

2. Restraints must be discontinued when the behaviors/threats are no longer exhibited, regardless of the order timing.

3. Telephone orders must be dated, timed and signed by the ordering physician in accordance with hospital policy.

D. Exclusions

1. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.

2. The devices and methods listed here would not be considered restraints, and, therefore, not subject to these requirements. These devices are typically used in medical-surgical care.

a. Use of an arm board to stabilize an IV unless the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized.

b. A mechanical support to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support.

c. A medically necessary positioning or securing device use to maintain the positions, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures is not considered a restraint.

d. Recovery from anesthesia that occurs when the patient is in a critical care or post anesthesia care unit is considered part of the surgical procedure; therefore medically necessary restraint use in this setting would not need to meet the requirements of the regulation. However, if the intervention is maintained when the patient is transferred to another unit, or recovers from the effects of the anesthesia (whichever occurs first), a restraint order would be necessary.

e. Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails and crib covers).

f. A physical escort would include a "light" grasp to escort the patient to a desired location- the patient must be able to easily move or escape the grasp.

g. Side rails used to protect the patient from falling out of bed or necessary for operation of the bed. Examples include raising the rails when a patient is: on a stretcher, on an ICU bed where the use of all four rails is necessary

for operation of the bed, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of the bed.

V. PROCEDURE

A. Non-violent/Non Self-Destructive Restraint

A. Orders

1. A physician's order is required when restraints are used. Prior to the application of a restraint, the RN will contact the attending physician to obtain the order for restraint. Physician evaluation will be completed in accordance with the Medical Staff Bylaws and Rules/Regulations.
    a. In an emergency situation, the RN may authorize the application of a restraint, and will obtain the physician's order after the application of the restraint and the safety of the patient established.
2. If a physician other than the attending ordered the restraint, the attending physician shall be notified as soon as possible. Documentation by the physician, after the restraints have been applied, whether or not it addresses the restraint, shall constitute evidence that the physician was notified.
3. The physician's order must include
    a. Date and time of application
    b. Restraint type
    c. Reason for restraint
    d. Date and time of order
    e. The original order must be renewed every calendar day
4. **Monitoring Patients in Non-Violent/Non-Self-Destructive Restraint:** Patients in non-violent/non-self-destructive restraints will have a safety check completed at a minimum, every two hours. Areas may include, and as applicable, but are not limited to:
    a. Nutrition and hydration
    b. Hygiene and elimination
    c. Circulation and range of motion in extremities
    d. Skin condition and care
    e. Physical and psychological care and comfort
    f. Readiness for discontinuance of restraint
    g. Vital signs (as patient's condition warrants)
    h. Repositioning and body alignment

i. Release and reapplication of restraint for direct patient care measures as appropriate to patient's condition.

5. **Documentation of Restraints**: Document each episode of restraint in patient's medical record:
    a. When restraint first applied
    b. Once per shift as close to the end of the shift as possible according to the Attestation of Care, which verifies that RN has completed a safety check at a minimum every 2 hours.
    c. When discontinuing the restraints
    d. The circumstances that lead to the use of the restraint. This documentation must provide **a description of the patient's behavior** that lead to the use and /or continued use of restraints.
    e. Date and time family notified if patient unable to participate.
    f. The use of restraints will be reflected in the patient's plan of care

B. Violent/Self-Destructive Restraint

A. Orders

1. A physician's order is required when restraints are used.
    a. In an emergency situation, the RN may authorize the application of a restraint, and will obtain the physician order immediately after the application of the restraint and the safety of the patient stabilized.
2. Within one hour following the application of V/SD restraints, a face-to-face assessment of the patients' physical and psychological behavior must be completed by the LIP. The assessment must include:
    a. Patient's immediate situation
    b. Patient's reaction to restraint
    c. Patient's medical and behavioral condition
    d. The need to continue or terminate the restraint.
3. The physician's order must include:
    a. Date and time of application
    b. Restraint type
    c. Reason for restraint
    d. Date and time of order
4. Prior to the expiration of the order (per time frames in 5), the RN will contact the LIP to report the results of the most recent patient assessment for behaviors that required continued need for V/SD restraints and request the renewal of the original order.

5. The original order may be renewed within the required time frames up to 24 hours, for continued need for the V/SD restraint
    a. Every 4 hours for patients 18 years and older
    b. Every 2 hours for patients 9-17 years old
    c. Every 1 hour for patients under 9 years of age
6. At the expiration of the original order (24 hours) the LIP will see and assess for the continued need for the V/SD restraint and write a new order as necessary.
7. **Patient and Family Awareness**: Staff will inform the patient and the patients' family about the hospital restraint process and the reason for the restraint. The staff will inform the patient of criteria to be met in order to discontinue the use of restraints, and will assist the patient in meeting the criteria.
8. **Documentation and ongoing assessment of patients in Violent/Self Destructive (V/SD) Restraint**: Patients in V/SD restraints will have a safety check every 15 minutes. An electronic or written record of monitoring will be maintained in the medical record. Areas may include but are not limited to:
    a. Nutrition and hydration
    b. Hygiene and elimination
    c. Circulation and range of motion in extremities
    d. Skin condition and care
    e. Physical and psychological care and comfort
    f. Readiness for discontinuance of restraint
    g. Vital signs (if patient's condition warrants)
    h. Repositioning and body alignment
    i. Release and reapplication of restraint for direct patient care measures as appropriate to patient's condition.
9. **Documentation of Restraints**: Document each episode of restraint in patient's medical record:
    a. In the EHR, the RN will document:
        i. The circumstances that led to the use of the restraint. This documentation must provide **specific descriptions of the patient's behavior** that led to the use of restraints.
    b. In the one hour face-to-face evaluation, the physician or the RN will document:
        i. The least restrictive alternative attempted and the rational for the type of restraint used.
            a. The patient's immediate situation
            b. The patients reaction to the intervention
            c. The patient's medical and behavioral condition.

d. The patient's family was notified of the need for restraint and the hospitals policy on restraint use.

10. If the ordering physician is not the physician responsible for the care of the patient, document the consult with the responsible physician regarding application of the restraints. Consultation with the responsible physician must occur as soon as the patient is safe and the situation is stable.
11. Document safety checks on the V/SD screen or paper.

B. **Training**

1. RNs having direct patient care responsibilities, including agency personnel, must demonstrate competencies in according with the Education and Training Department requirements:
    a. Initially as part of orientation and at last every 3 years.
2. Emergency Department RNs and Security must demonstrate competencies/training on Soft/Hard restraints consisting of Kevlar material (Emergency Department use only) annually.

Death Reporting

A. The Accreditation and Regulatory (A&R) Department directly reports to CMS no later than the close of business on the next business day following knowledge of the patient's death associated with restraints:
    1. Deaths occurring during or within 24 hours of discontinuation of 2-point soft, cloth-like non-rigid wrist restraints used in combination with any other restraint device.
    2. Deaths associated with the use of other types of wrist restraints, such as 2-point rigid or leather wrist restraints.

B. The A&R Department maintains the internal log for deaths that occur in the following circumstances listed below. The log includes the information specified at 42 CFR §482.13(g)(4)(ii) and the log entry is made no later than seven days after the date of death of the patient. Hospitals must not send reports of these deaths directly to the RO:
    1. While a patient is in only 2-point soft, cloth-like non-rigid wrist restraints and there is no use of seclusion; and
    2. Within 24 hours of the patient being removed from 2-point soft, cloth-like nonrigid wrist restraints where there was no use of any other type of restraint or seclusion
    3. The information in the log is available upon request.
    4. The A&R Department will document in the patient's medical record, any patient whose death associated with the use of restraint or seclusion:
        a. The date and time the death was reported to CMS for deaths required to be directly reported; and
        b. The date and time the death was recorded in the internal log for deaths that are required to be logged and not directly reported to CMS.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed.

VII. REFERENCES

A. The Joint Commission's Comprehensive Accreditation Manual for Hospitals: Provision of Care Chapter

B. California Code of Regulations; Title 22, Section 70213(a)(b)(c).

C. Department of Health & Human Services, Center for Medicare & Medicaid Services; § 482.13 (e) Standard: Restraint for Acute Medical and Surgical Care.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	07/2024
CNO	Carla Spencer: Chief Nursing Officer	06/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024
Policy Owner	Anna Linn: Clinical Manager	06/2024

Standards

No standards are associated with this document

EXTENDED CLOSED SESSION
(if necessary)

(Report on Items to be Discussed in Closed Session)

(Joel Hernandez Laguna)

RECONVENE OPEN SESSION/
CLOSED SESSION REPORT

(Joel Hernandez Laguna)

ADJOURNMENT