Salinas Valley Memorial Healthcare System
A Public Healthcare District

February 19, 2021

TO: Members of the Board of Directors
Victor Rey, Jr. – President
Regina M. Gage – Vice President
Juan Cabrera – Secretary
Richard Turner – Treasurer
Joel Hernandez Laguna – Assistant Treasurer

Legal Counsel
Ottone Leach & Ray LLP

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

The Regular Meeting of the Board of Directors of the Salinas Valley Memorial Healthcare System will be held **THURSDAY, FEBRUARY 25, 2021, AT 4:00 P.M., IN THE DOWNING RESOURCE CENTER, ROOMS A, B & C AT SALINAS VALLEY MEMORIAL HOSPITAL, 450 E. ROMIE LANE, SALINAS, CALIFORNIA, OR BY PHONE OR VIDEO (Visit svmh.com/virtualboardmeeting for Access Information)**.

Please note: Pursuant to Executive Order N-25-20 issued by the Governor of the State of California in response to concerns regarding COVID-19, Board Members of Salinas Valley Memorial Healthcare System, a local health care district, are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

Pete Delgado
President/Chief Executive Officer

REGULAR MEETING OF THE BOARD OF DIRECTORS
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

THURSDAY, FEBRUARY 25, 2021
4:00 P.M. – DOWNING RESOURCE CENTER, ROOMS A, B & C
SALINAS VALLEY MEMORIAL HOSPITAL
450 E. ROMIE LANE, SALINAS, CALIFORNIA
OR BY PHONE OR VIDEO
(Visit svmh.com/virtualboardmeeting for Access Information)

Please note: Pursuant to Executive Order N-25-20 issued by the Governor of the State of California in response to concerns regarding COVID-19, Board Members of Salinas Valley Memorial Healthcare System, a local health care district, are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

AGENDA

		Presented By
I.	**Call to Order/Roll Call**	Victor Rey, Jr.
II.	**Closed Session** (See Attached Closed Session Sheet Information)	Victor Rey, Jr.
III.	**Reconvene Open Session/Closed Session Report** (Estimated time 5:00 pm)	Victor Rey, Jr.
IV.	**Report from the President/Chief Executive Officer**	Pete Delgado
V.	**Public Input**	Victor Rey, Jr.

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.

VI.	**Board Member Comments**	Board Members
VII.	**Consent Agenda—General Business**	Victor Rey, Jr.

(A Board Member may pull an item from the Consent Agenda for discussion.)

A. Minutes of the Regular Meeting of the Board of Directors, January 28, 2021
B. Financial Report
C. Statistical Report
D. Policies Requiring Board Approval
   1. RC NICU Laryngeal Mask Airway Clinical Procedure
   2. Cardiac Telemetry Monitoring and Management
   3. Skin-to-Skin Contact in the NICU
   4. Enteral Tubes Insertion Maintenance
   5. Discharge/Transition Planning Guidelines
   6. Specimen/Foreign Body
   7. Temporary Transvenous and Epicardial Pacing
   8. Chest Tube Management
   9. Observation Status Charge Generation

10. Circumcision
11. Fire Safety Management Plan
12. Ordering Supplies from Materials Management
13. Student Affiliations
14. The Emergency Medical Treatment and Active Labor Act (EMTALA)
15. Quality Assessment and Performance Improvement Plan 2021
16. Safety Management Plan

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

VIII. Reports on Standing and Special Committees

A. **Quality and Efficient Practices Committee** - Minutes from the February 22, 2021 Quality and Efficient Practices Committee meeting have been provided to the Board. Additional Report from Committee Chair, if any. — Juan Cabrera

B. **Finance Committee** - Minutes from the February 22, 2021 Finance Committee meeting have been provided to the Board. One proposed recommendation has been made to the Board. — Richard Turner

1. Recommend Board Approval of Board Resolution No. 2021-01 Declaring Its Intent to Reimburse Project Expenditures from Proceeds of Indebtedness

   This item will be considered under Agenda Item IX.

C. **Personnel, Pension and Investment Committee** – Minutes from the February 23, 2021 Personnel, Pension and Investment Committee meeting have been provided to the Board. One proposed recommendation has been made to the Board. — Regina M. Gage

1. Recommend Board Approval of (i) the Findings Supporting Recruitment of Adrian Jordan, MD, (ii) the Contract Terms for Dr. Jordan’s Recruitment Agreement, and (iii) the Contract Terms for Dr. Jordan’s Hospitalist Services Professional Services Agreement

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

D. **Community Advocacy Committee** – Minutes from the February 23, 2021 Community Advocacy Committee have been provided to the Board. Additional Report from Committee Chair, if any. — Regina M. Gage

IX. **Consider Board Resolution No. 2021-01 Declaring Its Intent to Reimburse Project Expenditures from Proceeds of Indebtedness** — Richard Turner

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

X. **Report on Behalf of the Medical Executive Committee (MEC) Meeting of February 11, 2021, and Recommendations for Board Approval of the following:** — Rachel McCarthy Beck, M.D.

A. From the Credentials Committee:
   1. Credentials Committee Report
B. From the Interdisciplinary Practice Committee:
   1. Interdisciplinary Practice Committee Report

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

XI. **Extended Closed Session** (if necessary) — Victor Rey, Jr.
(See Attached Closed Session Sheet Information)

XII. **Adjournment** – The next Regular Meeting of the Board of Directors is scheduled for **Thursday, March 25, 2021, at 3:00 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.

Notes: 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 Executive Assistant during regular business hours at 831-755-0741. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM BOARD OF DIRECTORS
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

[ ] **LICENSE/PERMIT DETERMINATION**
(Government Code §54956.7)

Applicant(s): (Specify number of applicants)____

[ ] **CONFERENCE WITH REAL PROPERTY NEGOTIATORS**
(Government Code §54956.8)

Property: (Specify street address, or if no street address, the parcel number or other unique reference, of the real property under negotiation): ____

Agency negotiator: (Specify names of negotiators attending the closed session):__________________________
____
Negotiating parties: (Specify name of party (not agent):____
Under negotiation: (Specify whether instruction to negotiator will concern price, terms of payment, or both):__
____

[ ] **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):
____, or
Case name unspecified: (Specify whether disclosure would jeopardize service of process or existing settlement negotiations):____

[ ] **CONFERENCE WITH LEGAL COUNSEL-ANTICIPATED LITIGATION**
(Government Code §54956.9)

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

Additional information required pursuant to Section 54956.9(e):____

Initiation of litigation pursuant to Section 54956.9(d)(4) (Number of potential cases):______________________

[ ] **LIABILITY CLAIMS**
(Government Code §54956.95)

Claimant: (Specify name unless unspecified pursuant to Section 54961):_________________________________
____

Agency claimed against: (Specify name):____

[ ] <u>THREAT TO PUBLIC SERVICES OR FACILITIES</u>
(Government Code §54957)

Consultation with: (Specify name of law enforcement agency and title of officer):________________________

[ ] <u>PUBLIC EMPLOYEE APPOINTMENT</u>
(Government Code §54957)

Title: (Specify description of position to be filled):____

[ ] <u>PUBLIC EMPLOYMENT</u>
(Government Code §54957)

Title: (Specify description of position to be filled):____

[ ] <u>PUBLIC EMPLOYEE PERFORMANCE EVALUATION</u>
(Government Code §54957)

Title: (Specify position title of employee being reviewed): _____________________________________

[ ] <u>PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE</u>
(Government Code §54957)

(No additional information is required in connection with a closed session to consider discipline, dismissal, or release of a public employee. Discipline includes potential reduction of compensation.)

[ ] <u>CONFERENCE WITH LABOR NEGOTIATOR</u>
(Government Code §54957.6)

Agency designated representative: (Specify name of designated representatives attending the closed session):_
____

Employee organization: (Specify name of organization representing employee or employees in question):
____, or

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

[ ] <u>CASE REVIEW/PLANNING</u>
(Government Code §54957.8)

(No additional information is required to consider case review or planning.)

[X] **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):
Strategic planning/proposed new programs and services

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

[X] **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. Report of the Medical Staff Quality and Safety Committee
2. Report of the Medical Staff Credentials Committee
3. Report of the Interdisciplinary Practice Committee

[ ] **CHARGE OR COMPLAINT INVOLVING INFORMATION PROTECTED BY FEDERAL LAW** (Government Code §54956.86)

(No additional information is required to discuss a charge or complaint pursuant to Section 54956.86.)

ADJOURN TO OPEN SESSION

CALL TO ORDER/ROLL CALL

(VICTOR REY, JR.)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

(VICTOR REY, JR.)

RECONVENE OPEN SESSION/
CLOSED SESSION REPORT
(ESTIMATED TIME: 5:00 P.M.)

(VICTOR REY, JR.)

REPORT FROM THE PRESIDENT/ CHIEF EXECUTIVE OFFICER

(VERBAL)

(PETE DELGADO)

PUBLIC INPUT

BOARD MEMBER COMMENTS

(VERBAL)

REGULAR MEETING OF THE BOARD OF DIRECTORS
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

THURSDAY, JANUARY 28, 2021 – 4:00 P.M.
CISLINI PLAZA BOARD ROOM
SALINAS VALLEY MEMORIAL HOSPITAL
450 E. ROMIE LANE, SALINAS, CALIFORNIA AND BY PHONE
OR VIDEO (VISIT svmh.com/virtualboardmeeting FOR ACCESS INFORMATION)

Pursuant to Executive Order N-25-20 issued by the Governor of the State of California in response to concerns regarding COVID-19, Board Members of Salinas Valley Memorial Healthcare System, a local health care district, are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

Present: President Victor Rey, Jr., Directors Regina M. Gage, Joel Hernandez Laguna in person; Directors Richard Turner and Juan Cabrera by teleconference.

Also Present: Pete Delgado, President/Chief Executive Officer; Rachel McCarthy Beck, M.D., Chief of Staff, in person; Matthew Ottone, District Legal Counsel, by teleconference.

A quorum was present and the meeting was called to order by Vice President Regina M. Gage at 4:06 p.m.

Closed Session

Vice President Regina Gage announced that the closed session items to be discussed in Closed Session as listed on the posted Agenda are: (1) Report Involving Trade Secret – strategic planning/proposed new programs and services; and (2) Hearings/Reports – Report of the Medical Staff Credentials Committee, and Report of the Interdisciplinary Practice Committee.

The meeting was recessed into Closed Session under the Closed Session Protocol at 4:04 p.m.

Victor Rey, Jr., joined the meeting at 4:18 p.m.

The Board completed its business of the Closed Session at 5:00 p.m.

Reconvene Open Session/Report on Closed Session

The Board reconvened Open Session at 5:04 p.m. President Victor Rey, Jr. announced that in Closed Session the Board discussed: (1) Report Involving Trade Secret - strategic planning/proposed new programs and services; and (2) Hearings/Reports – Report of the Medical Staff Credentials Committee, and Report of the Interdisciplinary Practice Committee.

No action was taken by the Board in the Closed Session.

Mr. Rey stated that Agenda Item XI. – Extended Closed Session will not be held.

Appointment of Board Members to Standing Committees of the Board and Medical Staff Committees

Board President Rey made the following appointments of Board Members to standing committees of the Board for 2021-2022, and the medical staff committees:

Personnel, Pension and Investment Committee (Monthly)
Chair: Regina M. Gage
Vice Chair: Richard Turner

Quality and Efficient Practices Committee (Monthly)
Chair: Juan Cabrera
Vice Chair: Joel Hernandez Laguna

Finance Committee (Monthly)
Chair: Richard Turner
Vice Chair: Juan Cabrera

Transformation, Strategic Planning, and Governance Committee (Quarterly)
Chair: Joel Hernandez Laguna
Vice Chair: Richard Turner

Corporate Compliance and Audit Committee (Quarterly)
Chair: Juan Cabrera
Vice Chair: Joel Hernandez Laguna

Community Advocacy Committee (Quarterly)
Chair: Regina M. Gage
Vice Chair: Joel Hernandez Laguna

Medical Staff Committees

Joint Conference Committee (Quarterly)
Joel Hernandez Laguna
Victor Rey, Jr.

Quality and Safety Committee (Monthly)
One Board Member, alternating every quarter

There was brief discussion among the Board regarding the Quality and Safety Committee Meetings and recommendations to change dates / times of committee meetings.

Report from the President/Chief Executive Officer

Pete Delgado, President/Chief Executive Officer, shared the following thoughts: SVMHS came into the pandemic with a number of strengths - financial, employee engagement, and physician alignment. Hospital leadership quickly focused their time, talents and resources to effectively navigate the personal protective equipment supply chain to provide a safe environment for staff

and patients. Along the way, the Hospital developed aggressive case management and quickly responded to a surge in COVID cases by turning med/surg beds into ICU/isolation rooms and leveraging all clinical staff with an RN license to assist on the floors. Thanks was given to all staff for safely and successfully serving Hospital patients through this challenging pandemic.

The President/CEO's Report by Pete Delgado, President/CEO, members of Hospital Leadership and others, began with a Mission Moment about compassionate care and technology. A summary of key highlights, centered around the pillars that are the foundation of the Hospital's vision for the organization, and industry news, is as follows:

- Service
  - Clement Miller, Chief Operating Officer/Interim Chief Nursing Officer, introduced Sheilah Quentin, BSN, RN-CAPA, Chair, Professional Development Council, who presented the following activities of the Professional Development Council in 2020 and goals for 2021:
    - The Council is one of five central councils that comprise the shared governance model. The primary focus is to create a culture that values the advancement of nursing practice by recognizing nurses' accomplishments, contributions and dedication to lifelong learning.
    - The Council implements and evaluates processes that support and enhance the professional growth and development of its registered nurses. The Education Department hosted three specialty certification review classes in 2020 and two sessions are planned in 2021. Since the implementation of the Magnet journey, baseline certification and BSN rates have increased. The Education Department is in the process of developing a new oncology certification course.
    - The Council revised the Nurse of the Year award by expanding recognition into five categories to be awarded during Hospital Week. Implementation is pending the status of the pandemic.
    - 2021 Goals:
      - Support and encourage staff to pursue professional achievements: advanced degrees and specialty certifications
      - Monitor organizational vacancy and turnover rates to identify trends and opportunities for improvement
- Growth
  - Tiffany DiTullio, Executive Director, Blue Zones, provided an update of the Blue Zones Project Monterey County Expansion Project which began October 1, 2020. Colleagues have been hired and training and certification is in process. The expansion was announced through a virtual event on January 7, 2021.
- Finance
  - Legislative activities at the state and federal levels were reviewed by Kendra Howell, Director of Government Affairs.
- Quality
  - SVMHS was rated four stars in patient experience by the Centers for Medicare and Medicaid Services.
  - Nutrition Services was recognized by patients for its outstanding hospital food and service.
- People
  - Staff and physicians have been offered a COVID-19 vaccine.
  - The Annual Wellness at Work program for staff begins next week. Exercise Challenge also begins next week for staff and the community to encourage people to exercise.

  - In an effort to recognize all staff for their outstanding efforts, the Hospital offered a free jacket or vest with a hat. The Hospital also implemented Thankful Tuesdays to allow staff to receive a free lunch on Tuesdays.
  - Pete Delgado, President/CEO, visited staff on December 25 to thank them for their outstanding efforts.
  - An Ask the Experts Facebook Live event was recently held in English and Spanish where Pablo Romero, MD, discussed the importance of vaccines and how they work.
- Community
  - On behalf of the Salinas Downtown Rotary Club, Tiffany DiTullio, President, presented a check to the SVMH Foundation in the amount of $22,250. Funds were raised by the Club to help support families of SVMHS COVID-19 patients.
  - Monterey County’s first baby of 2021 was welcomed at SVMHS.
  - Several activities are planned in February for Heart Month.
  - Earned Media: COVID cases, vaccines, and Blue Zones Expansion and articles in Bloomberg, New York Times and the San Francisco Chronicle.
- Industry News
  - Houston hospital lockout forces physicians to treat patients in parking lot
  - Adeptus Health declares bankruptcy
  - Chicago, Los Angeles hospitals slated to close
  - State-by-state breakdown 897 hospitals at risk of closing
  - Tenant aims to acquire up to 40 surgery centers this year
  - Optum expects to add 10,000 physicians this year
  - Optum to buy Change Healthcare in $13B deal
  - 8 health systems opening new hospitals

Director Joel Hernandez Laguna commented on the collaborative Blue Zones Project Monterey County: Expansion Announcement event and the tremendous work of staff to include efforts toward building community gardens in North Salinas and East Salinas.

Public Input

An opportunity was provided for persons in the audience to make a brief statement, not to exceed three (3) minutes, on issues or concerns not covered by the agenda.

None.

Board Member Comments

Director Hernandez Laguna commented on the Ask the Experts Facebook Live forum with Pablo Romero, MD, which was used as a training tool for community health workers appointed by the Center for Community Advocacy to provide COVID-19 and vaccination information to the community. Mr. Hernandez Laguna also noted the gratitude expressed by Hartnell College of Salinas Valley Memorial Healthcare System’s outstanding support of its new nursing and health sciences center and opportunity for clinical rotations at the Hospital.

Director Gage thanked everyone at SVMHS for continued efforts to provide excellent care to the community.

Director Cabrera thanked everyone for the excellent efforts of the Blue Zones Monterey County Expansion Project. He also extended appreciation to everyone for keeping the community and staff safe during the pandemic, to the nurses and physicians for their outstanding efforts, and to the leadership team for maintaining financial stability.

Director Turner commented on everyone's great work - you all rock!

President Rey commented on his tour of the Hospital's COVID units and Pharmacy Department in December, He was pleased to see how the equipment purchased by the Hospital has been utilized and how quickly med/surg rooms were turned into isolation rooms to meet the needs of the community. Positive feedback and outlooks were received from nurses and physicians. Mr. Rey ended his comments by stating that there are not enough words to express appreciation to everyone.

Consent Agenda – General Business

A. Minutes of the Annual Meeting of the Board of Directors, December 17, 2020
B. Minutes of the Special Meeting of the Board of Directors, December 11, 2020
C. Financial Report
D. Statistical Report
E. Policies Requiring Board Approval
    1. Group Beta Streptococcus Perinatal Screening and Management
    2. RC NICU Surfactant Administration Clinical Procedure
    3. Cardiac Wellness: Patient Arrival Requirements for Cardiac Rehabilitation Therapy
    4. Abbreviations Use
    5. Preceptor Policy
    6. Scope of Service: Medical Staff Services

Mr. Rey presented the consent agenda items before the Board for action. This information was included in the Board packet.

No Public Comment.

> MOTION: The Board of Directors approves Consent Agenda – General Business, Items (A) through (E), as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

Consent Agenda – Approved Projects

A. Lease Assignment and Assumption with Liliart Publishing Company, LLC and The Fred and Margaret Goldsmith Living Trust for 451 Washington Street, Monterey, California

Mr. Rey presented the consent agenda item before the Board for action.

No Public Comment.

> MOTION: The Board of Directors approves Consent Agenda – Approved Projects, Item (A) as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

Reports on Standing and Special Committees

Finance Committee

Richard Turner, Committee Chair, reported the minutes from the Finance Committee Meeting of January 25, 2021, were provided to the Board. Background information supporting the proposed recommendations made by the Committee was included in the Board packet and summarized by Director Turner:

1. Recommend Board Approval of Change Order in Disaster Recovery Services from CloudWave as Sole Source Justification and Contract Award

No Public Comment.

> MOTION: The Board of Directors approves a change order in disaster recovery services from CloudWave as sole source justification and contract award for $100,894 over the life of the 61-month agreement, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

2. Recommend Board Approval of Project Budget and Lease Agreements for Development of 212 San Jose Street Suites 100 and 201

No Public Comment.

> MOTION: The Board of Directors approves the following: (i) the project budget for the development of 212 San Jose Street, Suites 100 and 201, in the amount of three million eight hundred twenty-five thousand two hundred eighty-one dollars ($3,825,281.00); (ii) Lease Agreement with Monterey Bay Endoscopy Center, LLC for 212 San Jose Street, Suite 100; and, (iii) Lease Agreement with Monterey Bay GI Consultants Medical Group, Inc. for 212 San Jose Street, Suite 201 (with final review of documents by District Legal Counsel), as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

3. Recommend Board Approval of Agreements Necessary for the Transition of Salinas Family Practice Medical Clinic, Inc. to Salinas Valley Medical Clinic

No Public Comment.

> MOTION: The Board of Directors approves the following agreements: (i) Clinic Professional Services Agreements with Mark Adame, MD and Douglas Cambier, MD;

(ii) Agreement for Purchase and Sale of Assets between Salinas Valley Memorial Healthcare System and Salinas Family Practice Medical Clinic, Inc. and CHM Leasing; (iii) Lease Agreement between CHM Leasing and Salinas Valley Memorial Healthcare System; and (iv) Sublease and Services Agreement between Salinas Valley Memorial Healthcare System and Salinas Family Practice Medical Clinic, Inc., as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

4. Recommend Board Approval of Epic Community Connect Project and Program Budget

No Public Comment.

MOTION: The Board of Directors approves the Epic Community Connect Project and Program Budget in the amount of four million one hundred sixty thousand two hundred sixty-five dollars ($4,160,265) over five years, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

Transformation, Strategic Planning and Governance Committee

Victor Rey, Jr., Committee Chair, reported the minutes from the Transformation, Strategic Planning and Governance Committee Meeting of January 26, 2021, were provided to the Board. No action was taken by the Committee.

Report on Behalf of the Medical Executive Committee (MEC) Meeting of January 14, 2021, and Recommendations for Board Approval of the following:

The following recommendations from the Medical Executive Committee (MEC) Meeting of January 14, 2021, were reviewed by Rachel McCarthy Beck, M.D., Chief of Staff, and recommended for Board approval.

Recommend Board Approval of the Following:

A. From the Credentials Committee:
   1. Credentials Committee Report
B. From the Interdisciplinary Practice Committee:
   1. Interdisciplinary Practice Committee Report

No Public Comment.

Dr. Beck commended the outstanding efforts of the Hospital and Medical Staff Services to administer the COVID-19 vaccine to physicians.

MOTION: The Board of Directors approves Recommendations (A) through (B) of the January 14, 2021, Medical Executive Committee Meeting, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

Extended Closed Session

An Extended Closed Session was not held.

Adjournment – The next Regular Meeting of the Board of Directors is scheduled for Thursday, February 25, 2021, at 4:00 p.m. There being no further business, the meeting was adjourned at 6:30 p.m.

Juan Cabrera
Secretary, Board of Directors

/ks

SALINAS VALLEY MEMORIAL HOSPITAL
SUMMARY INCOME STATEMENT
January 31, 2021

	Month of January,		Seven months ended January 31,	
	current year	**prior year**	**current year**	**prior year**
Operating revenue:				
Net patient revenue	$ 52,093,651	$ 50,726,711	$ 341,762,921	$ 341,649,722
Other operating revenue	1,100,917	802,767	9,042,060	9,867,402
Total operating revenue	53,194,568	51,529,478	350,804,981	351,517,124
Total operating expenses	43,029,898	40,729,604	290,880,695	272,016,543
Total non-operating income	(4,517,015)	714,354	(20,371,347)	(9,773,255)
Operating and non-operating income	$ 5,647,655	$ 11,514,228	$ 39,552,939	$ 69,727,326

SALINAS VALLEY MEMORIAL HOSPITAL
BALANCE SHEETS
January 31, 2021

	Current year	Prior year
ASSETS:		
Current assets	$ 410,871,460	$ 289,436,747
Assets whose use is limited or restricted by board	138,617,245	122,927,003
Capital assets	258,439,413	249,398,209
Other assets	187,407,642	187,832,365
Deferred pension outflows	83,379,890	62,468,517
	$ 1,078,715,650	$ 912,062,842
LIABILITIES AND EQUITY:		
Current liabilities	152,234,647	81,336,352
Long term liabilities	14,780,831	17,645,000
	126,340,336	108,929,468
Net assets	785,359,836	704,152,022
	$ 1,078,715,650	$ 912,062,842

SALINAS VALLEY MEMORIAL HOSPITAL
SCHEDULES OF NET PATIENT REVENUE
January 31, 2021

	Month of January,		Seven months ended January 31,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	2,155	2,208	12,099	13,557
Medi-Cal	1,121	1,080	7,617	7,555
Commercial insurance	918	756	5,589	5,994
Other patient	92	111	980	773
Total patient days	4,286	4,155	26,285	27,879
Gross revenue:				
Medicare	$ 89,275,838	$ 99,254,893	$ 568,607,622	$ 599,096,745
Medi-Cal	53,083,675	58,459,044	373,422,605	369,431,688
Commercial insurance	48,822,980	46,238,586	346,982,400	344,785,811
Other patient	7,967,921	9,087,934	60,479,514	60,193,466
Gross revenue	199,150,414	213,040,456	1,349,492,141	1,373,507,709
Deductions from revenue:				
Administrative adjustment	590,340	399,449	2,370,481	2,464,073
Charity care	1,263,827	1,514,164	6,516,386	7,213,469
Contractual adjustments:				
Medicare outpatient	19,223,263	27,250,282	166,825,661	181,630,416
Medicare inpatient	43,362,590	47,131,414	259,891,083	278,904,943
Medi-Cal traditional outpatient	2,018,330	3,182,452	13,726,968	21,209,530
Medi-Cal traditional inpatient	8,099,914	6,076,797	55,390,282	38,862,766
Medi-Cal managed care outpatient	15,277,900	23,307,714	123,741,299	142,170,541
Medi-Cal managed care inpatient	20,441,324	17,479,600	132,418,675	124,324,406
Commercial insurance outpatient	12,665,333	16,030,667	106,302,052	100,276,136
Commercial insurance inpatient	20,180,991	15,208,564	108,064,998	102,639,090
Uncollectible accounts expense	3,216,019	3,627,132	24,819,272	24,492,325
Other payors	716,932	1,105,508	7,662,063	7,670,290
Deductions from revenue	147,056,763	162,313,745	1,007,729,220	1,031,857,987
Net patient revenue	$ 52,093,651	$ 50,726,711	$ 341,762,921	$ 341,649,722
Gross billed charges by patient type:				
Inpatient	$ 125,522,978	$ 114,112,219	$ 754,859,351	$ 731,360,054
Outpatient	51,559,925	69,213,082	447,584,701	455,245,708
Emergency room	22,067,511	29,715,156	147,048,090	186,901,948
Total	$ 199,150,414	$ 213,040,456	$ 1,349,492,142	$ 1,373,507,709

SALINAS VALLEY MEMORIAL HOSPITAL
STATEMENTS OF REVENUE AND EXPENSES
January 31, 2021

	Month of January,		Seven months ended January 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 52,093,651	$ 50,726,711	$ 341,762,921	$ 341,649,722
Other operating revenue	1,100,917	802,767	9,042,060	9,867,402
Total operating revenue	53,194,568	51,529,478	350,804,981	351,517,124
Operating expenses:				
Salaries and wages	16,567,936	15,069,167	113,265,665	101,876,401
Compensated absences	2,526,510	2,555,957	18,688,981	18,114,773
Employee benefits	7,703,965	8,340,391	51,975,992	52,467,656
Supplies, food, and linen	6,334,207	6,029,937	43,808,456	39,665,052
Purchased department functions	3,172,890	3,320,666	21,448,862	21,098,655
Medical fees	1,901,467	1,596,100	11,947,514	11,642,242
Other fees	1,842,158	1,145,464	9,079,385	7,551,071
Depreciation	1,811,371	1,698,815	12,487,903	11,791,301
All other expense	1,169,394	973,107	8,177,937	7,809,392
Total operating expenses	43,029,898	40,729,604	290,880,695	272,016,543
Income from operations	10,164,670	10,799,874	59,924,286	79,500,581
Non-operating income:				
Donations	166,667	166,667	1,666,667	1,170,867
Property taxes	333,333	333,333	2,333,333	2,333,333
Investment income	(71,821)	2,150,552	2,037,743	2,023,325
Taxes and licenses	0	0	0	0
Income from subsidiaries	(4,945,194)	(1,936,198)	(26,409,090)	(15,300,780)
Total non-operating income	(4,517,015)	714,354	(20,371,347)	(9,773,255)
Operating and non-operating income	5,647,655	11,514,228	39,552,939	69,727,326
Net assets to begin	779,712,181	692,637,794	745,806,898	634,424,696
Net assets to end	$ 785,359,836	$ 704,152,022	$ 785,359,836	$ 704,152,022
Net income excluding non-recurring items	$ 5,647,655	$ 11,514,228	$ 37,933,830	$ 69,902,683
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	0	0	1,619,109	(175,357)
Operating and non-operating income	$ 5,647,655	$ 11,514,228	$ 39,552,939	$ 69,727,326

SALINAS VALLEY MEMORIAL HOSPITAL
SCHEDULES OF INVESTMENT INCOME
January 31, 2021

	Month of January,		Seven months ended January 31,	
	current year	prior year	current year	prior year
Detail of other operating income:				
Dietary revenue	$ 126,487	$ 145,474	$ 945,762	$ 1,192,758
Discounts and scrap sale	(666)	218,957	222,654	1,068,159
Sale of products and services	11,317	13,633	161,250	159,409
Clinical trial fees	0	0	46,128	0
Stimulus Funds	0	0	0	0
Rental income	145,184	130,444	1,115,503	1,003,298
Other	818,595	294,259	6,550,763	6,443,778
Total	$ 1,100,917	$ 802,767	$ 9,042,060	$ 9,867,402
Detail of investment income:				
Bank and payor interest	$ 109,167	$ 303,745	$ 972,614	$ 1,634,278
Income from investments	(179,871)	1,846,807	1,036,496	385,390
Gain or loss on property and equipment	(1,117)	0	28,633	3,657
Total	$ (71,821)	$ 2,150,552	$ 2,037,743	$ 2,023,325
Detail of income from subsidiaries:				
Salinas Valley Medical Center:				
Pulmonary Medicine Center	$ (82,010)	$ (162,027)	$ (1,255,723)	$ (733,602)
Neurological Clinic	(119,245)	(97,104)	(568,205)	(500,423)
Palliative Care Clinic	(111,340)	(8,660)	(545,008)	(376,696)
Surgery Clinic	(218,412)	(68,161)	(1,169,287)	(584,430)
Infectious Disease Clinic	(38,830)	(8,815)	(211,777)	(168,042)
Endocrinology Clinic	(236,882)	(124,636)	(1,332,827)	(894,352)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(530,306)	(222,181)	(3,463,636)	(3,002,962)
OB/GYN Clinic	(402,268)	(76,790)	(2,541,658)	(1,194,868)
PrimeCare Medical Group	(1,436,277)	(384,130)	(6,682,646)	(3,741,925)
Oncology Clinic	(250,280)	(136,702)	(1,814,162)	(1,416,994)
Cardiac Surgery	(373,472)	(83,391)	(1,231,757)	(611,614)
Sleep Center	(109,029)	(55,609)	(480,335)	(489,322)
Rheumatology	(82,615)	(36,905)	(402,838)	(149,458)
Precision Ortho MDs	(587,681)	(220,925)	(2,842,668)	(1,868,805)
Precision Ortho-MRI	(100)	548	(1,363)	6,637
Precision Ortho-PT	(64,833)	24,652	(329,496)	(3,667)
Dermatology	(49,153)	16,031	(227,452)	29,250
Hospitalists	0	(2)	0	(2)
Behavioral Health	(95,848)	(48,919)	(504,644)	(334,312)
Pediatric Diabetes	(37,436)	(23,139)	(235,601)	(207,249)
Neurosurgery	(68,755)	(9,867)	(249,665)	(123,095)
Multi-Specialty-RR	(30,025)	21,976	(1,878)	82,904
Radiology	(322,591)	0	(1,463,122)	0
Total SVMC	(5,247,388)	(1,704,756)	(27,555,748)	(16,283,027)
Doctors on Duty	218,535	251,430	207,688	499,109
Assisted Living	(7,965)	(4,836)	(49,548)	(40,863)
Salinas Valley Imaging	0	(22,465)	(19,974)	22,844
Vantage Surgery Center	28,591	61,369	145,340	134,247
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	133,147	159,115	545,786	1,025,986
Aspire/CHI/Coastal	(104,430)	(695,085)	(306,472)	(1,046,204)
Apex	(8,268)	55,221	39,189	118,980
21st Century Oncology	(12,454)	(35,319)	(116,907)	106,331
Monterey Bay Endoscopy Center	55,038	(872)	701,556	161,816
Total	$ (4,945,194)	$ (1,936,198)	$ (26,409,090)	$ (15,300,780)

SALINAS VALLEY MEMORIAL HOSPITAL
BALANCE SHEETS
January 31, 2021

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 297,450,193	$ 186,121,157
Patient accounts receivable, net of estimated uncollectibles of $24,204,049	93,746,118	83,266,423
Supplies inventory at cost	8,605,987	6,257,737
Other current assets	11,069,163	13,791,431
Total current assets	410,871,460	289,436,747
Assets whose use is limited or restricted by board	138,617,245	122,927,003
Capital assets:		
Land and construction in process	47,426,417	58,204,673
Other capital assets, net of depreciation	211,012,996	191,193,537
Total capital assets	258,439,413	249,398,209
Other assets:		
Investment in Securities	148,230,694	145,365,041
Investment in SVMC	7,679,960	13,285,751
Investment in Aspire/CHI/Coastal	4,503,941	3,494,866
Investment in other affiliates	25,484,532	21,895,532
Net pension asset	1,508,515	3,791,175
Total other assets	187,407,642	187,832,365
Deferred pension outflows	83,379,890	62,468,517
	$ 1,078,715,650	$ 912,062,842
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	$ 59,187,515	$ 53,776,672
Due to third party payers	74,900,827	10,020,934
Current portion of self-insurance liability	18,146,305	17,538,746
Total current liabilities	152,234,647	81,336,352
Long term portion of workers comp liability	14,780,831	17,645,000
Total liabilities	167,015,478	98,981,352
Pension liability	126,340,336	108,929,468
Net assets:		
Invested in capital assets, net of related debt	258,439,413	249,398,209
Unrestricted	526,920,423	454,753,813
Total net assets	785,359,836	704,152,022
	$ 1,078,715,650	$ 912,062,842

SALINAS VALLEY MEMORIAL HOSPITAL
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
January 31, 2021

	Month of January,				Seven months ended January 31,			
	Actual	**Budget**	**Variance**	**% Var**	**Actual**	**Budget**	**Variance**	**% Var**
Operating revenue:								
Gross billed charges	$ 199,150,414	$ 184,927,301	14,223,113	7.69%	$ 1,349,492,141	$ 1,174,468,613	175,023,528	14.90%
Dedutions from revenue	147,056,763	140,823,958	6,232,805	4.43%	1,007,729,220	891,098,998	116,630,222	13.09%
Net patient revenue	52,093,651	44,103,343	7,990,308	18.12%	341,762,921	283,369,615	58,393,306	20.61%
Other operating revenue	1,100,917	919,590	181,327	19.72%	9,042,060	6,437,127	2,604,933	40.47%
Total operating revenue	**53,194,568**	**45,022,932**	**8,171,636**	**18.15%**	**350,804,981**	**289,806,742**	**60,998,239**	**21.05%**
Operating expenses:								
Salaries and wages	16,567,936	14,361,059	2,206,877	15.37%	113,265,665	98,098,068	15,167,597	15.46%
Compensated absences	2,526,510	2,913,076	(386,566)	-13.27%	18,688,981	19,998,689	(1,309,708)	-6.55%
Employee benefits	7,703,965	7,863,997	(160,032)	-2.03%	51,975,992	50,974,407	1,001,585	1.96%
Supplies, food, and linen	6,334,207	5,336,093	998,114	18.70%	43,808,456	35,587,353	8,221,103	23.10%
Purchased department functions	3,172,890	3,121,448	51,442	1.65%	21,448,862	21,755,277	(306,415)	-1.41%
Medical fees	1,901,467	1,697,824	203,643	11.99%	11,947,514	11,886,484	61,030	0.51%
Other fees	1,842,158	827,445	1,014,713	122.63%	9,079,385	5,975,944	3,103,441	51.93%
Depreciation	1,811,371	1,789,255	22,116	1.24%	12,487,903	12,524,787	(36,884)	-0.29%
All other expense	1,169,394	1,417,902	(248,508)	-17.53%	8,177,937	9,880,700	(1,702,763)	-17.23%
Total operating expenses	**43,029,898**	**39,328,099**	**3,701,799**	**9.41%**	**290,880,695**	**266,681,711**	**24,198,984**	**9.07%**
Income from operations	**10,164,670**	**5,694,833**	**4,469,837**	**78.49%**	**59,924,286**	**23,125,031**	**36,799,255**	**159.13%**
Non-operating income:								
Donations	166,667	166,667	0	0.00%	1,666,667	1,166,667	500,000	42.86%
Property taxes	333,333	333,333	(0)	0.00%	2,333,333	2,333,333	(0)	0.00%
Investment income	(71,821)	160,094	(231,914)	-144.86%	2,037,743	1,120,655	917,088	81.84%
Income from subsidiaries	(4,945,194)	(3,143,458)	(1,801,736)	57.32%	(26,409,090)	(26,962,213)	553,123	-2.05%
Total non-operating income	**(4,517,015)**	**(2,483,365)**	**(2,033,650)**	**81.89%**	**(20,371,347)**	**(22,341,559)**	**1,970,211**	**-8.82%**
Operating and non-operating income	**$ 5,647,655**	**$ 3,211,468**	**2,436,187**	**75.86%**	**$ 39,552,939**	**$ 783,472**	**38,769,466**	**4948.42%**

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Jan and seven months to date

	Month of Jan		Seven months to date		
	2020	**2021**	**2019-20**	**2020-21**	**Variance**
NEWBORN STATISTICS					
Medi-Cal Admissions	37	37	321	314	(7)
Other Admissions	108	81	787	674	(113)
Total Admissions	145	118	1,108	988	(120)
Medi-Cal Patient Days	59	56	519	468	(51)
Other Patient Days	171	150	1,353	1,089	(264)
Total Patient Days of Care	230	206	1,872	1,557	(315)
Average Daily Census	7.4	6.6	8.7	7.2	(1.5)
Medi-Cal Average Days	1.6	1.5	1.7	1.6	(0.2)
Other Average Days	0.9	1.9	1.7	1.6	(0.1)
Total Average Days Stay	1.6	1.8	1.7	1.6	(0.1)
ADULTS & PEDIATRICS					
Medicare Admissions	466	351	2,778	2,262	(516)
Medi-Cal Admissions	295	251	1,803	1,671	(132)
Other Admissions	423	277	2,326	1,976	(350)
Total Admissions	1,184	879	6,907	5,909	(998)
Medicare Patient Days	2,001	1,819	12,232	1,344	(10,888)
Medi-Cal Patient Days	1,063	1,166	7,695	1,048	(6,647)
Other Patient Days	1,021	1,292	7,157	23,887	16,730
Total Patient Days of Care	4,085	4,277	27,084	26,279	(805)
Average Daily Census	131.8	138.0	126.0	122.2	(3.7)
Medicare Average Length of Stay	4.3	5.0	4.4	0.6	(3.8)
Medi-Cal AverageLength of Stay	3.6	3.6	3.7	0.5	(3.1)
Other Average Length of Stay	2.4	4.0	2.3	9.1	6.8
Total Average Length of Stay	3.5	4.2	3.4	3.8	0.4
Deaths	25	97	189	284	95
Total Patient Days	4,315	4,483	28,956	27,836	(1,120)
Medi-Cal Administrative Days	4	8	52	164	112
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	4	8	52	164	112
Percent Non-Acute	0.09%	0.18%	0.18%	0.59%	0.41%

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Jan and seven months to date

	Month of Jan		Seven months to date		
	2020	2021	2019-20	2020-21	Variance
PATIENT DAYS BY LOCATION					
Level I	323	292	2,012	1,786	(226)
Heart Center	378	360	2,464	2,406	(58)
Monitored Beds	959	888	6,410	6,302	(108)
Single Room Maternity/Obstetrics	356	315	3,013	2,457	(556)
Med/Surg - Cardiovascular	843	905	5,445	5,252	(193)
Med/Surg - Oncology	303	304	1,789	1,335	(454)
Med/Surg - Rehab	483	574	2,991	3,065	74
Pediatrics	45	172	778	609	(169)
Nursery	230	206	1,872	1,557	(315)
Neonatal Intensive Care	68	72	781	889	108
PERCENTAGE OF OCCUPANCY					
Level I	80.15%	72.46%	71.99%	63.90%	
Heart Center	81.29%	77.42%	76.40%	74.60%	
Monitored Beds	114.58%	106.09%	110.42%	108.56%	
Single Room Maternity/Obstetrics	31.04%	27.46%	37.88%	30.89%	
Med/Surg - Cardiovascular	60.43%	64.87%	56.28%	54.28%	
Med/Surg - Oncology	75.19%	75.43%	64.01%	47.76%	
Med/Surg - Rehab	59.93%	71.22%	53.51%	54.83%	
Med/Surg - Observation Care Unit	0.00%	74.95%	0.00%	59.59%	
Pediatrics	8.06%	30.82%	20.10%	15.74%	
Nursery	44.97%	40.27%	26.38%	21.95%	
Neonatal Intensive Care	19.94%	21.11%	33.02%	37.59%	

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Jan and seven months to date

	Month of Jan		Seven months to date		
	2020	**2021**	**2019-20**	**2020-21**	**Variance**
DELIVERY ROOM					
Total deliveries	142	114	1,097	975	(122)
C-Section deliveries	41	36	352	292	(60)
Percent of C-section deliveries	28.87%	31.58%	32.09%	29.95%	-2.14%
OPERATING ROOM					
In-Patient Operating Minutes	23,473	15,342	161,105	143,526	(17,579)
Out-Patient Operating Minutes	25,848	10,849	191,311	154,560	(36,751)
Total	49,321	26,191	352,416	298,086	(54,330)
Open Heart Surgeries	8	11	82	83	1
In-Patient Cases	181	115	1,205	992	(213)
Out-Patient Cases	273	117	2,005	1,702	(303)
EMERGENCY ROOM					
Immediate Life Saving	43	43	225	234	9
High Risk	728	570	4,486	3,650	(836)
More Than One Resource	2,807	2,170	19,350	14,872	(4,478)
One Resource	1,829	950	10,778	9,394	(1,384)
No Resources	64	31	350	278	(72)
Total	5,471	3,764	35,189	28,428	(6,761)

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Jan and seven months to date

	Month of Jan		Seven months to date		
	2020	2021	2019-20	2020-21	Variance
CENTRAL SUPPLY					
In-patient requisitions	15,586	16,315	108,545	102,118	-6,427
Out-patient requisitions	10,231	6,250	74,281	67,967	-6,314
Emergency room requisitions	3,383	1,375	22,719	11,273	-11,446
Interdepartmental requisitions	7,328	7,849	50,998	49,644	-1,354
Total requisitions	36,528	31,789	256,543	231,002	-25,541
LABORATORY					
In-patient procedures	38,736	42,107	249,350	253,735	4,385
Out-patient procedures	10,642	9,286	74,295	76,062	1,767
Emergency room procedures	11,318	9,433	73,541	60,934	-12,607
Total patient procedures	60,696	60,826	397,186	390,731	-6,455
BLOOD BANK					
Units processed	313	318	2,014	1,996	-18
ELECTROCARDIOLOGY					
In-patient procedures	1,140	1,041	7,491	6,566	-925
Out-patient procedures	522	349	3,414	2,706	-708
Emergency room procedures	1,044	1,045	6,901	6,142	-759
Total procedures	2,706	2,435	17,806	15,414	-2,392
CATH LAB					
In-patient procedures	85	64	588	512	-76
Out-patient procedures	77	51	608	571	-37
Emergency room procedures	0	0	0	1	1
Total procedures	162	115	1,196	1,084	-112
ECHO-CARDIOLOGY					
In-patient studies	359	298	2,158	2,033	-125
Out-patient studies	232	138	1,458	1,262	-196
Emergency room studies	3	2	11	16	5
Total studies	594	438	3,627	3,311	-316
NEURODIAGNOSTIC					
In-patient procedures	174	140	1,257	1,109	-148
Out-patient procedures	33	24	159	169	10
Emergency room procedures	0	0	1	0	-1
Total procedures	207	164	1,417	1,278	-139

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Jan and seven months to date

	Month of Jan		Seven months to date		
	2020	2021	2019-20	2020-21	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	1	1
Out-patient procedures	208	183	1,480	1,315	-165
Emergency room procedures	0	0	0	0	0
Total procedures	208	183	1,480	1,316	-164
RADIOLOGY					
In-patient procedures	1,478	1,654	9,385	9,708	323
Out-patient procedures	488	416	3,082	4,323	1,241
Emergency room procedures	1,548	1,217	10,299	7,939	-2,360
Total patient procedures	3,514	3,287	22,766	21,970	-796
MAGNETIC RESONANCE IMAGING					
In-patient procedures	151	105	997	860	-137
Out-patient procedures	75	127	598	953	355
Emergency room procedures	6	14	83	80	-3
Total procedures	232	246	1,678	1,893	215
MAMMOGRAPHY CENTER					
In-patient procedures	3,616	2,718	26,576	20,910	-5,666
Out-patient procedures	3,615	2,696	26,475	20,790	-5,685
Emergency room procedures	0	3	7	3	-4
Total procedures	7,231	5,417	53,058	41,703	-11,355
NUCLEAR MEDICINE					
In-patient procedures	24	12	144	86	-58
Out-patient procedures	78	61	607	506	-101
Emergency room procedures	0	1	3	4	1
Total procedures	102	74	754	596	-158
PHARMACY					
In-patient prescriptions	96,294	111,491	640,547	636,356	-4,191
Out-patient prescriptions	16,474	10,439	116,224	99,978	-16,246
Emergency room prescriptions	9,219	5,342	55,615	36,983	-18,632
Total prescriptions	121,987	127,272	812,386	773,317	-39,069
RESPIRATORY THERAPY					
In-patient treatments	17,676	29,606	110,102	156,457	46,355
Out-patient treatments	124	143	3,967	3,391	-576
Emergency room treatments	555	373	2,938	1,179	-1,759
Total patient treatments	18,355	30,122	117,007	161,027	44,020
PHYSICAL THERAPY					
In-patient treatments	2,699	2,256	17,716	16,109	-1,607
Out-patient treatments	224	99	1,948	1,751	-197
Emergency room treatments	0	0	0	0	0
Total treatments	2,923	2,355	19,664	17,860	-1,804

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Jan and seven months to date

	Month of Jan		Seven months to date		
	2020	2021	2019-20	2020-21	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,837	1,445	10,359	9,403	-956
Out-patient procedures	91	74	903	797	-106
Emergency room procedures	0	0	0	0	0
Total procedures	1,928	1,519	11,262	10,200	-1,062
SPEECH THERAPY					
In-patient treatments	397	348	2,622	2,682	60
Out-patient treatments	27	23	175	171	-4
Emergency room treatments	0	0	2	0	-2
Total treatments	424	371	2,799	2,853	54
CARDIAC REHABILITATION					
In-patient treatments	0	0	0	0	0
Out-patient treatments	519	498	3,386	2,637	-749
Emergency room treatments	0	0	0	1	1
Total treatments	519	498	3,386	2,638	-748
CRITICAL DECISION UNIT					
Observation hours	396	378	2,188	1,866	-322
ENDOSCOPY					
In-patient procedures	108	85	662	626	-36
Out-patient procedures	35	12	214	159	-55
Emergency room procedures	0	0	0	0	0
Total procedures	143	97	876	785	-91
C.T. SCAN					
In-patient procedures	671	537	4,614	3,803	-811
Out-patient procedures	239	445	1,882	3,598	1,716
Emergency room procedures	619	433	4,453	3,208	-1,245
Total procedures	1,529	1,415	10,949	10,609	-340
DIETARY					
Routine patient diets	21,185	17,554	142,568	113,154	-29,414
Meals to personnel	26,732	19,345	177,547	144,216	-33,331
Total diets and meals	47,917	36,899	320,115	257,370	-62,745
LAUNDRY AND LINEN					
Total pounds laundered	107,963	99,573	926,892	710,088	-216,804

Salinas Valley Memorial Healthcare System

Memorandum

To: Board of Directors

From: Allen Radner, M.D. CMO

Date: February 25, 2021

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.	RC NICU Laryngeal Mask Airway Clinical Procedure	Updated Policy Statement removed verbiage and listed it under General Information section. Updated Education section to standard verbiage and updated References section.	Clement Miller
2.	Cardiac Telemetry Monitoring and Management	Updated Operation section under E. Responsibilities added bullet #6 and updated bullet #10. Updated References	Clement Miller
3.	Skin-to-Skin Contact in the NICU	Updated Purpose and General Information sections. Updated References.	Clement Miller
4.	Enteral Tubes Insertion Maintenance	Updated Purpose Statement and Procedure section. Updated References.	Clement Miller
5.	Discharge/Transition Planning Guidelines	Updated Policy Statement removed verbiage that was not related to a Policy Statement and moved it to General Information section. Under Procedure updated Performance Improvement Plan section. Updated References.	Clement Miller

6.	Specimen/Foreign Body	Updated Policy Statement and General Information sections.	Clement Miller
7.	Temporary Transvenous and Epicardial Pacing	Updated Procedure section and updated References.	Clement Miller
8.	Chest Tube Management	Updated Definitions and Procedure sections. Updated References.	Clement Miller
9.	Observation Status Charge Generation	Updated Policy Statement removed verbiage that didn't pertain to a Policy Statement to General Information section. Updated Education Statement to standard verbiage. Updated References.	Clement Miller
10.	Circumcision	Moved information listed under Policy Statement to General Information.	Clement Miller
11.	Fire Safety Management Plan	Minor formatting changes made and a few typo's corrected. Updated Education statement to standard verbiage.	Clement Miller
12.	Ordering Supplies from Materials Management	Updated Procedure section.	Augustine Lopez
13.	Student Affiliations	Moved information from Policy Statement section to General Information section. Updated Purpose section.	Clement Miller
14.	The Emergency Medical Treatment and Active Labor Act (EMTALA)	Updated this policy, merged previous versions of EMTALA and related policies into one policy.	Clement Miller
15.	Quality Assessment and Performance Improvement Plan 2021	Annual Plan review no changes other than addition of year 2021. The Operational Oversight Structure included in the plan. Does not need Board approval as this is a dynamic document and may change routinely over the course of a year.	Allen Radner, M.D.
16.	Safety Management Plan	Annual Plan review no changes other than addition of year 2021.	Clement Miller

Salinas Valley Memorial Healthcare System

RC NICU LARYNGEAL MASK AIRWAY CLINICAL PROCEDURE

Reference Number	2286
Effective Date	Not Approved Yet
Applies To	NICU, RESPIRATORY CARE
Attachments/Forms	Attachment A

I. POLICY STATEMENT:

~~A. N/ALaryngeal mask insertion will be performed by trained Physicians, Respiratory Care Practitioners (RCP) or Registered Nurses (RN) when:~~

~~A. An airway must be established and the patient cannot be successfully intubated by a certified intubator.~~

~~A. A certified intubator is not available.~~

A. ~~Craniofacial anomalies prevent proper endotracheal intubation~~.

II. PURPOSE:

A. To guide the staff in providing an emergency airway to ensure adequate ventilatory support to a compromised newborn.

III. DEFINITIONS:

A. RCP: RESPIRATORY CARE PRACTITIONER

B. LMA: LARYNGEAL MASK AIRWAY

C. RN: REGISTERED NURSE

IV. GENERAL INFORMATION:

A. Laryngeal mask insertion will be performed by Physicians, Respiratory Care Practitioners (RCP) or Registered Nurses (RN) when:

1. An airway must be established and the patient cannot be successfully intubated by a certified intubator.
2. A certified intubator is not available.
3. Craniofacial anomalies prevent proper endotracheal intubation.

~~N/A~~

V. PROCEDURE:

in approval

RC NICU LARYNGEAL MASK AIRWAY CLINICAL PROCEDURE

A. The use of LMA devices in the infant are most often successful on the first attempt, providing a clinically patent airway with minimal or no complications directly attributed to its use.

B. Indications:

1. Positive pressure ventilation by bag and mask or T-piece resuscitator is ineffective or fails to achieve adequate ventilation.
2. Attempts at intubation are not feasible or are unsuccessful.
3. Craniofacial anomalies when achieving a good seal with a bag and mask is difficult. (e.g., Cleft palate)
4. A very small mandible (e.g., Pierre Robin syndrome)
5. Relatively large tongue (e.g., Trisomy 21)
6. Anomalies of the mouth, tongue, pharynx, or neck, when there is difficulty visualizing the larynx with a laryngoscope.

C. Insertion of device

1. ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS are utilized.
2. Reviews chart for patient history, diagnosis, physician orders and current status.
3. Select the most appropriate sized LMA considering the weight and size of the neonate.
4. Insert oral gastric tube, aspirate air/contents out.
5. Remove size appropriate device from the sterile package using clean technique.
6. Quickly inspect the device to ensure that the mask, airway tube, 15-mm connector, and pilot balloon are intact. (See Attachment A: Diagram)
7. Attach syringe to the pilot balloon valve port and deflate the mask.
8. Stand at the infant's head and position the head in the "sniffing" position as you would for endotracheal intubation.
9. Hold the device like a pen, with the index finger placed at the junction of the cuff and the tube
10. Lubricating the back of the LMA with water-soluble lubricant is optional.
11. Gently open the patient's mouth and press the leading tip of the mask against the baby's hard palate (See Attachment A: Insertion)

in approval

12. Flatten the tip of the mask against the patient's palate with the index finger. Ensure that the tip of the mask remains flat and does not curl backward on itself.
13. Using the index finger, gently guide the device along the contours of the patient's hard palate toward the back of the throat. Do not use force. Use a smooth movement to guide the mask past the tongue and into the hypopharynx until resistance is felt. (See Attachment A: Proper Placement)
14. Before removing the finger, use the other hand to hold the airway in place. This prevents the device form being pulled out of place when the finger is removed. At this point the tip of the mask should be resting near the entrance to the esophagus (upper airway sphincter).
15. Inflate the mask with enough air to achieve a minimal leak seal. Inflate the cuff of a size 1.0 LMA with up to 4 mL of air. (See Attachment A: Cuff Inflation)
16. Do not hold the airway tube when inflating the mask. The device may move slightly outward when it is inflated. This is normal.
17. Attach a carbon dioxide (CO2) detector then the resuscitation bag to the 15-mm adapter on the device.
18. Begin positive pressure ventilation.
19. Confirm proper placement by assessing a rising heart rate, CO2 detector color change, chest rise, and audible breath sounds with a stethoscope.
20. There should not be a large leak of air coming from the patient's mouth or a growing bulge in the patient's neck.
21. Secure the tube with tape or an airway securing device.
22. The LMA can be removed when the patient establishes effective spontaneous respirations or when an endotracheal tube can be inserted successfully
23. Patients can breathe spontaneously through this device.

D. Removal of device

1. Suction oral cavity.
2. Only partially deflate the cuff!
3. Slowly remove the device while applying suction to the secretions collected on the cuff.
4. Apply appropriate assessment and resuscitation skills as needed to support infant.

E. Complications:

1. Soft-tissue trauma

in approval

2. Laryngospasm
3. Gastric distension
4. Prolonged use over hours or days has been infrequently associated with oropharyngeal nerve damage or lingual edema.

F. Limitations:

1. The device cannot be used to suction meconium from the airway.
2. If high ventilation pressures are needed, air may leak through an insufficient seal between the larynx and the mask, resulting in insufficient pressure to inflate the lungs and causing gastric distension.
3. There is insufficient evidence to recommend the laryngeal mask when chest compressions are required. However, if an endotracheal tube cannot be placed successfully and chest compressions are required, it is reasonable to attempt compressions with the device in place.
4. There is insufficient evidence to recommend the LMA when intratracheal medications are required. Intratracheal medications may leak between the mask and the larynx, into the esophagus, and therefore not enter the lungs.
5. There is insufficient evidence to recommend the LMA when surfactant replacement therapy is required. Surfactant may leak between the mask and the larynx, into the esophagus, and therefore not enter the lungs.
6. There is insufficient evidence to recommend the LMA for prolonged assisted ventilations in newborns.
7. There is insufficient evidence to recommend use of the LMA as the primary airway device during Neonatal resuscitation in preterm infants. However, the appropriate sized LMA may enable effective ventilation if bag-mask ventilation is unsuccessful and tracheal intubation is unsuccessful or not feasible.

G. Hazards and Precautions:

1. Improper Placement
2. There should not be large air leak from the patient's mouth.
3. There should not be a growing bulge in the patient's neck.

H. Documentation:

1. Documentation will be done upon insertion and removal of airway and every 2 hours in the patient's electronic medical record.

in approval

RC NICU LARYNGEAL MASK AIRWAY CLINICAL PROCEDURE

VI. **EDUCATION/TRAINING:**

A. Training of RCPs/RNs are provided by annual competencies and Simulation Based Training.

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

VII. **REFERENCES:**

A. Neonatal Resuscitation Textbook. (7th Edition, 2016). A Joint Publication of the American Academy of Pediatrics and the American Heart Association.

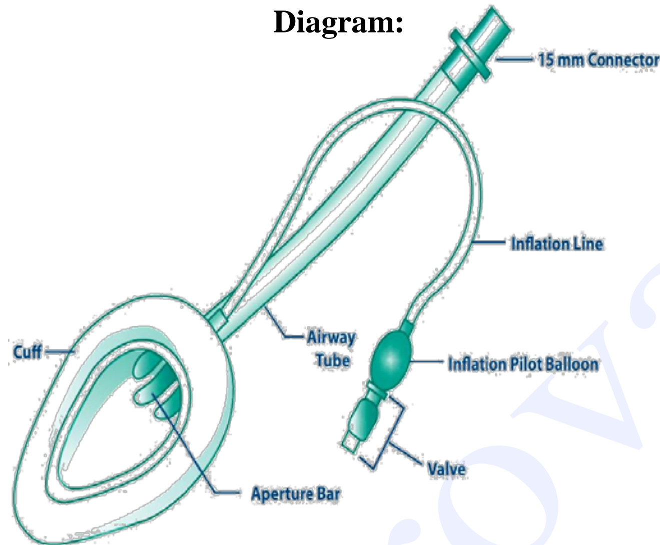
B. Cochrane database for systemic review. Mosaratt J. Qureshi, Manoj Kumar. Laryngeal mask airway versus bag-mask ventilation or endotracheal intubation for neonatal resuscitation. Published March, 15, 2018.

C. LarySeal Blue. (202013). Published March 13, 2013Retrieved November 18, 2020 from https://www.flexicare.com/en-us/product/laryseal-blue/www.flexicare.com

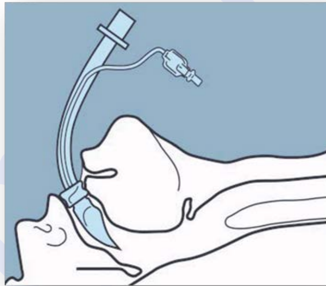
in approval

ATTACHMENT A

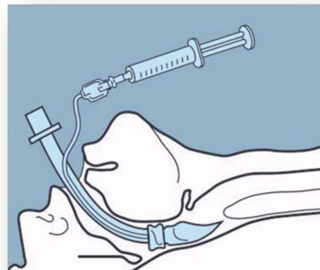
Diagram:



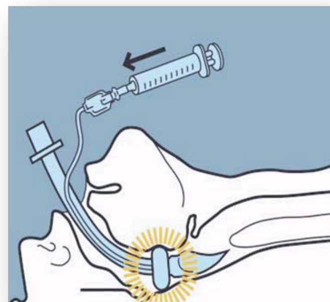
Insertion:



Proper Placement:



Cuff Inflation:



in approval

Salinas Valley Memorial Healthcare System

CARDIAC TELEMETRY MONITORING AND MANAGEMENT

Reference Number	6725
Effective Date	Not Approved Yet
Applies To	1Main, 4th Towers, HEART CENTER, Observation Care Unit, Telemetry / 5-Tower
Attachments/Forms	

I. POLICY STATEMENT:

A. N/A~~This policy applies to continuous cardiac telemetry monitoring of patients on the following units: Heart Center, 1 Main, 5 Tower and 5 Main (OCU), and includes roles and responsibilities for responding to high, medium and low priority telemetry alarms.~~

II. PURPOSE:

A. To guide staff in a standardized placement of leads and process for monitoring patients with cardiac monitoring needs.

B. To define roles and responsibilities for staff (Unit Clerk II's and Registered Nurses) who oversee the cardiac monitoring of patients on ICU, Heart Center, 1 Main, ~~3 Tower,~~ 4 Tower, 5 Tower and 5 Main/OCU.

C. To set guidelines for staff (Unit Clerk II's and Registered Nurses) who monitor telemetry patients, and required responses to clinical telemetry alarms.

III. DEFINITIONS:

A. TELEMETRY: Refers to the automatic measurement and transmission of data at a distance by radio, cellular or other means. It is an observation tool that allows for continuous monitoring of heart rate/cardiac rhythm, respiratory rate, SpO2, and blood pressure monitoring.

B. CARDIAC MONITORING: Continuous monitoring of heart activity, generally by electrocardiography with assessment of the patient's condition relative to their cardiac rhythm.

C. ECG: Electrocardiogram is a diagnostic tool that measures and records the electrical activity of the heart via electrodes placed on the skin.

in approval

D. ELECTRODE: The patch that is placed onto the patients and attaches to the lead wire.

E. LEAD WIRE: The lead that connects the electrodes to the telemetry/bedside cardiac monitoring unit.

F. ARRHYTHMIA: A rhythm in which the heart beats in an irregular or abnormal rhythm.

G. CRITICAL ALARMS: high priority alarms on medical equipment/devices designed to alert staff to the presence of a life threatening or potentially life threatening rhythms/conditions.

H. NON-CRITICAL ALARMS: medium or low priority alarms on medical equipment/devices designed to alert staff to the presence of a non-life threatening rhythms/conditions.

I. QUALIFIED STAFF: healthcare providers who have been trained in the use of medical equipment/devices. For the purpose of this policy, this includes Registered Nurse with telemetry experience and Unit Clerk II's who have been trained and serve as cardiac monitor clerks.

J. FIXED SETTING: critical alarm settings that can only be changed with a physician's order.

IV. GENERAL INFORMATION:

A. Within the Progressive Care Units (Heart Center, 1 Main, ~~3 Tower~~4 Tower Oncology Unit, 5 Tower and 5 Main/OCU) centralized monitoring is utilized to allow for all telemetry monitored cardiac rhythms to be displayed on display screens at the Unit Clerk II's workstation, also known as~~and~~ the central monitoring station.

B. Two PC monitors on Heart Center, 5 Tower and 1 Main display physiological waveforms, blood pressure with mean arterial pressure, SpO2 pulse oximetry and respiratory rates. On ~~3 Tower,~~ 4 Tower, and 5 Main/OCU, the telemetry monitors only display physiological waveforms, heart rate and SpO2.

C. Two main PC Monitors in ICU display physiological waveforms, blood pressure with mean arterial pressure, SpO2 pulse oximetry and respiratory rates

in approval

D. Unit Clerk II's are trained in rhythm recognition and staff the cardiac/telemetry monitoring roles on Heart Center, 1 Main, ~~3 Tower,~~ 4 Tower, and 5 Tower and 5 Main/OCU, 24 hour hours a day. If for some reason we are unable to staff the central monitoring station with a Unit Clerk II, a Registered Nurse with Telemetry experience and ACLS certification are assigned the role.

   1. It is the Registered Nurses responsibility to monitor the patient alarms within the ICU unit.

E. Hardwire ECG monitors have electrodes and lead wires that are attached directly to the patient. Impulses are transmitted directly from the patient to the monitor.

F. Telemetry systems have electrodes and lead wires that are attached from the patient to a battery pack transmitting impulses to the monitor via radio wave transmission.

G. The Progressive Care Units have the ability to monitor the cardiac activity for a total of 84 patients. Each individual unit has the ability to monitor the following numbers of patients:

   1. Heart Center: 15 monitored beds
   2. 1 Main: 23 monitored beds
   3. 5 Tower: 14 monitored beds
   4. 5 Main/OCU: 32 monitored beds (12 of the beds can be monitored on 4~~3~~ ~~Tower and~~Tower)

H. The ICU units has the ability to monitor the cardiac activity for 13 monitored beds.

V. **PROCEDURE:**

A. Equipment
   1. ECG Monitor (Central and Bedside monitor)
   2. Electrodes, pre-gelled and disposable
   3. 2x2 gauze pad
   4. Soap and water
   5. Scissors to clip hair from the chest as needed
   6. Telemetry unit with battery pack
   7. A five (5) lead cable

B. Prepare the skin area before applying electrodes.
C. For telemetry monitoring, insert battery into telemetry unit, matching polarity markings on transmitter.

VI. **OPERATION:**

in approval

CARDIAC TELEMETRY MONITORING AND MANAGEMENT

A. Connect electrodes and lead wires on patient
   1. Apply right arm (RA) to the right shoulder close to the junction of the right arm torso.
   2. Apply the left arm (LA) to the left shoulder close to the junction of the left arm torso.
   3. Apply the right leg (RL) electrode at the level of the lowest rib, on the right abdominal region or on the hip.
   4. Apply the left leg (LL) electrode at the level of the lowest rib on the left abdominal region or on the hip.
   5. Apply chest lead electrode on the selected site: V1 fourth ICS right sternal border or V6 fifth ICS midaxillary line.

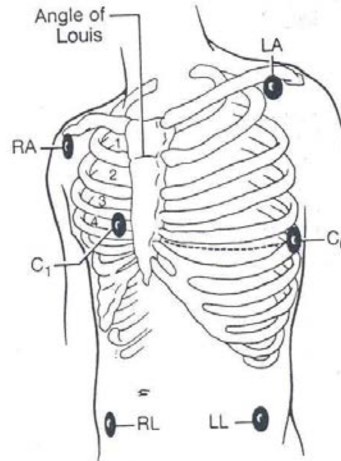


FIGURE 51–8. Five-lead application. (From Drew B. Bedside electrocardiographic monitoring. *AACN Clin Issues Crit Care.* 1993; 4(1):26.)

   6. Set lead selector monitor to appropriate leads, preferably lead II and V lead.
   7. For hardwire monitoring, fasten lead wire and patient cable to patient's gown to decrease tension which can cause interference or faulty recordings
   8. For telemetry monitoring, secure transmitter in pouch or pocket of patient's gown.
   9. Set alarms. Upper and lower alarm limits are set on the basis of the patient's current clinical status and heart rate or per Physician's order. Alarms should remain activated at all times.
      a. A physician order must be obtained to adjust alarms outside the upper and lower limits.
   10. Tips for selection of limb leads appropriate for the clinical situation
      a. Atrial flutter: II, III, AVF

b. Inferior myocardial infarction: II, III, and AVF select the lead with maximal elevation of ST segment on the 12 lead ECG
c. After angioplasty: Select III or AVF – whichever has the tallest R wave
d. If three channels are available, use V1 + I + AVF
e. Use lead II if none of this clinical situation applies

B. Maintenance/Care
1. Evaluate the ECG monitor pattern for the presence of P waves, QRS complex, a clear baseline, and absence of artifact or distortion.
2. Evaluate skin integrity and change electrodes every 24 hours. Rotate sites when changing electrodes. Monitor skin for any allergic reaction to the adhesive or the gel.

C. Obtain and post an ECG strip approximately every 4 hours and interpret for:
1. Rhythm
2. Rate
3. Presence and configuration of P waves
4. Length of PR interval
5. Length of QRS complex
6. Presence and configuration of T waves
7. Length of QT interval and QTc when indicated
8. Presence of extra waves (such as U waves)
9. Presence of dysrhythmias.

D. A monitor strip should be recorded whenever:
1. There is a change in the patient's rhythm, vital signs or and/or hemodynamic status.
2. The patient experiences chest pain
3. There is a change in lead placement.
4. When evaluating the effect of antidysrhythmic and cardiovascular agents

E. **Responsibilities**
1. The responsibilities of the Unit Clerk II's or Registered Nurse watching the telemetry monitors are:

a. Primary responsibilities are to monitor the patient's cardiac rhythm, blood pressure, SpO2 and respiratory rate while admitted to the unit.

2. Upon admission to the unit, the Unit Clerk II assigns the patient to the telemetry system by pulling up the account number. This operation pulls

in approval

the patient's name, DOB, age and room number into the system and sets the system up for monitoring the patient.

~~2.~~3. Upon admission to ~~3rd and~~ 4th Tower, the RN admitting the patient to telemetry will attach the Telemetry box to the patient. After the patient has been placed on the Telemetry box, the RN will call the 5 Main/OCU Unit Assistant 2 at extension 1715. The RN will provide the Unit Assistant the patients name, account number, medical record number and room assigned on ~~3rd or~~ 4th Tower so that the Unit Assistant will be able to add the patient to the Telemetry monitoring system.

~~3.~~4. Rhythm strips are printed every 4 hours for RN interpretation. Additionally, when there are changes to the rhythm or when a "Red" alarm is indicated, strips are printed for the primary nurse's review.

5. The telemetry monitoring systems sends three types of alarms classified as "Red", "Yellow", and "Blue" alarms.

~~4.~~6. The patient must be on the monitor or tele box at ALL TIMES. May not be taken off monitor and left unattended for any reason unless they have an "off monitor" MD order.

~~5.~~7. Red (Highest Priority) Critical Alarms are:

a. Extreme Bradycardia: An arrhythmia when the heart rate falls below the normal range, typically under 50 beats per minute or lower.

b. Extreme Tachycardia: An arrhythmia when the heart rate exceeds the normal range (dangerously high), currently set to alarm at 140 BPM or higher.

c. Asystole: A state of no cardiac electrical activity.

d. Ventricular Fibrillation (VFIB): An arrhythmia when the uncoordinated contraction of the ventricular cardiac muscle is causing the heart to quiver rather than contract properly.

e. Ventricular Tachycardia (VTACH): An arrhythmia with a rapid heartbeat starting in the ventricles.

~~6.~~8. Yellow (Medium Priority) Non-Critical Alarms are:

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a. Pacer Not Capturing: When no visible pacing spikes are seen on the ECG.

b. Pause: When no heart beat is detected for a period longer than the pause threshold set on the monitor.

c. Ventricular Rhythm: When several adjacent irregular heartbeats (greater than the vent rhythm limit) and ventricular heart rate falls less than the ventricular heart rate limit (typically 20-40 beats per minute).

d. Desaturation: When the SpO2 level falls below the desaturation limit. Oxygen saturation of 96% to 100% is considered normal and levels falling below 90% can indicate inadequate amounts of oxygen being delivered to the body.

~~7.~~9. Blue (Low Priority) Non-Critical Alarms are:

a. Battery Weak or need to replace the battery: A battery indicator is located on the telemetry monitor for each patient. The telemetry monitor tech will notify the nurse when the battery indicator gets low.

b. Leads Off: An indication that the caregiver needs to check that all of the required ECG lead wires are attached, and that none of the electrodes have been displaced.

While there are many other alarm types sounded through most physiological monitoring systems, the one's listed above have been determined to have the greatest priority to ensure timely escalation and communication to the primary nurse.

10. Escalates all "Red" High Priority alarms through the following process:

a. Although leads off is a low priority alarm it will be escalated following the high priority process.

~~a.~~b. Alerts the RN through face-to-face communication if readily available.

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~~b.~~c. If RN is not available for face-to-face, or when addressing a patient located on ~~3rd or~~ 4th Tower, the Unit Assistant will immediately escalates alarm to RN's Cisco phone.

~~c.~~d. If RN is not available on their Cisco phone, immediately escalates alarm to charge nurses Cisco phone. For patients located on ~~3rd or~~ 4th Tower, the Unit Assistant call the unit directly. ~~.~~

~~d.~~e. If Charge Nurse is not available, immediately escalates to the nearest RN for assistance.

f. If no response from primary RN, Charge RN, or in situations where no RN is immediately available at the nurse's station, and specifically when referring to "Red" alarms, a message will immediately be broadcasted through the patient call system requesting "Immediate Assistance to Room #".

~~a.~~

~~e.~~g. As a last resort, in situations where the primary nurse, charge nurse or any other available nurse isn't capable of responding, a call will be placed to the hospital operator at Extension 2222 to activate a Rapid Response.

~~9.~~11. Documents red alarms, rhythm interpretation and vital sign abnormalities on the Telemetry monitor tech report sheet used to track and pass on information to the next shifts monitor clerk.

~~10.~~12. Responds to the patient call light system.

~~11.~~13. Answer's incoming phone calls if possible.

~~12.~~14. Prepares charts for admissions coming to the unit.

F. **Responding to nuisance alarms:**

~~13.~~

1. When responding to nuisance alarms, or a need to adjust the clinical parameters within the telemetry monitoring system (example: patient who is a marathon runner with HR consistently in the 40's, but clinical parameter set at 60's), the monitor tech must contact the primary nurse to obtain a physician order to make adjustment outside the preset parameters.

in approval

G. **Competency**

1. Upon hire, new Registered Nurses are required to pass a rhythm strip recognition test while new graduate Registered Nurses and Unit Clerks II's are required to attend an initial telemetry monitoring class and pass a rhythm recognition test.
2. Annually, both registered nurses and Unit Clerk II's are required to pass a rhythm recognition test to maintain telemetry competencies.
3. Registered Nurses are required to maintain an active Advanced Cardiac Life Support (ACLS) certification.

VII. **EDUCATION/TRAINING:**

~~A.~~ Education and/or training is provided as needed. ~~Upon hire, new Registered Nurses are required to pass a rhythm strip recognition test while new graduate Registered Nurses and Unit Clerks II's are required to attend an initial telemetry monitoring class and pass a rhythm recognition test. annually.~~

~~B.~~

~~C. Annually, both registered nurses and Unit Clerk II's are required to pass a rhythm recognition test to maintain telemetry competencies.~~

~~D.~~

~~E. Registered Nurses are required to maintain an active Advanced Cardiac Life Support (ACLS) certification.~~

~~F.~~A.

VIII. **REFERENCES:**

A. The Joint Commission Perspectives on Patient Safety, December 2011, Volume 11, Issue 12. Sound the Alarm: Managing Physiologic Monitoring Systems. Joint Commission on Accreditation of Healthcare Organizations

B. George, K.J., Walsh-Irwin, C., Queen, C., & Hawkins, C. (2014). Development of evidence-based remote telemetry policy guidelines for a multi-facility hospital system. Dimensions of Critical Care Nursing, 34(1), 10-17. DOI: 10.1097/DCC.0000000000000084

C. 3M Red Dot Electrodes: Application and Removal Instructions http://multimedia.3m.com/mws/media/600820O/red-dot-electrodes-application-andremoval-guide.pdf

D. McKinley,M, Electrocardiographic Leads and Cardiac Monitoring. In Wiegand, D

in approval

(editor). AACN Procedure Manual for Critical Care, pp. 490-501. St. Louis, Missouri: (7th Edition 2016) Elsevier Saunders.

in approval

Salinas Valley Memorial Healthcare System

SKIN-TO-SKIN CONTACT IN THE NICU

Reference Number	2224
Effective Date	Not Approved Yet
Applies To	NICU
Attachments/Forms	

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To provide guidelines to staff for skin-to-skin contact (STS) in the Neonatal Intensive Care Unit (NICU).

A. ~~STS is a method of infant holding that promotes a close physical and emotional relationship between the parent and the child.~~

B. ~~Providers of STS must be clean, dry, and be free of rashes, lesions, or open areas of skin that could come in to contact with the baby.~~

C. ~~Eligible infants –~~

- ~~Stable premature~~
- ~~No weight or gestational age limits~~
- ~~Respiratory status stable, oxygen saturations within ordered parameters.~~
- ~~If a UAC/UVC (Umbilical Artery Catheter, Umbilical Venous Catheter), PICC (Peripherally Inserted Central Catheter) is present, nurse must ensure lines are well secured.~~

D. ~~Infants receiving STS will have continuous cardiorespiratory and oximetry monitoring as ordered. If the infant is stable off oximetry it is not necessary to initiate for STS.~~

E.

F. ~~STS can be performed before, during or after a feeding.~~

G. ~~Mutual planning shall be done with the family to determine eligibility for STS per day and increasing in time and frequency as infant tolerates.~~

~~III. PURPOSE:~~

A. ~~To provide guidelines to staff for skin-to-skin contact (STS) in the Neonatal Intensive Care Unit (NICU).~~

in approval

SKIN-TO-SKIN CONTACT IN THE NICU

IV. III. DEFINITIONS:

A. **Skin-to-skin contact (STS)**, also known as Kangaroo Care (KC) - When the infant, dressed only in a diaper and a hat, are placed against the parent's (or other person designated by parent) – bare chest in a prone, upright position.

V. IV. GENERAL INFORMATION:

A. STS is a method of infant holding that promotes a close physical and emotional relationship between the parent and the child.

B. Offer and encourage STS immediately after delivery, or as soon as possible once infant is determined to be stable.

C. Providers of STS must be clean, dry, and be free of rashes, lesions, or open areas of skin that could come in to contact with the baby.

D. Eligible infants –

E. Stable premature

F. No weight or gestational age limits

G. Respiratory status stable, oxygen saturations within ordered parameters.

H. If a UAC/UVC (Umbilical Artery Catheter, Umbilical Venous Catheter), PICC (Peripherally Inserted Central Catheter) is present, nurse must ensure lines are well secured.

I. Infants receiving STS will have continuous cardiorespiratory and oximetry monitoring as ordered. If the infant is stable off oximetry it is not necessary to initiate for STS.

J. MD order is not required to initiate/perform STS.

K. STS can be performed before, during or after a feeding.

B. L. Mutual planning shall be done with the family to determine eligibility, frequency and duration of STS per day. Goal should encourage increased time and frequency as infant tolerates.

VI. V. PROCEDURE:

A. Provide privacy

B. Position parent or designee as follows: remove shirt, bra or blouse and dress in cover gown per parent choice, provide warm blanket as needed for parent.

C. Record infant vital signs before STS

D. Infant is undressed with a diaper and hat on.

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E. STS recommended for a minimum of one hour, as tolerated, and can be up to 3-4 hours as infant tolerates.

F. Terminate STS at parent's request or if infant shows persistent signs of distress such as: respiratory distress, apnea, bradycardia, or desaturation that do not resolve with usual interventions.

G. STS can be performed simultaneously with twins.

H. Encourage lactating mothers to empty her breasts' before STS for her comfort.

I. Documentation:

1. Time STS began and ended in Electronic Health Record (EHR).
2. Document infant vital signs per policy
3. Any adverse reactions/cold stress
4. Parent interaction/education in EHR.

~~VII.~~VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

~~B.~~A. American Academy of Pediatrics. (2017). *Guidelines for Perinatal Care* (8th ed.). Elk Grove, IL: American Academy of Pediatrics & The American College of Obstetrics and Gynecologists. AWONN. (2021). *Perintal Nursing* (5th ed.). Philidephia, PA: Wolters Kluw

in approval

Salinas Valley Memorial Healthcare System

ENTERAL TUBES INSERTION MAINTENANCE

Reference Number	656
Effective Date	Not Approved Yet
Applies To	ALL NURSING UNITS, ICU/CCU, NS
Attachments/Forms	

in approval

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To provide guidance for insertion and maintenance of nasogastric, oroal gastric, nasogastricenteriande, percutaneous gastric tubes.

III. DEFINITIONS:

A. NG – Nasogastric.

B. OG – Oroal gastric.

IV. GENERAL INFORMATION:

A. N/A

V. PROCEDURE:

A. Tube Insertion:

1. The standard feeding tube utilized for NG feeding is the 10 Fr or 12Fr nasogastric feeding tube unless otherwise indicated by physician order.
2. Tube will be marked at nares upon insertion.
3. Tube placement shall be verified by checking marking at nares:
   a. Following tube insertion, once placement is confirmed with STAT Chest X-ray, the tube will be marked at the nares.
   b. Prior to each intermittent tube feeding.
   c. Every four (4) hours during continuous feeding.
   d. Anytime dislodgment suspected (i.e., vomiting, vigorous coughing).
   e. Prior to medication administration

4. **All initial placement of naso/oral feeding tubes are verified by STAT Chest x-ray, unless otherwise indicated by physician order.** The initial tube placement x-ray will not apply to newborns.

5. Licensed staff trained in inserting **naso/oral (naso to stomach**) feeding tubes with stylet, may do so when ordered.

   a. Assess nares prior to insertion. The insertion may be risky in patients with nasal fractures or bleeds and esophageal strictures, fistulas, varices, basilar skull fractures.

   b. Obtain the following supplies/equipment:

      - Standard nasogastric feeding tube 10Fr or 12Fr (unless otherwise ordered by physician), water soluble lubricant, tape or NG tube holder, stethoscope, 60 ml catheter tip or luer lock syringe, Lopez 3-way valve, prescribed formula, feeding container and connecting tubing, permanent marker.

      - For lavage and gavage: Obtain the following supplies: Salem pump, or Levine tubes, Lopez valve (3-way valve), tape, stethoscope, irrigation set with 60 ml syringe, suction source.

6. Determine the length of the nasogastric tube by measuring the distance from the tip of the nose to earlobe to xiphoid process of sternum. DO NOT insert excess nasogastric tubing, it will kink or curl.

   a. Mark the total length of tube to be inserted with a small piece of tape or with permanent marker.

7. Lubricate tube tip with water-soluble lubricant. Small-bore enteral tubes may be pre-lubricated which will be activated by placing it in water.

8. Position patient in a sitting position (90°) with the head bent slightly forward. If the patient is comatose, or unable to sit up, position patient supine with the head facing directly forward and the chin aligned with the sternal notch.

9. Insert tube by passing it gently along the floor of the nostril, aiming down and back towards the ear. Once tip is in the posterior pharynx, encourage patient to swallow sips H2O or dry swallows. Stop if there is any resistance. **DO NOT USE FORCE.** Resistance may be the result of mild vagal stimulation. Wait a few seconds and gently attempt to advance tube again. Stop advancing the tube when pre-determined mark reaches nostril **REMOVE THE TUBE AT ONCE IF THE PATIENT EXHIBITS ANY SIGNS OF DISTRESS, I.E., EXCESSIVE COUGHING, CHOKING, GASPING, CYANOSIS, OR INABILITY TO VOCALIZE.**

10. **Special Note: When assisting the physician with nasogastric tube placement, position the patient in the right lateral decubitus position which may facilitate passage of small-bore nasogastric feeding tubes through the pylorus and into the duodenum. Small bowel passage rate may also be improved by the use of IV metoclopramide. If allowing small-bore nasogastric tube to advance using peristalsis, tape the port-end loosely to patient's cheek to facilitate passage. Confirm placement of tube by Chest x-ray before removing guidewire or stylet.

B. **Confirmation of Placement:**

1. **Obtain STAT Chest x-ray** to confirm placement is in the stomach/gastric
   a. Once gastric placement confirmation obtained, if the enteral tube has a guidewire (weighted tip small bowel tube), remove the guidewire with one hand while holding the tube in place at the nostrils.
      i. Follow MD orders after initial gastric placement to confirm placement in jejunum
   b. Carefully mark placement at the nares and verify placement every four (4) hours during continuous feedings and before each intermittent feeding.
   c. Aspirating stomach contents using a 50-60ml syringe (slip-tip or luer lock). If unable to obtain aspirate, position patient on left side and wait a few minutes to allow tube tip to fall below fluid level. May also manipulate tube 2-4 cm (1-2 inches) and re-attempt aspiration.
2. Tape tube securely to patient in a position that is comfortable, does not interfere with patient's vision, and does not pull or rub against any part of the nasal mucosa.
   a. Nasogastric tubes should be secured so as not to rub the nares. This can be accomplished by allowing the tubing to hang straight out of the nose and secure with a continuous piece of tape from the bridge of the nose to the tube or by utilizing a tubing securement device.
      i. RNs in the ICU or 1 Main may use clinical judgement to insert a Nasal Bridle Retaining System for weighted tip small bowel or nasogastric tubes that are anticipated to be place for longer periods of time.
      ii. Contraindications:
         - Patients with nasal airway obstructions and abnormalities, facial and/or anterior cranial fractures, basilar skull fractures, patient that may pull on the device to such a degree as to cause serious injury

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- Refer to package insert/instruction booklet for placement
- Retain package insert booklet and opening tool at bedside until removal

B.C. **Tube Feedings:**

1. Requires physician nutritional order which includes:
   - Specific formula and strength.
   - Route of delivery.
   - Rate of delivery.
2. The standard feeding tube utilized for NG feeding is the 10 Fr or 12Fr nasoenteric feeding tube unless otherwise indicated by physician order.
3.2. Tubing for tube feeding is incompatible with IV tubing connectors.
4. Patient's current weight will be obtained/documented prior to initiating tube feedings and daily during administration of enteral feedings.
5. Tube will be marked at nares upon insertion.
6. Tube placement shall be verified by checking marking at nares:
7. Following tube insertion.
8. Prior to each intermittent tube feeding.
9. Every four (4) hours during continuous feeding.
10. Anytime dislodgment suspected (i.e., vomiting, vigorous coughing).
11.3. Prior to medication administration.
12.4. Feeding container and connecting tubing will be changed every twenty-four (24) hours.
13.5. Gastric residuals shall be checked only if ordered by a physician and held only per physicians ordered parameters.
14.6. Feeding hang times are based on manufacturer's recommendations:
    a. Twenty-four (24) hours for closed system Ready-to-Hang formulas.
    b. Eight (8) hours for ready to use formula.
    c. Four (4) hours for reconstituted formula.
15. Licensed staff trained in inserting naso/oral (naso to stomach) feeding tubes with stylet, may do so when ordered.

~~16. RN may re-insert a dislodged PEG tube once the PEG tube has been established.~~

~~17.~~ Feeding shall be stopped during supine or head down (position) treatment (i.e., postural drainage).

~~18. Refer to electronic reference manual for more information~~

~~19. Tube Insertion:~~

~~20. Assess nares prior to insertion. The insertion may be risky in patients with nasal fractures or bleeds and esophageal strictures, fistulas, varices, basilar skull fractures.~~

~~21. Obtain the following supplies/equipment for tube feeding: Feeding pump; standard nasoenteric feeding tube 10Fr or 12Fr (unless otherwise ordered by physician), water soluble lubricant, tape or NG tube holder, stethoscope, 60 ml catheter tip or luer lock syringe, Lopez 3-way valve, prescribed formula, feeding container and connecting tubing, permanent marker.~~

~~22. For lavage and gavage: Obtain the following supplies: Salem pump, or Levine tubes, Lopez valve (3-way valve), tape, stethoscope, irrigation set with 60 ml syringe, suction source.~~

~~23. Determine the length of the nasogastric tube by measuring the distance from the tip of the nose to earlobe to xiphoid process of sternum. DO NOT insert excess nasogastric tubing, it will kink or curl.~~

~~24. Once x-ray placement is confirmed in the stomach, if the enteral tube has a guidewire, remove the guidewire with one hand while holding the tube in place at the nostrils.~~

~~25. Mark the total length of tube to be inserted with a small piece of tape or with permanent marker.~~

~~26. Lubricate tube tip with water-soluble lubricant. Small-bore enteral tubes may be pre-lubricated which will be activated by placing it in water.~~

~~27. Position patient in a sitting position (90°) with the head bent slightly forward. If the patient is comatose, or unable to sit up, position patient supine with the head facing directly forward and the chin aligned with the sternal notch.~~

~~28. Insert tube by passing it gently along the floor of the nostril, aiming down and back towards the ear. Once tip is in the posterior pharynx, encourage patient to swallow sips H2O or dry swallows. Stop if there is any resistance. DO NOT USE FORCE. Resistance may be the result of mild vagal stimulation. Wait a few seconds and gently attempt to advance tube again. Stop advancing the tube when pre-determined mark reaches nostril REMOVE THE TUBE AT ONCE~~

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~~IF THE PATIENT EXHIBITS ANY SIGNS OF DISTRESS, I.E., EXCESSIVE COUGHING, CHOKING, GASPING, CYANOSIS, OR INABILITY TO VOCALIZE.~~

29. ~~**Special Note: When assisting the physician with nasoenteric tube placement, position the patient in the right lateral decubitus position which may facilitate passage of small-bore nasoenteric feeding tubes through the pylorus and into the duodenum. Small bowel passage rate may also be improved by the use of IV metoclopramide. If allowing small-bore nasoenteric tube to advance using peristalsis, tape the port-end loosely to patient's cheek to facilitate passage. Confirm placement of tube by x-ray before removing guidewire or stylet.~~

30. ~~Confirm placement by (1) aspirating stomach contents using a 50-60ml syringe (slip-tip or luer lock). If unable to obtain aspirate, position patient on left side and wait a few minutes to allow tube tip to fall below fluid level. May also manipulate tube 2-4 cm (1-2 inches) and re-attempt aspiration. (2) Obtain x-ray, unless ordered otherwise by physician. Once proper placement is verified, carefully mark placement at the nares and verify placement every four (4) hours during continuous feedings and before each intermittent feeding.~~

31. ~~Tape tube securely to patient in a position that is comfortable, does not interfere with patient's vision, and does not pull or rub against any part of the nasal mucosa. Nasoenteric tubes should be secured so as not to rub the nares. This can be accomplished by allowing the tubing to hang straight out of the nose and secure with a continuous piece of tape from the bridge of the nose to the tube or by utilizing a tubing securement device.~~

32. ~~RNs in the ICU or 1 Main may use clinical judgement to insert a Nasal Bridle Retaining System for dobhoff or nasogastric tubes that are anticipated to be place for longer periods of time.~~

33. ~~Contraindications:~~

34. ~~Patients with nasal airway obstructions and abnormalities, facial and/or anterior cranial fractures, basilar skull fractures, patient that may pull on the device to such a degree as to cause serious injury~~

35. ~~Refer to package insert/instruction booklet for placement~~

36. ~~Retain package insert booklet and opening tool at bedside until removal~~

37. ~~Care of patient with tube.~~

38. ~~Perform oral and nasal hygiene every shift and prn. Assess nares and nasal mucosa for skin breakdown every four (4) hours. Re-tape tube as necessary to maintain patient comfort and tube security. Comfort may be provided by lubrication of the tube at the nostril with K-Y Jelly.~~

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~~39. Observe for possible complications, such as nasal septal abscess, fever, chills, sinusitis, or pain.~~

~~40. Assess and/or observe for abdominal distention, diarrhea/constipation. Listen for bowel sounds every shift.~~

~~41. Assess type and amount of drainage if applicable.~~

~~42. Care of tube and/or equipment while in place.~~

~~43. Enteral devices require periodic flushing to keep them patent. It is recommended that small-bore feeding tubes be flushed with 30ml of warm water every four (4) hours during continuous feeding and before and after intermittent feedings, medications, after bolus feeds, if residuals are checked, and if feeding needs to be turned off for any length of time.~~

~~44. For continuous drainage or to suction, change canister lining when needed and discarding per infection control practice (~~MEDICAL EQUIPMENT CARE, CLEANING AND MAINTENANCE~~).~~

~~45. PEG insertion site, if less than seventy-two (72) hours old, site will be cleaned daily with normal saline using aseptic technique and covered with a sterile dressing. Sites over seventy-two (72) hours old shall be cleaned daily with warm water and mild soap, and then left open to air. If a dressing is needed due to drainage, it is to be changed daily or PRN.~~

~~46. Should tubing become clogged: using a 30 ml or larger syringe, aspirate as much fluid as possible from the tube and discard. Fill syringe with 5 ml of warm water and attach to the end of the enteral device. Instill water under manual pressure for one (1) minute, using a back and forth motion with the plunger to loosen the clog. Clamp the tube five (5) to fifteen (15) minutes. Re-attempt to aspirate or flush the tube with warm water. Repeat the process if necessary.~~

~~47.~~7. ~~Salem: Keep vent lumen above the patient's midline, otherwise it will act as a siphon.~~

~~48.~~8. Initiation and maintenance of continuous feeding.

a. Raise head of bed and maintain at 30°-45° during feedings. **Special Note: If patient is in restraints, keep head of bed up at all times.

b. Obtain prescribed formula from Nutrition Services. Prepare and hang formula for twenty-four (24) hours if it's Closed System Ready–to-Hang formula; eight (8) hours when using a bag to delivery Ready-to-Use formula.

c. Label container with date and time. Prime pump and program with prescribed rate.

~~49.~~9. Confirm tube placement before initiating feeding, every four (4) hours, before medication administration and any time dislodgment suspected.

~~50.~~10. **Do not check residuals unless specifically ordered by physician.** If residuals are ordered to be checked, hold feeding per physician hold parameter. Never check residuals of small-bore feedings, e.g., j-tubes. Return all residuals and flush with 30ml H_2O. If tube placement ever becomes questionable, hold feedings and notify physician.

~~51.~~11. Maintain patency of tube by flushing with 30ml of warm water every four (4) hours and before and after medication administration.

~~52.~~12. **Never** stop delivery of feedings into small-bore intestinal tube unless ordered by physician.

~~C.~~D. **Initiation and maintenance of bolus feeding:**

1. Raise head of bed and maintain at 30°-45° for one (1) hour post feedings. For patient in restraints, maintain head of bed up for four (4) hours post feeding.
2. Confirm tube placement.
3. Administer prescribed formula: remove plunger of 50-60 ml syringe and insert tip into open end of gastric feeding tube. Pour solution into syringe and administer by gravity. Follow administration with 30ml of warm water. Clamp off feeding tube.
4. Assess/observe and monitor patient's tolerance.

~~D.~~E. **Administration of medication or protein modular component into tube.**

1. Obtain medication(s) from pharmacy, in liquid form whenever possible. Crush tablets and dissolve fully in warm water. **NEVER** crush enteric coated or sustained release capsules. Do NOT administer drugs via nasojejunal or j-tube unless no other medical alternative (consult with pharmacist)
   a. Make every attempt to change medication to IV or liquid form.
2. Module protein products.
   a. Flush tube with 30 ml of warm water before and after each administration of protein product.
3. Confirm tube placement. Administer 30ml of warm water; administer medication and follow-up with an additional 30 ml of warm water. Leave patient with head of bed up at 30°-45° for one (1) hour post medication

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administration. **If patient is restrained**, head of bed must be raised to **45° at all times.**

F. **Care of patient with NG/OG/PEG Tube**

1. Perform oral and nasal hygiene every shift and prn. Assess nares and nasal mucosa for skin breakdown every four (4) hours. Re-tape tube as necessary to maintain patient comfort and tube security. Comfort may be provided by lubrication of the tube at the nostril with K-Y Jelly.
2. Observe for possible complications, such as nasal septal abscess, fever, chills, sinusitis, or pain.
3. Assess and/or observe for abdominal distention, diarrhea/constipation. Listen for bowel sounds every shift.
4. Assess type and amount of drainage if applicable. Enteral devices require periodic flushing to keep them patent. It is recommended that small-bore feeding tubes be flushed with 30ml of warm water every four (4) hours during continuous feeding and before and after intermittent feedings, medications, after bolus feeds, if residuals are checked, and if feeding needs to be turned off for any length of time.
5. For continuous drainage or to suction, change canister lining when needed and discard~~ing~~ per infection control practice (MEDICAL EQUIPMENT CARE, CLEANING AND MAINTENANCE).
6. PEG insertion site, if less than seventy-two (72) hours old, site will be cleaned daily with normal saline using aseptic technique and covered with a sterile dressing. Sites over seventy-two (72) hours old shall be cleaned daily with warm water and mild soap, and then left open to air. If a dressing is needed due to drainage, it is to be changed daily or PRN.

   In the event a PEG tube becomes dislodged, **Notify MD**.
7. Should tubing become clogged: using a 30 ml or larger syringe, aspirate as much fluid as possible from the tube and discard. Fill syringe with 5 ml of warm water and attach to the end of the enteral device. Instill water under manual pressure for one (1) minute, using a back and forth motion with the plunger to loosen the clog. Clamp the tube five (5) to fifteen (15) minutes. Re-attempt to aspirate or flush the tube with warm water. Repeat the process if necessary.
8. Salem: Keep vent lumen above the patient's midline, otherwise it will act as a siphon.

~~E.~~G. **Tube discontinuation:**

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1. Inform patient and provide privacy.
2. Position patient in a sitting position (90°), if possible. Place a bath towel on patient's chest. Apply gloves and remove tape or tube holder from nose.
   a. If Nasal Bridle Tube Retaining System is in place, cut one side of the securing string and slide the remaining secure string out of the nares. All clinical RNs may discontinue a Nasal Bridle Tube Retaining system.
3. Disconnect tube, if to suction from suction source. Pinch tube shut. This prevents tube contents from draining out during removal. If patient is able, have patient take a deep breath and hold. Withdraw tube gently but quickly. Wrap tube in towel and remove from chest. Clean nose and assist patient with oral care. Discard tube and towel in their appropriate receptacles.
4. Following removal, inspect the tube for holes or missing parts. If the tube is not intact, complete an Occurrence Report and notify physician.

~~F.~~H. **Documentation:**

1. Date and time of insertion.
2. Size, type and purpose for tube.
3. Methods of confirmation and tolerance of procedure.
4. Length of tube remaining outside of nares (from nares to tip of hub) if a stylet was used. Condition of nares and oral mucosa before/after insertion.
5. Every shift evaluate and document.
6. Condition of nares, oral mucosa and condition of skin surrounding NG or j-tubes.
   - Patient tolerance to treatments, i.e., decompression, lavage, feeding, i.e., residuals(if ordered to be checked by MD), diarrhea.
   - Intake, output, weights.
   - Gastrointestinal status, i.e., bowel sounds, distention.
   - Education: Patient and family provided education regarding procedure for recognizing and reporting signs and symptoms of discomfort.

~~V.~~VI. **EDUCATION/TRAINING:**

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

~~VI.~~VII. **REFERENCES:**

in approval

ENTERAL TUBES INSERTION MAINTENANCE

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Salinas Valley Memorial Healthcare System

DISCHARGE/TRANSITION PLANNING GUIDELINES

Reference Number	555
Effective Date	Not Approved Yet
Applies To	Case Management
Attachments/Forms	Attachment A - Screening Criteria- Triggers for Discharge Planning

I. **POLICY STATEMENT:**

A. ~~Initial~~ Screening ~~of Patients~~

1. All patients admitted for inpatient care shall receive a discharge planning screen ~~by nursing~~ within 24-48 hours of admission to identify the potential need for discharge services. Any patient who meets one of the following criteria shall be referred for a formal discharge planning evaluation:

   a. Acute change in functional or cognitive status that may impact post-hospitalization care needs

   b. Lives alone or with little or no discernable support system

   c. Currently require post-hospitalization care services

~~B. The discharge screening evaluation should be initiated within 24 hours of admission to inpatient status. Initially performed by Nursing, Case Managers and Social Workers will screen all patients within their caseloads within 24-48 hours.~~

~~C. Changes in the patient's condition during hospitalization may warrant development of a discharge plan for a patient not identified during the initial screening process. In these situations, a referral shall be made within 24 hours of identification to staff qualified to perform a discharge planning evaluation.~~

~~D. Discharge Planning Evaluation~~

~~1. In addition to the screening process, a discharge planning evaluation may be requested by the patient's physician, the patient, or a member of the patient's family.~~

~~2. Patients requiring a discharge planning evaluation shall have said evaluation performed at an early stage of their hospitalization (e.g. within 48 to 72 hours of referral/request) when possible. If necessary, a discharge planning evaluation may be performed within 48 hours of a patient's anticipated discharge provided there is no evidence that the patient's discharge will be delayed or that the patient was placed unnecessarily in a setting other than where he/she was admitted from primarily due to a delay in discharge planning.~~

~~3. The patient or patient representative shall be actively involved in the discharge planning evaluation. Information should be actively solicited not only from the~~

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~~patient or the patient's representative, but also as needed from family/friends/support persons.~~

4. ~~The discharge planning evaluation shall be performed by qualified personnel. The following are considered qualified personnel:~~

   a. ~~Registered Nurses~~

   b. ~~Social Workers~~

E. ~~The discharge plan will be formulated after direct patient/family interview. If the patient is unable to speak for themselves and there is no Durable Power of Attorney for Healthcare (DPAHC) and then an interview may be had with the patient's designated next of kin that is listed on the face sheet or with persons with legal responsibility for the patient.~~

F. ~~The attached criteria (See Attachment A) are to be used as screening criteria.~~

G. ~~The discharge planning evaluation shall include, but not necessarily be limited to, the following:~~

1. ~~An evaluation of what the patient's care needs will be immediately upon discharge and whether those needs are expected to remain constant or lessen over time. If the patient was admitted from his/her private residence, the evaluation must include an assessment of whether the patient is capable of addressing his/her care needs through self-care.~~

2. ~~An evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.~~

   a. ~~If the result of the evaluation is that the patient cannot receive required care if he/she returns to home, then an assessment must be made of options for transfer to another inpatient or residential healthcare facility that can address that patient's needs, including other types of hospitals, such as rehabilitation hospitals, skilled nursing facilities, assisted living facilities, nursing homes or inpatient hospice facilities.~~

   b. ~~If prior to the hospital admission the patient was a resident in a facility that he or she wishes to return to, such as an assisted living or nursing facility or skilled nursing facility, the evaluation must address whether that facility has the capability to provide the post-hospital care required by the patient.~~

3. ~~An evaluation of the likelihood of a patient needing post-hospital services and of the availability of those services.~~

   a. ~~The evaluation must include assessment of whether the patient will require specialized medical equipment or permanent physical modifications to the~~

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~~home and the feasibility of acquiring the equipment or the modifications being made.~~

~~b. If the patient is not able to provide some or all of the required self-care, the evaluation must also address whether the patient has family or friends available who are willing and able to provide the required care at the times it will be needed, or who could, if willing, be trained by the organizations sufficiently to provide the required care.~~

~~c. The results of the discharge planning evaluation must be discussed with the patient or the patient's representative. Documentation of this communication must be included in the medical record, including if the patient rejects the results of the evaluation.~~

~~H. Development Of A Discharge Plan~~

~~1. If the results of the discharge planning evaluation indicate the need for a discharge plan, then a plan shall be developed to meet the needs identified by the evaluation.~~

~~2. The patient and/or the patient's representative have the right to participate in the development of the discharge plan. Even if the discharge planning evaluation indicates no need for a discharge plan, the patient's physician may request a discharge plan. In such a case, a discharge plan shall be developed for the patient.~~

~~3. The discharge plan should be initiated as soon as possible. As changes in the patient's condition and needs occur, the discharge plan must be reassessed and updated to address those changes.~~

~~I. Use Of Home Health Agencies (HHA) And Skilled Nursing Facilities (SNF)~~

~~1. The organization shall include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the organization as available. The discharge plan shall not specify or limit qualified HHA's or SNFs.~~

~~2. This list must only be presented to patients for who home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation. The organization shall document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.~~

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DISCHARGE/TRANSITION PLANNING GUIDELINES

~~3. For patients enrolled in managed care organizations, the organization shall indicate the availability of home health and post-hospital extended care services through individuals and entities that have a contract with the managed care organizations.~~

~~4. The discharge plan must identify any HHA or SNF to which the patient is referred in which the organization has a disclosable financial interest, as specified by the Secretary of Health & Human Services, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.~~

~~5. The discharge plan must be discussed with the patient or the patient's representative. Documentation of this communication must be included in the medical record, including if the patient rejects the discharge plan. The discharge plan itself must also be documented in the patient's medical record.~~

~~J. Initial Implementation Of The Discharge Plan~~

~~1. The organization shall arrange for the initial implementation of the discharge plan. This includes providing in-hospital education/training to the patient for self-care or to the patient's family or other support person(s) who will be providing care in the patient's home. It also includes arranging:~~

~~a. Transfers to rehabilitation hospitals, long-term care hospitals or long-term care facilities;~~

~~b. Referrals to home health or hospice agencies;~~

~~c. Referral for follow-up with physicians/practitioners, occupational or physical therapists, etc.;~~

~~d. Referral to medical equipment suppliers; and~~

~~e. Referrals to pertinent community resources that may be able to assist with financial, transportation, meal preparation or other post-discharge needs.~~

~~f. Staff shall document in the patient's medical record the arrangements made for initial implementation of the discharge plan, including training and materials provided to the patient or patient's informal caregiver or representative, as applicable.~~

~~K. Transfer Or Referral~~

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1. ~~The organization shall assure that necessary medical information, to appropriate facilities, agencies or outpatient services as needed for follow-up or ancillary care is provided when patients are transferred or referred for post-discharge care.~~
2. ~~The "medical information" that is necessary for the transfer or referral includes, but is not limited to:~~
   a. ~~Brief reason for hospitalization (or, if hospital policy requires a discharge summary for certain types of outpatient services, the reason for the encounter) and principal diagnosis;~~
   b. ~~Brief description of hospital course of treatment;~~
   c. ~~Patient's condition at discharge, including cognitive and functional status and social supports needed;~~
   d. ~~Medication list (reconciled to identify changes made during the patient's hospitalization) including prescription and over-the-counter medications and herbal. (Note, an actual list of medications needs to be included in the discharge information, not just a referral to an electronic list available somewhere else in the medical record.);~~
   e. ~~List of allergies (including food as well as drug allergies) and drug interactions;~~
   f. ~~Pending laboratory work and test results, if applicable, including information on how the results will be furnished;~~
   g. ~~For transfer to other facilities, a copy of the patient's advance directive, if the patient has one; and~~
   h. ~~For patients discharged home:~~
      i. ~~Brief description of care instructions reflecting training provided to patient and/or family or other informal caregiver(s);~~
      ii. ~~If applicable, list of all follow-up appointments with practitioners with which the patient has an established relationship and which were scheduled prior to discharge, including who the appointment is with, date and time.~~
      iii. ~~If applicable, referrals to potential primary care providers, such as health clinics, if available, for patients with no established relationship with a practitioner.~~
3. ~~In the case of a patient being transferred to another inpatient or residential healthcare facility, the necessary information must accompany the patient to the facility. However, in the case of a patient discharged home who is being referred for follow-up ambulatory care, the transmittal of the information to the patient's physician may take place up to seven days after discharge or prior to the first~~

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~~appointment for ambulatory care services that may have been scheduled, whichever comes first.~~

II. PURPOSE:

A. ~~Patient admitted to the hospital have a right to discharge planning services.~~ The purpose of this policy is to codify processes necessary to assure the following:

1. Screening of all inpatients to determine which ones are at risk of adverse health consequences post-discharge if they lack discharge planning
2. Evaluation of the post-discharge needs of inpatients identified as the result of screening processes, or of inpatients who request an evaluation or whose physician requests one.
3. Development of a discharge plan if indicated by the evaluation or at the request of the patient's physician.
4. Initial implementation of the discharge plan prior to the discharge of an inpatient.

B. To guide staff to identify specific patient/family needs, ensure patient access and choices of services and coordinate appropriate community services in order to expedite timely discharge from the hospital to the next appropriate level of care and promote the continuity of patient care.

III. DEFINITIONS:

A. ECF- Extended Care Facility

B. DME-Durable Medical Equipment

C. VNA-Visiting Nurses Association

D. Case Manager-Registered Nurse

IV. GENERAL INFORMATION:

~~A. N/A~~

A. The initial discharge needs screening is completed during the nursing initial assessment. Case Managers and Social Workers will screen all patients within their caseloads within 48 hours of admission to determine the need for a discharge plan evaluation. See Attachment A

B. Changes in the patient's condition during hospitalization may warrant development of a discharge plan for a patient not identified during the initial screening process. In

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these situations, a referral shall be made to Case Management / Social Services within 24 hours of identification.

C. Planning Evaluation

1. In addition to the screening process, a discharge planning evaluation may be requested by the patient's physician, the patient, or a member of the patient's family at any time during the patient's stay.

2. Patients requiring a discharge planning evaluation shall have said evaluation performed at an early stage of their hospitalization (e.g. within 48 to 72 hours of referral/request) when possible. If necessary, a discharge planning evaluation may be performed within 48 hours of a patient's anticipated discharge provided there is no evidence that the patient's discharge will be delayed or that the patient was placed unnecessarily in a setting other than where he/she was admitted from primarily due to a delay in discharge planning.

3. The patient or patient representative shall be actively involved in the discharge planning evaluation. Information should be actively solicited not only from the patient or the patient's representative, but also as needed from family/friends/support persons.

D. The discharge plan will be formulated after direct patient/family interview. If the patient is unable to speak for themselves and there is no Durable Power of Attorney for Healthcare (DPAHC) and then an interview may be had with the patient's designated next of kin that is listed on the face sheet or with persons with legal responsibility for the patient.

E. The discharge planning evaluation shall include, but not necessarily be limited to, the following:

1. An evaluation of what the patient's care needs will be immediately upon discharge and whether those needs are expected to remain constant or lessen over time. If the patient was admitted from his/her private residence, the evaluation must include an assessment of whether the patient is capable of addressing his/her care needs through self-care.

2. An evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

   a. If the result of the evaluation is that the patient cannot receive required care if he/she returns to home, then an assessment must be made of options for transfer to another inpatient or residential healthcare facility that can address that patient's needs, including other types of hospitals, such as rehabilitation

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hospitals, skilled nursing facilities, assisted living facilities, nursing homes or inpatient hospice facilities.

b. If prior to the hospital admission the patient was a resident in a facility that he or she wishes to return to, such as an assisted living or nursing facility or skilled nursing facility, the evaluation must address whether that facility has the capability to provide the post-hospital care required by the patient.

3. An evaluation of the likelihood of a patient needing post-hospital services and of the availability of those services.

a. The evaluation must include assessment of whether the patient will require specialized medical equipment or permanent physical modifications to the home and the feasibility of acquiring the equipment or the modifications being made.

b. If the patient is not able to provide some or all of the required self-care, the evaluation must also address whether the patient has family or friends available who are willing and able to provide the required care at the times it will be needed, or who could, if willing, be trained by the organizations sufficiently to provide the required care.

c. The results of the discharge planning evaluation must be discussed with the patient or the patient's representative. Documentation of this communication must be included in the medical record, including if the patient rejects the results of the evaluation.

F. Development Of A Discharge Plan

1. If the results of the discharge planning evaluation indicate the need for a discharge plan, then a plan shall be developed to meet the needs identified by the evaluation.

2. The patient and/or the patient's representative have the right to participate in the development of the discharge plan. Even if the discharge planning evaluation indicates no need for a discharge plan, the patient's physician may request a discharge plan. In such a case, a discharge plan shall be developed for the patient.

3. The discharge plan should be initiated as soon as possible. As changes in the patient's condition and needs occur, the discharge plan must be reassessed and updated to address those changes.

G. Use Of Home Health Agencies (HHA) And Skilled Nursing Facilities (SNF)

1. The organization shall include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient

resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the organization as available. The discharge plan shall not specify or limit qualified HHA's or SNFs.

2. This list must only be presented to patients for who home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation. The organization shall document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

3. For patients enrolled in managed care organizations, the organization shall indicate the availability of home health and post-hospital extended care services through individuals and entities that have a contract with the managed care organizations.

4. The discharge plan must identify any HHA or SNF to which the patient is referred in which the organization has a disclosable financial interest, as specified by the Secretary of Health & Human Services, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

5. The discharge plan must be discussed with the patient or the patient's representative. Documentation of this communication must be included in the medical record, including if the patient rejects the discharge plan. The discharge plan itself must also be documented in the patient's medical record.

H. Initial Implementation Of The Discharge Plan

1. The organization shall arrange for the initial implementation of the discharge plan. This includes providing in-hospital education/training to the patient for self-care or to the patient's family or other support person(s) who will be providing care in the patient's home. It also includes arranging:

   a. Transfers to rehabilitation hospitals, long-term care hospitals or long-term care facilities;

   b. Referrals to home health or hospice agencies;

   c. Referral for follow-up with physicians/practitioners, occupational or physical therapists, etc.;

   d. Referral to medical equipment suppliers; and

   e. Referrals to pertinent community resources that may be able to assist with financial, transportation, meal preparation or other post-discharge needs.

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f. Staff shall document in the patient's medical record the arrangements made for initial implementation of the discharge plan, including training and materials provided to the patient or patient's informal caregiver or representative, as applicable.

I. Transfer Or Referral

1. The organization shall assure that necessary medical information, to appropriate facilities, agencies or outpatient services as needed for follow-up or ancillary care is provided when patients are transferred or referred for post-discharge care.
2. The "medical information" that is necessary for the transfer or referral includes, but is not limited to:

   a. Brief reason for hospitalization (or, if hospital policy requires a discharge summary for certain types of outpatient services, the reason for the encounter) and principal diagnosis;

   b. Brief description of hospital course of treatment;

   c. Patient's condition at discharge, including cognitive and functional status and social supports needed;

   d. Medication list (reconciled to identify changes made during the patient's hospitalization) including prescription and over-the-counter medications and herbal. (Note, an actual list of medications needs to be included in the discharge information, not just a referral to an electronic list available somewhere else in the medical record.);

   e. List of allergies (including food as well as drug allergies) and drug interactions;

   f. Pending laboratory work and test results, if applicable, including information on how the results will be furnished;

   g. For transfer to other facilities, a copy of the patient's advance directive, if the patient has one; and

   h. For patients discharged home:

      i. Brief description of care instructions reflecting training provided to patient and/or family or other informal caregiver(s);
      ii. If applicable, list of all follow-up appointments with practitioners with which the patient has an established relationship and which were scheduled prior to discharge, including who the appointment is with, date and time.

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iii. If applicable, referrals to potential primary care providers, such as health clinics, if available, for patients with no established relationship with a practitioner.

3. In the case of a patient being transferred to another inpatient or residential healthcare facility, the necessary information must accompany the patient to the facility. However, in the case of a patient discharged home who is being referred for follow-up ambulatory care, the transmittal of the information to the patient's physician may take place up to seven days after discharge or prior to the first appointment for ambulatory care services that may have been scheduled, whichever comes first.

V. **PROCEDURE:**

A. **Discharge Planning Assessment**

1. The patient will be screened by a RN Case Manager within 24-484 hours of admission to determine the need for further discharge planning. The Case Manager will document the findings from the screening and interview in the ~~Allscripts~~ electronic Case Management system, which interfaces into the electronic medical record.

2. The following items should be addressed in the initial discharge planning documentation if appropriate.

   a. Contact number #/ family cell phone number/Spokesperson for the patient

   b. Support system.

   c. Ability for self- care.

   d. Assess prior living environment and the ability to return to that environment

   e. Equipment used

   f. Services used

   g. Primary language

   h. Cultural issues

   i. Religious issues

   j. Advanced directives

   k. Barriers to discharge

      i. If the patient is admitted from the ECF, it is the expectation that the ECF facility will be contacted to discuss any issues that may have contributed to admission.

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DISCHARGE/TRANSITION PLANNING GUIDELINES

3. The Case Manager in conjunction with the patient/ family and interdisciplinary team should develop a primary as well as a secondary discharge plan.
4. The following should be included on all discharge plans:
   a. Goals of the discharge plan and preferences of the patient (or patient's representative) for post-hospitalization shall be documented.
   b. The patient's immediate care needs and whether those needs will lessen over time.
   c. For patients discharged home, document whether the patient can perform their activities of daily living, whom is their support network, and if they need specialized equipment.
   d. Potential barriers of the discharge plan.
5. Each patient should be re-assessed as necessary during the patient's clinical trajectory and the discharge plan updated as necessary. For extended LOS patients, the discharge plan should be reviewed and refreshed every 3-4 days.
6. RN Case Managers and Social Workers will assure congruency in discharge planning.
7. A list of community resources will be given to patients, family and healthcare team- members and documented in the Case Management documentation in the electronic medical record.
8. The Case Manager will keep the patient/family, members of the healthcare team and representatives from community agencies, informed of the discharge plan.
9. The Case Manager will collaborate with the physician and team to identify specific aspects of the home plan of care to include:
   a. Community Services
   b. Equipment needs
   c. Medications
   d. Orthopedic/family/teaching (i.e., ostomy, diabetic, etc.)
   e. Rehabilitation needs
   f. Wound Care
   g. Skilled Home Health Services (i.e., RN/PT/OT/ST/HHA/MSW
   h. Ability for the patient to perform self-care

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B. **Discharge/Transfer Process**

1. Identify payer source and determine what services will be paid for by insurance, Medicare, Medi-Cal or privately. This may involve contacting the patient's family, insurance carrier (or care manager) and agencies/vendors involved in the care. The hospital may also become a resource when the patient meets the criteria for charity care. (See Sponsorship guideline and process.)

    a. Meet with the patient and/or family/legal representative.

    b. Evaluate the family/significant others as potential care providers.

    c. Evaluate whether patient or family/care givers need counseling to prepare for post-hospitalization care. If support/counseling is needed, make referral to Social Services on duty for counseling.

    d. Provide the patient and /or family with an informational list of agencies, vendors, resources, etc. so that they can select the resources they wish to use. This list includes contact information for at least one public or non-profit agency dedicated to providing information or referral services related to community-based long term care options.

    e. Emphasis should be made to the patient or patient representatives that they have freedom of choice and if those choices aren't possible for any reason, including insurance reasons, this will be discussed with the patient and or representative and documented in the medical record.

    f. If the patient, family and MD have no preference of vendors or agencies, the Case Manager will disclose and refer to one of our affiliated organizations, providing they can supply the necessary services. Affiliated organizations are denoted in the patient information brochure with asterisks.

    g. If home health care is ordered, the home health agency that is chosen becomes the "primary" home health agency.

    h. Provide the selected agencies, vendors, etc., with details and all relevant information regarding patient care needs. If the VNA is referred to, release the case in the computer to allow access to the medical record. A copy of the discharge instruction sheet will be given or faxed to the appropriate Home Health Agency or DME Company.

    i. Facilitate the completion of the Face to Face Attestation for home health services and DME as needed to prevent delays at discharge. It remains the DME company or Home Health Agency's responsibility to assure completion of all requirements.

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j. Communicate plans, changes and progress to the patient, patient's family, physician, agencies, and if applicable, the insurance company representative.

k. Document all of the details in the Case Management notes in the electronic medical record.

l. Patients will be provided a copy of the Patient Health Summary upon discharge. This information will include but not limited to:

    i. Patient's Diagnosis
    ii. Hospital course
    iii. Pain treatment and management
    iv. Medication information/recollection
    v. Treatments
    vi. Dietary requirements
    vii. Rehabilitation potential
    viii. Known allergies
    ix. Treatment plan
    x. Care Notes

m. The home health agency will receive a copy of the Interdisciplinary Discharge Summary which includes the home health orders.

n. Primary care offices will have access to the Patient Portal or the EMR prior to the first hospital follow up appointment.

2. Discharge/Transfer to Post Acute Facilities: SNF or Acute Rehabilitation Unit (ARU):

    a. When the interdisciplinary team identifies that the patient may require skilled nursing facility (SNF) or ARU level of care:

    b. Discuss discharge plan with the patient and the patient's physician.

    c. Send a referral through the Case Management electronic documentation system to all skilled nursing facilities/ARU in the applicable area, unless patient's preference is available.

    d. Have a family member visit the skilled nursing facility/ARU during the patient's hospital stay.

    e. The skilled nursing facility/ARU will then verify the patient's financial information and negotiate details of the patient's admission.

    f. At the time of discharge every effort is made to match the patient with the facility of choice without delay of discharge.

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g. Keep the patient, family, physician, and nursing unit informed of skilled nursing facility/ARU decision to accept/deny patient admission.

h. Assure that the Interdisciplinary Discharge Summary is faxed to the receiving facility at the time of discharge.

i. For all patients transferred to SNF, intermediate care facilities, or acute rehabilitation, the receiving facility, and the patient (and/or patient's legal representative) will be provided with an Interdisciplinary Discharge Summary signed by a physician which will include the following information:

  i. Patient's diagnosis
  ii. Hospital course
  iii. Pain treatment and management
  iv. Medication information/reconciliation
  v. Treatments
  vi. Dietary requirements
  vii. Rehabilitation potential
  viii. Known allergies
  ix. Treatment plan

j. All patients that require post-acute services will be provided with the "Guide to Outpatient Services" brochure which contains numerous resources and referrals (profit and non-profit services).

3. Discharge/Transfer to Hospice Services:

a. Arrange for discharge to home or transfer to a skilled nursing facility.

b. The skilled nursing facility resident must have Medicare Part A or Media-Cal and Not be utilizing SNF benefits under either reimbursement program. The client may be receiving custodial care under the Medi-Cal program.

c. The patient converts Medicare A to Medicare Hospice Benefit. **Note: Under the Medicare Hospice Benefit, the patient is responsible for payment of the room rate when in an ECF setting.**

d. Referral can be made through the hospice agency liaison.

e. The client is seeking palliative care (comfort measures) and wishes to no longer have further aggressive treatment including: hospitalizations, surgeries, chemotherapy, radiation therapy or blood transfusions. The need for laboratory tests and x-rays will be considered on a case by case basis based upon the client's established Hospice Plan of Care.

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f. A copy of the hospital DNR(if in place) will be provided to the transportation agent at the time of discharge.

g. A copy of pertinent medical records (copied according to hospital guidelines) will be provided to the post-acute facility. For the patient being discharged to the home setting, the patient will receive a copy of the Discharge Packet. The home health agency will receive a copy of the Interdisciplinary Discharge Summary.

4. Discharge/Transfer to Board & Care Facility:

a. Furnish the patient and/or significant others(s) with a list of Board and Care facilities in the area. Explain that selection of the facility should be made by the patient and /or significant other(s) when possible. Remind the family to consider the patient's pay source when selecting the facility. Review the services that are available in the Board and Care setting with the patient/family.

b. Some patients going to a Board & Care may also need home health services, such as a RN or physical therapist. A referral will be made by the case manager before discharge. Follow the procedure for the "Discharge Transfer Process" detailed previously.

c. Upon Physician's Discharge Order, family or Board & Care will provide transportation to the facility.

5. Discharge of the homeless patient:

a. Assess the level of "homelessness". Make a social services referral. Collaborate with social services upon admission.

b. Refer to ~~MedAssist~~ financial medical assistance agency in the absence of a valid pay source.

c. Determine the medical after care needs. Make a referral to home healthcare, public health or local ECF.

d. Assess for potential sponsored care need for placement/home healthcare/medications.

e. Provide a taxi voucher to take the patient to a local shelter if there is no physical address provided.

6. Assessing the effectiveness of the discharge planning process:

a. The organization shall assure that the effectiveness of its discharge planning services is assessed and integrated into the QUALITY ASSESSMENT AND

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PERFORMANCE IMPROVEMENT PLAN (QAPI) and reported in accordance with the Quality Oversight Structure.

~~. At a minimum, the organization shall track readmission rates (defined as a patient readmitted with the same admitting diagnosis per DRG code within 30 days of discharge) on a quarterly basis, and identify potentially preventable readmissions. The Quality Management department will be responsible for tracking readmission rates.~~

~~For identified potentially preventable readmissions, the organization shall conduct an in-depth review of the discharge planning process for a sample of such readmissions (at least 10% of potentially preventable readmissions, or 15 cases/quarter, whichever is larger) in order to determine whether there was an appropriate discharge planning evaluation, discharge plan and implementation of the discharge plan.~~

~~Issues or trends identified shall be followed up to determine if changes to discharge planning services are warranted.~~

~~The organization tracks readmission rates on a quarterly basis at a minimum for the purpose of identifying potentially preventable readmissions. Issues and trends are identified and followed to determine if changes to discharge planning services are warranted.~~

~~Chart audits will be conducted to review the current state discharge planning process in order to determine whether there was an appropriate discharge plan evaluation, discharge plan and implementation of the discharge plan.~~

VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

A. The Joint Commission, Provision of Care standards~~TJC PC 04.01.01 The Hospital has a process that addresses the patient's need for continuing care, treatment, and service after discharge or transfer.~~

B. CMS Medicare Requirement Section 482.43(c)(6)(iii) Tag A-0827, 482.43(c)(8) Tag A-0831

~~C. CMS Medicare Requirement Section 482.43(c)(8) Tag A-0831~~

~~D.~~C. California Health and Safety Code HSC Section 1262.5

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ATTACHMENT A: ~~(REVISED):~~ Screening Criteria- T~~t~~riggers for D~~d~~ischarge P~~p~~lanning

A. Age 65 years or older/or lives alone/lives with an invalid

B. Chronically ill

C. Outliers = length of stay > 4 days

D. Catastrophic illness/chronic or newly diagnosed

E. Patient with moderate to severe functional deficits

F. Patient with permanent or unresolved disability

G. Patient who resides outside of the community

H. Patient with no known residence

I. Patient with no known method of payment for required services

J. Patient with new diagnosis of chronic renal failure

K. History of mental or emotional illness/confusion/disorientation/mental retardation

L. Patient residing in the ICU or NICU setting

M. Patient with a readmission < 30 days from discharge from an acute setting

N. Patient with a history of frequent use of the Emergency Department

O. Patient with four or more active co-existing health conditions

P. Patient with six or more required medications upon discharge

Q. Patient with wound care needs

R. Patient has had greater than 2 hospitalizations in the last three months

S. Documented history of non-adherence to the therapeutic regimen

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SPECIMEN/FOREIGN BODY

Reference Number	613
Effective Date	Not Approved Yet
Applies To	L & D, PATHOLOGY, SURGERY, WOUND CARE, PATIENT CARE UNITS, EMERGENCY, ENDOSCOPY, DI
Attachments/Forms	

I. **POLICY STATEMENT:**

A. Anatomical parts, tissues and foreign objects/devices removed during procedures are identified, recorded and delivered to a pathologist designated by the hospital and a report of his/her findings is filed in the patient's medical record.

1. Exemptions: cataracts, tubes, drains, and suture that have not contributed to patient illness, injury, or death and saphenous vein harvested for CABG.

~~B. Foreign bodies, removed for forensic purposes, must be documented and examined by a pathologist before release to a law enforcement official.~~

~~C. The Specimen reconciliation and transfer process is initiated and controlled by Pathology through the Lead Histology Tech. Discrepancy reports are generated by the Lead Histology Tech. and reviewed at the quarterly Pathology Meetings.~~

II. **PURPOSE:**

A. To establish a uniform guideline for the identification, preservation, transfer, and disposition of tissues and foreign bodies removed from patients during surgery/procedures.

III. **DEFINITIONS:**

A. Specimens: tissue, limbs, blood, body fluids, and foreign bodies removed from a patient.

B. Fixative: A solution used to preserve the cellular integrity of tissue submitted for pathology examination e.g. GTF (Glyoxl based, formalin free fixative)

C. Frozen section: Small pieces of tissue (5x5x3mm), which are placed in a cryoprotective embedding medium, frozen, and then sectioned in a freezing microtome or cryostat.

D. Permanent section: Examination of preserved and processed tissues/cells.

E. CABG: Coronary artery bypass graft.

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F. Circulator: an RN who identifies the patient, verifies correct procedure/site and consent, initiates the Time Out, ensures supplies are ready, and delivers items to the sterile field.

G. Scrub: the person, either RN or technician, who has scrubbed, donned sterile attire and assists the physician during the sterile procedure.

H. Fresh: without fixative

IV. GENERAL INFORMATION:

A. The identification, transfer, and examination of specimens is a multidisciplinary responsibility involving the physician doing the procedure, the circulator, the scrub person, and the pathologist.

B. Foreign bodies, removed for forensic purposes, must be documented and examined by a pathologist before release to a law enforcement official.

C. The Specimen reconciliation and transfer process is initiated and controlled by Pathology through the Lead Histology Tech. Discrepancy reports are generated by the Lead Histology Tech. and reviewed at the quarterly Pathology Meetings.

V. PROCEDURE:

A. Specimen collection begins with assessment and pre-planning.

1. The procedure schedule is consulted by the circulator, scrub, and pathologist to identify procedures for which specimens may be obtained.
2. Unusual specimen requests are clarified with the physician and dialogue is initiated with a pathologist to determine special requirements.
3. The type of container and fixative or transport medium is identified.
4. Containers must be large enough to accommodate the specimen and enough fixative, at a 10 part fixative to 1 part specimen ratio, in rigid leak proof containers.
   a. The exception is limbs, which are double bagged and labeled as biohazardous material and transported as soon as possible after removal.

B. Specimens are identified with consistent information, which includes the following:

1. For both specimen **container and forms**,
   a. Patient name.
   b. Patient medical record number and date of birth.

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SPECIMEN/FOREIGN BODY

c. Patient label when available.

d. Source or type of specimen and side, if a sided procedure is done.

2. **Additional container labeling**

a. Solution used to fix tissue when a fixative is needed

b. Biohazard label

3. **Additional data unique to specimen forms**,

a. Pre and post procedure diagnoses.

b. Date of collection.

c. Time of collection for blood, fluid, ~~and~~ culture, and breast specimens.

d. Name of physician completing the procedure and other physicians he/she indicates should receive a copy of the specimen/pathology report.

e. Pertinent information discovered during the procedure.

f. Study requested.

g. Circulator's name.

4. Specimens and forms not identified as described above will be rejected by Pathology and returned to the source department for corrections.

5. Specimen labels are placed on the container body and not the lid.

C. Specimens are identified: at the time of

1. Removal from the patient by the physician and scrub (if present):

a. The scrub or circulator verbally repeats back the tissue information.

2. Transfer to the circulator:

a. The scrub if present or physician verbalizes the specimen identity and the circulator verbally confirms the information.

b. The circulator places a specimen label on the container and the scrub visually confirms accuracy immediately ~~after~~ before the specimen is received.

c. The circulator documents the specimen in the procedure record.

d. The circulator prints the specimen form or hand writes the information on the form.

~~3. Relief of Staff during a procedure:~~

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~~4. If a surgical specimen has been obtained prior to the permanent relief of the surgical scrub of the OR circulator, then the specimen should be passed off of the sterile field prior to the relief taking place.~~

~~5. When the specimen cannot be passed off prior to the relief (using the CUSA), then the surgical specimen must be addressed in the hand-off report between the off going and on coming OR staff.~~

~~6. If the surgical specimen has not been obtained at the time of the permanent relief, then it is the responsibility of the relief staff to obtain the specimen.~~

3. Transfer to Radiology Technician:

   a. Breast specimens placed on speci-board with specific orientation for specimen mammography. After mammogram is completed the specimen is secured and wrapped with a waterproof wrapper prior to transport to Pathology . The labeled specimen container is taken with the specimen and pathology requisition.

~~7.~~4. Transfer to a pathologist:

   a. The circulator and procedure physician verbally identify the specimen.

   b. The circulator provides the labeled specimen/container and the specimen form, which is printed from the computerized record or hand written.

~~8.~~5. Transfer to a specimen collection area on the unit or the Lab:

   a. In the collection area of Surgery, the circulator identifies the specimen on the tracking sheet with a patient label, the number of specimens, the circulator's initials, and when a frozen section was sent indicates FS.

   b. In other units the specimen for permanent section is taken to the Histology Department by unit staff.

   c. The specimen form accompanies the specimen.

~~9.~~6. Transfer to the Lab/Pathology area.

   a. A final check is completed by the technician to verify the specimen label, specimen form, and procedure schedule all confirm the specimen is correct.

   b. For Surgery, the accurately identified specimen is initialed by the Lab technician on the specimen tracking sheet.

   c. For each specimen accepted by Pathology, the technician logs the specimens into Pathology and assigns an accession number.

   d. Specimens with conflicting or missing information are returned by the technician to the source unit for correct identification.

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10.7. For multiple specimens, each specimen is labeled and identified individually on the specimen form and procedure record.

D. Specimens for pathology: permanent and frozen section.

1. Anything removed from the patient during a procedure, unless exempted in the policy section, is considered a specimen e.g. tissue, limbs, foreign bodies, and implants, and must be examined by the pathologist.
2. Fixation with GTF is the primary means of preservation for permanent section. The primary fixative in Endoscopy, Diagnostic Imaging and Mammography is 10% Formalin.
   a. The volume of fixative required to fix tissue is 10:1; less fixative results in incomplete or no fixation and ruins the tissue for examination. When in doubt about quantity, use more.
   b. Hollow organs like the spleen do not fix well and should be taken to Pathology for fixation.
   c. The SDS sheets for GTF and Formalin are located in StarNet quick link for SDS.the SDS binder on the units in which GTF and formalin are used.
3. Tissues, which are not fixed and are sent to Pathology fresh, include the following:
   a. Renal and bladder stones, submitted dry.
   b. Amputated extremities, which are too large to fix.
   c. Muscle and nerve biopsies coordinated with a pathologist, Monday –Thursday.
   d. Lymph node biopsies, which are fragile.
      i. Sent immediately upon delivery to Pathology together with a handwritten pathology slip.
      ii. When cultures are ordered, the specimen is sent to microbiology first.
      iii. At case conclusion, the specimen is logged onto the Surgery specimen check sheet using a pre-printed patient label and lymph node protocol is noted. A printed specimen record is left with the check sheet.
   e. Breast excisions and mastectomies. To provide opportunity for the pathologist to examine the tissue fresh as soon as it is available.
      i. Breast tissue is not treated with fixative in Surgery.
      ii. Pathology Department is notified when the tissue is ready for pick up from the charge nurse. Documentation of the time of tissue removal is required.
      iii. After hours, weekends, and holidays, notify the pathologist on call.

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SPECIMEN/FOREIGN BODY

f. Uterus tissue from the oncologic gynecologists

    i. Uterus tissue suspicious for carcinoma is not placed in fixative in surgery.

    ii. Pathology Department is notified when the tissue is ready for pick up from the charge nurse.

    iii. After hours, weekends, and holidays, notify the Pathologist on call.

4. Frozen section specimens are **not** fixed and are transferred fresh to the pathologist by the physician doing the procedure, who communicates his procedural findings directly to the pathologist.

    a. For Surgery and DI, the Pathologist is paged to the OR/procedure room where he/she receives the specimen with its identifiers.

    b. When the frozen section is completed, the Pathologist reports the results directly to the physician and then takes the specimen to the Lab for final fixation.

    c. The circulator indicates on the patient's record that a FS was completed and to whom it was given.

    d. For Surgery, the circulator places a patient label on the specimen sheet in the collection area and indicates the frozen section.

5. Specimen orientation.

    a. The physician doing the procedure is responsible for communicating specimen orientation when needed.

    b. Orientation may be communicated verbally to the Pathologist or may be marked e.g. with suture and a description of the area marked, which the circulator will indicate on the pathology specimen form.

6. Gross exam is completed for teeth, hardware, and other devices.

E. Specimens the patient and/or family want to see:

1. The circulator notes the patient's desire on the pathology specimen form and verbally communicates that information to the Pathology unit.

2. The pathologist may exhibit the specimen to the patient/family.

F. Other specimens obtained during procedures e.g. cytology fluids, urine, tissue/ fluids for bacteriological exam, and prion contaminated samples.

1. The specimens are brought to the lab fresh, without fixative.

2. For Pathology specimens outside of working hours, the specimens are taken to the main lab for disposition.

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SPECIMEN/FOREIGN BODY

3. Specimens for both bacteriological and pathological exams.
   a. Whenever possible the specimen is divided in the procedure area and placed in a sterile container for transport to Bacteriology.
   b. For tiny specimens like pituitary tumor biopsy and culture, the specimen is sent intact to Bacteriology.
4. For Creutzfeldt Jacob disease suspect cases, refer to the policy, CJD PRECAUTIONS FOR UNDIAGNOSED BRAIN LESIONS, # 217.

G. Disposition of defective implants:
1. The circulator indicates on the Pathology specimen form the need to return the implant to the source or representative.
2. After the pathologist identifies the specimen, the implant is returned to Surgery for decontamination and terminal sterilization.
3. The implant final disposition is noted on the procedure record and in the case of tissue on the Tissue Tracking form which is retrieved by the unit clerk/secretary.

H. Radioactive specimens may occur in the rare instance a patient treated with radioisotopes presents for a procedure, which results in a specimen.
1. Lymphoscintigraphy sentinel node biopsies require no special handling.
2. All routine labeling requirements apply.
3. Additional labeling includes:
   a. Attachment of a radioactive material label.
   b. The type of radioisotope and the date it was administered to the patient.
4. Contact the pathologist immediately and he/she will consult with the Radiation Safety Officer or the alternate for recommendations and/or testing for radioactivity.

I. Forensic specimens
1. Specimen transfers:
   a. The Preservation of Chain of Evidence/Removal of Foreign Body form is completed by the circulating/primary care nurse transferring the evidence.
   b. Further transfers are documented by the designee for the Lab's Anatomical Pathology Division.
   c. Documentation includes the names of each individual handling the specimen.
2. Bullets should be handled using rubber shod instruments; metal instruments may scratch the surface interfering with later ballistics analysis.

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3. Penetrating objects should be handled minimally when possible and not wiped clean in order to preserve evidence.

J. Documentation:

1. Pathology Department specimen log.
2. Surgery/procedure pathology requisition form ~~specimen or~~ other specimen form.
3. Surgery/procedure patient record.
4. Surgery specimen log book. ~~tracking sheet.~~

VI. EDUCATION/TRAINING:

A. Education and/or training is provided as needed.~~Department specific orientation and education as the policy changes.~~

VII. REFERENCES:

A. AORN ~~(2014).~~ Recommended practices for specimen management. *Perioperative standards and recommended practices*. AORN, Denver, CO. current issue

B. College of American Pathologists (revised Nov 2007). Surgical specimens to be submitted for pathology examination. Retrieved from: http://www.cap.org/apps/docs/laboratory_accreditation/build/pdf/surgical_specimens.pdf

C. National Cancer Institute. Laboratory of pathology, Safety overview and training. Radioactive specimens in histology. Retrieved from: http://home.ncifcrf.gov/ccr/lop/intranet/PolicyManual/SafetyOverview/radioactive.asp

in approval

Salinas Valley Memorial Healthcare System

PACEMAKER: INSERTION OF A TEMPORARY PACEMAKER, TRANSVENOUS; BALLOON-TIPPED PACING ELECTRODE; AND EPICARDIAL

Reference Number	128
Effective Date	Not Approved Yet
Applies To	CATH LAB, EMERGENCY DEPT, HEART CENTER, ICU/CCU, 1MAIN
Attachments/Forms	

I. POLICY STATEMENT:

A. The insertion of a temporary trans venous pacemaker is performed in emergent and elective clinical situations when the normal conduction system of the heart fails to produce an electrical impulse, resulting in hemodynamic compromise. Exposed proximal ends of the pacing wires should be insulated when not in use to prevent micro shock.

II. PURPOSE:

A. To provide procedural guidelines in assisting physician with the insertion of a temporary trans venous pacemaker; balloon-tipped pacing electrode; and the management and care of patient with epicardial pacer wires.

III. DEFINITIONS:

A. Sensing - ability of pacemaker device to detect intrinsic myocardial electrical activity.

B. Pacing - When temporary pulse generator is activated, and the requisite level of energy travels from the pulse generator through the temporary pacing wires to the myocardium.

C. Capture - The successful stimulation of the myocardium by the pacemaker resulting in depolarization. It is evidenced on the ECG by a pacemaker spike followed by either an atrial or a ventricular complex, depending on the chamber being paced.

IV. GENERAL INFORMATION:

A. N/A

V. PROCEDURE:

A. Operation

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1. Transvenous approach/Balloon-tipped pacing electrode procedure
   a. Connect patient to bedside or procedural monitoring system, and monitor ECG continuously.
   b. Assess pacemaker functioning, and insert a new battery into the pulse generator if needed.
   c. Attach the connecting cable to the pulse generator~~, connecting the “positive” on the cable to the “positive” on the pulse generator and the “negative” on the cable to the “negative” on the pulse generator.~~
2. Epicardial pacing (ICU, OR, HC, 1Main only)
   a. Expose the epicardial pacing wires and identify the chamber of origin. Wires exiting to the right of the sternum are atrial in origin. Wires exiting to the left of the sternum are ventricular in origin.
   b. Connect the epicardial wires to the pulse generator via the connecting cable. ~~Ensure that both the positive and negative electrodes are connected to the respective positive and negative terminals on the pulse generator via the connecting cable.~~
3. Obtain Physicians order for pacemaker settings and initiate pacing.
   a. Determine the mode of pacing desired. Atrial or ventricular asynchronous, ventricular or atrial demand or dual chamber demand pacing.
   b. Set the pacemaker mode, rate and level of energy (output of mA) as prescribed or as determined by sensitivity and stimulation threshold testing.
   c. Turn all settings to the lowest level and then turn on the pacemaker.
   d. Determine sensitivity threshold for each chamber every shift~~as needed~~:
      i. Gradually turn the sensitivity dial counterclockwise (or to a higher numerical setting) and observe the pace indicator light for flashing

      ~~ii.~~

      ~~iii.~~ Slowly turn sensitivity dial clockwise (or to a lower numerical setting) until sense indicator light flashes with each complex and the pace indicator light stops. This value is the sensing threshold. ~~.~~

      ~~iv.~~ Set sensitivity dial to the number that was half the sensing threshold to provide 2:1 safety margin. Some physicians prefer to set sensitivity settings all the way to the demand mode (most sensitive), regardless of the sensitivity threshold~~.~~

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ii.

e. Determine stimulation threshold for each chamber every shift as needed:

i. Set pacing rate approximately 10 beats above the patient's intrinsic rate.

ii. Gradually decrease output from 20 mA until capture is lost.

iii. Gradually increase mA until 1:1 capture is established. This is the stimulation threshold.

iv. Set the mA at least two times higher than the stimulation threshold. This output setting is sometimes referred to as the maintenance threshold.

f. Assess rhythm for appropriate pacemaker function:

i. Capture: Is there a QRS complex for every ventricular pacing stimulus? Is there a P wave for atrial pacing stimulus?

ii. Rate: Is the rate at or above the pacemaker rate if in the demand mode?

iii. Sensing: Does the sensitivity light indicate that every QRS complex is sensed?

B. Maintenance/Care

1. Monitor vital signs and hemodynamic response to pacing as often as patient's condition warrants.

2. Evaluate ECG for presence of paced rhythm or resolution of initiating dysrhythmia.

3. Review and pPrint ECG rhythm strips every four (4) hours. (Not applicable to Cath Lab)

4. Restrict range of motion of extremity in which catheter is inserted.

5. Monitor for alteration of QRS configuration initiated by pacemaker.

6. Wear gloves when handling metal portion of pacemaker electrodes to prevent microshock hazard.

7. Assess pacemaker settings, function and thresholds every shift and document under "Pacemaker Function" screen on the worklist.

7.8. Battery life is typically 7 days of continuous operation at nominal values

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~~8.~~9. If the battery indicator light is flashing, this indicates that the pacemaker battery has <24 hours battery life. You must change the battery immediately upon noting the light flashing. To change the battery:

   a. Obtain ~~a~~ two new AA Alkaline batteries~~9V battery~~ from the PAR or in the black pacemaker case at bedside.

   b. Push ~~Squeeze~~ the black button ~~two gray buttons simultaneously~~ on the ~~lower end~~ bottom right side of the pacemaker to open the battery drawer.

   c. Remove the old batteries~~y~~ and place the new batteries~~y~~. The pacemaker has a~~n~~ 30 second internal battery backup

   ~~c.~~d. After installing new batteries, ensure the battery status indicator displays full battery power

~~9.~~10. Dressing change: (Not applicable to Cath Lab)

   a. Transparent dressing: Change every seven~~four~~ (7) days and PRN. Apply Biopatch at insertion site.

   b. Occlusive gauze dressing: Change every forty eight (48) hours and PRN.

C. Precautions

1. Monitor mA setting. Insufficient mA may result in loss of capture and dangerously slow rhythm; excessive mA may result in irritability and lead to ventricular dysrhythmias.

2. Monitor sensitivity setting; excessive sensitivity may cause sensing of “P” or “T” wave, resulting in failure to pace at appropriate times; insufficient sensitivity will cause fixed rate pacing with the possibility of the pacing stimulus being delivered during the vulnerable period of the cardiac cycle, leading to lethal dysrhythmias.

D. Related Care

1. Check external pacing electrode wire position, insulation, and security of catheter terminals within pacemaker connectors every shift (Not applicable to Cath Lab)

E. Complications

1. Pacemaker failure or malfunction

2. Failure to sense patient’s spontaneous beats; pacer spikes occur at regular intervals regardless of patient’s rhythm.

3. Failure to capture: pacer spikes visible but ventricles do not respond (no QRS).

4. Absence of generator discharge: complete or intermittent absence of pacer spikes, and rate of patient’s own rhythm is slower than pre-set rate of pulse generator.

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a. Change battery.

F. Documentation: Document under “Pacemaker Function” screen on the work list. (Not applicable to Cath Lab)

V. EDUCATION/TRAINING:

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

VI. REFERENCES:

A. Spotts, V., Temporary Transvenous and Epicardial Pacing, 2011, AACN Procedure Manual for Critical Care, pp. 429-442, In Weigand, D., 6th edition, St Louis Missouri, Elsevier Saunders. I

~~B. Overbay, D., Criddle, L., Mastering Temporary invasive cardiac pacing, Critical Care Nurse 24 (3), 25-32, 2004.~~

B. Hayes, D. (2019). Temporary cardiac pacing. *UpToDate.* Retreived from https://www.uptodate.com/contents/temporary-cardiac-pacing

C. Medronic.com (2019). Medtronic Academy. Retreived from https://www.medtronicacademy.com/

D. Model 5392 Temporary External Pacemaker. Medtronic user manual (2020)

in approval

Salinas Valley Memorial Healthcare System

CHEST TUBE MANAGEMENT

Reference Number	636
Effective Date	Not Approved Yet
Applies To	ALL NURSING UNITS, EMERGENCY DEPT
Attachments/Forms	~~Attachment A: Contraindications for Autotransfusion~~

I. POLICY STATEMENT:

A. The chest tube drainage system will be maintained as a closed system using either suction or gravity drainage under aseptic technique.

II. PURPOSE:

A. To provide guidance to staff for the care of patients with chest drainage systems.

III. DEFINITIONS:

~~A.~~ N/A~~Autotransfusion: the collection and reinfusion of the patient's own (autologous) blood.~~

~~B.~~A. ~~ATS – Autotransfusion System~~

IV. GENERAL INFORMATION:

A. N/A

V. PROCEDURE:

A. Insertion of a Chest Tube.

1. Obtain Consent for the procedure after the physician has provided the information. CONSENT: PATIENT'S RIGHTS AND THE BASICS TO CONSENT
2. Assemble drainage system according to manufacturer's instruction. Place the chest drainage unit below the patients' chest, on the floor or by hanging on the bed frame.
3. Pre-medicate for pain as ordered by the physician.
4. Perform "Time out" procedure UNIVERSAL PROTOCOL: PREVENTION OF WRONG PERSON, PROCEDURE, SITE SURGERY OR INVASIVE PROCEDURES POLICY
5. Upon insertion of the chest tube, connect the open end of the chest tube to the chest drainage unit tubing.
6. For gravity drainage leave the short tube from the water-seal chamber uncapped

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with the valve open. **<u>Closed valve or exit vents can cause collapse of the lung</u>**.

7. For suction drainage: connect the short tube from the water-seal chamber to a suction source. Slowly increase the suction [open the valve] until gentle bubbling is noted in the suction control chamber. Rapid bubbling depletes water level faster.
8. For dry suction units, attach the chest tube to the chest drainage unit. Leave the air vent tubing open. Establish ordered suction level using the control on the unit.
9. Tape or zip tie the chest tube connection securely.
10. Secure coiled excess tubing on the mattress next to the patient with two [2] chest tube clamps. Adjust tubing to hang in a straight line from chest tube to the drainage chamber, avoiding dependent loops.
11. Observe the drainage system for blood/air. Observe for fluctuation [tidling] in the tube and in the water seal column.
12. Obtain a follow-up chest x-ray.

~~B. **Autotransfusion**: For trauma patients who may benefit from autotransfusion, a chest drainage system compatible with ATS will be used.~~

~~1. **Setup**:~~

~~a. ATS chest drainage system, 40 micron microemboli blood filter, blood tubing, 0.9% normal saline bag.~~

~~2. Setup for self-filling ATS blood bag~~

~~a. Close chest drain ATS access line clamp and remove spike port cap. Insert ATS bag spike into access line. Position ATS bag below the base of the chest drain (2 to 4 inches below).~~

~~b. Open both clamps. Holding ATS bag below base of chest drain, bend ATS bag upward where indicated. Do not activate ATS bag prior to connecting chest drain.~~

~~c. If necessary, squeeze ATS bag to allow more blood volume into the bag.~~

~~d. Close ATS access line and ATS blood bag clamps. Remove spike from ATS access line and insert into spike holder. Recap ATS access line spike port and position access line in the holder located on top of the chest drain. Keep ATS clamp fully closed at all times when not in use.~~

~~3. ATS bag reinfusion setup~~

~~a. Prime IV blood administration and microemboli blood filter with sterile saline.~~

~~b. Invert ATS bag with spike port pointing upward and remove cap using sterile technique. Insert saline filter spike into ATS bag spike port. Return bag to upright position and place on standard height IV pole.~~

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~~c. Open air vent and IV clamp to complete priming. All air within the IV circuit must be evacuated prior to patient connection. Close IV clamp when primed.~~

~~d. Blood is ready to be infused.~~

~~4. A new microemboli filter must be used with each ATS bag. ATS bag and microemboli filter are for one time patient connection only.~~

~~5. May pressure infuse ATS bag with air vent closed. Maximum infusion pressure 150 mm Hg.~~

~~6. Collected autologous blood should not remain in the chest drain or ATS bag collectively for more than 6 hours prior to autotransfusion.~~

~~7. Do not reinfuse entire ATS blood bag contents completely through microemboli blood filter and IV set as air emboli can result.~~

~~8. Dispose of used blood collection and transfusion materials per infection control policy~~

~~C.~~B. Assess patient 15 minutes post chest tube insertion then every four [4] hours or more frequently as needed.

~~D.~~C. Care of the patient with a chest tube

1. Chest tube dressings are changed only when damp or no longer occlusive. It is no longer recommended to routinely change chest tube dressings.
2. Dressings may be dry sterile gauze or transparent semipermeable membrane. Petrolatum gauze is not recommended.
3. Every shift, assess water seal and suction level, tidaling, drainage, and lung expansion.
4. Assess for lung re-expansion.
   a. Fluctuations (tidaling) in the water-seal chamber occur normally during inhalation and exhalation until the lung re-expands and the client no longer requires chest drainage.
   b. Fluctuations greater than six (6) cm per respiration could mean the client has copious secretions.
   c. Cessation of fluctuations could also occur with kinked, occluded tubing or a loose connection.
5. If the system tips over and spillage in the chamber occurs, replace with a new drainage unit. [See Section E]
6. Manual high negativity vent: to manually lower the height of the water-seal column of patient pressure when connected to suction, temporarily depress the filtered manual vent located on the top, back of the unit until the float valve

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releases and the water column lowers the desired level. ****Do Not** depress the Negative Pressure release valve when the unit is to gravity drainage. Collapse of the lung can occur.

7. Chest tube dislodgement: immediately apply pressure over insertion site. Apply occlusive dressing and observe patient for signs of tension pneumothorax. Notify the physician.
8. Chest tube disconnection: cut off the contaminated tip of the chest tube and tubing from the drainage tube with sterile scissors, insert a sterile connector into the chest tubing and reattach to drainage unit tubing. Notify Physician.
9. Drainage unit is accidentally broken: disconnect it from the chest tube and submerge the end of the chest tube a few centimeters below the surface of a bottle of sterile water or saline [temporary water seal] Prepare new unit. Notify physician.

~~E.~~D. Specimen Collection.

1. Clean tubing with antiseptic swab [alcohol or chlorhexidine]
2. Insert needle at 45 degree angle and gently aspirate fluid from the tubing closest to the patient.
3. Observe patient for adverse effects such as: increased respiratory rate, air leak, infection.

~~F.~~E. Replacement of drainage Unit.

1. Prepare new unit per manufacturer's instruction.
2. Cross clamp chest tube for no longer than 1 minute. Be sure chest tube clamp is non-serrated.
3. Quickly disconnect old drainage unit tubing from the chest tube and aseptically connect new unit. If unable to remove old drainage unit tubing from chest tube, may clean tubing thoroughly with alcohol, clamp, cut with sterile scissors and reconnect new drainage unit tubing. This should only be performed if absolutely unable to disconnect the old drainage unit from the chest tube.
4. Remove clamp and re-tape the connections. Chest tubes should be clamped for a total of less than one minute (AACN)
5. Dispose of chest drainage unit, place unit in biohazard bin in dirty utility room.
6. Document patient's response to procedure.

~~G.~~F. Removal of the Chest Tube is done by physician/mid-level provider.

1. Medicate patient for pain as ordered.
2. The prepared dressing (petrolatum gauze) is held over the insertion site as the tube is removed and then taped as an occlusive dressing.

3. A chest x-ray may be ordered to assure the lung remains expanded.
4. Monitor patient for any signs of respiratory distress post removal.
~~4.~~5. Discard collection system and tubing in a red biohazard bag per infection control guidelines

~~H.~~G. Documentation:

1. Documentation procedures, patient’s response, and assessment findings in the patient’s electronic medical record.

VI. **EDUCATION/TRAINING:**

A. Education and/or training is provided as needed. ~~on is provided through nursing department orientation or per individual staff needs.~~

VII. **REFERENCES:**

A. Lynn-McHale Wiegand, D. J., & Carlson, K. K. (2017~~05~~). *AACN Procedure Manual for Critical Care* (7~~6~~th Ed.). Elsevier Saunders: Philadelphia.

B. http://procedures.lww.com/lnp/view.do?pId=3163188&hits=tube,chest,tubes&a=false&ad=false

~~B.~~ Getinge Chest Drain Education and Support. Retrieved 7/2020 from https://www.getinge.com/us/education/chest-drain-education/~~**Precautions**1. Federal (U.S.A.) law restricts this device to sale by or on the order of a physician.~~

~~C. 2. For any procedure requiring direct reinfusion of shed autologous blood, a microemboli blood filter suitable for autotransfusion must be used.~~

~~D. 3. In-line ATS bag clamps must remain firmly clamped at all times after disconnection from the chest drain, during patient infusion and for unit disposal.~~

~~E. 4. Do not hang or hand carry ATS bag by its tubing; use hanger provided.~~

~~F. 5. Replace spike port cap immediately following blood filter removal from ATS access line.~~

~~G. 6. This product is for single patient use and for one time patient connection only.~~

~~H. 7. Do not resterilize this device.~~

~~I. 8. Do not pressure infuse ATS bag with air vent open.~~

~~J. 9. Air vent must remain closed at all times when not in use.~~

~~K. 10. Maximum infusion pressure: 150mmHg.~~

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CHEST TUBE MANAGEMENT

L. ~~11. Anticoagulant therapy and dosage recommendations are at the discretion of a physician, and should be monitored carefully during and after patient reinfusion.~~

M. ~~12. Please refer to all manufacturer's directions for use, warnings and cautions for anticoagulant medications, microemboli filters, I.V. blood administration sets, blood compatible infusion pumps and pressure infuser devices prior to use with this ATS bag.~~

N. ~~13. All hospital protocols for blood handling, anti-coagulant administration, autotransfusion, pressureinfusion of blood; disposal handling and infection control should be carefully followed.~~

O. ~~14. A new microemboli blood filter must be used for each ATS bag.~~

P.

Q. Adverse Reactions

R.C. ~~Adverse reactions such as coagulopathy, D.I.C., blood trauma and particulate embolism have been reported to occur during and after autotransfusion of shed mediastinal/pleural blood from surgery and chest trauma~~

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Salinas Valley Memorial Healthcare System

OBSERVATION STATUS CHARGE GENERATION

Reference Number	85
Effective Date	Not Approved Yet
Applies To	All Departments
Attachments/Forms	

I. **POLICY STATEMENT:**

~~.~~A. Observation (OBS) is an outpatient service billed with hourly room charges. It requires a physician order and is used for patients that meet specific criteria and do not qualify for inpatient status.

~~I. Patients in Observation Status should beare assessed for conversion to another level of care (inpatient, discharge, or transfer to another facility) every shifteight (8) hours.~~

~~B. A Written physician admission orders is are required and must indicatestate the admission status as "Admit to Observation Status".~~

~~C. Observation patients are assigned to the appropriate nursing unit for the ordered level of care. All patients receive care consistent with the ordered level of service.~~

~~D. Consistent with CMS Outpatient Prospective Payment System Guidelines for Observation Services, ICU/CCU services do not qualify for Observation Status.~~

~~E. Observation patients may be converted to inpatient. Once the inpatient order is obtainedwritten, the order may not be changed or converted to Observation Status at a later time, unless Case Management initiates~~ CASE MANAGEMENT: CONDITION CODE # 44

~~F. All efforts are made to keep Observation length of stay to less than twenty-four (24) hours.~~

~~G.~~B. Charge Generation

1. Charges for Observation and Outpatient stays are generated in a manner consistent with all applicable regulations and payer plan requirements.
2. Charges are generated as soon as possible and no later than three (3) days following provision of services.

~~Observation accounts are edited and formatted to be consistent with Medicare APC reimbursement criteria requirements.~~

~~Observation (OBS) is an outpatient service billed with hourly room charges. It requires a physician order and is used for patients that meet specific criteria and do not qualify for inpatient status.~~

~~For purposes of this policy, diagnostic and therapeutic procedures are separately performed services on the patient bill identified by CPT and ICD-9 codes. Examples~~

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~~would be laboratory services, diagnostic imaging, cardiac catheterization and surgical procedures.~~

~~Indications for Observation Status:~~

~~Rule out symptomatic admissions.~~

~~Contraindications for Observation Status:~~

~~Patient holding because of social factors~~

~~Physician convenience for testing or exams~~

~~Routine preparation and recovery for diagnostic testing.~~

~~Routine recovery and aftercare for ambulatory surgery cases.~~

~~Substitute for appropriate inpatient admission.~~

~~3. ICU/CCU Care~~

II. PURPOSE:

A. To guide the staff in providing:

0. ~~provide~~An ~~an~~ alternative to inpatient status for patients who require a period of medically justified observation and assessment to determine whether an inpatient admission is necessary.

1.

~~0.~~2. To guide the staff in providing ~~To provide~~ physicians an opportunity to examine and observe patients before assigning a diagnosis.

~~C.~~B. To guide the staff in reducing ~~reduce~~ the number of retroactive denials from Medicare, Medi-Cal and third-party payers for inpatient admissions where it is determined the admission did not meet the severity of illness criteria.

~~D.~~C. To guide the staff in complying~~mpiling~~~~comply~~ with the Centers for Medicare and Medicaid Services (CMS) regulations and other health plan requirements.

~~E.~~D. To guide the staff in managing~~manage~~ health care resources in an efficient and cost-effective manner while promoting quality patient care.

III. DEFINITIONS:

A. Hospital Outpatient Prospective Payment System is a Medicare reimbursement system for hospital outpatient services.

B. Ambulatory Payment Classification is developed and assigned by Medicare as a methodology for determining payment for hospital outpatient services.

~~C. Observation (OBS) is an outpatient service billed with hourly room charges. It requires a physician order and is used for patients that meet specific criteria and do not qualify for inpatient status.~~

~~D. For purposes of this policy, diagnostic and therapeutic procedures are separately performed services on the patient bill identified by CPT and ICD-9 codes. Examples would be laboratory services, diagnostic imaging, cardiac catheterization and surgical procedures.~~

~~E.~~C. Observation provides those services that are reasonable and necessary to evaluate a patient's condition to determine whether or not inpatient admission is necessary, continued outpatient services are needed, or the patient may be discharged. Observation Status permits the physician to provide a level of care for short-term diagnostic and therapeutic interventions, to determine whether or not the patient's condition will stabilize and avoid inpatient admission.

D. Medicare limits Observation Status to twenty-four (24) hours. In rare instances, a patient may stay in Observation Status up to forty-eight (48) hours.

E. Lynx/Optum Insight Observation Charging Manager in ER Charge Capture Binder in ER Director's and/or Charge Master Manager Office.

~~F. Indications for Observation Status:~~

~~1. Rule out symptomatic admissions.~~

~~G. Contraindications for Observation Status:~~

~~1. Patient holding because of social factors~~

~~2. Physician convenience for testing or exams~~

~~3. Routine preparation and recovery for diagnostic testing.~~

~~4. Routine recovery and aftercare for ambulatory surgery cases.~~

~~5. Substitute for appropriate inpatient admission.~~

~~6. ICU/CCU Care~~

IV. **GENERAL INFORMATION:**

A. Patients in Observation Status should be assessed for conversion to another level of care (inpatient, discharge, or transfer to another facility) every shift.

B. A physician admission order is required and must indicate the admission status as "Observation".

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OBSERVATION STATUS AND CHARGE GENERATION

C. Observation patients are assigned to the appropriate nursing unit for the ordered level of care. All patients receive care consistent with the ordered level of service.

D. Consistent with CMS Outpatient Prospective Payment System Guidelines for Observation Services, ICU/CCU services do not qualify for Observation Status.

E. Observation patients may be converted to inpatient. Once the inpatient order is obtained, the order may not be changed or converted to Observation Status at a later time, unless Case Management initiates CASE MANAGEMENT: CONDITION CODE # 44

F. All efforts are made to keep Observation length of stay to less than twenty-four (24) hours.

G. Observation accounts are edited and formatted to be consistent with Medicare APC reimbursement criteria requirements.

H. For purposes of this policy, diagnostic and therapeutic procedures are separately performed services on the patient bill identified by CPT and ICD-9 codes. Examples would be laboratory services, diagnostic imaging, cardiac catheterization and surgical procedures.

I. Indications for Observation Status:

1. Rule out symptomatic admissions.

J. Contraindications for Observation Status:

1. Patient holding because of social factors
2. Physician convenience for testing or exams
3. Routine preparation and recovery for diagnostic testing.
4. Routine recovery and aftercare for ambulatory surgery cases.
5. Substitute for appropriate inpatient admission.
~~0.~~6. ICU/CCU Care~~N/A~~

V. **PROCEDURE:**

A. Admission Process

- All patients are screened for appropriate Admission Status at all times Case Management is available to review with Admitting MD, in ER or other locations to provide clarification on appropriate Admission Status.
- The physician is contacted when the status order is unclear, ICC/CCU is ordered, or the medical condition is inconsistent with Observation Status.

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OBSERVATION STATUS AND CHARGE GENERATION

~~3.~~ Admitting/Registration clerk advises patient he is in Observation Status at the time of assignment. ~~(Reference Observation Patients Policy and Procedure in Admitting Department.)~~

-

- Admitting/Registration Clerk has patient (or representative) sign and acknowledge the Observation Letter Form.

B. Charge Nurse verifies the physician admission order states "~~Admit to~~ Observation Status~~" in Meditech or written order states "Admit to Observation Status."Physician is contacted for unclear orders; order using correct terminology is written on order sheet.~~

~~C. Charge Nurse and/or Unit Assistant verify that the order and face sheet status match.~~

~~D.~~C. Physician orders are expedited to ensure adherence to Observation Status time limits.

~~E.~~D. Physician is notified when procedure results are available. Charge Nurse clarifies continued Observation Status or obtains orders for conversion to Inpatient Status, discharge, or transfer.

~~F.~~E. Patients in Observation Status are assessed at least once every shift for need to continue Observation Status.

~~G.~~F. Nurse responsible for patient's care documents the time of the patient's arrival in the department. (Medicare specifies that hourly Observation charges begin with the time that the nurse documents that the patient has arrived in the unit.)

~~H.~~G. Case Management assesses Observation patients for appropriateness of orders and medical necessity within twenty-four (24) hours of admission to Observation Status. ~~(Reference CASE MANAGEMENT: REVIEW FOR OBSERVATION PATIENTS .)~~

~~I.~~H. Social Services should be contacted for assessment and intervention as indicated.

~~J.~~I. All Admission Status changes are updated in the electronic medical record ~~Meditech system~~.

1. Registration Clerk follows registration procedures for Change in Patient Status and Observation Patients.

~~K.~~J. Requirements for Physician Documentation

1. Observation services are covered only when they are ordered by the physician responsible for the patient's care.
2. The physician must order "~~Admit to~~ Observation Status." An initial ~~written or dictated initial~~ assessment is required.
3. Daily progress notes must specify:
    1. ~~Daily progress notes must specify~~Inpatient admission or

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OBSERVATION STATUS AND CHARGE GENERATION

2. The need to continue Observation.
3. The reason for the ongoing care decision must be clearly demonstrated.

4. During the twenty-four (24) hour Observation period, efforts are made to expedite the care, diagnosis and treatment of the Observation patient. The physician evaluates the patient's condition against standard inpatient criteria, making a determination to discharge or admit the patient to Inpatient Status, as appropriate.
5. If the decision is made to admit to inpatient status, the physician will order a status change ~~write an order~~ to "~~Admit to~~ Inpatient."

~~L.~~K. Observation Status charges are generated by designated staff.

~~1.~~ Reports are available in the electronic medical record ~~Meditech system a~~as well as the Lynx/Optum E-Point software ~~(See Lynx/Optum Insight Observation Charging Manager in ER Charge Capture Binder in ER Director's and/or Charge Master Manager Office).~~

~~2.~~1. Calculate hourly charges for each day using Admission, Discharge and/or Inpatient conversion times in the E-Point system that are correctly in Observation Status.

1. Calculations include all hours in Observation Status.
2. Do not charge any Observation hours for the date the patient converts to Inpatient Status.
3. Enter Observation charges for each date of service for the appropriate level of care through Lynx/Optum E-Point, using the algorithm for excluded procedures and editing needed infusion/injection times per regulations.
4. For all Medicare patients, all observation hours, with excluded times deducted from total time, shall be placed on first date of service.
5. For all other payers, including self-pay patients, all observation hours, with excluded times deducted from total time, shall be placed on each day of service.

VI. **EDUCATION/TRAINING:**

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

~~about Medicare observation rules and regulations is provided to Audit staff upon publication and with each revision of this policy.~~

~~Education is provided during general or department-specific orientation and periodically as practice or policy changes.~~

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OBSERVATION STATUS AND CHARGE GENERATION

~~On-going education is provided as needs are identified and review is necessary.~~

~~Education is provided with each regulatory update.~~

~~**DOCUMENTATION**~~

~~IF NOT APPLICABLE, TYPE N/A.~~

~~VIII.~~ VII. **REFERENCES:**

~~A. TJC: CC.2; CC.2.1~~

~~B.~~ A. Medicare Hospital Manual

in approval

Salinas Valley Memorial Healthcare System

CIRCUMCISION

Reference Number	381
Effective Date	Not Approved Yet
Applies To	Mother/Baby, NICU
Attachments/Forms	

I. POLICY STATEMENT:

A. N/A

~~Circumcision is performed by a Physician. The Registered Nurse (RN) or licensed designee will assist with the procedure as needed.~~

~~**CONTRAINDICATION**: High-risk infants will not be circumcised until their condition is stable enough, as determined by the physician, to tolerate this procedure.~~

II. PURPOSE:

A. To guide staff in assisting the physician with the removal of foreskin on an infant.

III. DEFINITIONS:

A. N/A

IV. GENERAL INFORMATION:

A. Circumcision is performed by a Physician. The Registered Nurse (RN) or licensed designee will assist with the procedure as needed.

~~A.~~B. **CONTRAINDICATION**: High-risk infants will not be circumcised until their condition is stable enough, as determined by the physician, to tolerate this procedure.~~N/A~~

V. PROCEDURE:

A. **Equipment/Consent**

- Circumcision informed consent must be signed by one (1) parent/legal guardian. Informed consent must be documented by the physician.
- Infant restraint board with Velcro restraining straps for arms and legs.
- Disposable sterile circumcision tray (Tray includes; drapes, instruments; knife blade, and betadine scrub). Sterile Gloves

- ~~The physician will designate the type and appropriate size of device to be used for circumcision.~~
- Sterile suture or sterile safety pins (Gomco type circumcision only). Optional use at the Physician's discretion.
- Topical ointment or Petrolatum gauze. .
- Coagulation agent (gelfoam absorbable gelatin powder). Obtain additional supply from the Pharmacy)
- Pillowcase
- Bulb syringe.
- Analgesia – consider the following
  1. Swaddling
  2. Oral sucrose
  3. ~~0.~~ Acetaminophen

B. **Optional Equipment:**

- Local anesthesia: 1% Lidocaine Hydrochloride without Epinephrine (preservative free)
- Tuberculin Syringe
- Alcohol
- Pacifier

C. **Set-up**

- Assemble equipment
  1. Maintain sterile technique, open appropriate size circumcision device and any other supplies as requested by the Physician.
  2. Have new, single use topical ointment or Petrolatum sterile gauze gel foam available if needed.
  3. Verify completed circumcision informed consent is signed and placed in the infant's chart. Be sure the correct name of the Physician performing the procedure is on the consent.
  4. Check the infant's identification bands. PATIENT IDENTIFICATION POLICY
  5. Restrain the infant on the circumcision board. Leave T-shirt on infant and pad board with pillowcase or baby blanket. Have bulb syringe available.

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CIRCUMCISION

- Process:
  1. Hand hygiene must be completed by physician and RN or other licensed designee assisting with procedure.
  2. Perform and document universal protocol (time-out).
  3. Assist the Physician as needed during the surgical procedure.
  4. After circumcision, gently cleanse genital area and put a clean diaper on the infant.
  5. Following circumcision, place topical ointment or petrolatum gauze around the tip of the penis.
  6. Notify physician if excessive bleeding noted.
     a. May use gel foam to assist coagulation as ordered by the physician. Contact the Physician as needed if unable to control bleeding.
  7. Instruct the infant's parents/legal guardians on care of circumcision.
  8. Check circumcision condition every fifteen (15) minutes x four (4) and then at each diaper change or as needed. Document amount of any bleeding or oozing.
  9. Infant may not be discharged until one (1) hour after time of circumcision.
- Disposal of Equipment:
  1. Circumcision tray;
     a. Place all sharps in sharp disposal container.
     b. Dispose of remaining tray items in appropriate trash container.
  2. Place instrument parts in the soiled utility room for return to Sterile Processing for wrapping and sterilization.
     a. Rinse, and remove any foreskin from the instruments; discard in the red biomedical waste container.
     b. Be sure that all parts of instrument are together.
  3. Restraint board
     a. Remove velcro restraints from the board and discard. Clean the board with hospital approved disinfectant. Allow board to air dry. MEDICAL EQUIPMENT CARE, CLEANING AND MAINTENANCE
- ~~Clean circumcision procedural area with hospital approved disinfectant and allow to air dry.~~Parent/Guardian education
  1. Cleaning of genital area:

in approval

CIRCUMCISION

a. Circumcision requires no special cleaning. Instruct parents/legal guardians to cleanse diaper area as normal with diaper changes.

2. Plastibell Circumcision: Instruct parents/legal guardians that plastic ring will fall off tip of penis in four-five (4) to (5) days. Caution: parents/legal guardians that if plastic ring initially comes only partially off do NOT pull it off. The ring should fall off completely on its own.

3. Gomco Circumcision: Instruct parents/legal guardians to place a small amount of A & D in the diaper for a few days after the circumcision to prevent abrasion from the diaper.

D. Documentation:

1. Procedural note will be completed by physician.
2. Chart circumcision checks every fifteen (15) minutes x four (4) and prn on circumcision screen in the electronic health record (EHR) or on nursery shift assessment screen. Include pain assessment and appropriate interventions as necessary.
3. Document any medication used on MAR.
4. Chart any applications of gelfoam and complications, if any, on nurse's notes.
5. Chart instructions to parents regarding care of circumcision in the electronic health record.

~~Urination: Instruct parents/legal guardians that infant should urinate within twenty-four (24) hours of the procedure. They should call the infant's Physician if this does not occur.~~

VI. EDUCATION/TRAINING:

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

~~Cleaning of genital area:~~

~~Circumcision requires no special cleaning. Instruct parents/legal guardians to cleanse diaper area as normal with diaper changes.~~

~~Plastibell Circumcision: Instruct parents/legal guardians that plastic ring will fall off tip of penis in four-five (4) to (5) days. Caution: parents/legal guardians that if plastic ring initially comes only partially off do NOT pull it off. The ring should fall off completely on its own.~~

~~Gomco Circumcision: Instruct parents/legal guardians to place a small amount of A & D in the diaper for a few days after the circumcision to prevent abrasion from the diaper.~~

~~Urination: Instruct parents/legal guardians that infant should urinate within twenty-four (24) hours of the procedure. They should call the infant's Physician if this does not occur.~~

VII. REFERENCES:

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CIRCUMCISION

A. Guidelines for Perinatal Care, 87th Edition (20172) American Academy of Pediatrics/American College of Obstetricians and Gynecologists

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~~FIRE SAFETY MANAGEMENT PLAN 2018~~FIRE SAFETY MANAGEMENT PLAN 2021

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~~Effective Date: Not Approved Yet~~

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I. SCOPE

A. The Fire Safety Management Plan describes the methods for preventing the potential for a fire through the use of equipment and training for the Salinas Valley Memorial Hospital (SVMH) (the hospital and its licensed offsite locations are covered by this management plan). The Fire Safety Management Program is designed to assure appropriate, effective response to fire emergency situations that could affect the safety of patients, staff, and visitors, or the environment, and protect building occupants from fire and the products of combustion for Salinas Valley Memorial Hospital. The Program is also designed to assure compliance with applicable codes and regulations, as applied to the buildings and services provided at Salinas Valley Memorial Hospital.

II. OBJECTIVES

A. **Objectives**

~~1.~~ The objectives of the Fire Safety Management Program is to use information gathered from environmental tours, risk assessments is to minimize the potential for harm from fire, smoke, and other products of combustion.

~~2.~~1.

B. **Goals**

The goals for the Fire Safety Management Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, reports and environmental tours.

III. DEFINITIONS

A. Salinas Valley Memorial Hospital (SVMH) and its licensed off site locations.

B. Interim Life Safety Measures (ILSM)

C. Statement of Conditions (SOC)

D. Environment of Care (EOC)

E. Chief Executive Officer (CEO)

F. Environmental Health and Safety – EH&S

G. California Office of Statewide Health Planning and Development (OSHPD

IV. PLAN MANAGEMENT

A. Plan Elements

1. The hospital buildings are designed and maintained in compliance with law, regulation, and accreditation requirements, including compliance with the *Life Safety Code*®, 2012 Edition.
2. The fire alarm, detection, and suppression systems are designed, installed, and maintained to ensure reliable performance.
3. Staff Training is an essential part of safety.

B. Plan Management

1. Management Plan
   - The organization develops, maintains and on an annual basis, evaluates the effectiveness of the Fire Safety Management Plan to effectively manage the fire safety risk of the staff, visitors, and patients at SVMH.
2. Minimize Potential for Harm
   - The EH&S Manager or designee is responsible for managing the program for minimizing potential harm from fire, smoke, and other products of combustion. The fire protection program includes three phases.
   - The first phase is the design of buildings and spaces to assure compliance with current local, state, and national building and fire codes. SVMH employs qualified architects and engineers to develop building and fire protection system designs. All designs are reviewed by OSHPD (as a part of the construction and permitting process. A vigorous construction monitoring and building commissioning program round out the design phase.
   - The second phase is testing, inspection, and maintenance of the fire prevention aspects of the facility. The EH&S Manager or designee is responsible for setting testing, inspection and maintenance standards and frequency based on applicable codes, equipment history, and other parameters. The work is done by SVMH staff and contractors. The EH&S Manager or designee ensures the end product of all work maintains or improves the level of life safety in each affected area.
   - The third phase is an active training program of fire prevention, fire safety, and fire response. The EH&S Manager or designee manages this phase of the program.
3. Surgical Safety
   - Periodic evaluations are made of potential fire hazards that could be encountered during surgical procedures. Written fire prevention and response procedures, including safety precautions related to the use of

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flammable germicides or antiseptics, are established. See FIRE SAFETY FOR SURGERY, L&D, AND PROCEDURE AREAS.

4. Unobstructed Exits in Business Occupancy

- For those areas designated as Business Occupancy by NFPA 101® – Life Safety Code® 2012, all exits must be maintained free and unobstructed. The status of these areas will be determined routinely by the staff and during environmental tours. Storage will not be allowed in any exit lobby or exterior anteroom.

5. Fire Response Plan

- The FIRE RESPONSE PLAN EC#618 provides clear, specific instructions for staff responding to a fire emergency. Each department leader is responsible for maintaining copies of emergency procedures in a continuously accessible location.
- The EH&S Manager or designee and department leadership is responsible for developing and training staff about department specific emergency fire response procedures. Department leadership is responsible for providing departmental and area personnel with an orientation to emergency procedures related to their job. Additional departmental training is provided on an annual basis as part of the continuing education program or on an as-needed basis. Department leadership is responsible for reviewing department specific Fire Safety Program emergency procedures annually.
- The roles of all staff and licensed independent practitioners (LIPs) are detailed specifically in the Fire Response Plan. The roles of all staff and LIPs at and near the point of fire origin are defined. The basic plan in the organization is based on the acronym "RACER":
  - i. Rescue anyone in immediate danger from the fire if safe to do so
  - ii. Activate by a pulling fire alarm pull station and dialing 2-2-2-2 on the phone and announcing the alarm to staff. Off site location staff should call 9-911.
  - iii. Contain smoke and fire by closing doors and windows
  - iv. Extinguish if safe to do so
  - v. Relocate and evacuate if necessary
- The role of all staff and LIPs away from the point of fire origin is to close doors and evaluate the situation. If the fire is in horizontally adjacent areas or in areas where relocation is planned, move patients to an adjacent smoke department if it is safe to do so.

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- The Administrative Supervisor, Engineering personnel, or designee is responsible for shutting off the oxygen in the area when deemed appropriate.

6. Fire Drills

- Fire drills are a critical tool for maintaining the readiness of staff to respond to a fire emergency and to minimize the likelihood of injury to patients, visitors and staff. Staff participation is necessary to maintain an acceptable level of readiness and to ensure staff knowledge of the equipment and procedures necessary to protect the staff and patients. To evaluate staff knowledge, drill activities are observed, and staff is questioned about their role and responsibilities during a fire emergency nearby and elsewhere in the building.
- Fire drills are conducted in the hospital once per shift per quarter and scheduled at varying times of day. Fire drills are conducted every 12 months in all licensed freestanding buildings classified as business occupancies These drills are witnessed, documented, and evaluated to identify improvements that may be made. Additional drills are held as deemed appropriate.
- All drills will be unannounced, with the exception of those done as corrective training activities.
- All SVMH staff will participate in drills, according to the fire response plan. This includes all hospital staff and all Salinas Valley Memorial Healthcare System staff in buildings where space is shared with others.
- Fire drills are observed and critiqued to evaluate fire safety equipment, fire safety building features and staff response. In addition, fire response knowledge is evaluated during fire drills and environmental tours.
- The results of the critique and evaluation of drills and evaluation of staff knowledge are used to identify improvements needed in training programs, fire protection equipment, and administrative compliance issues. Such improvements are inspected during monitoring activities and the results are to identify the effectiveness of the activities.

7. Maintaining Fire Safety Equipment and Building Features

- The Sr. Administrative Director of Facilities Management Services (or designee) is responsible for maintenance of the fire alarm and related systems. Troubleshooting fire alarm system and performing corrective and preventive testing, inspection and maintenance is performed by staff and an approved vendor . All testing, maintenance, inspection, and repairs are documented and reviewed by the Director of Facilities Management Services Any fire protection feature that is not operating properly will be evaluated for the appropriate Interim Life Safety Measure (ILSM).

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- . When appropriate, competent contractors are used to test, inspect, maintain, and repair the fire protection features dDocumentation is maintained as part of the SVMH database to assure activities are conducted in a timely fashion.

8. Life Safety

    - The EH&S Manager (or designee)is responsible for assessing compliance of the organization with the Life Safety Code and managing the Statement of Conditions (SOC) when addressing survey-related deficiencies. In time frames defined by the hospital, the EH&S Manager performs a building assessment to determine compliance with the Life Safety Code. A quarterly report any deficiencies identified is provided to the EOC Committee.. The organization maintains documentation of any inspections and approvals made by state or local fire control agencies.
    - Current and accurate drawings denoting features of fire safety and related square footage are maintained.
    - The hospital does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, are either maintained or removed.

9. Managing Fire Life Safety Risks

    - The organization has a written Interim Life Safety Measure (ILSM) policy that covers situations when Life Safety Code deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent SVMHS compensates for increased life safety risk. The criteria include the assessment process to determine when interim life safety measures are implemented.
    - The Interim Life Safety Program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific plan is designed. The implementation may include training, installation of engineering controls, posting of temporary advisory signs, etc. Affected staff are oriented and drilled, as appropriate.
    - The EH&S Manager or designee is responsible for monitoring the effectiveness of the implementation of the appropriate ILSM. When deficiencies are identified, appropriate actions are taken to resolve the deficiencies. All monitoring and actions to resolve deficiencies are documented. The documentation is presented to the EOC Committee as part of the quarterly Fire Safety Management Plan report to the Committee. All Interim Life Safety valuations, plans, and monitoring documentation are maintained for at least three years.

C. **Plan Responsibility**

1. The EH&S Manager or designee, in collaboration with the EOC Committee, is responsible for monitoring all aspects of the Fire Safety Management Program. The EH&S Manager advises the EOC Committee regarding fire safety issues, which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.

D. **Performance Measurement**

1. On an annual basis, the EOC Committee evaluates the scope, objectives, performance, and effectiveness of the Plan to manage the fire safety risks to the staff, visitors, and patients at SVMH

E. **Orientation and Education**

~~1. Orientation, education and/or training is provided on an as needed basis.~~

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

V. REFERENCES

A. The Joint Commission Standards, Environment of Care and Life Safety chapters

B. National Fire Protection Association Life Safety Code 101, 2012 edition.

in approval

Salinas Valley Memorial Healthcare System

ORDERING SUPPLIES FROM MATERIALS MANAGEMENT

Reference Number	1067
Effective Date	Not Approved Yet
Applies To	All Departments
Attachments/Forms	

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To create a schedule for the ordering and delivering of medical supplies, office supplies, and forms that are not on a PAR level within the department placing the order.

III. DEFINITIONS:

A. N/A

IV. GENERAL INFORMATION:

A. Materials Management (MM) will provide medical and office supplies to SVMH departments in a timely and consistent manner. MM will ensure that the fulfillment process is completed effectively and efficiently.

V. PROCEDURE:

A. STAT supplies will be delivered ~~immediately (~~within-1 5 minutes~~)~~.

B. Patient orders will be delivered at the top of the hour ~~within 15 minutes~~ of first notification.

C. Department suppl~~ies~~y requests received between 8 am and 2pm, will be ~~related to customer care will be~~ delivered the next business day~~the same day (requisition must be in by noon for same day delivery)~~

~~C.~~D. Department supply requests received after 2pm, will be delivered in 48 hours (2nd business day)~~.~~

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ORDERING SUPPLIES FROM MATERIALS MANAGEMENT

D. Office supplies will be delivered by the end of the Thursday (requisition must be in by noon on Tuesday). Department requisitions will be processed on specific days to ensure timely arrival. The schedule will be as follows:

DEPARTMENT	ORDER	DAY DEADLINE
SSPD	Twice Daily	6pm
		10pm for next day delivery
Surgery	Twice Daily	9am, 2pm
Pharmacy	Once Daily	3pm
Lab	Mon, Wed, Fri	12pm
All other departments	Tuesday	12pm

E. **Documentation:**

1. Department Requisitions

a. MMaterials Management and each department head/designee will create a custom requisition that will list frequently ordered items. This will allow departmental staff to order from a pre-determined list. This list can only be changed by approval of department head/ designee.

b. A requisition can be entered in the MM Supply Order Interface in Meditech or a hard copy can be filled out and faxed to 831-771-5074.

c. All requisitions are kept electronically in Meditech for a period of 365 days.

d.c. Paper copies of requisitions are delivered to the requesting department for verification of products received.

e.d. Items with extensive usage will be evaluated by MM Staff and added to department PAR levels as deemed necessary.

VI. **EDUCATION/TRAINING:**

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

VII. **REFERENCES:**

A. N/A

in approval

Salinas Valley Memorial Healthcare System

STUDENT AFFILIATIONS

Reference Number	882
Effective Date	Not Approved Yet
Applies To	All Departments
Attachments/Forms	Attachment A: SN Student / Preceptor Supervised Skills Attachment B2: VN Students Supervised Skills and Documentation of Care Attachment C: Pre-Placement Requirements Department Locations and Map Attachment D: Required Elements for Placement Sample Letter Attachment E: Compliance Process, Documents and Orientation Requirements Attachment F: Employee Declaration of Records Form

I. **POLICY STATEMENT:**

A. N/A

B. Staff personnel of the hospital will retain ultimate responsibility for the delivery of patient care.

C. Staff personnel caring for patients assigned to students will document, as it may apply, that they have reviewed and concurred with the student's documentation..

D. Student activities will be coordinated through the Education Manager or designee.

E. Students must complete required qualifications prior to clinical placement.

- Background Check within twelve (12) months prior to placement.

1. Information obtained must be from a consumer reporting agency contracted for the purpose of obtaining job/role related background. Student's affiliates may comply with the process through their sponsoring school. (policy BACKGROUND CHECKS POLICY. Criminal record search must be conducted to include a court records search from all counties where the candidate has lived or worked during the past seven (7) years BACKGROUND CHECKS POLICY HR #831)

2. An Office of Inspector General (OIG) check must be completed for positions involved in the care of patients BACKGROUND CHECKS POLICY HR#831)

3. SVMH does not reimburse students for any fees incurred with obtaining their background check.

- A repeat background check will not be required for returning / continuing students / interns where lapses between clinical practicums have not advanced beyond the last twelve (12) month.

STUDENT AFFILIATIONS

- Drug Screen

1. A drug screen is required within thirty (30) days prior to start of practicum (applies to all). (Employee Processing for New hire, Transfers and Temporary Employee, LD #642) (Contract)

2. Drug screen to be compliant with SVMH current a seven panel drug screen as listed below. (PRE-EMPLOYEE / EMPLOYEE TOXICOLOGY SCREENING PROCEDURE #2599)

   Amphetamine / Methamphetamine
   Barbiturates
   Benzodiazepines
   Cannabinoids
   Cocaine
   Opiates
   Phencyclidine

3. If taking prescribed medication(s), the medication(s) dosage & frequency must be listed on the drug test form. (PRE-EMPLOYEE / EMPLOYEE TOXICOLOGY SCREENING PROCEDURE #2599

4. A positive drug screen will require confirmation / repeat drug screen.

5. Drug screen results are sent to the student's sponsoring school

6. Drug screen may be completed at Salinas Urgent Care at 558-A Abbott, Salinas California or by a certified Lab qualified to perform such test

7. SVMH does not reimburse students for any fees incurred with obtaining their drug screen.

8. A repeat drug screen will be required for returning /continuing students/interns, if the lapse of clinical practicum has advance greater than thirty (30) days.

- Proof of current immunization

1. Chicken Pox immunization or a positive history of disease

2. Measles, Mumps, and Rubella (MMR) immunization or a positive blood titer

3. Hepatitis B vaccine: three (3) shot series, positive titer, or documentation of declination

4. Seasonal flu vaccine: form is submitted to Employee Health prior to orientation

- Proof of current Tuberculosis Screening Test (TST)

1. Negative / 0mm TST

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2. Positive TB skin test (TST) will require a chest x-ray, if not done within the last six (6) months

- Documentation of health exam – physical clearance within the past twelve (12) months prior to start of clinical practicum.
- Current BLS (CPR) Cards for students that provide direct patient care, i.e., Student Nurse (SN), Vocational Nurse (VN) student, Paramedic, Physical Therapy / Occupational Therapy (PT/OT) student, Radiology student, from:

1. American Heart Association for Healthcare Provider
2. American Red Cross CPR / Automated External Defibrillator (AED) for the Professional Rescuer

- A Medication exam, appropriate to the type of student, with a score ≥ 80%

1. Type of student:

a. Student Nurse (SN) prior to start of a clinical preceptorship and / or forth semester

b. Vocational Nurse (VN) student prior to start of their clinical practicum (rotation)

c. Bachelor of Science in Nursing (BSN) / Master of Science in Nursing (MSN) / Clinical Nurse Specialist (CNS) / Doctor of Nursing Practice (DNP) interns as applicable for their clinical practicum (rotation)

d. RN Resident (student) prior to start of clinical practicum

e. SN and VN instructors

f. Paramedic intern prior to start of their clinical internship

g. An SN student, who successfully completed SVMH medication examination within six (6) months of hire as an RN at SVMH, will not be required to repeat SVMH medication examination.

2. Medication exam criteria

a. Test is taken after all pre-placement requirements are successfully completed

b. One hour is given to complete medication exam

c. There are no repeats

F. Criteria for institutions / programs requesting clinical placement:

- Clinical program placement prioritization - Nursing

1. Returning

a. Formal written request will occur no later than May 1st of the current academic year

b. Establish contract status

Salinas Valley Memorial Healthcare System

c. ~~Request will be made through the Department of Education, Education Manager or designee using form School Academic Profile; see Attachment "A"~~

d. ~~Attend annual orientation meeting~~

e. ~~Provide clinical objective for all areas of participation~~

f. ~~Prioritization is given to established programs meeting established requirement / criteria deadline.~~

2. ~~New~~

a. ~~Formal written request is made to the Department of Education, Education Manager or designee by the school's Placement Coordinator and / or Director.~~

b. ~~Establish a meeting with SVMH Department Director(s), School Director and / or Placement Coordinator, the Department of Education, Education Manager or designee.~~

c. ~~Obtain a contract between school and SVMH. School to provide "Certificate of Liability" insurance~~

d. ~~School to provide program course description overview, clinical objectives for all areas of participation~~

- ~~Clinical program placement prioritization – Allied Health~~

1. ~~Returning~~

a. ~~Department (Unit) student coordinator will notify the Department of Education, Education Manager or designee of all pending students requesting placement at SVMH.~~

b. ~~Establish contract status~~

c. ~~School's Placement Coordinator makes a formal written request through the Department of Education, Education Manager or designee~~

d. ~~Provide clinical objectives~~

2. ~~New~~

a. ~~Formal written request is made through the Department of Education, Education Manager or designee by the school's Placement Coordinator and / or Director.~~

b. ~~Establish a meeting with SVMH Department Director(s), School Director and / or Placement Coordinator, the Department of Education, Education Manager or designee.~~

c. ~~Obtain a contract between school and SVMH. School to provide "Certificate of Liability" insurance~~

d. ~~School to provide program course description overview, clinical objections for all areas of participation~~

in approval

G. All schools must have available and maintain current documentation of the school's program entrance requirements and when applicable clinical instructor's annual competencies.

- SVMH will request quarterly periodic audits to ensure that appropriate information is available. SVMH will select at random students names to be audited. Percent of students audited will depend on number of students on site at any given time.
- Information is mailed to the Department of Education no later than five (5) working days from the date of audit notification.
- For a Joint Commission (TJC) site visit: Information must be made available and faxed immediately upon request.

H. Nursing Schools:

- Schedule of assignments prior to start of clinical rotation

1. The length of clinical experience and the number of students will be agreed upon by SVMH and the school at least thirty (30) days prior to start of clinical rotation

- Instructor / student ratio will not exceed:

1. One (1) instructor for eight (8) SN students
2. One (1) instructor for six (6) VN students

- Directors of unit will determine the final number of students that can be accommodated on their unit at any given time
- There will only be one level / type of student on a unit at any given time, with the exception of the RN Resident doing an advance clinical practicum, whereas the RN Resident, in the capacity of a student, will not have capacity of oversight / supervision of any type of student.
- Instructor's responsibility

1. Provide unit orientation to the student
2. Complete a unit orientation checklist and provide a copy to the Education Manager or designee.
3. Assign tasks that are within the student's capability and properly supervise student while performing those tasks. Refer to "SN Student / Preceptor Supervised Skills" matrix, Attachment "B"
4. Post weekly student assignment, objectives and student level of skill. File students daily assignment in the charge nurse binder in the unit of participation
5. Assist student with computer and Medication Administration Record (MAR) documentation
6. Document in patient note "direct supervision provided" during / for any order management transaction; CPOE, telephone orders, knowledge of orders, etc.

in approval

STUDENT AFFILIATIONS

~~7. Returning instructors to include preceptorship instructor (advisor)~~

~~a. Complete identified hospital unit specific annual competencies for all units of student participation~~

~~8. New instructor to include preceptorship instructor~~

~~a. Attend a week of Nursing / Computer Orientation~~

~~b. For all units of student participation~~

~~i. Complete unit specific orientation for a minimal of one (1) day; a full eight (8) hour shift~~

~~ii. Complete SVMH unit specific orientation checklist~~

~~iii. Validate identified unit specific competencies for unit of student participation~~

~~iv. Review all required procedures and documentation practices~~

~~v. Provide all orientation documents to the Education Manager or designee~~

~~9. Substitute Clinical Instructor~~

~~a. Planned Absence(conference, workshop): School or instructor will notify the Department of Education, Education Manager or designee in writing, five (5) working days prior to the start of next scheduled clinical day, substitute instructor's name and contact phone number~~

~~b. Unplanned Absence (personal emergency): School or instructor will notify the Department of Education, Education Manager or designee via e-mail, phone, substitute instructor's name and contact number, prior to start of next scheduled clinical day.~~

~~c. Illness: Instructor will notify charge nurse / nursing unit one hour prior to start of clinical rotation. The school will notify the Department of Education, Education Manager or designee the name of the substitute clinical instructor and the instructor's contact number.~~

~~d. Substitute clinical instructor (advisor) will have completed and have on file all provisions set forth within this policy relating to clinical instructor (advisor)~~

~~I. Preceptorship / Internship / Residency~~

~~• A formal letter from a school's Placement Coordinator requesting a preceptorship / internship / residency at SVMH will be provided twenty (20) working days prior to the student's orientation. The letter will include:~~

~~1. List student level of competency / skills, as applicable;~~

~~2. List of learning objectives~~

In approval

3. The amount of hours student needs to complete for his / her clinical practicum (rotation)

4. Contact number (phone / cell) of placement coordinator and instructor who is responsible for the student.

- BSN / MSN / CNS / DNP - placement

1. As stated above under "H", first bullet

J. Allied Health

- Paramedic Intern – placement

1. As stated above under "H", first bullet

1. Paramedic intern, will perform tasks and give limited types of medications within their scope of practice as identified by their school and the County of Monterey

2. Intern will perform these tasks under the direction of an SVMH staff person acting as a preceptor within his / her respective units.

- Emergency Medical Training (EMT) Student

1. EMT students will be limited to observation status only. For in-processing refer to HR#1818 "JOB OBSERVATION AND INTERNSHIPS PROCEDURE " policy.

- PT / OT, Radiology, Health Information Management (H.I.M.), Dietetic interns, Cancer Registry, Lactation Nurse

1. As stated above under "H", first bullet

2. Perform tasks at the level of their educational program under the direction of an SVMH staff person acting as a preceptor within his / her respective unit / department

K. In-processing of SVMH employees

- As stated above under "G", first bullet

- Complete Declaration of Employee Record. See Appendix " G "

L. Student Responsibility

- All students, at all times, must wear an SVMH identification badge above the waist and the student's school identification badge. Students not compliant will be sent home.

- Adhere to the established policies, procedures, standards, rules and regulation, of SVMH.

- Respect the safety and wellbeing of the patient and their family

- Introduce themselves to the patient and ask permission to participate in their care

in approval

Salinas Valley Memorial Healthcare System

- Use clear, accurate and effective professional communication
- Recognize knowledge, skills, abilities, limitation of responsibilities, and supervision requirements
- Be knowledgeable and adhere to the information provided in the student handbook

M. Discrepancy Resolution

- When patient care, treatment, and / or service differ between primary care provider (RN) and student (instructor), the student will be taken out of the line of care until the discrepancy has been resolved.
- The instructor will notify the charge nurse and Education Manager or designee of the disagreement / discrepancy between the primary care provider (RN) and student (instructor).

N. Education Manager or designee Responsibility

- Coordinate with unit Director or designee (department Education Manager or designee), school, and student request for clinical practicum (rotation)
- Coordinate request for contract between SVMH and school and ensure current contract status for on-going schools programs
- Develop a clinical practicum (rotation) schedule in collaboration with the school
- Provide student orientation, in collaboration with Employee Health, to meet regulatory requirements, to include as applicable, but not limited to, Meditech, MAR, Pyxis and Accu-Chek certification, fire safety, injury prevention, Lift Device training, and N95 Respirator fit testing.
- Coordinate orientation for the clinical (nursing) instructors include preceptorship instructor

O. Failure of any institution / program to meet established deadlines, requirements as stated in this policy, and /or attend required orientation meetings will forfeit clinical placement

P. SVMH retains the ultimate responsibility for its patients and reserves the right to deny the use of its facilities to any student(s). SVMH, at its sole and absolute discretion, may request withdraw of any student(s) from the Program for failure to meet established policies, procedures, rules and regulations or violates any local, federal or state laws.

Q. SVMH will maintain and have available student's orientation documents and in-processing information for five (5) years

R. Job Shadowing, refer to HR # 1818, JOB OBSERVATION AND INTERNSHIPS PROCEDURE.

II. **PURPOSE:**

STUDENT AFFILIATIONS

~~A. To define the initiation process and maintenance of student affiliations excluding medical students, medical residents, fellows, PAs).~~

~~III.~~II. PURPOSE:

A. To define the initiation process and maintenance of student affiliations excluding medical students, medical residents, fellows,

~~IV.~~III. DEFINITIONS:

A. Clinically Competent Faculty: a faculty member who possesses and exercises the degree of knowledge, skill, care and experience of a staff RN in clinical area to which they are assigned to teach. (References: Board of Register Nursing (BRN), Department of Consumer Affairs)

B. Student: one who is enrolled or attends classes at a school, college, university.

C. Preceptor: a teacher, tutor, who provides knowledge, insight

D. Preceptee~~or~~: one who is being precepted

E. Intern(ship): a student or graduate completing an advance clinical practicum in a chosen field of study who is in-processed by the Department of Education

F. Extern(ship): a student or a graduate doing an advance practicum in a chosen field of study who is in-processed by Human Resource

G. RN Provider: one that provides direct patient care within the scope of BRN as it applies to registered and student nurses.

~~H. RN Resident: a new grad RN completing an extended clinical practicum.~~

~~I.~~H. Direct supervision: physically present, onsite, close contact, directly at the side of the student, whereby the supervisor is able to respond quickly to the needs of the supervisee.

~~J.~~I. Indirect supervision: available for guidance and consultation but is not directly at the side of the student; to have the direction and oversight of the performance. ~~of other~~

~~K.~~J. Indirect remote supervision by instructor or clinical advisor: available for consultation and guidance but is not physically present in the location where the care is being provided but is able to be contacted by phone, either land line or cell. Applies to CNS, D~~PN~~NP, MSN, and BSN enrolled in college or university program whose clinical rotation is limited to in-direct patient care.

~~V.~~IV. GENERAL INFORMATION:

in approval

STUDENT AFFILIATIONS

A. Staff personnel of the hospital will retain ultimate responsibility for the delivery of patient care.

B. Staff personnel caring for patients assigned to students will document, as it may apply, that they have reviewed and concurred with the student's documentation.

C. Student activities will be coordinated through the Education Manager or designee.

D. Students must complete required qualifications prior to clinical placement.

- Background Check within twelve (12) months prior to placement.
  1. Information obtained must be from a consumer reporting agency contracted for the purpose of obtaining job/role related background. Student's affiliates may comply with the process through their sponsoring school. (BACKGROUND CHECKS POLICY). Criminal record search must be conducted to include a court records search from all counties where the candidate has lived or worked during the past seven (7) years (BACKGROUND CHECKS POLICY HR #831)
  2. Department of Health and Human Services (HHS) and Office of Inspector General (OIG) checks will be performed for positions involved in the care of patients (BACKGROUND CHECKS POLICY HR#831)
  3. SVMH does not reimburse students for any fees incurred with obtaining their background check.
- A repeat background check will not be required for returning / continuing students / interns where lapses between clinical practicums have not advanced beyond the last twelve (12) month.
- Drug Screen
  1. A drug screen is required within thirty (30) days prior to start of practicum (applies to all).
  2. Drug screen to be compliant with SVMH current a seven panel drug screen as listed below. (PRE-EMPLOYEE / EMPLOYEE TOXICOLOGY SCREENING PROCEDURE #2599)

     Amphetamine / Methamphetamine
     Barbiturates
     Benzodiazepines
     Cannabinoids
     Cocaine
     Opiates
     Phencyclidine

In approval

3. If taking prescribed medication(s), the medication(s) dosage & frequency must be listed on the drug test form. (PRE-EMPLOYEE / EMPLOYEE TOXICOLOGY SCREENING PROCEDURE #2599
4. A positive drug screen will require confirmation / repeat drug screen.
5. Drug screen results are sent to the student's sponsoring school
6. Drug screen may be completed at Salinas Urgent Care at 558-A Abbott, Salinas California or by a certified Lab qualified to perform such test
7. SVMH does not reimburse students for any fees incurred with obtaining their drug screen.
8. A repeat drug screen will be required for returning /continuing students/interns, if the lapse of clinical practicum has advance greater than thirty (30) days.

- Proof of current immunization
  1. Chicken Pox immunization or a positive history of disease
  2. Measles, Mumps, and Rubella (MMR) immunization or a positive blood titer
  3. Hepatitis B vaccine: three (3) shot series, positive titer, or documentation of declination
  4. Seasonal flu vaccine: form is submitted to Employee Health prior to orientation
- Proof of current Tuberculosis Screening Test (TST)
  1. Negative / 0mm TST
  2. Positive TB skin test (TST) will require a chest x-ray, if not done within the last six (6) months
- Documentation of health exam – physical clearance within the past twelve (12) months prior to start of clinical practicum.
- Current BLS (CPR) Cards for students that provide direct patient care, i.e., Student Nurse (SN), Vocational Nurse (VN) student, Paramedic, Physical Therapy / Occupational Therapy (PT/OT) student, Radiology student, from:
  1. American Heart Association for Healthcare Provider
- A Medication exam, appropriate to the type of student, with a score > 80%
  1. Type of student:
     a. Student Nurse (SN) prior to start of a clinical preceptorship and / or forth semester

In approval

b. Vocational Nurse (VN) student prior to start of their clinical practicum (rotation)

c. Bachelor of Science in Nursing (BSN) / Master of Science in Nursing (MSN) / Clinical Nurse Specialist (CNS) / Doctor of Nursing Practice (DNP) interns as applicable for their clinical practicum (rotation)

d. SN and VN instructors

e. Paramedic intern prior to start of their clinical internship

f. An SN student, who successfully completed SVMH medication examination within six (6) months of hire as an RN at SVMH, will not be required to repeat SVMH medication examination.

g. Physician Assistant (PA) student

2. Medication exam criteria

a. Test is taken after all pre-placement requirements are successfully completed

b. One hour is given to complete medication exam

c. There are no repeats

E. Criteria for institutions / programs requesting clinical placement:

- Clinical program placement prioritization - Nursing

1. Returning

a. Formal written request will occur no later than May 1st of the current academic year

b. Establish contract status

c. Request will be made through the Department of Education, Education Manager or designee. Attend annual orientation meeting

d. Provide clinical objective for all areas of participation

e. Prioritization is given to established programs meeting established requirement / criteria deadline.

2. New

a. Formal written request is made to the Department of Education, Education Manager or designee by the school's Placement Coordinator and / or Director.

in approval

b. Establish a meeting with SVMH Department Director(s), School Director and / or Placement Coordinator, the Department of Education, Education Manager or designee.

c. Obtain a contract between school and SVMH. School to provide "Certificate of Liability" insurance

d. School to provide program course description overview, clinical objectives for all areas of participation

- Clinical program placement prioritization – Allied Health

1. Returning

   a. Department (Unit) student coordinator will notify the Department of Education, Education Manager or designee of all pending students requesting placement at SVMH.

   b. Establish contract status

   c. School's Placement Coordinator makes a formal written request through the Department of Education, Education Manager or designee

   d. Provide clinical objectives

2. New

   a. Formal written request is made through the Department of Education, Education Manager or designee by the school's Placement Coordinator and / or Director.

   b. Establish a meeting with SVMH Department Director(s), School Director and / or Placement Coordinator, the Department of Education, Education Manager or designee.

   c. Obtain a contract between school and SVMH. School to provide "Certificate of Liability" insurance

   d. School to provide program course description overview, clinical objections for all areas of participation

F. All schools must have available and maintain current documentation of the school's program entrance requirements and when applicable clinical instructor's annual competencies.

- SVMH will request quarterly periodic audits to ensure that appropriate information is available. SVMH will select at random students names to be audited. Percent of students audited will depend on number of students on site at any given time.
- Information is mailed to the Department of Education no later than five (5) working days from the date of audit notification.

in approval

- For a Joint Commission (TJC) site visit: Information must be made available and faxed immediately upon request.

G. Nursing Schools:

- Schedule of assignments prior to start of clinical rotation
  1. The length of clinical experience and the number of students will be agreed upon by SVMH and the school at least thirty (30) days prior to start of clinical rotation
- Instructor / student ratio will not exceed:
  1. One (1) instructor for eight (8)-SN students
  2. One (1) instructor for six (6)-VN students
- Directors of unit will determine the final number of students that can be accommodated on their unit at any given time
- There will only be one level / type of student on a unit with the same preceptor at any given time.
- Instructor's responsibility
  1. Complete a unit orientation
  2. Provide unit orientation to the student
  3. Assign tasks that are within the student's capability and properly supervise student while performing those tasks. Refer to "SN Student / Preceptor Supervised Skills" matrix, Attachment "A"
  4. Post weekly student assignment, objectives and student level of skill. File students daily assignment in the charge nurse binder in the unit of participation
  5. Assist student with computer and Medication Administration Record (MAR) documentation
  6. Returning instructors to include preceptorship instructor (advisor)
     a. Complete identified hospital unit specific eLearning/skills/ competencies for all units of student participation
  7. New instructor to include preceptorship instructor
     a. Attend a week of Nursing / Computer Orientation
     b. For all units of student participation
        i. Complete unit specific orientation for a minimal of one (1) day; a full eight (8) hour shift

in approval

ii. Validate identified unit specific competencies for unit of student participation

iii. Review all required procedures and documentation practices

iv. Provide all orientation documents to the Education Manager or designee

8. Substitute Clinical Instructor

a. Planned Absence (conference, workshop): School or instructor will notify the Department of Education, Education Manager or designee in writing, five (5) working days prior to the start of next scheduled clinical day, substitute instructor's name and contact phone number

b. Unplanned Absence (personal emergency): School or instructor will notify the Department of Education, Education Manager or designee via e-mail, phone, substitute instructor's name and contact number, prior to start of next scheduled clinical day.

c. Illness: Instructor will notify charge nurse / nursing unit one hour prior to start of clinical rotation. The school will notify the Department of Education, Education Manager or designee the name of the substitute clinical instructor and the instructor's contact number.

d. Substitute clinical instructor (advisor) will have completed and have on file all provisions set forth within this policy relating to clinical instructor (advisor)

H. Preceptorship / Internship / Residency

- A formal letter from a school's Placement Coordinator requesting a preceptorship / internship / residency at SVMH will be provided twenty (20) working days prior to the student's orientation. The letter will include:

1. List student level of competency / skills, as applicable;

2. List of learning objectives

3. The amount of hours student needs to complete for his / her clinical practicum (rotation)

4. Contact number (phone / cell) of placement coordinator and instructor who is responsible for the student.

- BSN / MSN / CNS / DNP - placement

1. As stated above under "H", first bullet

I. Allied Health

- Paramedic Intern – placement
  1. As stated above under “H”, first bullet
  2. Paramedic intern, will perform tasks and give limited types of medications within their scope of practice as identified by their school and the County of Monterey
  3. Intern will perform these tasks under the direction of an SVMH staff person acting as a preceptor within his / her respective units.
- Emergency Medical Training (EMT) Student
  1. EMT students will be limited to observation status only. For in-processing refer to HR#1818 “JOB OBSERVATION AND INTERNSHIPS PROCEDURE ” policy.
- PT / OT, Radiology, Health Information Management (H.I.M.), Dietetic interns, Cancer Registry, Lactation Nurse
  1. As stated above under “H”, first bullet
  2. Perform tasks at the level of their educational program under the direction of an SVMH staff person acting as a preceptor within his / her respective unit / department

J. In-processing of SVMH employees

- As stated above under “G”, first bullet
- Complete Declaration of Employee Record. See Attachment F

K. Student Responsibility

- All students, at all times, must wear an SVMH identification badge above the waist and the student’s school identification badge. Students not compliant will be sent home.
- Adhere to the established policies, procedures, standards, rules and regulation, of SVMH.
- Respect the safety and wellbeing of the patient and their family
- Introduce themselves to the patient and ask permission to participate in their care
- Use clear, accurate and effective professional communication
- Recognize knowledge, skills, abilities, limitation of responsibilities, and supervision requirements
- Be knowledgeable and adhere to the information provided in the student handbook

L. Discrepancy Resolution

in approval

- When patient care, treatment, and / or service differ between primary care provider (RN) and student (instructor), the student will be taken out of the line of care until the discrepancy has been resolved.
- The instructor will notify the charge nurse and Education Manager or designee of the disagreement / discrepancy between the primary care provider (RN) and student (instructor).

M. Education Manager or designee Responsibility

- Coordinate with unit Director or designee (department Education Manager or designee), school, and student request for clinical practicum (rotation)
- Coordinate request for contract between SVMH and school and ensure current contract status for on-going schools programs
- Develop a clinical practicum (rotation) schedule in collaboration with the school
- Provide student orientation, in collaboration with Employee Health, to meet regulatory requirements, to include as applicable, but not limited to, Meditech, MAR, Pyxis and Accu-Chek certification, fire safety, injury prevention, Lift Device training, and N95 Respirator fit testing.
- Coordinate orientation for the clinical (nursing) instructors include preceptorship instructor

N. Failure of any institution / program to meet established deadlines, requirements as stated in this policy, and /or attend required orientation meetings will forfeit clinical placement

O. SVMH retains the ultimate responsibility for its patients and reserves the right to deny the use of its facilities to any student(s). SVMH, at its sole and absolute discretion, may request withdraw of any student(s) from the Program for failure to meet established policies, procedures, rules and regulations or violates any local, federal or state laws.

P. SVMH will maintain and have available student's orientation documents and in-processing information for five (5) years

Q. Job Shadowing, refer to HR # 1818, JOB OBSERVATION AND INTERNSHIPS PROCEDURE.

VI.V. **PROCEDURE:**

A. Submission of Placement Request

- The school student placement coordinator will contact and notify the Education Manager or designee of request for placement

- Education Manager or designee will forward the ~~Pre-Placement Requirement document and the~~ Requirements Element for Placement letter template to the school's placement coordinator ~~and the student~~. ~~See "Pre-Placement Requirements" Appendix "C"~~ See Attachment D

- ~~An Academic Profile form will be forwarded to the school, as applicable, "Sample Letter" Appendix "D"~~

B. Submission of Required Documentation

- The school will submit a formal request, using the Required Elements for Placement letter template. The letter will be composed on school letter head paper. This letter will list SVMH pre-placement requirements having been met and the name of student(s) being placed.

- SVMH pre-placement requirements, not fulfilled by the school's program entrance requirement, will be obtained by the student at their own cost.

  1. Medical information (immunizations), drug screen results and background checks results will be forwarded to the school
  2. The school will list pre-placements requirements completed on the formal Required Elements for Placement request letter.
  3. No documents are to be sent to the Department of Education

C. Attend / Complete Orientation

- Upon completion of all pre-placement requirements the student will

  1. Complete SVMH medication examination when applicable
  2. Attend orientation in the Department of Education to meet regulatory requirements
  3. Obtain SVMH picture ID badge ~~and parking permit~~
  4. Provide copy of BLS, *as applicable*
  5. Provide a letter of introduction, listing level of competency, skill, and learning objectives, *as applicable*

D. Prior to start of Clinical Practicum (Rotation)

- The nursing instructor and *as applicable*, the unit Education Manager or designee will provide the following information

  1. List of students assigned on each unit and their shift
  2. A copy of the objectives the student is to complete.
  3. Name, shift and schedule of preceptor(s) *as applicable* ?

in approval

E. End of Clinical Practicum (Rotation)

- Upon completion of the students clinical rotation (preceptorship / internship / residency).

  1. The student, preceptor, intern, resident will notify the Education Manager or designee of his / her clinical rotation completion
  2. Send copy of the student's logged hours with preceptors name, *as applicable*
  3. Provide a short summary of clinical experience

F.E. Documentation:

1. Student patient assignment will be documented and records maintained in the Daily Assignment (Charge Nurse) binder on unit of student participation.
2. Refer to "RN Student / Preceptees Supervised Skills and Documentation of Care". Appendix Attachment "BA", for documentation guidelines by SN students.

VII.VI. **EDUCATION/TRAINING:**

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

VIII.VII. **REFERENCES:**

A. N/A

in approval

~~**Academic / Clinical Placement Request**~~

~~**Direction:** Please provide information for each clinical/unit rotation for the new academic year and/or clinical rotation. Complete form(s) and send electronic or fax to Lourdes Escolta @ faxed number (831) 753-6294 or lescolta@svmh.com.~~

~~Check with applies…~~

~~**For new academic year provide information by May 1st**~~

~~**For a new clinical rotation provide information 20 working days prior to start of clinical.**~~

~~Institution/School: ____________________ Program: ____________~~

~~Instructor: ____________________________ Semester: 1, 2, 3, 4~~

~~Clinical Rotation Start Date: ____________ Finish Date: ____________~~

~~Unit(s): ☐ MS ☐ ONS ☐ CCC ☐ Peds ☐ Mother / Baby~~

~~☐ Towers ☐ Heart Center ☐ ED Other: ________~~

~~Shift: ☐ Days ☐ Evenings Clock Time on Unit: ________~~

~~Room request for pre and/or post conference…~~

~~Pre: Day of week: M T W TH F SA SU Clock Time(s): ______~~

~~Post: Day of week: M T W TH F SA SU Clock Time(s): ______~~

~~Prior to Nursing Orientation the following must be provided / completed. If item(s) are not provided /completed student(s) may not start clinical rotation.~~

~~Required Element for Placement Letter~~

~~Copy of HealthStream assigned module transcripts~~

~~Copy of BLS (CPR) card~~

~~Obtain picture ID Badge and Parking Permit~~ **ATTACHMENT ~~B-1~~A**

in approval

SN Students / SN Preceptees ~~/ RN Resident~~ providing Direct Patient Care: Supervised Skills and Documentation of Care Grid

Skills↓	1st Semester	2nd Semester	3rd Semester	4th Semester	Preceptee
Pyxis Access	Direct Sup	Direct Sup	In-Direct Sup	In-Direct Sup	Preceptor:

Salinas Valley Memorial Healthcare System

STUDENT AFFILIATIONS

Skills↓	1st Semester	2nd Semester	3rd Semester	4th Semester	Preceptee
					In-Direct Sup
Medications	Direct Sup	Direct Sup	In-Direct Sup	In-Direct Sup	Preceptor: Direct Sup
IV Starts	**N/A**	Direct Sup	Direct Sup	Direct Sup	Preceptor: Direct Sup
IV Push	**N/A**	Direct Sup	Direct Sup	Direct Sup	Preceptor: Direct Sup
Hanging an IV Piggyback	**N/A**	Direct Sup	Direct Sup	Direct Sup	Preceptor: Direct Sup
Hanging a new ordered IV Bag	N/A	Direct Sup	Direct Sup	Direct Sup	Preceptor: Direct Sup
Replacing an existing IV Bag	Direct Sup	Direct Sup	Direct Sup	Direct Sup	Preceptor: Direct Sup
Access or flush a Central Line (3LCVP) or PICC	**N/A**	**N/A**	Direct Sup	Direct Sup	Preceptor: Direct Sup
Blood Administration	**N/A**	**N/A**	N/A	Direct Sup	Preceptor: Direct Sup
IV Discontinuation	Direct Sup	Direct Sup	Direct Sup	Direct Sup	Preceptor: Direct Sup
Peripheral Line NS Flush	Direct Sup	Direct Sup	In-Direct Sup	In-Direct Sup	Preceptor: Direct Sup
Blood Glucose (MBG)	In-Direct Sup	In-Direct Sup	In-Direct Sup	In-Direct Sup	Preceptor: Direct Sup
Order Management & COPE Acknowledge Orders	**N/A**	**N/A**	**N/A**	~~**Instructor / RN: Direct Sup**~~**N/A**	~~**Preceptor: Direct Sup**~~**N/A**
Telephone Orders	**N/A**	**N/A**	**N/A**	~~**Instructor / RN Listen In Direct Sup**~~	~~**Instructor / RN Listen In Direct Sup**~~
Documentation Screens →	1St and 2nd Semester: • Patient Care, Physical Assessment • VTE Risk Assessment • Safety Assessment: Fall, Skin • O2 Delivery • IV location: peripheral • Pain Management Screen				

Salinas Valley Memorial Healthcare System

STUDENT AFFILIATIONS

Skills↓	1st Semester	2nd Semester	3rd Semester	4th Semester	Preceptee
	• Vital Signs, I&O, Feeding Intake • Patient notes 2nd Semester Add: • ~~IV Spread Sheet~~ • ~~Influenza / Pneumonia/ MRSA~~ • Teaching Record, Universal Protocol				

Special Note:

- ~~SVMH staff caring for patients assigned to students will document that they have reviewed and concur with the student's documentation.~~ SVMH staff caring for patients assigned to students will also document in the computer the appropriate screens even when documented by the nursing students.
- ~~Instructor will document in patient notes "direct supervisor provided for all order management" transactions / processes~~
- ~~An LVN may not supervise an SN student, as this does not fall within their scope of practice~~
- Students do not work under the nurse or instructor's license. They are covered under the school's program accreditation.

Supervision Definition Key:

- Direct Supervision: physically present, onsite, close contact, at the side of the student
- Indirect Supervision: available for guidance, consultation, but not directly at the side of the student

in approval

STUDENT AFFILIATIONS

ATTACHMENT B~~-2~~

VN Students Supervised Skills and Documentation of Care

Skills↓	1st Semester	2nd Semester	3rd Semester	4th Semester
Pyxis Access	Direct Supervision Instructor	Direct Supervision Instructor	Direct Supervision Instructor	Direct Supervision Instructor
Medications	Direct Supervision Instructor	Direct Supervision Instructor	Direct Supervision Instructor	Direct Supervision Instructor
MBG	Direct Supervision Instructor	Direct Supervision Instructor	Direct Supervision Instructor or RN Supervision	Direct Supervision Instructor or RN Supervision
Documentation Screens	• Vital Signs • I & O • Patient Care Record • Patient Notes			

Special Note:

- SVMH staff caring for patients assigned to students will also document in the computer the appropriate screens even when documented by the nursing student.
- Students will document every shift
- Students do not work under the nurse or instructors license. They are covered under the schools program accreditation.

Supervision Definition Key:

- Direct Supervision: physically present, onsite, close contact, at the side of the student

in approval

STUDENT AFFILIATIONS

~~ATTACHMENT C~~

~~Dear Student, Preceptee, Intern, Resident, Instructor~~

~~Thank you for your interest in doing a clinical practicum (rotation) at Salinas Valley Memorial Healthcare Systems (SVMH). It will be our pleasure to have you. We will do our best to help you gain valuable information and experience in your chosen health career field. There are a few pre-placement requirements that need to be completed and fulfilled prior to your clinical practicum (rotation) placement.~~

~~Pre-Placement Requirements:~~

1. ~~A formal written request from the School Placement Coordinator.~~

2. ~~Background Check~~
   a. ~~Information obtained must be from a consumer reporting agency contracted for the purpose of obtaining job/role related background. Student's affiliates may comply with the process through their sponsoring school. (Policy HR#831) It must have been done within twelve (12) months prior to start of clinical rotation.~~
   b. ~~Criminal record search must be conducted to include court records search of all counties that the candidate has lived or worked during the past seven [7] years (HR #831)~~
   c. ~~An Office of Inspector General (OIG) check must be completed for positions involved in the care of patients (HR#831)~~
   d. ~~SVMH does not reimburse the student for any fees incurred with obtaining his / her background check.~~
   e. ~~www.mybackgroundcheck.com is a common site for students. Select "Student".~~

3. ~~Drug Screen~~
   a. ~~A drug screen is required to be done within thirty (30) days prior to start of your practicum (applies to all). (Employee Processing for New hire, Transfers and Temporary Employee, LD #642) (Contract)~~
   b. ~~Drug screen to be compliant with SVMH current a seven panel drug screen. (Pre-Employee / Employee Toxicology Screening Procedure Policy #2599)~~
      - ~~Amphetamine / Methamphetamine~~
      - ~~Barbiturates~~
      - ~~Benzodiazepines~~
      - ~~Cannabinoids~~
      - ~~Cocaine~~
      - ~~Opiates~~
      - ~~Phencyclidine~~

c. ~~If taking prescribed medication(s), the medication(s) dosage & frequency must be listed on the drug test form. (Pre-Employee / Employee toxicology Screening Procedure Policy #2599~~
d. ~~A positive drug screen will require confirmation / repeat drug screen~~
e. ~~Your drug screen may be completed at Salinas Urgent Care at 558-A Abbott, Salinas California. If drug screen is completed elsewhere, the drug screen must be done by a certified Laboratory qualified to perform such tests.~~
f. ~~Your drug screen results are to be sent to your sponsoring school.~~
g. ~~SVMH does not reimburse the students for any fees incurred with obtaining his / her drug screen.~~

4. ~~Proof of current immunization~~
   a. ~~Chicken Pox immunization or a positive history of disease~~
   b. ~~Measles, Mumps and Rubella (MMR) immunization or a positive blood titer~~
   c. ~~Hepatitis B vaccine three (3) shot series, positive titer or documentation of declination~~

5. ~~Proof of current Tuberculosis Screening Test (TST)~~
   a. ~~Negative / 0mm TST~~
   b. ~~Positive TB skin test (TST) will require a chest x-ray, if not done within the last six (6) months, and review of signs and symptoms of tuberculosis to rule out TB.~~

6. ~~Proof of seasonal flu vaccination by submitting a flu vaccine form to Employee Health~~

7. ~~Documentation of Health Exam: physical clearance within the past twelve (12) months prior to start of your clinical practicum (rotation).~~

8. ~~Current BLS (CPR) Card for students that provide direct patient care: Student Nurse (SN), Vocational Nurse (VN) students, Paramedic, Physical Therapy / Occupational Therapy (PT/OT) student, Radiology, from:~~
   a. ~~American Heart Association for Healthcare Providers~~
   b. ~~American Red Cross – CPR / Automated External Defibrillator (AED) for the Professional Rescuer~~

9. ~~Provide copy of BLS (CPR) card as applicable~~

10. ~~Medication Exam, appropriate to type of student, with a score ≥ 80% required by …~~
    a. ~~SN student prior to start of a clinical preceptorship~~
    b. ~~VN student prior to start of their clinical practicum (rotation)~~
    c. ~~Bachelor of Science in Nursing (BSN) / Master of Science in Nursing (MSN) / Clinical Nurse Specialist (CNS) / Doctor of Nursing Practice (DNP) interns as applicable for their clinical practicum (rotation)~~
    d. ~~RN Resident (student) prior to the start of their clinical practicum (rotation)~~
    e. ~~SN and VN instructors~~

In approval

f. Paramedic interns prior to start of their clinical internship

11. Medication exam criteria
  a. Test is taken after all pre-placement requirements are successfully completed
  b. One hour is given to complete medication exam
  c. There are no repeats of the medication exam. This applies to all types of students.

12. Formal Request
  a. A formal request using the Required Element for Placement (REP) letter template is required. Please list all pre-placement requirements having been met on this letter. Please use paper with school letter head. (See accompanying document: Required Elements for Placement template)
  b. Pre-placement requirements not fulfilled by the school' program entrances requirement are obtain by the student at their own cost.
    - Medical information (immunization), drug screen, and background check
    - Results of the above are sent to your sponsoring school
    - No documents are to be sent to the Department of Education

13. Orientation
  a. Once the pre-placement requirements have been completed and a formal request for clinical placement has been received, an appointment for completing the in-processing (orientation) is scheduled.
  b. Please allow one (1) to two (2) hours for orientation which will include,
    - Medication exam, *as applicable*
    - Computerized e-Learning modules
    - Completing Student / Preceptee / Intern Clinical Rotation and Orientation profile
    - Obtain a SVMH ID badge and parking permit
    - N95 fitting, *as applicable*, in Employee Health Department
  c. ID badge and parking permit:
    - For clinical participants; please come in your school uniform or scrubs and have your school ID badge as they are both required for obtaining SVMH ID badge. Upper division nursing (BSN, MSN, CNS,DNP, and instructors) and non-clinical participants, please come in business attire, bring a lab coat and have your school ID badge.
    - The cost for both ID badge and parking permit is $40 of which $30 is refunded

If you have questions, please email: lescolta@svmh.com Monday – Friday, 0800-1630

Best Regards
Lourdes Escolta, MSN, RN, CNS, CMSRN, CNN, ONC
Manager, Education Department
Salinas Valley Memorial Hospital

in approval

~~e-mail: lescolta@svmh.com~~
~~Phone: 831-759-1928~~

in approval

Salinas Valley Memorial Healthcare System

STUDENT AFFILIATIONS

ATTACHMENT C

Location Addresses

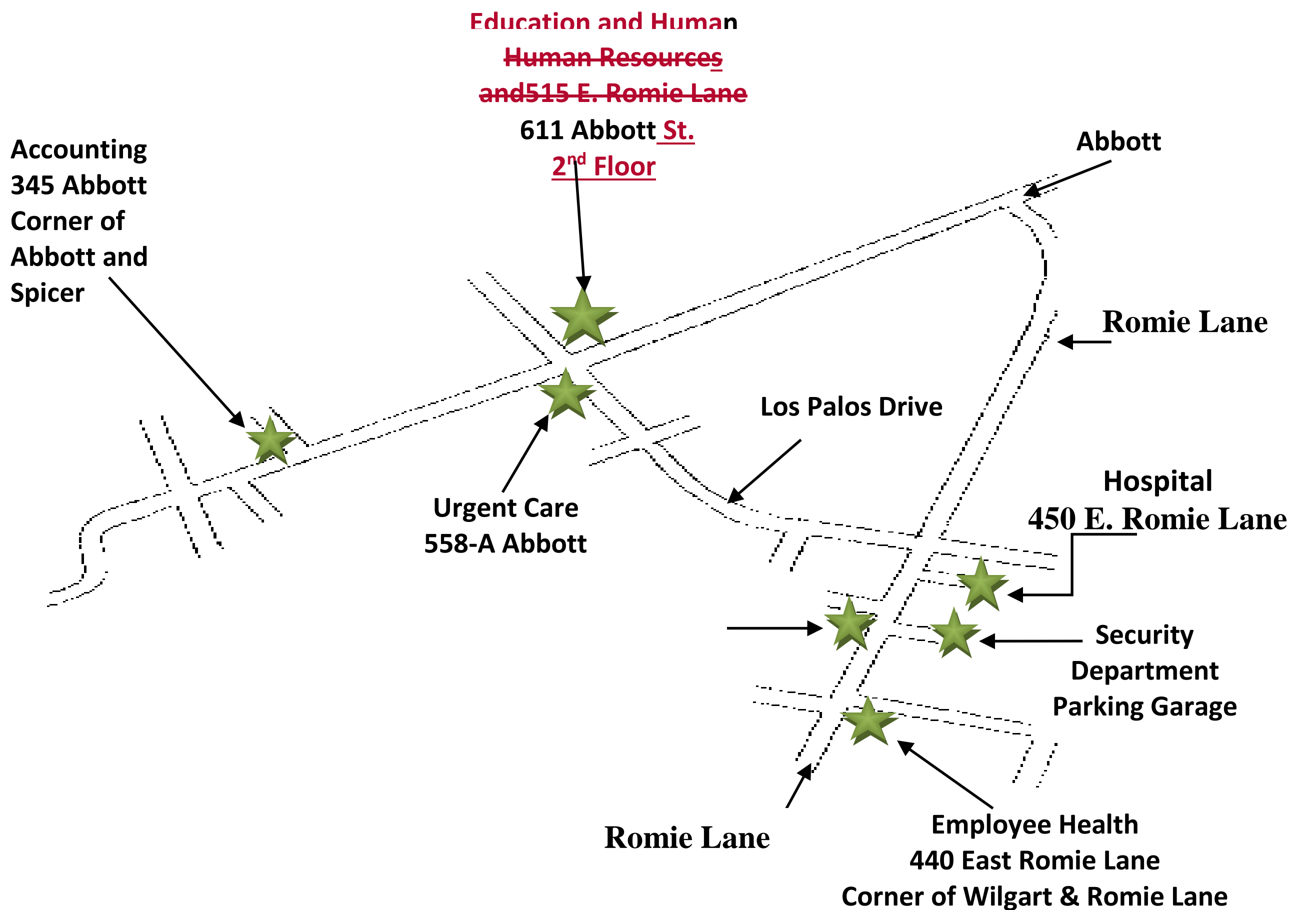
Department of Employee Health
440 East Romie Lane, Suite A
Hours: 0730 -1630: Monday, ~~Tuesday~~Wednesday, Thursday
~~Hours: 0730-1430: Tuesday~~
Hours: 0730-1200: Tuesday, Friday
Phone: 759-1986, Fax # (831) 753-5127

Salinas Urgent Care
558-A Abbot Street
Hours: 0800 – 2200, Monday – Friday
Phone: (831) 755-7800

Department of Education
611 Abbott, Suite 201(Upstairs)
Hours: 0730 – 1630: Monday, Tuesday, Thursday
Hours: 0730 - 120~~3~~0: Wednesday, Friday
Phone: (831) 755-07447~~-4333~~
Fax # (831) 753- 6294

Human Resource
~~515 E Romie Lane~~ 611 Abbott, Suite 201 (Upstairs)
Hours: 0800 – 160~~3~~0: Monday~~, Wednesday, Thursday~~ – Friday

~~Hours: 0800 – 1200: Tuesday, Friday~~
Phone: (831) 755-0759



Salinas Valley Memorial Healthcare System

STUDENT AFFILIATIONS

ATTACHMENT D

Attachment D~~Name of College Letter Head~~

~~Sample Letter~~

~~Date~~

~~Salinas Valley Memorial Healthcare System~~
~~450 East Romie Lane~~
~~Salinas California, 93901~~

~~Attention: Lourdes Escolta~~
~~Manager, Education Department~~

~~{Name of college / university} is requesting student(s) placement for clinical rotation at Salinas Valley Memorial Healthcare System. Salinas Valley Memorial Healthcare System requires all students complete and be current with the requirements listed below before entering a clinical practice site. {Name of college and program} student(s) have met and have the following listed requirements on file with the {Name of department and school address}.~~

~~These requirements consist of:~~

- ~~Proof of immunization against Chicken Pox, Measles, Mumps, and Rubella~~
- ~~Freedom from active tuberculosis~~
- ~~Either poof of immunization against Hepatitis B or a signed declination form refusing immunization against Hepatitis B~~
- ~~Evidence of a physical exam~~
- ~~Background Check~~
- ~~Drug Screen~~
- ~~Current BLS (CPR) card (when applicable)~~
- ~~Evidence to Medical Malpractice Insurance~~
- ~~Proof of seasonal flu vaccination~~

~~The following student(s) have met the above requirements~~

~~Name of Students…..~~

in approval

~~{Signature of Program Director}~~

~~Name of Program Director~~

{Name of College Letter Head}

{Date}

SAMPLE LETTER

Salinas Valley Memorial Healthcare System
450 East Romie Lane
Salinas California, 93901

Attention: Vanessa Irwin-Nieto,
Director, Education Department

{Name of college/university} is requesting student/intern(s) placement for clinical rotation in {Department Name}at Salinas Valley Memorial Healthcare System from {Begin date} to {End date}. Salinas Valley Memorial Healthcare System requires all student/intern(s) complete and be current with the requirements listed below before entering a clinical practice site. {Name of college and program} student/intern(s) have met and have the following listed requirements validated and on file with the {Name of department and school address}.

These requirements consist of:

- ☐ Proof of immunization against Chicken Pox, Measles, Mumps, and Rubella:
  - May be immune titre or documentation of two (2) vaccinations appropriately given according to CDC recommendation.
- ☐ Documented Tdap immunization within the last ten (10) years
- ☐ Freedom from active tuberculosis:
  - Documentation indicating free from active tuberculosis which includes:
  - Annual TB screening which includes
  - Initial TST 2-Stemp with annual TST or annual IGRA
  - Annual signs and symptoms screening for those that have a positive TST or IGRA in the past
- ☐ Hepatitis B immunization
  - Either poof of immunization and immune titre for Hepatitis B or
  - A signed declination form refusing immunization against Hepatitis B
- ☐ Evidence of a physical exam
- ☐ Background Check
- ☐ Drug Screen
  - Within thirty (30) days prior to start of clinical

In approval

Salinas Valley Memorial Healthcare System

STUDENT AFFILIATIONS

□ Current BLS (CPR) card (when applicable)
□ Evidence to Medical Malpractice Insurance

The following student/intern(s) have met the above requirements

- List name of the student/intern(s))…

{Signature of Program Director}
Name of Program Director

in approval

STUDENT AFFILIATIONS

ATTACHMENT E

Compliance Process, Documents and Orientation Requirements

Required Documents	Nurse	Allied Health	Instructor	Comments
Current Contract	X	X	X	No student will be accepted for placement without a current contract between SVMH and School
Request from Schools	X	X	X	~~New school: Formal letter of request~~ Returning and new school: Formal written request ~~completion of "Academic / Clinical Placement Request" form~~ ~~See Appendix "A"~~
Medical Requirements • Negative Drug Screen • Pre-placement Assessment	X	X	X	• Drug screen within 30 days prior to placement by a certified Lab • If taking prescribed medication it must be taken from original RX bottle and listed on drug screening test form • A written verification from Physician of prescribed medications that may show up on drug screen results • Documentation of pre-placement (physical exam) assessment within the past 12 months (from entrance to current program)
Immunization Records • TST (TB Skin Test) • Varicella • Measles • Mumps • Rubella • Hepatitis B	X	X	X	• Annual TST or chest x-ray if prior positive TST~~, within six (6) months~~ • Varicella (Chicken Pox; proof of immunization or immunity required ~~(positive history of the disease is accepted)~~ • Measles, Mumps and Rubella: proof of immunization or immunity required • Hepatitis B Compliance: three (3) shot series, positive titer, or documentation of declination
Background Check • To include OIG	X	X	X	• Of all counties candidate has lived or worked during past seven (7) years and completed no greater than 12 months prior to placement • Department of Health and Human Services (HHS) and Office of Inspector General (OIG)

in approval

STUDENT AFFILIATIONS

Required Documents	Nurse	Allied Health	Instructor	Comments
				checks will be performed for positions involved in the care of patients. • ~~Office of Inspector General (OIG) Check for placement involved in patient~~ • ~~Certificate stating either "Clear" or "Certificate ID # and Shared Password"~~
SVMH Medication Exam	X	X	X	• SN, VN students and instructors must pass with 80% or better. • Paramedic: pass with at least 80% SVMH Medication exam for Emergency Medical Training and Emergency Medical Services students • There are NO repeats
BLS card	X	X	X	• American Heart Association for Healthcare • American Red Cross – CPR / AED for the Professional Rescuer ?
Current / Active California License	X		X	• Required from RN and LVN instructors • Required from RN in Upper Division course/clinical practicum • ~~Required from RN Residents~~
Malpractice Insurance	X	X	X	• Must have available Malpractice Insurance
SVMH Student ID Badge	X	X	X	• ~~$40.00 fee which $30.00 is refundable when~~ ID Badge ~~/ Parking permit~~ is returned to Human Resource upon completion of clinical rotation/program • ID Badge must be worn and visible at all times student is on SVMH campus.
Orientation	X	X	X	• Complete assigned e-Learning orientation module(s). Must repeat with each new academic year.
Computer Training • Meditech • MAR	X		X	• Complete training ~~and validate~~ prior to start of clinical rotation
Pyxis Tutorial	X		X	• Required of all nursing students, interns, preceptees and instructors prior to receiving access. • Must repeat with each new academic year.
Accu-Chek Tutorial	X		X	• Required of all nursing students, interns, preceptees and instructors. • Must repeat with each new semester and academic year.

Salinas Valley Memorial Healthcare System

STUDENT AFFILIATIONS

Required Documents	Nurse	Allied Health	Instructor	Comments
Injury Prevention	X	X	X	• Required by all students, intern, preceptees and instructors having patient contact • Paramedic may be done in Employee Health
~~Lift Device Class~~ Safe Patient Handling Class	X	X	X	• Required of students, interns, preceptees having patient contact. • Excluded, PT/OT student, interns which will have their training by their preceptor.
N95 Respirator Fit Testing	X	X	X	• Required of students, interns, preceptees, and instructors having patient contact.
Proof of seasonal flu vaccine	X	X	X	• Required of students, interns, preceptees, and instructors having patient contact.

in approval

ATTACHMENT F

Employee Declaration of Records Form

For a

Student / Preceptee / Intern Clinical Rotation

in approval

Salinas Valley Memorial Healthcare System

STUDENT AFFILIATIONS

Direction: Student / Preceptee / Intern initial and date each section when completed. Print, initial, sign and date back page. Items	**Initial & Date**

1. **Student / Preceptee / Intern Handbook**
• Read the following…
  • Welcome Letter
  • Location / Addresses
  • Salinas Valley Memorial Hospital History
  • Mission and Vision Statement
• Read, understand and compile with items presented below…
  • Professional Standards for Students / Preceptees / Interns
  • Dress Code
  • Golden Rules of Customer Service
  • AIDETS
  • ID Badge Guidelines
  • Parking Rules and Regulation / Shuttle Service
  • Security ~~Duties~~ & Safety
  ~~• National Safety Goals~~ Infection Control
  ~~• Preventing Medication Errors *[As applicable]*~~
  • Codes ~~Identification~~ & Colored Armbands	

2. **Declaration of Employee Records**
• Date of employment: ______________________
• Current position: _________________________
• The following is on file in Human Resources
  • Background Check
• The following are on file in Employee Health (Provide Dates)
  • Immunization records: __________________________
  • Tuberculin Skin Test (TST): ______________________
  • Drug Screen :__________________	

in approval

Salinas Valley Memorial Healthcare System

STUDENT AFFILIATIONS

Items	Initial & Date
Clinical Rotation Type of Student: ____________________________ Clinical Department / Unit: ____________________ Clinical Mentor/Preceptor: ____________________ *[If applicable]* Hours needed: ___________	

I affirm, as an employee of Salinas Valley Memorial HealthCare System, all required regulatory requirements and competencies reviewed on an annual basis are current and date of completion are on file on my Unit / Directors office.

Student / Preceptee / Intern:

Employee Name: (Print): ____ **Date:** __________

Employee Name (Signature): _____________________________________

Director / Designee (Print): _____________________________________ **Date:** __________

Director / Designee (Signature): __________________________________

in approval

Developed: 01/10

Title: Employee Declaration of Records Form

Revised: 01/10, 09/10, 01/2011, 08/11, 10/13, 11/20 vi

Author: Education Department

Salinas Valley Memorial Healthcare System

THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

Reference Number	1034
Effective Date	Not Approved Yet
Applies To	All Departments
Attachments/Forms	N/A
Related Policies	EMERGENCY MEDICAL SCREENING EXAMINATION-NON-EMERGENCY DEPARTMENT

~~I. PURPOSE~~

~~To define and describe how Salinas Valley Memorial Healthcare System~~Hospital ~~(SVMHS) will comply with the Emergency Medical Treatment and Active Labor Act (EMTALA) and outline essential policies and procedures.~~

~~II.~~I. POLICY STATEMENT:

A. ~~COMPLIANCE:~~ It is the policy of the SVMH~~S~~ to comply with the EMTALA obligations. ~~These policies are mandated by Section 1867 of the Social Security Act, as amended, and regulations adopted by the Centers for Medicare and Medicaid Services (CMS), and applicable state laws governing the provision of emergency services and care.~~

II. PURPOSE:

A. To define and describe how Salinas Valley Memorial Hospital (SVMH) will comply with the Emergency Medical Treatment and Active Labor Act (EMTALA) and outline essential policies and procedures.

~~B. **NON-DISCRIMINATION**: SVMHS will provide emergency services and care without regard to an individual's race, color, ethnicity, national origin, ancestry, citizenship, age, sex, marital status, sexual orientation, preexisting medical condition, physical or mental disability, insurance status, economic status or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.~~

~~C. **ENFORCEMENT**: The two (2) primary agencies responsible for EMTALA enforcement are the CMS and the Office of the Inspector General (OIG). The California Department of Public Health is responsible for state hospital licensing laws. Violations of EMTALA may be reported to other federal and state agencies and to The Joint Commission.~~

in approval

Salinas Valley Memorial Healthcare System

THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

~~D. **SANCTIONS**: Failure to comply with EMTALA may result in termination by CMS of the Hospital's participation in the Medicare and Medicaid programs, as well as civil monetary penalties imposed by the OIG for both SVMHS and Physicians of up to $50,000 and possible exclusion from Medicare/Medicaid. Failure to comply with State laws on emergency services is subject to a licensing enforcement action. A violation of EMTALA is also subject to injunctive relief and civil lawsuits for damages.~~

III. **DEFINITIONS:**

A. **APPROPRIATE TRANSFER** means a transfer of an individual with an emergency medical condition that is implemented in accordance with EMTALA requirements (See Section IV.M below).

B. **CAMPUS** means the buildings, structures and public areas of the Hospital that are located on Hospital property (See III.K. below).

C. **CAPABILITY** means the physical space, equipment, staff, supplies and services (e.g., surgery, intensive care, pediatrics, obstetrics and psychiatry), including ancillary services available at the Hospital.

D. **CAPACITY** means the ability of the Hospital to accommodate the individual requesting or needing examination or treatment of a transferred individual. Capacity encompasses the numbers and availability of qualified staff, beds and equipment and the Hospital's past practices of accommodating additional patients in excess of its occupancy limits.

E. **CENTRAL LOG** means a log maintained by the Hospital on each individual who comes to its dedicated emergency department(s) or any location on Hospital property seeking emergency assistance, and the disposition of each individual.

F. ~~**C**~~**COMES TO THE EMERGENCY DEPARTMENT** means an individual who:

1. Presents at the Hospital's dedicated emergency department and requests or has a request made on his/her behalf for examination or treatment for a medical condition, or a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;

2. Presents on Hospital property other than a dedicated emergency department and requests or has a request made on his/her behalf for examination or treatment for what may be an emergency medical condition, or a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination and treatment; or

3. Is in a Hospital owned ground or air ambulance that is on Hospital Property for presentation for examination or treatment for a medical condition at the Hospital's dedicated emergency department.

G. **DEDICATED EMERGENCY DEPARTMENT** means any department of the Hospital, (whether located on Hospital property or off-campus) that meets at least one of the following requirements

1. It is licensed under applicable state law as an emergency room or emergency department; or
2. It is held out to the public (by name, posted signs, advertising or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. During the immediately preceding calendar year, it provided (based on a representative sample) at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent bases without requiring a previously scheduled appointment.

**At SVMH~~S~~, the dedicated emergency departments are identified as Obstetrics Emergency Department (OB ED) and the Emergency Department.

~~Emergency Department (OB ED) and the Emergency Department.~~

H. **DEPARTMENT OF THE HOSPITAL** means a Hospital facility or department that provides services under the name, ownership, provider number and financial and administrative control of the Hospital. For purposes of EMTALA, a department of the Hospital does not include a skilled nursing facility, home health agency, rural health clinic, free-standing ambulatory surgery center, private physician office or any other provider or entity that participates in the Medicare program under a separate provider number.

I. **EMTALA** means the Emergency Medical Treatment and Active Labor Act codified in Sections 1866 and 1867 of the Social Security Act (42 U.S.C. Section 1395dd), and the regulations and interpretive guidelines adopted by CMS. EMTALA is also referred to as the "patient anti-dumping" law".

J. **EMERGENCY MEDICAL CONDITION** means:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in.

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or

2. With respect to a pregnant woman who is having contractions
   - When there is inadequate time to effect a safe transfer to another hospital before delivery; or
   - The transfer may pose a threat to the health or safety of the woman or unborn child.

K. **HOSPITAL PROPERTY** means the entire main Hospital campus, including areas and structures that are located within 250 yards of the main buildings, and any other areas determined on an individual basis by the CMS regional office, to be part of the main Hospital's campus. Hospital property includes the parking lots, sidewalks, and driveways on the main Hospital campus. Hospital property does not include areas and structures within 250 yards of the main building that are not part of the Hospital. The excluded areas and structures include;

1. Private physician offices, rural health clinics, skilled nursing facilities and other entities that participate in the Medicare program under separate provider numbers;
2. Privately owned businesses such as restaurants and shops, private residences and other non-medical facilities.

L. **INPATIENT** means an individual who is admitted to the Hospital for bed occupancy for purposes of receiving inpatient services with the expectation that he/she will remain at least overnight and occupy a bed, even though the individual may be discharged or transferred to another facility and does not actually use a Hospital bed overnight.

M. **LABOR** means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman is in true labor unless a physician or certified nurse midwife certifies that, after a reasonable time of observation, the woman is in false labor.

N. **MEDICAL SCREENING EXAMINATION** means the process required to reach within reasonable clinical confidence, the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. The medical screening examination is an ongoing process, including monitoring of the individual, until the individual is either stabilized or transferred.

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O. **OFF-CAMPUS** means the buildings, structure and public areas of the Hospital that are located off-site of the Hospital property.

P. **ON- CALL LIST** means the list of physicians who are "on-call" after the initial medical screening examination to provide further evaluation and/or stabilizing treatment to an individual with an emergency medical condition.

Q. **OUTPATIENT** means an individual who has begun to receive outpatient services as part of an encounter, other than an encounter that triggers the EMTALA obligations. An "encounter" is a direct personal contact between an outpatient and a physician or qualified medical person who is authorized by State law to order or furnish Hospital services for the diagnosis or treatment of the outpatient.

R. **PHYSICIAN** means: (a) a doctor of medicine or osteopathy; (b) a doctor of dental surgery or dental medicine; (c) a doctor of podiatric medicine; or (d) a doctor of optometry, each acting within the scope of his/her respective licensure and clinical privileges.

S. **PHYSICIAN CERTIFICATION** means the written certification by the treating physician ordering a transfer and setting forth, based on the information available at the time of transfer, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of a woman in labor, to the unborn child, from effecting the transfer.

T. **QUALIFIED MEDICAL PERSON** means a healthcare professional other than a physician who:

1. Is licensed or certified by the State of California within his/her profession;
2. Practices in a category of health professionals that has been designated by the Hospital and the Medical Staff Bylaws, Rules and Regulations, to perform medical screening examinations;
3. Has demonstrated current competence in the performance of medical screening examinations within his/her health profession; and
4. As applicable, performs the medical screening examination in accordance with protocols, standardized procedures or other policies as may be required by law or Hospital policy. A qualified medical person may include registered nurses, nurse practitioners, nurse midwives, psychiatric social workers, psychologists and physician assistants.

U. **SIGNAGE** means the signs posted by the Hospital in its dedicated emergency department(s) and in a place or places likely to be noticed by all individuals entering the dedicated emergency department(s) (including waiting room,

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admitting area, entrance and treatment areas), that inform individuals of their rights under EMTALA.

V. **STABILIZED** means, with respect to an emergency medical condition, that no material deterioration of the condition is likely within reasonable medical probability, to result from or occur during the transfer of the individual from the Hospital or in the case of a woman in labor, that the woman delivered the child and the placenta. An individual will be deemed stabilized if the treating physician has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

W. **TO STABILIZE** means, with respect to an emergency medical condition, to either provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the Hospital or, in the case of a woman in labor, that the woman has delivered the child and the placenta.

X. **TRANSFER** means the movement (including the discharge) of an individual outside the Hospital at the direction of any person employed by (or affiliated or associated, directly or indirectly) with the Hospital, but does not include such a movement of an individual who has been declared dead or who leaves the Hospital against medical advice or without being seen.

Y. **TRIAGE** means a process to determine the order in which individuals will be provided a medical screening examination by a physician or qualified medical person. For purposes of EMTALA, triage is **not** the equivalent of a medical screening examination and does not determine the presence or absence of an emergency medical condition.

IV. GENERAL INFORMATION:

A. **NON-DISCRIMINATION**: SVMH will provide emergency services and care without regard to an individual's race, color, ethnicity, national origin, ancestry, citizenship, age, sex, marital status, sexual orientation, preexisting medical condition, physical or mental disability, insurance status, economic status or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

B. **ENFORCEMENT**: The two (2) primary agencies responsible for EMTALA enforcement are the CMS and the Office of the Inspector General (OIG). The California Department of Public Health is responsible for state hospital licensing

laws. Violations of EMTALA may be reported to other federal and state agencies and to The Joint Commission.

C. **SANCTIONS**: Failure to comply with EMTALA may result in termination by CMS of the Hospital's participation in the Medicare and Medicaid programs, as well as civil monetary penalties imposed by the OIG for both SVMHS and Physicians of up to $50,000 and possible exclusion from Medicare/Medicaid. Failure to comply with State laws on emergency services is subject to a licensing enforcement action. A violation of EMTALA is also subject to injunctive relief and civil lawsuits for damages.

IV. V. **PROCEDURE:**

A. **SCOPE OF EMTALA**

1. EMTALA **is** applicable to any individual who "comes to the emergency department" seeking or needing an examination or treatment
2. EMTALA does **not** apply to the following:
   - An outpatient during the course of his/her encounter (even if the outpatient develops an emergency medical condition while receiving outpatient services and is taken to the dedicated emergency department for further examination and treatment).
   - An individual who presents to any off-campus department or facility of SVMHS that is not a dedicated emergency department.
   - An inpatient (including inpatients who are "boarded" in the dedicated emergency department waiting for an available bed);
   - An individual who presents to a rural health clinic, skilled nursing facility or home health agency owned or operated by SVMHS, whether located on-campus or off-campus, or a private physician's office or other ambulatory care clinic that participates separately in the Medicare program.
   - Restaurants, private residences, shops or other non-medical facilities that are not part of the Hospital.
3. **PHYSICIANS:** EMTALA is applicable to any physician who is responsible for the examination, treatment or transfer of an individual to whom EMTALA applies, including an on-call physician and other members of the Medical Staff who provide for the care of such an individual.

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4. **DEDICATED EMERGENCY DEPARTMENTS:** SVMHS has determined that the following departments of the Hospital meet the definition of a dedicated emergency department.
   - Emergency Department
   - Obstetrics (OB)

B. **SIGNAGE:** SVMHS will post signage that inform patients of their rights under EMTALA conspicuously in lobbies, waiting rooms, admitting areas and treatment rooms where examination and treatment occurs, in the form required by CMS that specifies the rights of individuals to examination and treatment for emergency medical conditions and whether SVMHS participates in the Medicaid program. Signage will be posted in each dedicated emergency department.

C. **CENTRAL LOG:** Each dedicated emergency department of SVMHS will maintain a central log recording the names of individuals who come to the emergency department. The central logs will record the name of each person who presents for emergency services and whether the person refused treatment, was refused treatment by SVMHS or whether the individual was transferred, admitted and treated, stabilized and transferred or discharged. These logs are maintained electronically.

D. **ON-CALL COVERAGE:** SVMHS will maintain a list of physicians who are on-call to come to the Hospital to consult or provide treatment necessary to stabilize an individual with an emergency medical condition.

1. The on-call list will be maintained in a manner that best meets the needs of the individuals who are receiving emergency services in accordance with the resources available to the Hospital, including the availability of on-call physicians.
2. The Medical Staff Bylaws, Rules and Regulations will define the responsibilities of on-call physicians to respond (including response times), examine and treat emergency patients. Labor and Delivery and the Emergency Department will be prospectively aware of the physicians who are on-call to the department.
3. SVMHS will have policies and procedures to respond to situations in which a particular on-call specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control.
4. The notification of an on-call physician will be documented in the medical record and any failure or refusal of an on-call physician to respond to call will be reported to the Medical Staff.

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E. **MAINTENANCE OF RECORDS:** Medical and other records (such as transfer logs, on-call lists and changes to the on-call list and central logs) are maintained in accordance with Hospital record-retention policies, but not less than five (5) years.

F. **DISPUTES:** In the event of any concern over emergency services to an individual, or a dispute with another facility regarding a transfer or a concern about SVMHS's compliance with EMTALA, Hospital staff or physicians will refer the dispute to the Chief Nursing Officer or the Chief Medical Officer.

G. **REPORTING EMTALA VIOLATIONS:** All SVMH~~S~~ personnel or physicians who believe that an EMTALA violation has occurred will report the possible violation to the Chief Nursing Officer or the Chief Medical Officer who will investigate. ~~Administration~~ The Accreditation and Regulatory Department will report to CMS or the state survey agency within 72 hours if it has a reason to believe that it has received an individual who has been inappropriately transferred in an unstabilized emergency medical condition from another hospital. (refer to section N (4). below)

~~G. . (Refer to Ethics, Rights & Responsibilities/Reporting of Improperly Transferred Patients Policy.)~~

H. **RETALIATION:** SVMH~~S~~ will not retaliate, penalize or take adverse action against any physician or qualified medical person for refusing to transfer an individual with an emergency medical condition that has not been stabilized, or against any SVMH~~S~~ employee for reporting a violation of EMTALA or state laws to a governmental enforcement agency.

I. **MEDICAL SCREENING EXAMINATION**

1. **PROCEDURE:** A medical screening examination will be offered to any individual who comes to the emergency department. The medical screening examination must be provided within the capability of the dedicated emergency department, including ancillary services routinely available to the dedicated emergency department (including the availability of on-call physicians). The medical screening examination must be the same appropriate examination that SVMH~~S~~ would perform on any individual with similar signs and symptoms, regardless of the individual's ability to pay for medical care.

2. **SCOPE:** The scope of the medical screening examination must be tailored to the presenting complaint and the medical history of the individual. The process may range from a simple examination (such as a brief history and physical) to a complex examination that may include laboratory tests, MRI or diagnostic imaging, lumbar punctures, other diagnostic tests and procedures and the use of on-call physicians.

3. **COMPARISON WITH TRIAGE:** Triage is not equivalent to a medical screening examination. Triage merely determines the "order" in which individuals will be seen, not the presence or absence of an emergency medical condition.
4. **FURTHER EXAMINATION AND STABILIZING TREATMENT:** If an individual is determined to have an emergency medical condition, the Hospital, within its capability and capacity, will provide further examination and treatment as may be required to stabilize the emergency medical condition, or make an appropriate transfer of the individual to another hospital.
5. **CONTINUOUS MONITORING:** The medical screening examination is a continuous process reflecting ongoing monitoring in accordance with an individual's needs. Monitoring will continue until the individual is stabilized or appropriately transferred. Reevaluation of the individual should occur prior to discharge or transfer.
6. **PERSONNEL QUALIFIED TO PERFORM MEDICAL SCREENING EXAMINATIONS:** The categories of qualified medical persons qualified to perform medical screening examinations in the dedicated emergency departments will be defined in the Medical Staff Rules and Regulations.
7. **DEPARTMENTAL POLICIES:** Policies and procedures will be adopted which describe the conduct of the medical screening examinations in its dedicated emergency departments. The policies will also describe the documentation of patient records, on-going in-service training of SVMHS personnel and quality management review of medical screening examinations.

J. **PATIENT REGISTRATION**

1. PROCEDURE: The Hospital may not delay the provision of an appropriate medical screening examination or any necessary stabilizing medical treatment in order to inquire about the individuals' method of payment or insurance status.

   - Registration personnel will not initiate any discussions with the patient or the family about financial status, coverage, authorization requirements, charges, co-pays or any other issue involving financial or payment procedure issues prior to notification by the responsible physician or nurse that the medical screening examination and necessary stabilizing care has been initiated.
   - Questions regarding financial issues shall be deferred until after completion of the medical screening examination and necessary stabilizing care has been initiated. If the patient or their family

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insist on resolution of financial questions prior to completion of the medical screening examination, the details of their requests and hospital personnel response shall be noted in the records, and a financial counselor knowledgeable in EMTALA requirements shall be contacted to discuss these issues with the family. Patient will be told that the Hospital will provide a medical screening examination and stabilizing treatment, regardless of their ability to pay, and encouraged to remain for examination.

- If a patient asks Hospital personnel if it accepts his/her health plan, personnel should respond to the patient. If the patient is not a member of a health plan that contracts with the Hospital, personnel should reaffirm and document its offer to provide a medical screening examination, and should take reasonable steps to encourage the patient to remain for examination.
- No co-payment shall be obtained prior to the medical screening examination and initiation of stabilizing treatment. If a patient offers a co-payment and insist that he/she does not want to defer its collections until after emergency services are rendered, then registration personnel should note that the patient voluntarily offered the copayment.
- If the patient informs nursing staff or registration personnel of a decision to leave the Hospital before receiving a medical screening examination, nursing staff will document on a "Refusal of Medical Screening Examination Form" #NS 8700-026 the time of the patients departure and the reasons (if stated by the patient) for the patients decision to leave the Hospital. The physician will be notified.
- After patients have received a medical screening examination and it is determined that no emergency condition exists; or if stabilizing treatment has been initiated, registration personnel may then obtain signatures on the necessary authorization or financial forms.

2. ~~**PATIENT REGISTRATION:** SVMHS may follow reasonable registration processes for individuals for whom examination or treatment is required under EMTALA so long as the registration process does not delay the medical screening examination or stabilizing treatment, or unduly discourage an individual from remaining for further evaluation.~~

~~3. **PRIOR AUTHORIZATION:** SVMHS may not seek, or direct and individual to seek, authorization from the individual's insurance company or health plan for the medical screening examination or stabilizing treatment until SVMHS has provided the medical screening examination and initiated any further examination and treatment that may be required to stabilize the emergency medical condition.~~

K. **TRANSFER OF INDIVIDUALS WITH AN EMERGENCY MEDICAL CONDITION**

1. ~~**PROCEDURE:**~~ SVMH~~S~~ will not transfer an individual with an emergency medical condition that is not stabilized unless the individual requests the transfer or a physician certifies that the medical benefits reasonably expected from the provision of treatment at the receiving facility outweigh the risks to the individual from the transfer. SVMH~~S~~ must provide additional examination and treatment as may be required to stabilize the emergency medical condition until the individual leaves SVMHS.

    - The Emergency Department (ED) and the Obstetrics Emergency Department (OB ED) will maintain a log of each individual who came seeking care, and whether he/she refused treatment, was refused treatment, transferred, admitted and treated, stabilized and transferred, or discharged.

2. ~~**REQUIREMENTS FOR AN APPROPRIATE TRANSFER:**~~ An individual with an emergency medical condition who has received a medical screening examination and stabilizing treatment within the capacity of SVMH~~S~~ may be transferred to another hospital or acute care facility provided that:~~that is not stabilized may be transferred only if SVMHS complies with ***all*** of the following standards:~~

    - The patient requires specialized services that are not offered or available at SVMH~~S~~.
    - SVMH~~S~~ provides medical treatment within its capacity to minimize the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child; the medical record will reflect the vital signs and condition of the individual at the time of the transfer;
    - The receiving facility has available space and qualified personnel for treatment of the individual; and the receiving facility and receiving physician have agreed to accept the individual and to provide appropriate medical treatment; the treating physician is responsible to determine whether an emergency medical condition is stabilized and the mode of transportation for the transfer.

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- SVMHS sends to the receiving facility copies of all medical records (or copies thereof) available at the time of transfer related to the emergency medical condition of the individual, including:
  a. Records related to the individual's emergency condition;
  b. The individual's informed written consent to transfer or the physician certification (or copy thereof); and
  c. The name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; and
  d. The transfer is affected using proper personnel and equipment, as well as necessary and medically appropriate life-support measures.

3. **TRANSFERS FOR OFF-SITE TESTS:** If an individual who has or may have an emergency medical condition is transferred to another facility for a test with the intention of the individual returning to the Hospital after the test, the Hospital will affect an appropriate transfer.

4. **DEPARTMENT POLICIES:** Each dedicated emergency department and other appropriate departments of SVMHS that transfer individuals with emergency medical conditions will adopt policies and procedures which describe the procedures for the transfer of individuals and documentation of the transfer, and conduct ongoing in-service training of dedicated emergency department personnel.

5.3. **DISPUTES:** The treating physician is responsible to determine whether an emergency medical condition is stabilized and the mode of transportation for the transfer.

(Refer to ACCEPTING INTERFACILITY TRANSFERS TO SVMH PROCEDURE , # 2668 and the Transfer of Patients to Another Acute Care Facility Policies and Procedures)

L. **ACCEPTANCE OF TRANSFERS**

1. SVMHS will accept from a transferring hospital's Emergency Department (ED), within the boundaries of the United States, an appropriate transfer of an emergency patient with an unstable emergency medical condition who requires the specialized services of SVMHS, if SVMHS has the capacity and capability to treat the individual.

2. Acceptance/Non-Acceptance of patients from the referring facilities' ED will not be based upon, or affected by, the individual's race, ethnicity, religion,

ancestry, national origin, citizenship, age, sex, marital status, sexual orientation, pre-existing medical condition, physical or mental disability, insurance status, economic status or ability to pay for medical services, or any other characteristic listed in the Unruh Civil Rights Act, except to the extent that a circumstance such as age, sex, pre-existing medical condition or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

3. Prior to accepting or refusing a transfer, SVMHS may not make financial or insurance inquiries of a sending hospital if the transfer involves a patient in the emergency department who has an unstabilized emergency medical condition.

4. Transfers for patients from the referring hospital's ED, with an unstabilized emergency medical condition as defined by law, will be declined only under the following conditions:

   - SVMHS does not have the capacity or capability to provide care for the patient; ***or***
   - The transferring facility has the present capacity or capability to provide the emergency medical services required for the patient (lateral transfer).

5. Procedure for Accepting an EMTALA Transfer

   a) The transferring facility will contact the SVMH Administrative Supervisor and give basic patient information including the reason for transfer. No inquiry regarding financial or insurance status will be made by the SVMH ADMINISTRATIVE SUPERVISOR prior to accepting the transfer from the transferring hospital's ED. Physicians or personnel in other SVMH departments, who receive calls from other hospitals, seeking transfer of a patient, will transfer the call to the SVMH ADMINISTRATIVE SUPERVISOR. Transferring facilities will not be directed to call a SVMH physician until authorized by an SVMH ADMINISTRATIVE SUPERVISOR -or SVMH ED physician. **If the transferring ED is requesting transfer of a patient meeting Code STEMI or Code Stroke criteria, calls will immediately be forwarded to the ED Physician to expedite acceptance.**

   b) The SVMH ADMINISTRATIVE SUPERVISOR -will determine if there is capacity at SVMH to appropriately care for the patient being transferred. The "Documentation of Request for Transfer to SVMH" Form will be completed by the Administrative Supervisor.

c) If SVMH **does not** have the capacity, the transferring facility/accepting physician will be informed that the hospital cannot accept the patient at this time and will state the reason. **The only exception will be for patients meeting Code STEMI or Code Stroke criteria. These patients will be accepted as expeditiously as possible.**

d) If SVMH **does** have the capacity and a SVMH physician has not already accepted the patient, the SVMH Administrative Supervisor will contact the SVMH Emergency Department (ED) physician. The ED physician will be asked to speak with the transferring physician to determine whether the transfer will be accepted.

e) If the ED physician has any questions as to whether the on-call physician has the capabilities to provide care for the transferring patient, or whether the transfer is in all manners an appropriate one, he/she will consult with the appropriate on-call physician and then contact the transferring physician regarding acceptance. While Medical Staff Rules and Regulations do not obligate SVMH on-call specialists to speak with other facilities, they do obligate the specialists to confer with SVMH ED physicians to aid in an understanding of the appropriateness of the Interfacility transfer of ED patients.

f) The ED physician will notify the Administrative Supervisor of the decision to accept or decline the transfer. If the transfer is declined, the reason will be documented by the Administrative Supervisor.

g) If the transferring facility has already obtained an accepting SVMH physician, the SVMH ADMINISTRATIVE SUPERVISOR will contact the accepting SVMH physician to verify acceptance and determine level of care required. The Administrative Supervisor will obtain the telephone order for admission if the patient is accepted as a "direct admit".

h) The transferring physician is responsible to determine whether an individual's emergency medical condition is stabilized, and the means, personnel and equipment for the transfer.

i. In the event the ED or on-call pIn the event the ED or on-call physician does not agree with the judgment of the transferring physician as to the stability or clinical needs of the patient or the means, personnel, and equipment for the transfer, the ED or

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on-call physician or ~~the~~ SVMH ~~Hospital~~ may request the transferring physician or transferring facility to send, by fax or electronically, portions of the individual's medical record as may be pertinent to the Hospital's acceptance of the individual so long as the delay does not jeopardize the condition of the individual.

ii. If the review of the patient record does not resolve the disagreement, the judgment of the emergency physician at the ~~sending~~ transferring hospital will take precedence, and the ED or on-call physician will accept the patient if SVMH has the capacity and capability to meet the anticipated needs of the patient.

iii. If upon arrival of the individual from the sending facility, the ED or on-call physician or Hospital believes that the transferring physician should not have transferred the individual or that the transfer was not an appropriate transfer as required by EMTALA, the ED or on-call physician or Hospital staff should report the disagreement or suspected violation to the Chief Nursing Officer or the Chief Medical Officer.

i) In the event that the ~~Administrative Supervisor~~ SVMH Administrative Supervisor is notified that a transfer has been declined under circumstances where the hospital is obligated to accept the patient, or the transferring facility has not been responded to in a timely manner, the Administrative Supervisor shall contact the ED physician to secure acceptance of the patient. If the Administrative Supervisor is unable to obtain acceptance by that physician when the Hospital is obligated to accept, the Administrative Supervisor shall contact the Chair of the appropriate department. If the Chair is unavailable, the Chief of Staff or the Chief Medical Officer will be contacted.

j) The Administrative Supervisor and Admitting will coordinate the transfer with the appropriate receiving department. If the patient is being transferred for surgery or another procedure, the Administrative Supervisor will ensure that the patient is on the appropriate schedule. The scheduling department will follow their standard operating procedures to schedule the patient. The transferring facility will be asked to call report to the nurse in the receiving department at SVMH.

~~L.~~M. **REFUSAL OF EMERGENCY SERVICES OR TRANSFER**

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THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

1. **PROCEDURE:** An individual retains the right to refuse necessary stabilizing treatment and further medical examination, as well as a transfer to another facility.

   - **REFUSAL OF MEDICAL SCREENING EXAMINATION:** If an individual leaves SVMHS before receiving a medical screening examination, either with or without notice to staff of his/her departure, staff should document the circumstances and reasons (if known) for the individual's departure and the time of departure.

   - **REFUSAL OF FURTHER EXAMINATION OR STABILIZING TREATMENT:** If an individual who has received a medical screening examination refuses to consent to further examination or stabilizing treatment, SVMHS must offer the examination and treatment to the individual, inform the individual of the risks and benefits of the examination and treatment and request that the individual sign a form that he/she has refused further examination or treatment. XXXXXX ?? LWBS policy

   - **REFUSAL OF TRANSFER:** If an individual refuses to consent to a transfer, SVMHS must inform the individual of the risks and benefits to the individual of the transfer and request that the individual sign a form that he/she refused the transfer. Care will continue within the capabilities of SVMH.

M. ACCEPTANCE OF TRANSFERS

1. **PROCEDURE:** SVMHS has the obligation to accept an appropriate transfer of an individual with an unstabilized emergency medical condition who requires specialized capabilities or facilities if SVMHS has the capacity to treat the individual.

2. **POLICIES AND DOCUMENTATION:** SVMHS will have policies and procedures for receiving inquiries from other facilities, including documentation of calls, the names (if known) and conditions of individuals, the outcomes of the calls and the reasons if SVMHS refuses to accept the transfer.

DISPUTES: The treating physician is responsible to determine whether an individual is stabilized and the mode of transportation for the transfer.

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(Refer to ACCEPTING INTERFACILITY TRANSFERS TO SVMH PROCEDURE and TRANSFER OF PATIENTS TO ANOTHER ACUTE CARE FACILITY.

N. **QUALITY IMPROVEMENT AND REPORTING OF POTENTIAL EMTALA LVIOLATIONS**

1. Monitoring EMTALA compliance is a responsibility of SVMHS administration, the Medical Staff, department heads and risk management. SVMHS and Medical Staff will adopt a monitoring program to evaluate the key elements of EMTALA compliance (for example, but not limited to, on-call performance, conduct of medical screening examinations, transfers) and other areas for which SVMHS determines the need for oversight in order to maintain compliance with the EMTALA obligations.

2. An EMTALA violation means that a hospital has denied care, limited care, discharged the patient or transferred the patient to this facility under the following circumstance:

   - The patient arrives at this hospital; and
   - The patient has an emergency medical condition as defined by EMTALA; and
   - The patient's condition is unstabilized at the time of arrival; and
   - The patient presented to an emergency department (or labor and delivery or other department) at another hospital prior to this Hospital; and
   - One or more of the following appears to be true:

     i. The patient was refused examination at the prior hospital;

     ii. The patient was refused treatment at the prior hospital;

     iii. The patient was discharged by the prior hospital with an unstabilized emergency condition;

     iv. The patient was transferred to this facility without prior acceptance;

     v. The patient's condition was misrepresented to this Hospital to obtain acceptance for transfer;

     vi. The patient was transferred by private vehicle or with inadequate personnel and equipment to safeguard the patient;

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vii. The patient was transferred without medical records accompanying the patient, unless the delay for records would have jeopardized the condition of the patient;

viii. The patient was transferred as a result of a failure or refusal of an on-call specialist to attend the patient; or

ix. There is no physician certification for the transfer if the transfer was made for clinical reasons (such as access to a higher level of care), unless the transfer was arranged at the informed request of the patient.

3. Any member of the nursing staff, administrative staff or medical staff of this Hospital who has reason to suspect that any patient has been received at this facility as a result of an EMTALA violation shall complete an occurrence report.

4. The ~~Accreditatyion~~Accreditation and Regulatory Department will review the occurrence report and obtain such necessary information as is reasonably necessary to validate or explain the facts of the incident, within 48 hours of the suspected improper transfer or discharge from the prior hospital. If the investigation indicates a violation has occurred, the Accreditation and Regulatory ~~and Risk Management~~ Department will report the incident to CDPH within 72 hours of the occurrence.

5. The Accreditation and Regulatory ~~and Risk~~ Department will maintain a record of all EMTALA related occurrence reports for at least five (5) years from the date of the report.

O. DOCUMENTATION

1. A Transfer Summary: Physician Certification and Patient Transfer Acknowledgement Form shall be completed for all patients being transferred to another acute care facility

~~V.~~VI. EDUCATION/TRAINING:

A. Education and/or training is provided ~~during general or department-specific orientation and periodically as practice or policy changes~~as needed.

~~A. EMTALA Education will be provided at orientation and on an on-going basis for key departments such as the Emergency Department, Obstetrics, Medical Staff, Case Management and Administrative Supervisors.~~

~~1. Staff education records are maintained by the Education department.~~

2. Documentation of Physician education is maintained by the Medical Staff Office.

VI. **DOCUMENTATION**

A. Central logs will be created and maintained for all individuals who come to the Emergency Department and the OB Emergency Department and will be kept for a minimum of five (5) years.

B. A prospective list of all On-Call Physicians will be created and maintained by the Medical Staff Office and will be kept for a minimum of five (5) years in the Medical Staff Office.

C. An Occurrence Report shall be completed by staff whenever an EMTALA violation is suspected. The Chief Nursing Officer and the Chief Medical Officer will investigate and report as appropriate.

D. A Transfer Summary: Physician Certification and Patient Transfer Acknowledgement Form (#7230-8331) shall be completed for all patients being transferred to another acute care facility. XXXX PUT DOCUMENTATION UNDER P

VII. **REFERENCES:**

A. California Healthcare Association, "A Guide to Patient Anti-Dumping Laws," 8th Edition (2012).

B.A. EMTALA Statute, United States Code, Title 42, Section 1395dd

C. EMTALA Regulations, Code of Federal Regulations Title 42, Sections 489 and 489.24

D.B. CCalifornia Health & Safety Code, Sections 1317 – 1317.9a

C. CMS Revised Interpretive Guidelines, State Operations Manual, 3/26/20125/29/09XXXXX

D. California Healthcare Association, *"EMTALA - A Guide to Patient Anti-Dumping Laws"*, 9th Editions, 20188th XXXXXXXXXXXXX

E. California Healthcare Association, "Consent Manual", 46th Edition (2019) EVIDENCE BASED REFERENCES

F. A. California Healthcare Association, "A Guide to Patient Anti-Dumping Laws", 8th Edition (2012)

G. B. EMTALA Statute, United States Code, Title 42, Section 1395dd

H. C. EMTALA Regulations, Code of Federal Regulations 42, Sections 489.20 and 489.24

I. D. California Health & Safety Code, Sections 1317 – 1317.9a

J. E. California Healthcare Association, "Consent Manual", 43rd Edition (2016)F. CMS Interpretive Guidelines, State Operations Manual, May 29, 2009

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QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN 2021

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I. SCOPE

A. The purpose of the Organizational Quality Assessment and Performance Improvement (QAPI) Program Plan at Salinas Valley Memorial Hospital (SVMH), under the Salinas Valley Memorial Healthcare System (SVMHS) is to ensure that the Governing Body, medical staff and professional service staff demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risk. Furthermore, the QAPI Plan is used as a mechanism to develop, implement, and maintain an effective, ongoing, organization-wide, data-driven quality assessment and performance improvement program through a planned, systematic, and interdisciplinary approach to improving the care, treatment and services provided. This is an organization-wide plan. It applies to all inpatient, outpatient departments and ambulatory outpatient services, licensed under SVMH including those services furnished under contract or arrangement.

B. The QAPI Program is designed to promote an environment where patient care and services are continually improved, where professional performance and employee competence are maximized, and in which operational systems are efficient. Through an interdisciplinary and integrated process, patient care and the processes that affect patient care are measured and assessed to provide optimal outcomes. The Board of Directors, Medical Staff, organizational leaders and all personnel assume appropriate accountability for the quality of care and services provided at SVMH. The QAPI Program is designed to align with and support the organizational <u>MISSION, VISION, AND GOALS STATEMENT</u>.

C. In concert with the organizational QAPI Program, professional nursing practice care at Salinas Valley Memorial Hospital is guided by a Professional Practice Model, developed by the nursing staff. The nursing mission is to heal, protect, empower and teach. The nursing vision is to be an innovative leader in nursing excellence - a place where patients choose to come and nurses want to practice. Other components of the Professional Practice Model include shared governance, respectful, collaborative professional relationships, recognition and reward for professional nursing development and a care delivery model which embraces a relationship-based, collaborative approach emphasizing partnerships with our colleagues, patients, families and the community. Clinical Nurses, ancillary staff, support staff and medical staff participate in quality committees to make interprofessional decisions at the organizational level to improve processes and quality of care. These decision making committees include committees in Administrative Quality; Safety and Reliability; Shared Governance and ad hoc subcommittees where nursing sensitive measures and nursing practice initiatives are incorporated into the overall organizational performance improvement.

II. OBJECTIVES/GOALS

A. Objectives

1. The organizational QAPI program includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided and on patient safety practices conducted throughout the organization. The program encompasses elements of the mission, vision, goals and organizational strategic objectives and consists of performance improvement, patient safety and quality control activities. Indicators are objective, measurable, based on current knowledge and experience, and are structured to produce statistically valid, data driven measures of care provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time when appropriate.

2. The QAPI Plan includes data collection, data aggregation and analysis, analysis of undesirable patterns or trends, identifying and managing sentinel events, improving performance, patient safety and reducing risk of adverse / sentinel events, and conducting proactive risk reduction activities, including processes that involve the Medical Staff as well as clinical and support services. The QAPI program is implemented in conjunction with the organizational PATIENT SAFETY PROGRAM PLAN and the RISK MANAGEMENT PLAN

B. Goals

1. The goals for the QAPI Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance monitoring and environmental monitoring.

2. Annually the organization defines at least one improvement priority. In collaboration with organizational strategic objectives, the following priorities have been established for 2021:

    - Annual Quality and Safety Pillar Strategic Initiatives
    - Patient Perception of Care, Services and Treatment
    - Patient Flow Initiatives
    - Regulatory Reporting Requirements, including Value Based Purchasing
    - Adherence to National Patient Safety Goals
    - Maintenance of Disease Specific Care Certification Designations Pain Management and Opioid reduction
    - Safety and Reliability
    - Magnet Journey

III. DEFINITIONS

A. CMS – Centers for Medicare and Medicaid Services
B. MEC – Medical Executive Committee
C. PIT – Process Improvement team
D. QAPI – Quality and Performance Improvement
E. QSC – Quality and Safety Committee

IV. PLAN MANAGEMENT

A. Plan Elements

1. Measuring Performance
   a. Data Collection

The Board of Directors, in collaboration with medical staff and hospital administrative leaders, establish priorities for data collection as well as the frequency for collection. Data collected for high priority processes are used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement, or sustain improvement. The Program is expected to show improvement in measures for which there is evidence that patient outcomes will be improved and medical errors will be reduced. Data are collected and analyzed for the following but not comprehensive list:

- Performance improvement priorities identified by leaders
- Operative or other procedures that place patients at risk of disability or death
- All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
- Adverse patient events
- Adverse events related to using moderate or deep sedation or anesthesia
- Blood management
- The results of resuscitation / Effectiveness of its response to change or deterioration in a patient's condition
- Medication errors
- Adverse drug reactions
- Patient perception of the safety and the quality of care, treatment or services
- Processes that improve patient outcomes such as fall reduction activities including assessment, interventions and education
- National Patient Safety Goals

- Processes as defined in the organizations Infection Control Program, Environment of Care Program, and Patient Safety Program
- Organ Procurement Organization processes
- Staff opinions and needs, staff perceptions of risk to individuals, staff suggestions for improving patient safety, and willingness to report adverse events
- Core measure data and other required Centers for Medicare and Medicaid Services (CMS)
- Patient flow processes
- Contracted services
- Emergency Management
- Other areas as outlined in the Quality Oversight structure

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments and services, or focused on selected populations. A reporting calendar has been defined for department and operational reporting. This is a dynamic document and may change throughout the year based on priorities and/or compliance to metrics.

Relevant information developed from the following activities is integrated into performance improvement initiatives as required:

- Patient safety
- Clinical outcomes
- Key financial/utilization indicators including length of stay
- Risk management
- Quality control
- Infection control surveillance and reporting
- Research when applicable
- Autopsies
- Other relevant data as required or identified

2. Assessing Performance
   a. Data Compilation and Analysis

      Data aggregation and analysis transforms data into information. Data are systematically aggregated and analyzed in order to monitor the effectiveness and safety of services and quality of care, and assess performance levels, patterns, or trends.

      i. Data aggregation is performed at the frequency appropriate to the activity or process.
      ii. Statistical tools and techniques are used to display and analyze data whenever possible.

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iii. Data are analyzed and compared internally over time and externally with other sources of information when available.

iv. When available, comparative data are used to determine if there is excessive variability or unacceptable levels of performance.

v. Results of data analysis are used to identify improvement opportunities.

3. Improving Performance
   a. Information from data analysis is used to make changes that improve performance and safety. The Board of Directors, in collaboration with medical staff and hospital leaders, establish priorities for improvement opportunities and requests action be taken on those priorities.
      - Information from data analysis including data from new or modified services is used to identify and implement changes that will improve performance and patient safety.
      - Improvement strategies are evaluated to confirm that they have resulted in improvement, and are tracked to ensure that improvements are sustained.
      - Additional actions are taken when the improvements do not achieve or sustain the desired outcomes.
      - Changes that will reduce the risk of sentinel events are identified and implemented.

4. Identifying and Managing Adverse or Unexpected Occurrences
   a. Processes for identifying and managing sentinel events are defined in the organization wide REPORTABLE ADVERSE EVENTS.

5. Proactive Risk Reduction Program
   a. Salinas Valley Memorial Hospital has dedicated a consistent effort to reduce potential harm to patients and prevent unanticipated adverse events by remaining proactive in approaches to performance improvement. Periodically, a systematic proactive evaluation method is completed on a process to evaluate and identify how it might fail and determine the relative impact a failure might have. This process assists to identify the key parts in a process that require change.

6. Priority Patient Population
   a. The priority patient populations are based on high-risk, high volume, high risk/low volume and/or problem prone areas with consideration of the incidence, prevalence and severity of problems in those areas which may affect patient outcomes, safety and quality of care.

7. Analysis of Staffing
    a. When undesirable patterns, trends or variations in performance related to the safety or quality of care are identified from data analysis or a single undesirable event, the adequacy of staffing (number, skill mix, competency), including nurse staffing is analyzed for possible cause. Additionally, processes related to work flow, competency assessment, credentialing, supervision of staff, orientation, training and education may also be analyzed.
    b. When analysis reveals a problem with the adequacy of staffing, the QSC is informed of the results of the analysis and actions taken to resolve the identified problem(s).

B. Plan Management

1. Performance/Process Improvement Model
    a. Salinas Valley Memorial Hospital utilizes a wide range of systematic and structured problem-solving approaches to plan, design, measure, assess and improve organizational performance/processes. Methodologies include Lean for Healthcare, F O C U S – P D C A and Rapid Cycle Improvement.

- F O C U S – P D C A.
  F – Find a process to improve.
  O – Organize a team that understands the process.
  C – Clarify how the current process works.
  U – Understand the causes of process variation, the "root cause".
  S – Select changes that will improve the process.

  P – Plan how the changes will be implemented.
  D – Do/implement the plan.
  C – Check the results of the improvement plan by collecting post-implementation data.
  A – Act on the findings of post-implementation data by standardizing the process or testing another change.
- Systems Redesign
  Utilizes concepts such as eliminating waste, process mapping, one piece flow; just in time, standardization, and workload leveling.
- Rapid Cycle Improvement / Kaizen
  When appropriate, the *rapid cycle improvement* process may be utilized. The advantages of the rapid cycle improvement process include:
    - Using a small sample to test a proposed change idea quickly.
    - Testing ideas side by side with existing processes.
    - Testing many ideas quickly.
    - Providing opportunities for failures without impacting performance.
    - Minimizing resistance to successful change.

2. Performance/Process Improvement Teams
    a. A performance/process improvement team is defined as a group of knowledgeable people, who are close to the process, that cooperate to achieve a common goal. Teams are composed of individuals with expertise in the process(es) that require(s) improvement.

3. Performance/Process Improvement Team Request
    a. A request for approval for a formal performance/process improvement team (PIT) may be presented to the Quality Interdisciplinary or Safety and Reliability Committee for consideration of a performance improvement team. PITs will be considered when interdisciplinary and/or interdepartmental processes require improvement that cannot be accomplished by an individual or by the individual department(s) or discipline(s). In order to prioritize and coordinate organizational improvement processes and resources, interdisciplinary / interdepartmental teams may be approved by the Quality and Safety Committee. NOTE: Individual departments may charter teams for the purpose of improving processes specific to their departments.

C. **Plan Responsibility**

1. Performance / Process Improvement Structure
    a. The Quality Oversite Structure outlines the quality and performance improvement structure and processes. A calendar for reporting is defined annually and changes made ongoing as the needs of the organization changes. The Quality Management Department, in collaboration with facility leaders, staff and medical staff, facilitates the implementation of the QAPI Program.
    b. Governing Board
        i. Responsibility for performance improvement rests with every employee of Salinas Valley Memorial Hospital. Overall responsibility rests with the Board of Directors. The Board of Directors requires review and evaluation of patient care activities to measure and improve the quality and efficiency of patient care and services in the organization. While maintaining overall responsibility, the Board delegates operational authority to the Medical Staff and Hospital Leadership. The MEC authorizes the establishment of an interdisciplinary Quality and Safety Committee to implement the QAPI Program.
        ii. In exercising its supervising responsibility, the Board:
            1) Reviews and approves the QAPI, Risk Management and Patient Safety Program Plans.

2) Reviews periodic reports on findings, actions, and results of program activities, including input from the populations served via results of patient experience data.
3) Reviews reports on the following: all system or process failures; the number and type of sentinel events; whether the patients and the families were informed of the event; results of analyses related to adequacy of staffing; all actions taken to improve safety, both proactively and in response to actual occurrences.
4) Assesses the QAPI, Risk Management and Patient Safety Programs' effectiveness and efficiency and required modification, as necessary.
5) Provides resources and support for performance improvement, change management, patient safety and risk management functions related to the quality and safety of patient care, including sufficient staff, access to information and training throughout the hospital.

c. Medical Executive Committee

i. The Medical Executive Committee (MEC) is accountable to the Board of Directors for the oversight of performance improvement activities to ensure that one level of care is rendered to all patients.
ii. The Medical Staff participates in developing measures to evaluate care systematically. Their participation may be in individual departments, medical staff committees, or on interdepartmental or interdisciplinary process/performance improvement teams.
iii. The medical staff departments review and evaluate the results of ongoing measures that include the medical staff review functions as well as risk management, patient safety, infection control, case management, and organizational planning.

d. Organizational Leaders

i. Set expectations for performance/process improvement.
ii. Develop plans for performance/process improvement.
iii. Manage processes to improve hospital performance.
iv. Review results from key financial indicators in order to ensure overall financial stability.
v. Monitor contracted services by establishing expectations for the performance of the contracted services.
vi. Participate in performance/process improvement activities when appropriate.
vii. Ensure participation from appropriate individuals in organization wide performance/process improvement activities.

viii. Ensure that new or modified processes or services incorporate the following:
   - Needs and/or expectations of patients, staff and others.
   - Results of performance improvement activities, when available.
   - Information about potential risk to patients, when available.
   - Current knowledge, when available and relevant.
   - Information about sentinel events, when available and relevant.
   - Testing and analysis to determine whether the proposed design or redesign is an improvement.
   - Collaboration with staff and appropriate stakeholders to design services.

ix. Ensure that an integrated patient safety program is implemented throughout the organization.

x. Establish and maintain operational linkages between risk management activities related to patient care and safety, and performance improvement activities.

xi. Ensure compliance with state and federal laws, and the Joint Commission regulations/standards.

e. <u>Support Service Departments/Department Directors</u>

i. The Department leaders are accountable to the Organizational Leaders, QSC and the Board of Directors for the quality of care/services and performance of their staff and departments. Departments participate in the systematic measurement and assessment of the quality of care/services they provide. The Department Directors:

ii. Promote the development of standards of care and measures to assess the quality of care/services rendered in their departments.

iii. Monitor the processes in their areas, which affect patient safety, care, outcomes and the patient's perception of care received.

iv. Promote the integration of their department's performance improvement activities with those of other support services and the Medical Staff through participation in performance improvement teams.

v. Report the results of applicable performance improvement activities in accordance with the established Quality Oversight Structure

D. Performance Measurement

1. The performance measurement process is one part of the evaluation of the effectiveness of the QAPI Program Plan. Performance measures have been established to measure important aspects of care. Leaders are responsible to

determine what measures will be evaluated at least every 2 year. These measures are updated / revised ongoing as compliance is sustained.

2. To ensure that the appropriate approach to planning processes of improvement; setting priorities for improvement; assessing performance systematically; implementing improvement activities on the basis of assessment; and maintaining achieved improvements, the organizational QAPI program is evaluated for effectiveness at least annually and revised as necessary.

3. Confidentiality
   a. All information related to performance improvement and patient safety activities performed by the Medical Staff or hospital personnel in accordance with this plan are confidential and protected under the Patient Safety Work Product and California Evidence Code 1157.
   b. Some information may be disseminated on a "need to know basis" as required by agencies such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proves a "need to know" as approved by the Medical Executive Committee, Organizational Leaders, and/or the Governing Body.
   c. HIPAA regulations will be followed.

E. **Orientation and Education**

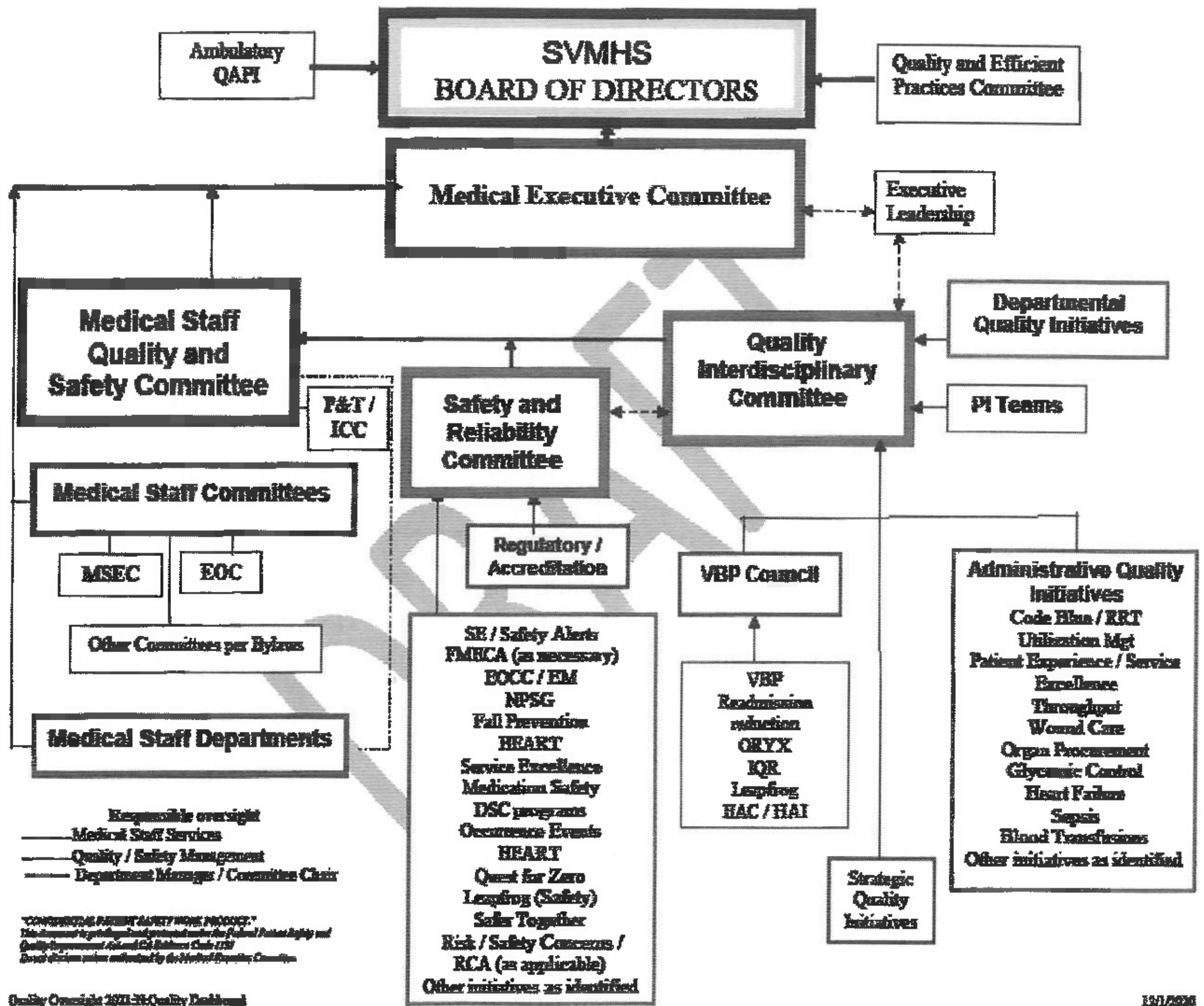
1. Orientation, education and/or training is provided on an as needed basis.

V. REFERENCES

A. The Joint Commission

B. Title 22 (CDPH)

C. CMS



Ambulatory QAPI
SVMHS
BOARD OF DIRECTORS
Quality and Efficient Practices Committee
Medical Executive Committee
Executive Leadership
Medical Staff Quality and Safety Committee
Departmental Quality Initiatives
Quality Interdisciplinary Committee
P&T / ICC
Safety and Reliability Committee
PI Teams
Medical Staff Committees
MSEC
EOC
Regulatory / Accreditation
VBP Council
Administrative Quality Initiatives
Code Blue / RRT
Utilization Mgt
Patient Experience / Service Excellence
Throughput
Wound Care
Organ Procurement
Glycemic Control
Heart Failure
Sepsis
Blood Transfusions
Other initiatives as identified
Other Committees per Bylaws
SE / Safety Alerts
FMECA (as necessary)
EOCC / EM
NPSG
Fall Prevention
HEART
Service Excellence
Medication Safety
DSC programs
Occurrence Events
HEART
Quest for Zero
Leapfrog (Safety)
Safer Together
Risk / Safety Concerns / RCA (as applicable)
Other initiatives as identified
VBP
Readmission reduction
ORYX
IQR
Leapfrog
HAC / HAI
Medical Staff Departments
Strategic Quality Initiatives
Responsible oversight
Medical Staff Services
Quality / Safety Management
Department Manager / Committee Chair

SAFETY MANAGEMENT PLAN
2021

in approval

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I. SCOPE:

A. The Safety Management Plan describes the programs used to manage a safety program to reduce the risk of injury for patients, staff and visitors for Salinas Valley Memorial Hospital and its licensed offsite locations are covered by this management plan). Safety risks may arise from the structure of the physical environment, from the performance of everyday tasks, or they are related to situations beyond the organization's control, such as the weather.

II. OBJECTIVES:

A. The Objectives for the Safety Management Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, Incident Reports and environmental tours.

III. DEFINITIONS:

A. EOC – Environment of Care

B. CEO – Chief Executive Officer

C. SVMH – Salinas Valley Memorial Hospital and its licensed off site locations

IV. RESPONSIBILITY:

A. The EOC Committee is responsible for monitoring all aspects of the Safety Program. The Environmental Health and Safety Manager advises the EOC Committee regarding safety issues.

V. PLAN MANAGEMENT:

A. **Fundamentals**

- The Safety Office will provide department leadership with information and training to assist them is the development of safe working conditions and safe work practices within their area of responsibility.
- Safe working conditions and practices are established by using knowledge of safety principles to educate staff, design appropriate work environments, purchase appropriate equipment and supplies, and monitor the implementation of the processes and policies.
- Safety is dynamic. Regular evaluation of the environment for work practices and hazards is required to maintain a current relevant safety program. The

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program will change as needed to respond to identified risks, hazards and regulatory compliance issues.

B. **Processes of the Managing Safety Risks**

- **Safety Risk Management**
The EOC Committee is designated to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. The EOC Committee ensures that compliance with applicable codes and regulations, as applied to the buildings and services are provided at SVMH.

- **Safety Management Plan**
The organization develops, maintains and on an annual basis, evaluates the effectiveness of the Safety Management Plan to effectively manage the safety risk of the staff, visitors, and patients at SVMH.

- **Safety Risk Assessment**
The EOC Committee manages the Safety risk assessment process for SVMH. The Committee is designated to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. The Committee ensures that compliance with applicable codes and regulations.

  SVMH identifies safety risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessment of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

  The risk assessment is used to evaluate the impact of the environment of care on the ability of the organization to perform clinical and business activities. The impact may include disruption of normal functions or injury to individuals. The assessment will evaluate the risk from a variety of functions, including structure of the environment, from the performance of everyday tasks, falls, exposures, MRI, Lasers, etc.

- **Use of Risk Assessment Results**
A risk assessment is used to evaluate the impact of the environment of care on the ability of the hospital to perform clinical and business activities. Where risks are identified, the current programs and processes to manage those risks are compared to the risks that have been identified. Where the identified risks are not appropriately handled, action must be taken to eliminate or minimize the risk. The actions may be creating new programs, processes, procedures, or training programs. Monitoring programs may be developed to ensure the risks have been controlled to achieve the lowest potential for adverse impact on the safety and security of patients, staff, and visitors.

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- **Maintaining Grounds & Equipment**
  The Facilities Management Department is responsible for maintaining the lawns, plantings, drives, walks, parking areas, building exterior and roofs, etc., of all properties covered by this management plan. An inspection of the grounds is conducted on an annual basis as part of the environmental tours program

  The Facilities Management Department is responsible for maintaining the equipment used for grounds, such as lawnmowers/tractors, chainsaws, etc. An inspection of this equipment will be conducted at least annually and a report forwarded to the Chief Engineer.

  The Environmental Health and Safety Manager provides assistance and recommendations to maintain the grounds and improve the safety of patients, staff and visitors.

- **Product Notices and Recalls**
  SVMH ensures responses to product recalls and/or notices for various types of products including, consumer products, medical and non-medical equipment, other equipment used to operate and maintain the facility by appropriate hospital representatives. The Materials Management Department manages the process by reviewing information from the Consumer Product Safety Commission (CPSC), ECRI, FDA, and other hospital. They also receive reports from manufacturers and vendors. This information is distributed to those departments identified as using or managing the products. They document the follow-up, and report the results to the EOC on a periodic basis. Critical recalls or alerts are brought to the attention of the Environmental Health and Safety Manager and Risk Manager upon receipt. The Environmental Health and Safety and Risk Manager will assist when needed to Assur effective response. For more information, see RECALL POLICY-HOSPITAL #1100

- **Managing risk in the MRI environment**
  The Radiation Safety Officer manages safety risks in the MRI environment associated with the following:
  - Patients who may experience claustrophobia, anxiety, or emotional distress
  - Patients who may require urgent or emergent medical care
  - Patients with metallic implants and devices, such as shrapnel
  - Ferrous objects entering the MRI environment
  - Acoustic noise

- **Taking actions to minimize risk for MRI services**
  The Radiation Safety Officer manages safety risks by doing the following:

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- Restricting access of everyone not trained or screened by MRI-trained staff scanner room and the area that immediately precedes the entrance to the MRI scanner room
- Making sure that this area is controlled by and under the direct supervision of MRI-trained staff
- Posting signage at the entrance to the MRI scanner room that conveys that potentially dangerous magnetic fields are present in the room. Signage should also indicate that the magnet is always on except in cases where the MRI unit, by design, can have its magnetic field routinely turned on and off by the operator.

- **Prohibit Smoking**
  SVMH has developed and enforces a facility wide SMOKING POLICY

- **No Smoking Enforcement**
  The hospital security team makes routine rounds of the building and grounds. They have standing orders to ensure the hospital remains a smoke-free environment.

- **Safe Interior Spaces**
  The EOC Committee manages the safety risk assessment process for SVMH and manages risk, coordinates risk reduction activities in the physical environment, collects deficiency information, and disseminates summaries of actions and results. The assessments of the facility safety inspections include, but limited to, lighting, furnishings and indoor air quality (including odors). The Committee ensures compliance with applicable codes and regulations.

  The organization designs, constructs, and maintains features of the environment to promote patient safety will providing diagnosis, treatment and care for the appropriate needs of the patients. To provide the appropriate environment, the organization conducts planning activities and inspections of the following items:
  - Interior spaces shall meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.
  - Lighting is suitable for care, treatment, and services.
  - Areas used by patients are clean and free of offensive odors.
  - Furnishing and equipment are maintained to be safe and in good repair.

  The Environmental Health and Safety Manager manages a process of environmental rounds designed insure a safe environment is provided. The tours evaluate staff knowledge and skills, observe current environmental and patient safety practices, and to evaluate environmental conditions. Findings of the environmental rounds are used as a resource for improving environmental and patient safety procedures and controls, updating orientation and education programs, and improving staff performance.

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The Environmental Health and Safety Manager analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.

- **Following Design and Construction Criteria**
  When planning for new, altered, or renovated space, the organization uses one of the following design criteria: -State rules and regulations, or Guidelines for Design and Construction of Health Care Facilities, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE)

- **Conducting a Preconstruction Risk Assessment (PRA)**
  When planning for demolition, construction, renovation, or general maintenance, the hospital conducts a Preconstruction Risk Assessment (PRA) of risks that may affect care, treatment, and services. The risk elements include:
  - Air quality requirements
  - Infection control
  - Utility requirements
  - Noise and vibration
  - Other hazards
  - Life safety

  The appropriate individuals conduct the risk assessment activities. SVMHtakes action based on its assessment to minimize risks during demolition, construction, or renovation. SVMH takes action based on its assessment to minimize risks during demolition, construction, renovation, or general maintenance. The status of the measures are inspected or monitored at the appropriate frequency to provide the adequate patient safety protection. Periodically, the project is re-evaluated and the measures implemented adjusted to meet the current conditions. Monitoring data is maintained

- **Conducting a Risk Assessment for Radiation Sources Before Installation**
  Prior to installation of computed tomography (CT), positron emission tomography (PET), or nuclear medicine (NM) services, a medical physicist or health physicist conducts a structural shielding design assessment to specify required radiation shielding. This includes installing new imaging equipment, replacing existing imaging equipment, or modifying rooms where ionizing radiation will be emitted or radioactive materials will be stored (such as scan rooms or hot labs). This requirement does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. See the National Council on Radiation Protection and Measurements Report No. 147 (NCRP-147). Guidance on shielding designs

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and radiation protection surveys. The date of the survey and results are documented

- **Conducting a Risk Assessment for Radiation Sources After Installation**
  After installation of computed tomography (CT), positron emission tomography (PET), or nuclear medicine (NM) services imaging equipment, or construction in rooms where ionizing radiation will be emitted or radioactive materials will be stored, a medical physicist or health physicist conducts a radiation protection survey to verify the adequacy of installed shielding. This survey is conducted prior to clinical use of the room. The date of the survey and results are documented

  This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

- **Orientation and Education**
  All new staff attend New Employee Orientation. New Employee Safety Orientation addresses key issues and objectives of various areas in the Environment of Care. In addition, all staff participates in periodic safety training. Staff members, licensed independent practitioners, students, and volunteers are instructed on the everyday precautions to minimize environmental safety risks via New Employee Safety Orientation, in-services, training, or other activities. During the environmental tours, unsafe practices are identified and the employee is advised of the proper procedures.

  Staff responsible for the maintenance, inspection, testing, and use of medical equipment, utility systems and equipment, fire safety systems and equipment, and safe handling of hazardous materials and waste are competent and receive continuing education and training.

- **Incident Reporting and Investigation**
  Injuries to patients or others within the hospital's facilities are reported to the Patient Safety Officer, the appropriate manager(s) and Risk Management Department when applicable. An incident reporting system is used. The supervisor will complete an Investigation Report. The Environmental Health and Safety Manager and Employee Health will participate in the investigation whenever appropriate. Corrective actions identified through the investigation will be communicated to appropriate departments and personnel.

  Occupational illness and injuries are reported to Employee Health Department. Department leadership will complete an Incident Investigation Report with the employee and report findings back to Employee Health Department. Appropriate departments and personnel are contacted for corrective actions needed.

in approval

Incidents of damage to the hospital property or the property of others are reported to the hospital security team and the Risk Management Department who will investigate the issue, complete a report and assess prevention options.

- **Evaluating the Management Plan**
  On an annual basis, the EOC Committee evaluate the scope, objectives, performance, and effectiveness of the Plan to manage the safety risks to the staff, visitors, and patients at SVMHS.

- **Identifying Opportunities to Resolve Environmental Issues**
  The EOC Committee evaluates activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates reports and data analysis to determine if there are needs for improvement or environmental issues to resolve. When a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

- **Taking action on Opportunities to Resolve Environmental Issues**
  The EOC Committee uses the results of data analysis and other information, including risk assessments, environmental rounds, incident analysis, regulatory changes, and other information, to identify opportunities to resolve safety issues. The organization, through the EOC Committee or other necessary resources, takes actions on the identified opportunities to resolve environmental safety issues.

  The Committee evaluates changes to determine if they resolved environmental safety issues and reports performance improvement results to those responsible for analyzing environment of care issues. The Committee provides reports when appropriate to senior leadership. Leaders collaborate to assure budget and staffing resources are available to support the environmental safety program. The Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objectives for improvement.

- **Performance Monitoring and Improvement**
  The performance measurement process is one part of the evaluation of the effectiveness of the Safety program. Performance measures are established to measure at least one important aspect of the Safety Management Plan and are meant to focus on areas that need improvement or affect the overall safety of patient, staff, or visitors.

in approval

VI. DOCUMENTATION:

A. N/A.

VII. EVIDENCE-BASED REFERENCE:

A. The Joint Commission standards; Environment of Care chapter

in approval

QUALITY AND EFFICIENT PRACTICES COMMITTEE

Minutes from the February 22, 2021 meeting of the Quality and Efficient Practices Committee will be distributed at the Board Meeting

(JUAN CABRERA)

FINANCE COMMITTEE

Minutes from the February 22, 2021 meeting of the Finance Committee will be distributed at the Board Meeting

(RICHARD TURNER)

THE PROPOSED RECOMMENDATION FOR BOARD APPROVAL OF BOARD RESOLUTION NO. 2021-01 DECLARING ITS INTENT TO REIMBURSE PROJECT EXPENDITURES FROM PROCEEDS OF INDEBTEDNESS WILL BE CONSIDERED UNDER AGENDA ITEM IX.

PERSONNEL, PENSION AND INVESTMENT COMMITTEE

Minutes from the February 23, 2021 meeting 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

(REGINA M. GAGE)

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

Salinas Valley Memorial Healthcare System

Board Paper: Personnel, Pension and Investment Committee

Consider Recommendation for Board Approval of (i) the Findings Supporting Recruitment of Adrian Jordan, MD, (ii) the Contract Terms for Dr. Jordan's Recruitment Agreement, and (iii) the Contract Terms for Dr. Jordan's Hospitalist Services Professional Services Agreement

Executive Sponsor: Allen Radner, MD, Chief Medical Officer
Stacey Callahan, Physician Services Coordinator

Date: February 11, 2021

Executive Summary

In 2017, Salinas Valley Memorial Healthcare System (SVMHS) transitioned the hospitalist program to operate under Salinas Valley Medical Clinic (SVMC) rather than under a third party. SVMHS Administration determined that staffing the program as part of SVMC would provide more effective operation of the program. Since this transition, the SVMC Hospitalist Program continues to focus on increasing patient satisfaction, referring community provider satisfaction, and improved retention of hospitalist physician staffing. As identified at the start of the program transition, the growth SVMHS has experienced in the adult daily census, the need to recruit and retain additional hospitalists to the program remains a priority. In addition, one of the current full-time hospitalists will be reducing to a part time schedule in March, thus emphasizing the need for another part-time hospitalist to provide care to the inpatient population.

The recommended physician, Dr. Adrian Jordan, received his Doctor of Medicine degree at National University of Ireland, Galway in 2011. He received training at Western Training Practice in General Practice in Ireland. Dr. Jordan will be graduating in June from the Family Medicine Residency Program at Natividad Medical Center. Dr. Jordan is excited to stay in in community and set down roots upon completion of his training. He plans to join SVMC in September as a part-time hospitalist.

Background/Situation/Rationale

The proposed physician recruitment requires the execution of two agreements:

(1) Professional Services Agreement which includes the following terms:

- Professional Services Agreement that provides W-2 relationship for IRS reporting.
- Two (2) year term
- Physician compensation for services of one hundred forty nine dollars and ninety six cents ($149.96) per hour for the hours of 7am-7pm, one hundred fifty nine dollars and ninety six cents ($159.96) per hour for the hours of 7pm-7am
    - Expectation of the eight (8) twelve (12) hour shifts per month and no less than ninety six (96) twelve (12) hour shift per year
    - Physicians that work Hospitalist shifts in excess of one hundred eighty (180) twelve (12) hour shifts per year, will be paid an additional seventy dollars ($70.00) per hour credited during each excess shift
- 0.5 Full-Time Equivalent (FTE)
- Eligible to participate in the Performance Incentive Program. Bonus payments are made at an interval aligned with the SVMHS fiscal year and carry eligibility requirement of at least one thousand (1,000) hours worked during the measurement period and a current PSA at time of payment in order to qualify
- Access to SVMHS Health Plan. Physician premium is projected based on 15% of SVMHS cost
- Access to SVMHS 403(b) and 457 retirement plans. 5% base contribution to 403b plan that vests after 3 years. Based on federal contribution limits this contribution is capped at fourteen thousand five hundred dollars ($14,500) annually
- One thousand dollars ($1,000) annual stipend for Continuing Medical Education (CME)
- The physician will receive an occurrence based professional liability policy through BETA Healthcare Group

(2) Recruitment Agreement that provides a recruitment incentive and does not exceed the value of twenty thousand dollars ($20,000.00)

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

The addition of Dr. Jordan to the SVMC Hospitalist program is aligned with SVMHS' strategic priorities for service, quality, finance and growth pillars. We continue to develop SVMC 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 opening up 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 compensation proposed in the agreement has been reviewed by HealthWorks, an independent valuation and compensation consulting firm, to confirm that the terms contemplated are both commercially reasonable and fair market value.

Recommendation

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

(i) The Findings Supporting Recruitment of Adrian Jordan, MD,

- **That the recruitment of a hospitalist to Salinas Valley Medical Clinic is in the best interest of the public health of the communities served by the district; and**
- **That the recruitment benefits and incentives the hospital proposes for this recruitment are necessary in order to attract an appropriately qualified physician to practice in the communities served by the District;**

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

(iii) The Contract Terms of the Hospitalist Services Professional Services Agreement for Dr. Jordan.

Attachments

(1) Curriculum Vitae for Adrian Jordan, MD

Curriculum Vitae

ADRIAN JORDAN

EDUCATION

Medical School	National University of Ireland, Galway (2005-2011)
Post-Graduate	Western Training Program in General Practice, Ireland (2013-2017)
	Natividad Family Medicine Residency (Expected Graduation June 2021)

LICENSURE

Current	California Postgraduate Training License*
Work Eligibility	Permanent Residency

**Board Certification in Family Medicine and California Physician and Surgeon License expected prior to graduation*

PROFESSIONAL EXPERIENCE

2018 – present	**Natividad Family Medicine Residency**
	30 weeks of inpatient medicine, 5 weeks ICU, 10 weeks night float
	Elective rotations in Hospitalist Procedures and Anesthesia
	Resident Chair of the Medical Student Committee
	Resident Daily Education Coordinator
2017 – 2018	**Locum General Practitioner, Ireland**
	Rural Primary Care Clinics, Spiddal and Kiltormer Medical Centers
2013 – 2017	**Senior Resident, Western Training Program in General Practice, Ireland**
	Including hospital medicine posts in Emergency Medicine (6 months), Nephrology (3 months), Care of the Elderly (3 months), Pediatrics (6 months)
2012 - 2013	**Senior Resident, Stroke Rehabilitation Unit**
	6 months at the Queen Alexandra Hospital, Portsmouth, UK
2011 - 2012	**Medical / Surgical Internship**

QUALIFICATIONS & RESEARCH

Medical School	MB BCh BAO, graduated with honors (2011)
Post-Graduate	Member of the Irish College of General Practitioners (2017)
Research	Antenatal Pertussis Vaccination (*Irish Medical Journal, 2017)*

COMMUNITY ADVOCACY COMMITTEE

Minutes from the February 23, 2021 meeting of the Community Advocacy Committee will be distributed at the Board Meeting

(REGINA M. GAGE)

RESOLUTION NO. ~~2018~~2021-01 OF
THE BOARD OF DIRECTORS OF
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

DECLARING ITS INTENT TO REIMBURSE PROJECT EXPENDITURES
FROM PROCEEDS OF INDEBTEDNESS

WHEREAS, Salinas Valley Memorial Healthcare System (~~"~~“District~~"~~”) is a public health care district organized and operated under Division 23 of the California Health and Safety Code;

WHEREAS, the District is authorized under the California Health and Safety Code ("Local Health Care District Law") to enter into agreements to finance construction and the purchase of equipment to be used for any District purpose;

WHEREAS, the District intends to finance (i) the construction of certain improvements and additions to its health care facilities, including its acute care facility and a parking garage annex and related improvements, and the purchase of certain equipment (including electronic medical records systems) for use at its health care facilities, including its acute care facility, expected to include an emergency generator, Taylor Farms Family Health &~~and~~ Wellness Center, and other capital expenditures in support of the ~~SVMHS~~District’s mission to support health care in the community it serves, (ii) such improvements, additions and equipment as are identified in the capital plan of the District as approved by the Board of Directors of the District (the ~~"~~“Board~~"~~”), as modified from time to time, and (iii) such other capital expenditures for strategic investment purposes identified from time to time as will enable the District to better serve the population in Monterey County;

WHEREAS, the District expects to pay for certain expenditures ("Reimbursement Expenditures") in connection with the projects described above (hereinafter collectively referred to as the "Project") prior to obtaining debt financing for the purpose of financing costs associated with the Project on a long term basis;

WHEREAS, the District reasonably expects that debt obligations in an amount not expected to exceed $~~300~~450 million will be used to reimburse the Reimbursement Expenditures;

WHEREAS, proceeds of such debt obligations will be allocated to Reimbursement Expenditures no later than 18 months after the later of (i) the date the cost is paid, or (ii) the date the Project (or each component thereof) is placed in service or abandoned (but in no event more than three years after the cost is paid);

WHEREAS, Section 1.150-2 of the Treasury Regulations requires the District to declare its official intent to reimburse prior expenditures for the project with proceeds of a subsequent borrowing; and

WHEREAS, it appears to the Board that the declaration of the District's intent to reimburse its prior payments of costs of the Project is desirable and in the best interests of the District;

NOW, THEREFORE, BE IT RESOLVED, ORDERED AND DIRECTED AS FOLLOWS:

1. Recitals. This Board finds and determines that all of the above recitals are true and correct.

2. Official Intent. The District hereby declares that the District reasonably expects to reimburse its expenditures on costs of the Project with proceeds of debt to be incurred by the District. The foregoing statement is a declaration of official intent that is made under and only for the purpose of establishing compliance with the requirements of Treasury Regulations section 1.150-2. This declaration of official intent does not bind the District to make any expenditure for Project costs or to incur any debt for Project costs or to proceed with the Project. This declaration of official intent supplements the declarations of official intent adopted by the Board on February 28, 2013 ~~and~~, June 24, 2015 and November 29, 2018.

3. This resolution shall take effect from and after its adoption.

This Resolution was adopted at a Regular Meeting of the Board of Directors of the District on ~~November 29~~February 25, ~~2018~~2021, by the following vote.

AYES:
NOES:
ABSTENTIONS:
ABSENT:

____
Board Member~~Secretary~~
Salinas Valley Memorial Healthcare System

~~4159-9685-8923.1~~4159-9685-8923.2

RESOLUTION NO. 2021-01
OF THE BOARD OF DIRECTORS OF
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

DECLARING ITS INTENT TO REIMBURSE PROJECT EXPENDITURES FROM PROCEEDS OF INDEBTEDNESS

WHEREAS, Salinas Valley Memorial Healthcare System ("District") is a public health care district organized and operated under Division 23 of the California Health and Safety Code;

WHEREAS, the District is authorized under the California Health and Safety Code ("Local Health Care District Law") to enter into agreements to finance construction and the purchase of equipment to be used for any District purpose;

WHEREAS, the District intends to finance (i) the construction of certain improvements and additions to its health care facilities, including its acute care facility and a parking garage annex and related improvements, and the purchase of certain equipment (including electronic medical records systems) for use at its health care facilities, including its acute care facility, expected to include an emergency generator, Taylor Farms Family Health & Wellness Center, and other capital expenditures in support of the District's mission to support health care in the community it serves, (ii) such improvements, additions and equipment as are identified in the capital plan of the District as approved by the Board of Directors of the District (the "Board"), as modified from time to time, and (iii) such other capital expenditures for strategic investment purposes identified from time to time as will enable the District to better serve the population in Monterey County;

WHEREAS, the District expects to pay for certain expenditures ("Reimbursement Expenditures") in connection with the projects described above (hereinafter collectively referred to as the "Project") prior to obtaining debt financing for the purpose of financing costs associated with the Project on a long term basis;

WHEREAS, the District reasonably expects that debt obligations in an amount not expected to exceed $450 million will be used to reimburse the Reimbursement Expenditures;

WHEREAS, proceeds of such debt obligations will be allocated to Reimbursement Expenditures no later than 18 months after the later of (i) the date the cost is paid, or (ii) the date the Project (or each component thereof) is placed in service or abandoned (but in no event more than three years after the cost is paid);

WHEREAS, Section 1.150-2 of the Treasury Regulations requires the District to declare its official intent to reimburse prior expenditures for the project with proceeds of a subsequent borrowing; and

WHEREAS, it appears to the Board that the declaration of the District's intent to reimburse its prior payments of costs of the Project is desirable and in the best interests of the District;

NOW, THEREFORE, BE IT RESOLVED, ORDERED AND DIRECTED AS FOLLOWS:

1. Recitals. This Board finds and determines that all of the above recitals are true and correct.

2. Official Intent. The District hereby declares that the District reasonably expects to reimburse its expenditures on costs of the Project with proceeds of debt to be incurred by the District. The foregoing statement is a declaration of official intent that is made under and only for the purpose of establishing compliance with the requirements of Treasury Regulations section 1.150-2. This declaration of official intent does not bind the District to make any expenditure for Project costs or to incur any debt for Project costs or to proceed with the Project. This declaration of official intent supplements the declarations of official intent adopted by the Board on February 28, 2013, June 24, 2015 and November 29, 2018.

3. This resolution shall take effect from and after its adoption.

This Resolution was adopted at a Regular Meeting of the Board of Directors of the District on February 25, 2021, by the following vote.

AYES:
NOES:
ABSTENTIONS:
ABSENT:

____

Board Member
Salinas Valley Memorial Healthcare System

Medical Executive Committee Summary
February 11, 2021

The following items from the meeting of the Medical Executive Committee (MEC) are presented to the Board of Directors and recommended for approval or as informational as indicated:

Items for Board Approval:

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Bargo, Lonnie, MD	Diagnostic Radiology	Surgery	Remote Radiology
Korya, Dani, MD	Neurology	Medicine	Tele-Neurology
Lattin, Grant, MD	Diagnostic Radiology	Surgery	Remote Radiology
Lucchesi, Archana, MD	Diagnostic Radiology	Surgery	Remote Radiology
Williams, Jason, MD	Neurology	Medicine	Tele-Neurology

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Abdoo, David, DPM	Podiatric Surgery	Surgery	Podiatry Category A & B
Castellanos, Edgar, MD	Family Medicine	Family Medicine	Family Medicine – Active Community
Khieu, William, MD	Ob/Gyn	Ob/Gyn	Obstetrics Gynecology
Kissell, Nicolas, MD	Endocrinology	Medicine	Endocrinology General Internal Medicine
Moshfeghi, Darius, MD	Ophthalmology	Surgery	Remote Pediatric Ophthalmology
Ramos, David, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Sepulveda, Michael, MD	Internal Medicine	Medicine	Hospitalist – Adult
Tardieu, Bert, MD	Orthopedic Surgery	Surgery	Orthopedic Surgery
Wong, Willard, MD	Orthopedic Surgery	Surgery	Orthopedic Surgery Orthopedic Spine Surgery
Yaeger, Carl, MD	Neonatology	Pediatrics	Neonatology
Zhao, Hong, MD	Hematology/ Oncology	Medicine	Hematology/ Oncology
Jani, Atul, MD	General Surgery	Surgery	General Surgery

Staff Status Modifications:

NAME	SPECIALTY	RECOMMENDATION
Lizcano, Jennifer, DO	Adult Hospitalist/ Internal Medicine	Advance to Active Status
Nguyen, Bich-Ha, MD	Adult Hospitalist/ Internal Medicine	Advance to Active Status
Arteaga, Vasthie, MD	Tele-Psychiatry	Resignation effective 12/27/20
Bahia, Surinder, MD	Adult Hospitalist/Family Medicine	Resignation effective 02/14/21

Other Items: ***(attached)***

ITEM	RECOMMENDATION
Department of Anesthesiology: Clinical Privileges Delineation reviewed with no recommended changes.	Recommend approval of the privilege form as presented.

Department of Medicine: Clinical Privileges Delineation Cardiac Diagnostic Outpatient Center reviewed with no recommended changes.	Recommend approval of the privilege form as presented.
Departments of Medicine and Surgery: Clinical Privileges Delineation Taylor Farms Family Health & Wellness Center – Additions and Revisions	Recommend approval of revisions that include the addition of core Gastroenterology as a new privilege and clarification of core privileges for other surgical specialties.
Department of Ob/Gyn: Clinical Privileges Delineation Ob Hospitalist and Ob/Gyn Forms – Revisions to Criteria	Recommend approval of the revision to initial and reappointment criteria with regard to C-Section activity requirements.

Interdisciplinary Practice Committee

Initial Appointment:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Ganzhorn, Susan, PA-C	Physician Assistant	Family Medicine	Taylor Farms Family Health & Wellness Center

Reappointment:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Allen, Kamron, PA-C	Physician Assistant	Surgery	Physician Assistant
Goodman, Dawn, NP	Nurse Practitioner	Medicine	Nurse Practitioner Outpatient Infusion Center
Markham, Morgan, PA-C	Physician Assistant	Surgery	Physician Assistant.

Staff Status Modifications:

NAME	SPECIALTY	RECOMMENDATION
Sakhi, Hajar, PA-C	Family Medicine at Taylor Farms Family Health & Wellness Clinic	Resignation effective 2/2/2021.

Other Items: ***(attached)***

ITEM	RECOMMENDATION
Clinical Privileges Delineation Form - Taylor Farms Family Health & Wellness Center Physician Assistant-Ambulatory Care	Recommend approval of proposed revisions to the Clinical Privileges/Delineation form (**now entitled Clinical Privileges/Practice Agreement Taylor Farms Family Health & Wellness Center**). In part, the recommended revisions are in response to the numerous changes to the California Physician Assistant Practice Act. The Act now **requires that a practice agreement** between a physician assistant and a physician/surgeon meet specified requirements.

Informational Items:

The following items were approved/accepted as appropriate:

I. Committee Reports:

a. Quality and Safety Committee
b. Medical Staff Excellence Committee

II. Other Reports:

a. Financial Performance Review – December 2020
b. Executive Update
c. Summary of Executive Operations Committee Meetings
d. Summary of Medical Staff Department/Committee Meetings
e. Annual Review of Radiology and Nuclear Medicine Job Descriptions
f. Review of Medical Director Contract Evaluations
g. Health Information Management Update
h. Medical Staff Treasury
i. Medical Staff Statistics

III. Order Sets:

BRS173 - Sacituzumab govitecan-hziy 10 mg/kg, Q21D (BRS173)

IV. Policies: The Emergency Medical Treatment And Active Labor Act (EMTALA)

V. Informational/Educational Items:

a. TJC Sentinel Event Alert 62 – *Voices from the Pandemic*
b. HCAHPS Update – February 5, 2021
c. SVMH Foundation Update – February 2021

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 to provide documentation of the number and types of hospital 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 anesthesiology 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; 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 of current ability to perform requested privileges; those physicians who have fewer than 150 patient contacts 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.

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	5 cases	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

Acknowledgment of practitioner

I have requested only those privileges for which by education, training, current experience, demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Memorial Healthcare System. 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):

Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated below.

☐ 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 Memorial Healthcare System - Department of Anesthesiology

Definition of 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. Initiation of Q Pump Relief System
9. Intravenous conscious sedation
10. 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
11. Management of common intraoperative problems
12. Management of common PACU problems
13. Management of acute perioperative pain
14. Management of fluid, electrolyte. and metabolic parameters
15. Management of hypovolemia from any cause
16. Management of malignant hyperthermia
17. Manipulation of body temperature
18. Manipulation of cardiovascular parameters
19. Obstetric anesthesia
20. Peripheral nerve block
21. Preoperative evaluation/anesthetic
22. Pulmonary artery catheter insertion and management consultation
23. Resuscitation of patients of all ages
24. Sedation/monitored anesthetic care
25. Sedation and analgesia
26. Single lung anesthesia

Applicant: Complete this section only if you wish to exclude specific core procedures listed above:
Please indicate any privilege on this list you would like to ***delete*** 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:

Clinical Privileges Delineation
Cardiac Diagnostic Outpatient Center (CDOC)
230 San Jose Street
Salinas, CA 93901

Applicant Name: ____

New applicants will be required to provide documentation of the number and type of cases performed/interpreted 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.

Eligibility Criteria for Privileges:

To be eligible to apply for imaging privileges the applicant must meet the following criteria:

Successful completion of an ACGME- or AOA- accredited post-graduate training program in Diagnostic Radiology or Cardiovascular Medicine.
And
Documentation of active Cardiology or Diagnostic Radiology practice in an accredited hospital or healthcare facility for at least two (2) years or demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship in cardiac imaging within the past two years.

Cardiac Imaging Privileges consist solely of the special procedures described on the attached page.

****

Proctoring Requirements:

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

Reappointment Criteria for Renewal Privileges:

To be eligible to apply for renewal of privileges the applicant must meet the following criteria:

Documentation of 200 cardiac imaging cases within the past two years.

Cardiac Imaging Special Procedures

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.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Diagnostic Cardiovascular And Peripheral Vascular Ultrasound	Current unrestricted Cardiology Privileges **AND** 200 peripheral vascular ultrasound cases in the past 24 months **AND** 15 hours of CME as required by ICAVL accreditation standards	1	Documentation of 200 vascular ultrasound cases in the past 24 months
				Myocardial Perfusion Imaging ***Interpretation And Supervision***	Certification in nuclear cardiology by the Certification Board of Nuclear Cardiology (CBNC) **OR** Board certification in cardiology and completion of a minimum of a 4 month training program in nuclear cardiology (1995 or later) **OR** Board certification in Nuclear Medicine **AND** Documentation of having read at least 30 cardiac nuclear studies over the past 24 months.	1	Documentation of having read at least 30 cardiac nuclear studies in the past 24 months

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Myocardial Perfusion Imaging ***Supervision Only***	Successful completion of an ACGME- or AOA-accredited post-graduate training program in cardiovascular medicine **Required Previous Experience:** Supervision of at least 30 nuclear myocardial perfusion studies during the past 12 months.	**N/A**	Documented supervision of at least 30 nuclear myocardial perfusion studies during the past 12 months

Salinas Valley Memorial Healthcare System-Cardiac Diagnostic Outpatient Center

Core Procedure List: 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

Cardiology Only:

1. Electrocardiogram (ECG) interpretation (formal interpretation requires panel membership)
2. Signal average ECG
3. Stress echocardiography (exercise and pharmacologic stress)
4. Treadmill stress testing without imaging
5. Transthoracic echocardiography
6. Trans-esophageal echocardiography

Radiology Only:

Limited to Diagnostic Cardiovascular Ultrasound

Applicant:

Please indicate any privilege on the Core Procedures list you would like to ***delete*** by writing it 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.

____ ___________________________________

____ ___________________________________

____ ___________________________________

Applicant 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 Memorial Healthcare System. 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

Taylor Farms Family Health & Wellness Center (TFFHWC)
Delineation of Ambulatory Procedural Privileges

Applicant Name: ______________________________________

Qualifications:

- Membership with unrestricted privileges at Salinas Valley Memorial Hospital in:
  - Cardiology
  - Endocrinology/Diabetes Care
  - Gastroenterology
  - General Surgery
  - Orthopedic Surgery
  - Obstetrics and Gynecology
  - Podiatry
- Evidence of current BLS Certification (at minimum)

Applicant Check Box to Request Privileges:

☐ **Cardiology Core Privileges:**
Assess, evaluate, diagnose, treat and provide consultation to adult patients (18 years or older) presenting to TFFHWC with diseases of the heart, lungs, and blood vessels and manage complex cardiac conditions such as heart attacks, and life-threatening, abnormal heartbeat rhythms.

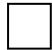
☐ **Endocrinology Core Privileges:**
Assess, evaluate, diagnose, treat and provide consultation to patients who present to TFFHWC with injuries, or disorders of the endocrine glands such as thyroid and adrenal glands, and metabolic and nutritional disorders, diabetes mellitus, calcium and bone disorders, pituitary diseases, and menstrual and sexual problems. Interpretation of immunoassays; and radionuclide, ultrasound, radiologic, and other imaging studies and basic laboratory techniques. Performance of fine needle aspiration of the thyroid.

☐ **Gastroenterology Core Privileges:**
Assess, evaluate, diagnose, treat and provide consultation to patients who present to TFFHWC with diseases, injuries, and disorders of the digestive organs including the stomach, bowels, liver and gallbladder, and related structures such as the esophagus, and pancreas ~~including the use of diagnostic and therapeutic procedures using endoscopes to see internal organs~~.

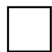
☐ **General Surgery Core Privileges:**
Assess, evaluate, diagnose, consult, and provide pre and post-operative care to patients of all ages ~~, except where specifically excluded from practice~~ who present to TFFHWC, to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Core privileges include wound care, ~~debridement at five levels: partial thickness; full thickness; subcutaneous tissue; subcutaneous tissue & muscle and subcutaneous tissue, muscle & bone;~~ biopsies, incision & drainage~~,~~ ~~biopsies and application of artificial skin equivalents~~ and such other procedures that are extensions of the same techniques and skills.

☐ **Orthopedic Surgery Core Privileges:**
Assess, evaluate, diagnose, provide consultation and care to patients of all ages~~, except as specifically excluded from practice~~ who present to TFFHWC, to correct or treat various conditions, illnesses and injuries of the extremities, spine, and associated structures by medical

and physical means including but not limited to congenital deformities, trauma, infections, tumors, metabolic disturbances of the musculoskeletal system, deformities, injuries, and degenerative diseases of the hands, feet, knee, hip, shoulder, and elbow including primary and secondary muscular problems and the effects of central or peripheral nervous system lesions of the musculoskeletal system. Core privileges include wound care, ~~debridement at five levels: partial thickness; full thickness; subcutaneous tissue; subcutaneous tissue & muscle and subcutaneous tissue, muscle & bone; incision & drainage,~~ biopsies ~~and application of artificial skin equivalents~~ and such ~~-~~other procedures that are extensions of the same techniques and skills.



Obstetrics/Gynecology Core Privileges:
Assess, evaluate, diagnose, treat and provide consultation to pregnant (≥12 week pregnancy) patients of all ages, who present to TFFHWC and provide medical care of the female reproductive system, including major medical diseases that are complicating factors in pregnancy.



Podiatry Core Privileges:
Assess, evaluate and treat patients of all ages ~~except as specifically excluded from practice,~~ who present to TFFHWC with podiatric problems/conditions of the digital, forefoot, and simple rearfoot to include all soft tissue and bony procedures involving the phalanges and metatarsal bones distal to the tarso-metatarsal joint; all soft tissue and bony procedures involving the cuneiform, navicular, and cuboid bones distal to the midtarsal joint. Core privileges include wound care, ~~debridement at five levels: partial thickness; full thickness; subcutaneous tissue; subcutaneous tissue & muscle and subcutaneous tissue, muscle & bone;~~ incision & drainage~~,~~ ~~biopsies and application of artificial skin equivalents~~ and such other procedures that are extensions of the same techniques and skills.

Core Proctoring Requirements:
Proctoring is waived for those applicants who have successfully completed the Provisional Staff proctoring requirements at SVMH.

Reappointment Criteria for Core Privileges:
Documentation of a minimum of 10 patient contacts per year at TFFHWC.

Practitioners who do not meet the criteria above and who cannot provide acceptable documentation of current competence from another facility, will not qualify to reapply.

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 Memorial Healthcare System. 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

Clinical Privileges Delineation
Obstetrical Hospitalist

Applicant Name: ____

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

- Successful completion of an ACGME or AOA accredited post-graduate training program in obstetrics and gynecology; and

- Documentation of at least 100 deliveries, including at least 20 C-Sections or 25 C-Section assists within the past 24 months **or** demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship within the past 24 months.

  And

- Current certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American College of Osteopathic Obstetrics and Gynecology.

  And

- Completion of an American College of Obstetricians and Gynecologists (ACOG) endorsed fetal monitoring strip interpretation course that includes NICHD nomenclature within three months of appointment

New applicants will be required to provide documentation of the number and types of their hospital 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.

Obstetrical Core privileges for the Obstetrical Hospitalist

Privileges to admit, evaluate, diagnose, treat, and provide consultation to female patients presenting in any condition or stage of pregnancy, including injuries and disorders of the reproductive system. Privileges include, but are not limited to, amniocentesis, amniotomy, incidental appendectomy, management of labor, obstetrical ultrasound, cerclage, vaginal deliveries and related procedures, trial of labor after cesarean section and related procedures, cesarean section and related procedures, all other procedures related to normal and complicated delivery, emergent Cesarean Hysterectomy, surgical treatment of post-partum complications, i.e. post-partum hemorrhage and management of high-risk pregnancies including major medical diseases that are complicating factors in pregnancy, perform and interpret nitrazine tests.

Gynecology Core privileges for the Obstetrical Hospitalist

Privileges include admission, evaluation, diagnosis, and consultation on female patients of all ages presenting with illness, injuries, and disorders of the gynecological or genitourinary system and illness and injuries of the mammary glands.

Reappointment Criteria for Core Privileges:

- Applicant must provide evidence of current ability to perform requested privileges, at a minimum this shall include documentation of 25 deliveries; 10 of which must be C-Sections or 25 C-Section assists.

  And

- Participation in the annual assessment of EFM (electronic fetal monitoring) principles (assessed at the time of reappointment)

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.

Special Proctoring Requirements for deliveries:
A minimum of 3 proctored deliveries.
In the event an unscheduled C-Section is performed, that case shall be retrospectively reviewed and a proctoring form completed.

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.
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	1	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases

Salinas Valley Memorial Healthcare System – OB HOSPITALIST

Core Procedure List: The core privileges in this specialty include the procedures on the attached procedure 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. Amnio infusion
2. Amniotomy
3. Amniocentesis, 3rd trimester
4. Induction of labor
5. Application of internal fetal and uterine monitors
6. Augmentation and induction of labor by use of Oxytocin
7. Caesarean hysterectomy
8. Caesarean section
9. Cervical biopsy or conization of cervix in pregnancy
10. D&C for abortion, less than 14 weeks
11. D&C for termination of pregnancy (greater than 14 weeks) – D&E
12. External cephalic version
13. Hypogastric artery ligation
14. I&D of Bartholin cyst or perineal abscess
15. Manual removal of placenta
16. Obstetrical ultrasound (limited)
17. Operations for Sterilization (tubal ligation) – Postpartum Sterilization
18. Operative vaginal delivery
    (including forceps, vacuum extraction, breech extraction)
19. Postpartum D&C
20. Pudendal and paracervical blocks
21. Repair of fourth-degree perineal lacerations
22. Repair of cervical, vaginal or vulvar lacerations

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

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.

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Applicant 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 Memorial Healthcare System. 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 Memorial Healthcare System

Clinical Privileges Delineation
Obstetrics & Gynecology

Applicant Name: ______________________________________

Scope: Obstetrics & Gynecology, Gynecologic Oncology, Reproductive Endocrinology and Maternal Fetal Medicine: New applicants for all privileges will be required to provide documentation of the number and types of hospital cases within 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.

Physicians involved in the evaluation and management of cancer patients must be either Board Certified. in the process of becoming board certified; or demonstrate ongoing cancer-related education by documenting 12 CME hours annually.

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

Initial Appointment:

• Current certification or board eligibility in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology.

And

• Documentation of at least 100 deliveries, including at least 20 C-Sections or 25 C-Section assists, in the past 24 months or demonstrate successful participation in a hospital-affiliated formalized residency or special clinical fellowship within the past 24 months.

And

- Completion of an American College of Obstetricians and Gynecologists (ACOG) endorsed fetal monitoring strip interpretation course that includes NICHD nomenclature within three months of appointment

Reappointment Criteria for Core Obstetrical Privileges:

- Applicant must provide reasonable evidence of current ability to perform requested privileges, at a minimum this shall include documentation of 25 deliveries; 10 of which must be C-Sections or C-Section assists.

And

- Participation in the annual assessment of EFM (electronic fetal monitoring) principles (assessed at the time of reappointment).

Obstetrics Core Privileges (*check box if requested*)

☐ **Requested**

Admit, evaluate, diagnose, treat and provide consultation to pregnant (≥12 week pregnancy) patients of all ages, and/or provide medical and surgical care of the female reproductive system, including major medical diseases that are complicating factors in pregnancy. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

<u>GYNECOLOGY</u>: To be eligible to apply for core privileges in gynecology, the applicant must meet the following qualifications:

Initial Appointment:

• Current certification or board eligibility in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology.

And

• Documentation of at least 50 gynecological surgical procedures in the past 24 months or demonstrate successful participation in a hospital-affiliated formalized residency or special clinical fellowship within the past 24 months.

Reappointment Criteria for Core Gynecologic Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges, at a minimum this shall include documentation of 25 gynecologic procedures; 10 of which must be major procedures.

Gynecology Core privileges (*check box if requested*)

☐ **Requested**

Admit, evaluate, diagnose, treat and provide consultation to pregnant (≤12 week pregnancy) patients of all ages; pre-, intra- and post-operative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the female reproductive system and the genitourinary system and nonsurgically treat disorders and injuries of the mammary glands. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

GYNECOLOGIC ONCOLOGY: To be eligible to apply for core privileges in gynecologic oncology, the applicant must meet the following qualifications:

Initial Appointment:

• As for gynecology plus, current certification or board eligibility in gynecologic oncology by the American Board of Obstetrics and Gynecology or Special Qualifications in gynecologic oncology by the American Osteopathic Board of Obstetrics and Gynecology or alternative specialty training. The alternative specialty training for physicians without completion of an accredited fellowship program in gynecologic oncology must be evaluated on a case-by-case basis, looking specifically at the physician's relevant postgraduate continuing medical education and recent gynecologic oncological surgery experience.

And

• Documentation of the performance of at least 25 gynecologic oncology procedures within the past 24 months.

And

• Physicians involved in the evaluation and management of cancer patients must be either Board Certified, in the process of becoming board certified; or demonstrate ongoing cancer-related education by documenting 12 CME hours annually.

Reappointment Criteria for Core Gynecologic Oncology Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges, at a minimum this shall include documentation of 25 gynecologic oncology procedures.

<u>Special Requirements:</u>

Physicians involved in the evaluation and management of cancer patients must be either Board Certified, in the process of becoming Board certified; or demonstrated ongoing cancer-related education by documenting earning 12 CME hours annually.

Gynecologic Oncology Core privileges *(check box if requested)*

☐ **Requested**

Includes all core privileges for Gynecology plus, admit, evaluate, diagnose, treat, provide consultation and surgical and therapeutic treatment to female patients with gynecologic cancer and complications resulting therefrom, including carcinomas of the cervix, ovary and fallopian tubes, uterus, vulva, pelvis, and vagina. Also included within this core set of privileges are microsurgery, chemotherapy, radical hysterectomy, vulvectomy, pelvic exenteration and staging by lymphadenectomy, and the performance of procedures on the bowel, liver, ureters, omentum, bladder, and other abdominal structures as indicated. 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.

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

Initial Appointment:

•To be eligible to apply for privileges in female pelvic medicine and reconstructive surgery, the applicant must meet the following criteria:

•The same as for obstetrics and gynecology

And

•Successful completion of an ABOG-approved fellowship in female pelvic medicine and reconstructive surgery/urogynecology or AOA–approved fellowship in female pelvic medicine and reconstructive surgery within the past 12 months

•***Required current experience:*** At least 10 female pelvic medicine and reconstructive surgical procedures, reflective of the scope of privileges requested, within the past 24 months.

Reappointment Criteria:

Applicant must provide reasonable evidence of current ability to perform requested privileges, at a minimum this shall include documentation of 6 successful Urogynecology procedures.

Urogynecology Core privileges: *(check box if requested)*

☐ **Requested**

Includes all core privileges for Gynecology plus, admit, evaluate, diagnose, treat, and provide consultation and the pre-, intra-, and postoperative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the genitourinary system. Includes diagnosis and management of genitourinary and rectovaginal fistulae, urethral diverticula, injuries to the genitourinary tract, congenital anomalies (excluding the kidney and/or bladder), infectious and noninfectious irritative conditions of the lower urinary tract and pelvic floor, and the management of genitourinary complications of spinal cord injuries. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills.

MATERNAL FETAL MEDICINE: To be eligible to apply for core privileges in maternal and fetal medicine, the applicant must meet the following qualifications:

Initial Appointment:

- As for obstetrics plus, current certification or board eligibility in maternal-fetal medicine by the American Board of Obstetrics and gynecology or Special Qualifications in maternal-fetal medicine by the American Osteopathic Board of Obstetrics and Gynecology or alternative specialty pathway.The alternative specialty training for physicians without completion of an accredited fellowship program in maternal-fetal medicine must be evaluated on a case-by-case basis, looking specifically at the physician's relevant postgraduate continuing medical education and recent maternal-fetal medicine experience

And

Applicants must demonstrate that they provided MFM inpatient or consultative services for at least 50 patients in the past 12 months.

Reappointment Criteria for Core Maternal Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges, at a minimum this shall include documentation of 25 maternal fetal medicine inpatient consultations.

Maternal-Fetal Medicine Core Privileges*(check box if requested)*

☐ **Requested**

Admit, evaluate, diagnose, treat and provide consultation to female patients with medical and surgical complications of pregnancy such as maternal cardiac, pulmonary, metabolic, connective tissue disorders, and fetal malformations, conditions, or disease. 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: 2nd trimester amniocentesis, level 2 & 3 obstetrical ultrasound, chorionic villus sampling, and transvaginal and intraabdominal cerclage placement.

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. At least one laparoscopic procedure must be proctored as part of core requirements.

OBSTETRICAL PROCTORING REQUIREMENTS FOR DELIVERIES

A minimum of 3 proctored deliveries ~~2 of which must be C Sections if C Section privileges are requested (remaining delivery may be demonstrated by vaginal delivery or C Section.)~~

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.
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	1	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases within the past 24 months

ADVANCED LAPAROSCOPY CRITERIA:
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Laparoscopic Burch Procedure	Unrestricted "Operative laparoscopy" privileges **AND** Residency training in the advanced privilege requested <u>or</u> an approved, recognized hands-on course in the advanced procedure when such a course exists **AND** Privileges in the same procedure by laparotomy. Applicant much submit documentation of having assisted on or performed at least four (4) cases within the past 24 months for each procedure requested.	1 case proctored by a staff member with unrestricted laparoscopic burch privileges.	Documentation of successful performance of at least four (4) cases within the past 24 months
				Laparoscopic Lymph Node Biopsy or Excision	Unrestricted "Operative laparoscopy" privileges **AND** Residency training in the advanced privilege requested <u>or</u> an approved, recognized hands-on course in the advanced procedure when such a course exists **AND** Privileges in the same procedure by laparotomy. Applicant much submit documentation of having assisted on or performed at least four (4) cases within the past 24 months for each procedure requested.	1 case proctored by a staff member with unrestricted laparoscopic lymph node biopsy or excision privileges.	Documentation of successful performance of at least four (4) cases within the past 24 months
				Laparoscopic Urethropexy – repair pelvic floor defects	Unrestricted "Operative laparoscopy" privileges **AND** Residency training in the advanced privilege requested <u>or</u> an approved, recognized hands-on course in the advanced procedure when such a course exists **AND** Privileges in the same procedure by laparotomy. Applicant much submit documentation of having assisted on or performed at least four (4) cases within the past 24 months for each procedure requested.	1 case proctored by a staff member with unrestricted laparoscopic urethropexy privileges.	Documentation of successful performance of at least four (4) cases within the past 24 months

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Laparoscopic Uterosacral Nerve Excision or Ablation	Unrestricted "Operative laparoscopy" privileges **AND** Residency training in the advanced privilege requested or an approved, recognized hands-on course in the advanced procedure when such a course exists **AND** Privileges in the same procedure by laparotomy. Applicant much submit documentation of having assisted on or performed at least four (4) cases in the past 2 years for each procedure requested.	1 case proctored by a staff member with unrestricted laparoscopic uterosacral nerve excision or ablation privileges.	Documentation of successful performance of at least four (4) cases within the past 24 months
				Laparoscopic ~~Hysterectomy~~ Or Supracervical[k1] Hysterectomy	Unrestricted "Operative laparoscopy" privileges **AND** Residency training in the advanced privilege requested or an approved, recognized hands-on course in the advanced procedure when such a course exists **AND** Privileges in the same procedure by laparotomy. Applicant much submit documentation of having assisted on or performed at least four (4) cases within the past 24 months for each procedure requested.	1 case proctored by a staff member with unrestricted laparoscopic hysterectomy privileges.	Documentation of successful performance of at least four (4) cases within the past 24 months
				Operation for treatment of urinary stress incontinence; vaginal approach, retropubic urethral suspension, sling procedure **AND** Urethrovesical sling placement **AND** Paravaginal repair using mesh	**Minimum formal training**: The applicant must be able to demonstrate successful completion of an Accreditation Council for Graduate Medical Education (ACGME)/American Osteopathic Association (AOA)-accredited obstetrics and gynecology residency training program, which included reconstructive pelvic surgery training or an approved, recognized hands-on course, in the advanced procedure when such a course exists.	N/A	A total of five (5) reconstructive pelvic surgery procedures within the past 24 moths

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Interstim Sacral Nerve Stimulation	The applicant must be able to demonstrate 1. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) / AOA Accredited training program in FPMRS (Female Pelvic Medicine & Reconstructive Surgery) that included training in SNS **OR** 2. Completion of ACGME or AOA accredited residency in OB/GYN or urology and Completion of a training course in InterStim Therapy **AND** Demonstrate that they have performed at least six (6) InterStim Therapy simulator tests and implant procedures within the past 12 months	1 case	Documentation of successful performance of at least six (6) cases within the past 24 months
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	N/A	Current California State X-Ray S&O Fluoroscopy Certification

Salinas Valley Memorial Healthcare System

Core Procedure List: The core privileges in this specialty include the procedures on the attached procedure 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, Vice President of Medical Affairs and/or the Chief of Staff.

Obstetrics

1. Amnio infusion
2. Amniotomy
3. Amniocentesis, 3rd trimester
4. Induction of labor
5. Application of internal fetal and uterine monitors
6. Augmentation and induction of labor by use of Oxytocin
7. Caesarean hysterectomy
8. Caesarean section
9. Cervical biopsy or conization of cervix in pregnancy
10. D&C for abortion, less than 14 weeks
11. D&C for termination of pregnancy (greater than 14 weeks) – D&E
12. External cephalic version
13. Hypogastric artery ligation
14. Manual removal of placenta
15. Obstetrical ultrasound (limited)
16. Operative vaginal delivery (including forceps, vacuum extraction, breech extraction)
17. Postpartum D&C
18. Pudendal and paracervical blocks
19. Q-Pump Pain Relief System
20. Repair of fourth-degree perineal lacerations
21. Repair of cervical, vaginal or vulvar lacerations

Gynecology *(Procedures marked with an asterisk [*] are considered "major" procedures)*

1. *Adnexal surgery(including ovarian cystectomy, oophorectomy, salpingectomy, and conservative procedures for treatment of ectopic pregnancy)
2. *Anterior and posterior colporrhaphy and perineorrhaphy
3. ***Basic Operative laparoscopy:**
    a. Diagnostic Laparoscopy
    b. Tubal Sterilization
    c. Management of ectopic pregnancy
    d. Simple ovarian cysts
    e. Adhesiolysis
    f. Excision of and/or fulguration of endometriosis
    g. Oophorectomy and/or salpingectomy
    h. Laser pelviscopic laparoscopy
    i. Non-laser pelviscopic laparoscopy
4. *Burch, retropubic bladder neck suspension, laparotomy
5. Cervical biopsy
6. *Closure or repair of enterocele
7. *Colpoceleisis
8. *Colpoplasty
9. Colposcopy
10. Cystoscopy as part of gynecological procedure
11. D&C
12. Diagnostic laparoscopy

13. Endometrial ablation
14. *Exploratory laparotomy for pelvic disorders
15. *Hysterectomy, abdominal or vaginal
16. Hysteroscopy
17. I&D of bartholin cyst or perineal abscess
18. *I&D of pelvic abscess
19. Incidental appendectomy
20. Laparoscopic Assisted Vaginal Hysterectomy (LAVH)
21. Marsupialization of bartholin cyst
22. *Metroplasty
23. *Myomectomy
24. Operations for sterilization (tubal ligation)
25. Q-Pump Pain Relief System
26. *Repair of rectocele, enterocele, cystocele, or pelvic prolapse (to include sphincteroplasty)
27. *Sacrospinous fixation
28. *Transabdominal or vaginal paravaginal repair
29. Treatment/Management of ectopic pregnancy
30. Umbilical hernia repair
31. *Uterosacral vaginal vault fixation
32. *Vaginal hysterectomy
33. *Vaginal vault suspension
34. *Vesicovaginal fistula, rectovaginal fistula repair
35. Vulvar biopsy
36. Vulvectomy, simple

Gynecologic Oncology:

Gynecology

1. Adnexal surgery(including ovarian cystectomy, oophorectomy, salpingectomy, and conservative procedures for
2. treatment of ectopic pregnancy)
3. Cervical biopsy
4. Chemotherpy for gyn malignancies; Central venous vascular and intraperitoneal access port insertion
5. Colpoceleisis
6. Colpoplasty
7. Colposcopy
8. Cystoscopy as part of gynecological procedure
9. D&C
10. Diagnostic laparoscopy
11. Exploratory laparotomy for pelvic disorders
12. Endometrial ablation
13. Gynecologic ultrasound
14. Hysterectomy, abdominal or vaginal
15. Hysteroscopy
16. I&D of bartholin cyst or perineal abscess
17. I&D of pelvic abscess
18. Incidental appendectomy
19. Marsupialization of bartholin cyst
20. Minor gynecological surgical procedures
21. (endometrial biopsy, dilation and curettage, treatment of Bartholin cystand abscess)
22. Metroplasty
23. Myomectomy
24. Operations for sterilization (tubal ligation)
25. Percutaneous feeding
26. Q-Pump Pain Relief System
27. Urethrovesical sling placement

Oncology

1. Microsurgery
2. Myocutaneous flaps, skin grafting
3. Para aortic and pelvic lymph node dissection
4. Pelvic exenteration
5. Q-Pump Pain Relief System
6. Radical hysterectomy, vulvectomy and staging by lymphadenectomy
7. Radical surgery for treatment of gynecological malignancy (to include procedures on bowel, ureter, bladder, as indicated)
8. Treatment of invasive carcinoma of the vagina by radical vaginectomy (and other related surgery)
9. Treatment of invasive carcinoma of vulva by radical vulvectomy (with groin dissection)
10. Treatment of malignant disease with chemotherapy (to include gestational trophoblastic disease)
11. Uterine/vaginal isotope implants

Urogynecology: Female pelvic medicine and reconstructive surgery:

Continence procedures for genuine stress incontinence

1. Synthetic mid-urethral slings
2. Periurethral bulk injections (e.g., polytef, collagen, fat)
3. Long-needle procedures (e.g., Pereyra, Raz, Stamey, Gittes, Muzsnai)
4. Vaginal urethropexy (e.g., bladder neck placation, vaginal paravaginal defect repair)
5. Retropubic urethropex (e.g., Marshall-Marchetti-Krantz, Burch, and paravaginal defect repair)
6. Sling procedures (e.g., fascia lata, rectus fascia, heterologous materials, vaginal wall)

Continence procedures for overflow incontinence due to anatomic obstruction following continence surgery

1. Cutting of one or more suspending sutures
2. Retropubic urethrolysis with or without repeat bladder neck suspension
3. Revision, removal, or release of a suburethral sling

Other surgical procedures for treating urinary incontinence

1. Sacral nerve stimulator implantation
2. Urethral closure and suprapubic cystotomy
3. Cystoscopic botox injection

Pelvic floor dysfunction and genital prolapse procedures

1. Abdominal or Laparoscopic (closure or repair of enterocele, transabdominal sacrocolpopexy, paravaginal repair, uterosacral ligament suspension)
2. Vaginal (transvaginal hysterectomy with or without colporrhaphy, anterior and posterior colporrhaphy and perineorrhaphy, paravaginal repair, Manchester operation, enterocele repair, vagina vault suspension, colpocleisis, retrorectal levator plasty and postanal repair)
3. Placement of transvaginal mesh for prolapse
4. Sacrocolpopexy (laparoscopic or open)
5. Anal incontinence procedures:
    a. Anal sphincteroplasty
    b. Sacral nerve stimulator implantation

Diagnostic Procedures and other

1. Ureteral stenting
2. Retrograde pyelogram
3. Closure of cystotomy (vaginal, laparoscopic or open), or urethrotomy
4. Urethral diverticulectomy
5. Surgical repair of rectovaginal and genitourinary fistulas

Treatment of pelvic and bladder pain

1. Cystoscopy with:
   a. Biopsy
   b. Intravesical botox injection
   c. Hydrodistention
   d. Fulguration or ijection of lesion
2. Vaginal mesh excision
3. Injection of botox into muscles of pelvic floor
4. Performance and interpretation of diagnostic tests for urinary incontinence and lower urinary tract dysfunction, fecal incontinence, and pelvic organ prolapse

Maternal Fetal Medicine

Management of high-risk pregnancy inclusive of such conditions as preeclampsia, post-datism, third trimester bleeding, intrauterine growth retardation, premature rupture of membranes, premature labor, and multiple gestation

Management of patients with/without medical surgical or obstetrical complications for normal labor, including mild toxemia, threatened abortion, normal puerperal patient, normal antepartum and postpartum care, postpartum complications, and fetal demise

Treatment of medical complications of pregnancy, including pregnancy-induced hypertension, chronic hypertension, diabetes mellitus, renal disease, coagulopathies, cardiac disease, anemias and hemoglobinopathies, thyroid disease, sexually transmitted disease, pulmonary disease, thromboembolic disorders, infectious diseases.

Procedures:

Amniocentesis
Targeted obstetric ultrasound

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.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Applicant 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 Memorial Healthcare System. 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

Clinical Privileges ~~Delineation Form~~/Practice Agreement
Taylor Farms Family Health & Wellness Center
Physician Assistant-Ambulatory Care

Applicant Name: ____

To be eligible to apply for core privileges as a Physician Assistant (PA), the applicant must meet the following qualifications:

- Minimum formal training: Applicants must be able to demonstrate successful completion of a PA program accredited by the ARC-PA or its predecessors.
- In addition, the PA applicant must meet the following requirements:
  - Successful completion of the national certifying examination given by the NCCPA
  - Possession of a current unrestricted California PA license
  - Possession of adequate professional liability insurance
  - Possession of current BLS certification at minimum
  - Documentation of adequate physical and mental health to exercise the privileges requested
  - Employment or agreement with a physician who is a member of the SVMHS Medical Staff with privileges at Taylor Farms Family Health & Wellness Center who is in good standing with unrestricted privileges appropriate to the supervision of a PA
    - According to a written agreement, the physician must assume responsibility for supervision or monitoring of the PA's practice as stated in the appropriate medical staff policy governing PA's, be continuously available or provide an alternate to provide consultation when requested and to intervene when necessary
    - assume total responsibility for the care of any patient when requested by the PA or required by this policy or in the interest of patient care
- Required previous experience: Documentation of training and experience of requested practice prerogatives and 200 patient care activities for the PA providing services for patients for the preceding two (2) years.

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.

Physician Assistant Core Privileges *(Core privileges are defined starting on page 5~~6~~)*

Core Proctoring Requirements:
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:
Applicants must be able to document continued NCCPA certification and inpatient services for at least 50 patients annually over the reappointment cycle.

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 Taylor Farms Family Health & Wellness Center, and I 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.

_______________________________________ _______________________
(Physician Assistant's Signature) Date

_______________________________________ _______________________
Supervising Physician's Endorsement Date

Physician Assistant

Delegated Services Agreement and Clinical Practice Functions Supervising Physician Endorsement - Addendum

Core List of Supervising Physicians

This list of supervising physicians represents the core group of physicians with whom I will be working and is not all inclusive.

*Supervising Physician's Endorsement Name DateSpecialty

*Supervising Physician's Endorsement Name DateSpecialty

*Supervising Physician's Endorsement Name DateSpecialty

*Supervising Physician's Endorsement Name DateSpecialty

*Supervising Physician's Endorsement Name DateSpecialty

*Supervising Physician's Endorsement Name DateSpecialty

*Supervising Physician's Endorsement Name SpecialtyDate

*Supervising Physician's Endorsement Name SpecialtyDate

*Supervising Physician's Endorsement Name SpecialtyDate

*Supervising Physician's Endorsement Name SpecialtyDate

*****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 Memorial Healthcare System-Tayler Farms Family Health & Wellness Center

Physician Assistant Core Procedure/Condition List for Ambulatory Care: The following procedures/conditions are considered to be included in the core privileges for this specialty. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Supervising Physician, Department Chair, Chief Medical Officer and/or the Chief of Staff. PAs may assess, diagnose, monitor, promote health and protection from disease, and manage patients within the age group of their supervising physician. ~~PAs may not admit patients to the hospital.~~ General core privileges include the procedures on the following procedure list and such other procedures that are extensions of the same techniques and skills. Core privileges for PAs include:

1. Perform history and physical examination
2. Dictate history and physical examination results
3. Develop and implement patient management plans, record progress notes, and provide continuity of care
4. Perform/interpret laboratory, radiologic, cardiographic, and other diagnostic procedures used to identify pathophysiologic processes
5. Order therapies, using procedures reviewed and approved by the supervising physician
6. Write orders for treatments and tests consistent with the scope of practice of the PA and the supervising physician
7. Cleanse and debride wounds and suture lacerations and remove sutures and staples
8. Perform debridement and general care for superficial wounds and minor superficial surgical procedures
9. Apply, remove, and change dressings and bandages
10. Perform incision and drainage of superficial abscesses
11. Perform routine immunizations
12. Perform venipuncture
13. Perform electrocardiogram tracing
14. Counsel and instruct patients, families, and caregivers as appropriate
15. Administer local anesthetic
16. Initiate appropriate referrals
17. Write orders for medications and treatments tests consistent with the scope of practice of the PA and the supervising physician
    - Each supervising physician who delegates the authority to issue a drug order to a physician assistant shall first prepare a written formulary.
    - Each formulary will be reviewed and approved by the relevant Department prior to being presented to IDPC/MEC/Board for approval.
    - Under direction of a supervising physician, the physician assistant (PA) may dispense to a patient a properly labeled prescription medication prepackaged by a physician, a manufacturer (as defined by pharmacy law) or pharmacist.
    - PA's may not administer, provide or transmit a prescription for controlled substances in Schedules II through V of the Bureau of Narcotic Enforcement without a patient-specific order from the supervising physician.
    - All physician assistants who are authorized to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA) and maintain a valid registration.
18. **Treat a Patient with Worker's Comp Injury/Illness:** May provide medical treatment of a work-related injury within their scope of practice. The treating physician is to make the determination of temporary disability and sign the Doctor's First Report of Occupational Injury or Illness report. A physician assistant may authorize the patient to receive time off from work for a period not to exceed three calendar days and may co-sign the report.

EXTENDED CLOSED SESSION
(if necessary)

(VICTOR REY, JR.)

ADJOURNMENT – THE NEXT REGULAR MEETING OF THE BOARD OF DIRECTORS IS SCHEDULED FOR THURSDAY, MARCH 25, 2021, AT 3:00 P.M.