January 18, 2024

TO: Legal Counsel

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

The next regular meeting of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **THURSDAY, JANUARY 25, 2024, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA** or via **TELECONFERENCE** (*visit* **SalinasValleyHealth.com/virtualboardmeeting** *for Access Information*).

Allen Radner, MD
Interim President/Chief Executive Officer

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

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

THURSDAY, JANUARY 25, 2024, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C
SALINAS VALLEY HEALTH MEDICAL CENTER
450 E. ROMIE LANE, SALINAS, CALIFORNIA
or via TELECONFERENCE

(Visit salinasvalleyhealth.com/virtualboardmeeting for Access Information)

AGENDA

Presented By

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

2. CLOSED SESSION *(See Attached Closed Session Sheet Information)* — *Victor Rey, Jr.*

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION — *Victor Rey, Jr.*
(Estimated time 4:30 pm)

4. PUBLIC COMMENT — *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.

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

- Salinas Valley Health Mobile Clinic Milestones

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

7. CONSENT AGENDA - GENERAL BUSINESS — *Victor Rey, Jr.*
(Board Member may pull an item from the Consent Agenda for discussion.)

A. Minutes of September 28, 2023, Regular Meeting of the Board of Directors
B. Minutes of December 14, 2023, Regular Meeting of the Board of Directors
C. Financial Report
D. Statistical Report
E. Policies Requiring Approval
   1. Blood Borne Pathogen Exposure Guidelines
   2. Capital Equipment
   3. Capitalization of Interest Cost
   4. College of American Pathologists Terms of Accreditation
   5. Disclosure of Unanticipated Outcomes
   6. Disinfection of Instruments/Scopes
   7. Education and Staff Development
   8. Emergency Management for Mass Casualty Incidents (MCI)
   9. Fan Use / Cleaning
   10. Hand Hygiene
   11. Isolation - Standard and Transmission Based Precautions
   12. Latex Allergy-Surgery

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13. Leave of Absence
14. Outbreak Investigation
15. Paid Time Off (PTO) - Non-Affiliated Employees
16. Respiratory Care Point of Care Testing (RC POCT) Lab Arterial Blood Gas Quality Management Plan
17. Reprocessing Single Use Devices
18. Scope of Service: Employee Health
19. Scope of Service: Nursing Administration

F. Board Member Compensation and Expenditure Reimbursement Policy (2024 Update)

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

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE — *Catherine Carson*

Minutes of the January 15, 2024 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair.

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

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

1. Consider Recommendation for Board Approval of (i) The Findings Supporting Recruitment of Najwa Bahu-Baugh, MD, (ii) The Contract Terms for Dr. Bahu-Baugh's Recruitment Agreement, and (iii) The Contract Terms for Dr. Bahu-Baugh's Internal Medicine Professional Services Agreement

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

C. FINANCE COMMITTEE — *Joel Hernandez Laguna*

Minutes of the January 22, 2024 Finance Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

D. TRANSFORMATION, STRATEGIC PLANNING AND GOVERNANCE COMMITTEE — *Victor Rey, Jr.*

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

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

A. Reports
   1. Credentials Committee Report
   2. Interdisciplinary Practice Committee Report

B. Policies/Procedures/Plans:
   1. Cardiovascular Nursing Standardized Procedure
   2. Vaginal Bleeding Nursing Standardized Procedure

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

10. EXTENDED CLOSED SESSION *(if necessary)* *Victor Rey, Jr.*

11. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION *Victor Rey, Jr.*

12. ADJOURNMENT *Victor Rey, Jr.*

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, February 22, 2023, at 4:00 p.m.**

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

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

SALINAS VALLEY HEALTH BOARD OF DIRECTORS

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

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

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

Case name unspecified: (Specify whether disclosure would jeopardize service of process or existing settlement negotiations): _____

PUBLIC EMPLOYEE APPOINTMENT
(Government Code §54957)

Title: (Specify description of position to be filled): President/Chief Executive Officer

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

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

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

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 from Quality and Efficient Practices
    - Report of the Medical Staff Quality and Safety Committee- from December, 2023
    - Report of the Medical Staff Quality and Safety Committee- from January, 2024
    - Consent Agenda:
      Quality and Safety Committee Reports: December 2023
        - Palliative Care
        - Risk Management Reports
        - Environment of Care Committee Reports
        - Accreditation and Regulatory Full Report
        - TJC National Patient Safety Goals: Safety of Clinical Alarms

      Quality and Safety Committee Reports: January 2024
        - Emergency Department
        - Outpatient Infusion Center and Wound Healing Center
        - Diagnostic Imaging/ Mammography

- Case Management
- Health Information Management
- Pharmacy and Therapeutics Committee Report

2. Medical Executive Committee

   - Report of the Medical Staff Credentials Committee (With Comments)
   - Report of the Medical Staff Interdisciplinary Practice Committee (With Comments)

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

(VICTOR REY, JR.)

PUBLIC COMMENT

AWARDS AND RECOGNITION

(VERBAL)

(RADNER)

BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
SEPTEMBER 28, 2023

Committee Members Present:
In-person: President Victor Rey, Jr., Juan Cabrera, Rolando Cabrera MD., and Catherine Carson
Via Teleconference: None
Absent: Vice-President Joel Hernandez Laguna
Also Present:
Pete Delgado, President/Chief Executive Officer
Rakesh Singh, MD., Chief of Staff
Matthew Ottone, Esq., District Legal Counsel
Julian Lorenzana, Board Clerk
Juan Cabrera joined the meeting at approximately 3:45 p.m.

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Rey called the meeting to order at 3:36 p.m. in the Downing Resource Center, Rooms A, B, and C.

1.1 PROPOSED ADDITIONS TO THE AGENDA

A request was made to add one Open Session item *Request for Ratification: Substantive Financial Elements of Collective Bargaining Agreement between Salinas Valley Health Medical Center (SVHMC) and Engineers and Scientists of California, Local 20 (ESC)* and two Closed Session items (1) *Conference with Labor Negotiator – Engineers and Scientists of California, Local 20 (ESC)* and (2) *Conference with Legal Counsel – Anticipated Litigation – One Case* to the agenda under the Trade Secrets Safe Harbor, related to matters that were unknown at the time of the original posting of the agenda for the Committee.

MOTION:

Upon motion by Board member R. Cabrera and second by Board member Carson, citing the need to add a Closed Session to the attention of the Board Meeting subsequent to the Board agenda being posted, the Board of Directors approved adding one Open Session item *Request for Ratification: Substantive Financial Elements of Collective Bargaining Agreement between Salinas Valley Health Medical Center (SVHMC) and Engineers and Scientists of California, Local 20 (ESC)* and two Closed Session items (1) *Conference with Labor Negotiator – Engineers and Scientists of California, Local 20 (ESC)* and (2) *Conference with Legal Counsel – Anticipated Litigation – One Case*

Public Comment
No Public Comment

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

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

Motion Carried

2. CLOSED SESSION

President Rey announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Hearings and Reports, , (2) Reports Involving Trade Secret, (3) Conference with Real Property Negotiators, (4) Conference with Legal Counsel-Anticipated Litigation.* The meeting recessed into Closed Session under the Closed Session Protocol at 3:41 p.m. The Board completed its business of the Closed Session at 5:10 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 5:28 p.m. President Rey reported that in Closed Session, the Board discussed *(1) Hearings and Reports, (2) Public Employee Performance Evaluation– President/CEO, (3) Reports Involving Trade Secret, (4) Conference with Real Property Negotiators, (5) Conference with Legal Counsel-Anticipated Litigation.* No action was taken.

4. REPORT FROM THE PRESIDENT/CHIEF EXECUTIVE OFFICER

Mr. Delgado announced, "*The* Mission of Salinas Valley Memorial Healthcare System is to provide quality healthcare for our patients and to improve the health and well-being of our community," and our Vision is "A community where good health grows with every action, in every place, for every person."

The following Mission Moment video was presented: "Spinal Fusion at Salinas Valley Health" featuring the experience of patient Carl Breton who had a lumbar decompression surgery.

Avrie Calabro, RN, SNII, OPS and Arnold Failano, MSN, MBA, RN, CNML, Clinical Manager of the Perioperative Clinical Practice Council reviewed current projects including outpatient surgery relocation; perioperative Hospital Acquired Pressure Injury (HAPI) prevention; enhancing patient experience; annual competency; bladder management with cath lab; and the standardized workflow for Diagnostic Imagining (DI) patients receiving anesthesia. The four initiatives this year are improving the pre-admission testing and surgery cancellation processes, family communication/messaging using Tiger Connect and patient warming.

Mr. Delgado presented a summary of how the District is meeting each of its foundational pillars Service, Quality, Growth, Finance, People, and Community.

Public Comment:
No public comment

4.1. REQUEST FOR RATIFICATION: SUBSTANTIVE FINANCIAL ELEMENTS OF COLLECTIVE BARGAINING AGREEMENT BETWEEN SALINAS VALLEY HEALTH MEDICAL CENTER (SVHMC) AND ENGINEERS AND SCIENTISTS OF CALIFORNIA, LOCAL 20 (ESC)

MOTION:

Upon motion by Board member R. Cabrera and second by Board member J. Cabrera, the Board of Directors ratifies substantive financial elements of Collective Bargaining Agreement Between Salinas Valley Health Medical Center (SVHMC) and Engineers and Scientists of California, Local 20 (ESC

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

Motion Carried

4.2 PUBLIC COMMENT
No public comment

5. BOARD MEMBER COMMENTS

President Victor Rey: none
Director Rolando Cabrera, MD: none
Director Juan Cabrera: none
Director Catherine Carson: none

6. CONSENT AGENDA – GENERAL BUSINESS

A. Minutes of August 24, 2023, Regular Meeting of the Board of Directors
B. Financial Report
C. Statistical Report

PUBLIC COMMENT:
No public comment

MOTION:
Upon motion by Director R. Cabrera, second by Director J. Cabrera, the Board of Directors approved the Consent Agenda, Items (A) through (C), as presented.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, and Rey
Noes: None;
Abstentions: None;
Absent: Rey

Motion Carried

7. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Catherine Carson regarding the Quality and Efficient Practices Committee. The committee received an update from the Peri-Operative Clinical Practice Council. The team is working to improve the pre-admission testing and the surgery cancellation processes, the family update process using Tiger Connect and patient warming

B. FINANCE COMMITTEE

A report was received from Director Cabrera regarding the Finance Committee. The following recommendation was made:

1. ***Consider Recommendation for Board Approval of the preliminary project budget for the Medical Center Campus Colorization Project.***

PUBLIC COMMENT:
No public comment.

MOTION:
Upon motion by Director R. Cabrera and second by Director Carson, the Board of Directors approves the total estimated project budget for the Medical Center Campus Colorization Project in the preliminary budgeted amount of $3,500,000.

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

Motion Carried

C. PERSONNEL, PENSION, AND INVESTMENT COMMITTEE

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

1. ***Consider Recommendation for Board Approval of the Amendment to the Salinas Valley Memorial Healthcare System 403(b) Retirement Plan ("403b plan")***

PUBLIC COMMENT:
No public comment

MOTION:
Upon motion by Director R. Cabrera, second by Director J. Cabrera, the Board of Directors approved the Amendment to the Salinas Valley Memorial Healthcare System 403(b) Retirement Plan ("403b plan").

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

Motion Carried

2. ***Consider recommendation for Board approval of:***
   a. ***The findings supporting recruitment of Nima Beheshti, DO.;***
   b. ***The contract terms for Dr. Beheshti's Recruitment Agreement, and;***
   c. ***The contract terms for Dr. Beheshti's Neurology Professional Services Agreement***

PUBLIC COMMENT:
No public comment

MOTION:
Upon motion by Director R. Cabrera, second by Director Carson, the Board of Directors approved the findings supporting recruitment, the Recruitment Agreement and the Neurology Professional Service Agreement for Nicholas Klimberg, MD.

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

Motion Carried

3. ***Consider recommendation for Board approval of:***
   a. ***The findings supporting recruitment of Gurvinder Kaur, MD.***
   b. ***The contract terms for Dr. Beheshti's Recruitment Agreement, and;***
   c. ***The contract terms for Dr. Beheshti's Neurosurgery Professional Services Agreement***

PUBLIC COMMENT:
No public comment

MOTION:
Upon motion by Director R. Cabrera, second by Director Carson, the Board of Directors approved the findings supporting recruitment, the Recruitment Agreement and the Neurology Professional Service Agreement for Gurvinder Kaur, MD.

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

Motion Carried

D. CORPORATE COMPLIANCE AND AUDIT COMMITTEE

A report was received from Director Juan Cabrera regarding the Corporate Compliance and Audit Committee. The Committee received verbal report from Lori Oelkers, Director of Internal Audit & Compliance who reviewed the elements of an effective compliance program, the process for anonymous reporting and explained all issues are tracked and monitored until appropriate corrective action is taken and the matter is resolved.

REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON SEPTEMBER 14, 2023, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING

Theodore Kaczmar, Jr., MD, Chief of Staff reviewed the reports of the Medical Executive Committee (MEC) meeting of October 12, 2023, and Rules and Regulations revision. A full report was provided in the Board packet.

Recommend Board Approval of the Following:

A. Reports
   1. Credentials Committee Report
   2. Interdisciplinary Practice Committee Report
B. Policies, Plans and Privilege Forms:

1. Chest Pain Standardized Procedure – Revised
2. Intraosseous Infusion Standardized Procedure Nursing Standardized Procedure – Revised
3. Vaginal Bleeding Standardized Procedure – Revised
4. Surgical Wound Classification System – Revised
5. Antibiotic Stewardship Policy – Revised
6. Medication Error Reduction Plan (MERP) - Revised

PUBLIC COMMENT:
No public comment

MOTION:
Upon motion by Director R. Cabrera, second by Director J. Cabrera, the Board of Directors approves the Medical Executive Committee Credentials Committee Report, the Interdisciplinary Practice Committee Report, and the Policies, Plans and Privilege Forms as presented.

ROLL CALL VOTE:

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

Motion Carried

8. EXTENDED CLOSED SESSION

Vice-President Hernandez Laguna announced item to be discussed in Extended Closed Session is *Public Employee Appointment - Chief Executive Officer.* The meeting recessed into Closed Session under the Closed Session Protocol at 6:30p.m. The Board completed its business of the Closed Session at 7:05 p.m.

Juan Cabrera left the meeting at 6:50 p.m.

9. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, October 26 at 4:00 p.m.** There being no further business, the meeting was adjourned at 7:06 p.m.

_____
Rolando Cabrera, MD
Secretary, Board of Directors

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM[1]
ANNUAL MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
DECEMBER 14, 2023

Board Members Present:
In-person: President Victor Rey, Jr., Vice-President Joel Hernandez Laguna, Juan Cabrera, and Rolando Cabrera MD.
Via Teleconference: None
Absent: None

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

Juan Cabrera arrived at 4:16 p.m.

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Victor Rey, Jr., called the meeting to order at 4:04 p.m. in the Downing Resource Center, Rooms A, B, and C.

2. CLOSED SESSION

President Rey announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Report Involving Trade Secret, strategic planning/proposed new programs and services, (2) Hearings and Reports, and (3) Public Employment: President/Chief Executive Officer*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:04 p.m. The Board completed its business of the Closed Session at 4:17 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:30 p.m. President Rey reported that in Closed Session, the Board discussed *(1) Hearings and Reports*. The Board received and accepted the reports listed on the Closed Session agenda.

President Rey announced there is a need for an extended closed session. The item to be discussed in Extended Closed Session will be (1) *Report Involving Trade Secret, strategic planning/proposed new programs and services, and (2) Public Employment: President/Chief Executive Officer.*

4. PUBLIC COMMENT

Kathy Vasco. Spoke in Spanish regarding access to healthcare. She asserts that there is a disconnect with hospital policy and the community.

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

Interim President/CEO Radner commented that issues of affordability are incredibly important.

5. BOARD OF DIRECTORS AWARDS AND RECOGNITION

Karina Rusk and Tiffany DiTullio were introduced. Salinas Valley Health was a sponsor of the 2023 Relay for Life of the Salinas Valley. Agnes Lalata, Director/MedSurg, and her team led the Hope Warriors Team, under the Salinas Valley Health umbrella. Nancy Valdez, American Cancer Society, Mark Kennedy Relay for Life Chair and Julie Laughton were available to recognize the Hope Warriors as the #3 top fundraiser (out of 87 teams). This year Relay for Life of Salinas Valley ranked #1 – top relay – in the state of California. Salinas Valley Health for their support with Relay for Life.

President Rey congratulated Team Hope Warriors.

6. ANNUAL BOARD OF DIRECTORS REPORT

President Rey presented the Overall Performance of Salinas Valley Memorial Health for 2023 as follows:

Looking back on all that we accomplished this past year, I am very proud to be part of a team that has never stopped answering the call – a team that knows challenges are a part of life. A team that consistently rises to embrace change with optimism. A year is but twelve months, and we have achieved a lot during that time. Most importantly, we have persevered for the benefit of our patients, our staff and our community.

In celebrating our 70th anniversary, we paid tribute to our legacy of leadership while moving toward a bright future with the launch of our new brand Salinas Valley Health.

We honored the achievements of Pete Delgado, a CEO who dedicated ten-plus years of his life to our healthcare system and to improving public health in Monterey County.

And we were fortunate to have Allen Radner, MD – a longtime leader at Salinas Valley Health and within the medical community – step forward to provide solid and capable leadership that will ensure our organization's continued advancement during this time of transition.

Recent success following months of bargaining with Anthem Blue Cross resulted in an agreement that supports valuable patient care options while aligning reimbursement rates with improved health outcomes.

We are proactively building a sustainable future as we – like thousands of medical centers nationwide – face financial challenges related to the pandemic, rising labor and supply costs and reimbursement shortfalls. Economic conditions are challenging across the board, yet with careful stewardship, including the help of Guidehouse, one of the world's leading management consulting firms, we aim to grow our margins and continue our robust investment in our people, technology and infrastructure.

The opening of our new parking garage brought the welcome addition of 250 parking spaces to our campus. It provides a renewable source of clean energy, expanded charging stations for electric vehicles and water-wise landscaping including milkweed to attract the Monarch butterflies that so many of us enjoy.

November's unveiling at Hartnell College of the Center for Nursing and Health Sciences in Partnership with Salinas Valley Health represents a significant step forward in increasing education, training and employment opportunities for our future healthcare leaders.

A full house attended our second Schwartz Rounds® session yesterday. The forums are a new component of our Care for the Caregiver program. They focus on the importance of the human side of healing by providing a structured outlet for the feelings that come with the challenges of patient care.

More than 300 board-certified physicians work across a broad spectrum of specialties, providing state-of-the-art care close to home for patients at every stage of life. Their expertise is matched only by their compassion. Our nurses are a driving force of innovation, regularly implementing care delivery improvements.

Salinas Valley Health Clinics continue to grow in their scope of service. Thanks to the dedication of a wide range of talented professionals, the payer-blind clinic network has increased from 21,000 patient visits in 2014 to 550,000 today.

Other significant Salinas Valley Health achievements include:

- Becoming one of the first medical centers nationwide to perform a revolutionary procedure to treat people suffering debilitating pain from blocked arteries in the leg.
- Helping NICU babies with respiratory challenges breathe easier with a new, minimally-invasive intervention that was rolled out in September.
- Supporting nurses new to emergency department care with the Emergency Nurse Residency Program.
- Achieving a ninth straight ranking of an "A" letter grade for patient safety from the Leapfrog Group and four-stars from Medicare for overall rating as well as patient survey ratings.
- Earning recognition from U.S. News & World Report, the global authority in hospital ranking, as a 2023-2024 High Performing Hospital for Maternity Care.
- Opening our Retail Pharmacy to public in December, offering convenience and personalized service in a welcoming environment.
- Our Mobile Clinic, which has provided free medical service to nearly 15,000 patients, added an extra aspect of care this year with home delivery of fresh fruits and vegetables to patients in the Fresh Produce Prescription Program.
- We supported our cancer community by raising more than $33,000 through staff-led volunteer efforts and donations for the 2023 Relay for Life.
- Blue Zones Project Monterey County continued its forward trajectory, expanding engagement with events held countywide and the number of businesses, restaurants, school sites and other organizations receiving project approval now totaling nearly 190.
- Aspire Health and Blue Zones Project Monterey County recently launched the Double Up Food Bucks program through which CalFresh shoppers can receive a 50% discount on California grown-produce.
- Staff with military service now receive special badges recognizing their Veteran status, sparking an immediate connection with patients who share that common bond.
- Events bringing attention to concerns that unite us as a community included the Rose River Memorial honoring lives impacted by more than 800 COVID deaths in Monterey County; our inaugural Overdose Awareness Day observance drawing attention to a growing crisis; and the establishment of an Honor Walk paying tribute to organ donors for their life-saving gifts.
- Our Foundation continues to deliver an extra dimension of care for our patients and staff. Programs like Small Business, Big Impact, Monthly Miracle Makers, Employee Giving and others are making a significant difference.

- The Service League celebrated its 71st anniversary this year and remains the largest single contributor to the Foundation, having donated more than $3.4 million.

As the current board president, I am deeply honored to help lead such an extraordinary team. While Salinas Valley Health is recognized regularly for high levels of medical services, quality patient care and top-ranked safety, it is our heart for those we serve that makes us stand out amongst other medical centers. We are fortunate to have a relatively low staff turnover rate, with many individuals working here for decades or being part of multi-generational families employed at our healthcare system. Indeed, our staff is one of our greatest assets, if not the greatest.

On behalf of this board, our administration and everyone who relies on our healthcare system, I extend my deep appreciation for the exemplary work of our Salinas Valley Health team. Their motivation and compassion are directly responsible for our ongoing ability to help our community rise in good health.

7. BOARD MEMBER COMMENTS

Vice President Joel Hernandez Laguna: Vice President Hernandez Laguna reported he represented Salinas Valley Health in a City of Gonzalez meeting. He would like to offer a tour of Salinas Valley Health for this group. Salinas Valley Health sponsored the snow at the Closter Park event last weekend. Kudos to finance team, Augustine and his team, for Anthem negotiation.

Director Rolando Cabrera, MD: No comment

Director Catherine Carson: Director Carson appreciated annual report; it was very well done and she would like a copy

Director Juan Cabrera: Dr. Cabrera thinks the Team is doing good work. In listening to our public comment speaker, it is true we are community mostly Spanish speaking community and applications should be in both English and Spanish to help ensure services.

President Victor Rey, Jr.: President Rey also attended Christmas in Closter Park. He was asked to make a check presentation for Salinas Valley Health sponsoring the snow. It was an honor to represent Salinas Valley Health; the community showed their appreciation. Additionally, recently two people told him stories of their loved ones who came to our hospital with strokes. Neither knows he is on the board and they both reported they received outstanding care for their fathers and the family.

8. CONSENT AGENDA – GENERAL BUSINESS

A. Minutes of November 16, 2023, Regular Meeting of the Board of Directors
B. Financial Report
C. Statistical Report
D. Policies Requiring Approval
    1. Chargemaster Available to the Public Payer's Bill of Rights AB 1627
    2. Financial Assistance Program/Full Charity Care and Discount Partial Charity Care
    3. Infant Driven Feeding Protocol
    4. Information Technology Acquisition
    5. Intraosseous Infusion Nursing Standardized Procedure
    6. Neonate Gavage Feeding
    7. Percutaneous Ventricular Assist Device Implantation (Clinical)
    8. Scope of Service-Critical Care
    9. Visitors

- Questions to Board President/Staff

- Public Comment
- Board Discussion/Deliberation
- Motion/Second
- Action by Board/Roll Call Vote

PUBLIC COMMENT:
None

BOARD MEMBER DISCUSSION: Lisa CNO, was thanked for the infant driven feeding protocol. The Scope of Service CC is excellent; it is a very good example. The Visitor policy is excellent; will serve hospital well. Joel will work with Lisa on some inconsistent language.

MOTION:

Upon motion by Director Dr. Cabrera second by Director J. Cabrera the Board of Directors approved the Consent Agenda, Items (A) through (D), as presented.

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

Motion Carried

9. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. FINANCE COMMITTEE

Director Hernandez Laguna reported there is background information supporting the proposed recommendations made by the Committee was included in the Board packet.

The Committee made the following recommendations:

1. Consider Recommendation for Board Approval of AMN Healthcare Solution Service Justification and Contract Renewal Award

COMMENTS FROM THE BOARD: None

MOTION:

Upon motion by Director Dr. Cabrera, and seconded by Director Carson, the Finance Committee recommends the Board of Directors consider approval of AMN Healthcare Solutions contract renewal justification and contract award in the estimated amount of $1,822,285, over the five-year term.

PUBLIC COMMENT:
None.

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

Motion Carried

2. Consider Recommendation for Board Approval of Lease Agreement Terms for 225 East Romie Lane, Salinas, CA Between SVMHS and Hilltop Family Medical Group, Inc.

COMMENTS FROM THE BOARD: Further discussion with staff clarified this propertery was previously used by Dr. Sonia Rodriguez for her practice. Her patients will be encorporated into Salinas Valley Health Medical Clinic and this location is being consider for a dermatology clinic.

MOTION:

Upon motion by Director Dr. Cabrera, and seconded by Director Carson, the Board of Directors approved the Lease Agreement Terms for 225 East Romie Lane, Salinas, CA Between SVMHS and Hilltop Family Medical Group, Inc., pending final review by District Legal Counsel.

PUBLIC COMMENT:
None.

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

Motion Carried

B. PERSONNEL, PENSION, AND INVESTMENT COMMITTEE

The Personnel, Pension and Investment Committee was cancelled. It was clarified that any Committee Meeting can be cancelled up until the time of the meeting but the Cancellation Notice must be posted; which is was.

C. CORPORATE COMPLIANCE COMMITTEE

Director Juan Cabrera, reported background information supporting the proposed recommendations made by the Committee was included in the Board packet.

1. Consider Recommendation for Board of Directors Approval of the Years Ended June 30, 2023 and 2022 Draft Audited Financial Statements for Salinas Valley Memorial Healthcare System. Consider Recommendation for Board of Directors Approval of the Year Ended June 30, 2023 Draft Single Audit Report for Salinas Valley Memorial Healthcare System.

COMMENTS FROM THE BOARD: None

MOTION:

Upon motion by Director Dr. Cabrera, and seconded by Director Hernandez Laguna, the Board of Directors approved the Years Ended June 30, 2023 and 2022 Draft Audited Financial Statements for Salinas Valley Memorial Healthcare System. Consider Recommendation for Board of Directors Approval of the Year Ended June 30, 2023 Draft Single Audit Report for Salinas Valley Memorial Healthcare System.

PUBLIC COMMENT:
None.

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

Motion Carried

2. Consider Recommendation for Board of Directors Approval of the Years Ended December 31, 2022 and 2021 Draft Audited Financial Statements for the Salinas Valley Memorial Healthcare District Employee's Pension Plan.

COMMENTS FROM THE BOARD: It was commented the audit team did a great job on audits.

MOTION:

Upon motion by Director Hernandez Laguna, and seconded by Director Dr. Cabrera, the Board of Directors approved Years Ended December 31, 2022 and 2021 Draft Audited Financial Statements for the Salinas Valley Memorial Healthcare District Employee's Pension Plan.

PUBLIC COMMENT:
None.

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

Motion Carried

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON NOVEMBER 9, 2023, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING

Rakesh Singh, MD, Chief of Staff, reviewed the reports of the Medical Executive Committee (MEC) meeting of December 14, 2023, the Policies/Procedures/Plans revisions and Medical Staff Bylaws/General Rules and Regulations revisions. A full draft report was provided in the Board packet. As this meeting took place earlier this same day, Dr. Singh reported that MEC approved the items that were submitted.

Recommend Board Approval of the Following:

A. Reports
    1. Credentials Committee Report
    2. Interdisciplinary Practice Committee Report

B. Policies/Procedures/Plans:
    1. Clinical Privilege Delineation – Critical Care/Pulmonary Medicine Revision
    2. Clinical Privilege Delineation – Emergency Medicine

C. Medical Staff Bylaws/General Rules and Regulations
    1. Article II, Section 2.3: Responsibility of the Attending Provider
    2. Article VII, Section 1-16: Emergency Call Panel

3. Focused Professional Practice Evaluation: Article VII, Section C: Termination of Proctorship

BOARD MEMBER DISCUSSION:
None

MOTION:

Upon motion by Director Dr. Cabrera, second by Director Hernandez Laguna, the Board of Directors receives and approves the Medical Executive Committee (MEC) meeting of December 14, 2023 recommendations (A) through (C) as presented.

PUBLIC INPUT:
None

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

Motion Carried

11. EXTENDED CLOSED SESSION

President Rey announced items to be discussed in Extended Closed Session are *(1) Report involving trade secret, strategic planning/proposed new programs and services, and (2) Public Employment – President/Chief Executive Officer.* The meeting recessed into Closed Session under the Closed Session Protocol at 5:18 p.m. The Board completed its business of the Closed Session at 7:47 p.m..

The Board President sought a motion to add an item to the agenda – to wit, Item 12: Report from Closed Session. Upon motion by Director Juan Cabrera, and seconded by Director Dr. Cabrera, the Board of Directors added Item 12: Report from Closed Session.

PUBLIC INPUT:
None

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

Motion Carried

12. REPORT FROM CLOSED SESSION

President Rey announced that the following action was taken in Closed Session:

the Board appoints the following members to the CEO Search Committee:

Chair: Joel Lagana Hernandez (Board Member)
Catherine Carson (Board Member)
Carmen Gil
Dr. Rakesh Singh, M.D.
Dr. Deborah Kaczmar, Ph.D.

Dr. Christopher Oh, M.D.
Judge John Phillips (Ret.)

12. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, January 25 at 4:00 p.m.** There being no further business, the meeting was adjourned at 7:49 p.m.

_____

Rolando Cabrera, MD
Secretary, Board of Directors

Financial Performance Review

December 2023

Finance Committee - Open Session

Augustine Lopez

Chief Financial Officer

Consolidated Financial Summary
For the Month of December 2023

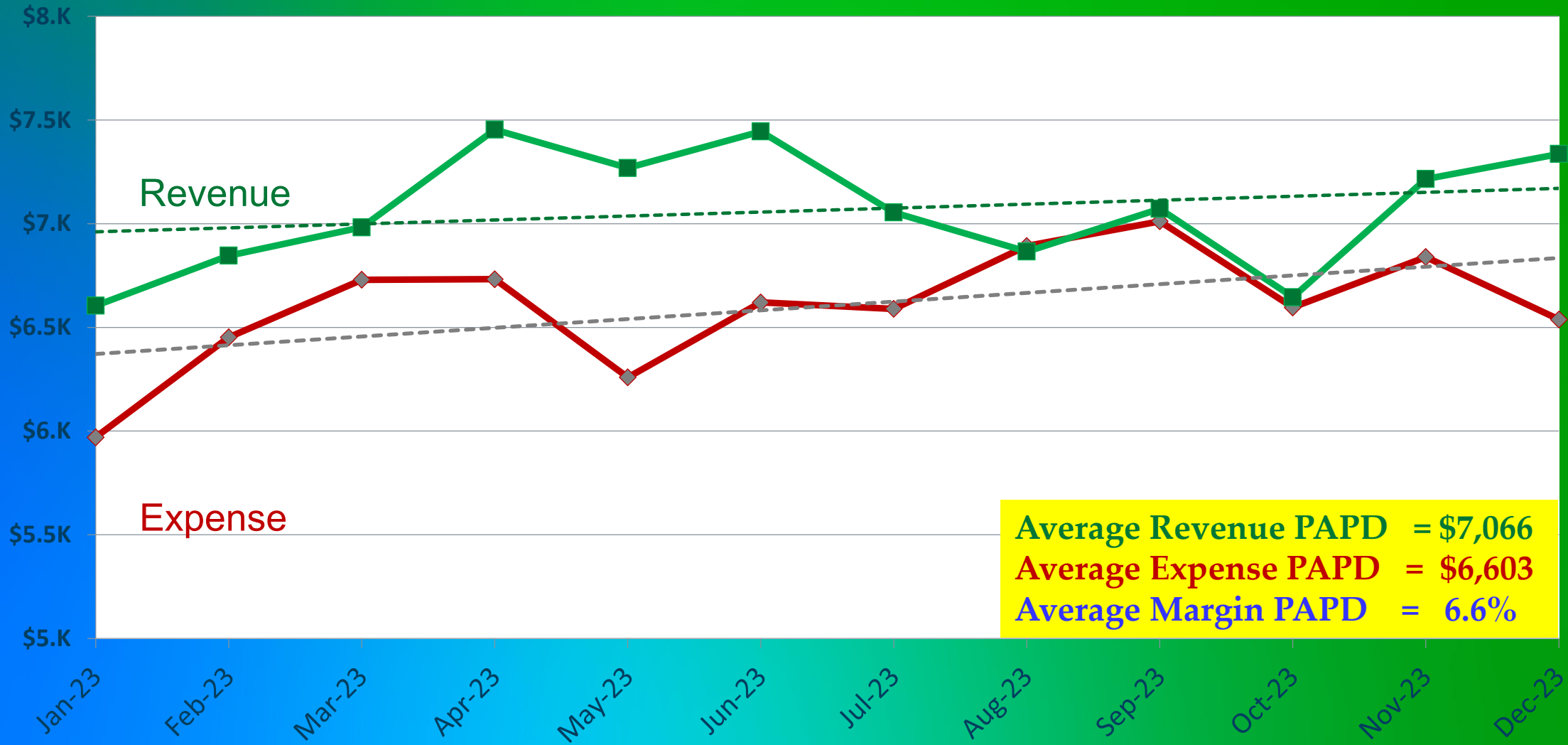
$ in Millions	For the Month of December 2023			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 63.2	$ 59.8	$ 3.4	5.7%
Operating Expense	$ 61.9	$ 59.6	$ (2.3)	-3.9%
Income from Operations	**$ 1.3**	**$ 0.2**	**$ 1.1**	**550.0%**
Operating Margin %	*2.1%*	*0.3%*	*1.8%*	*600.00%*
Non Operating Income	$ 6.2	$ 1.9	$ 4.3	226.3%
Net Income	**$ 7.5**	**$ 2.1**	**$ 5.4**	**257.1%**
Net Income Margin %	*12.0%*	*3.5%*	*8.5%*	*242.9%*

Investment earnings were higher than expected due to a favorable bond market for the period.

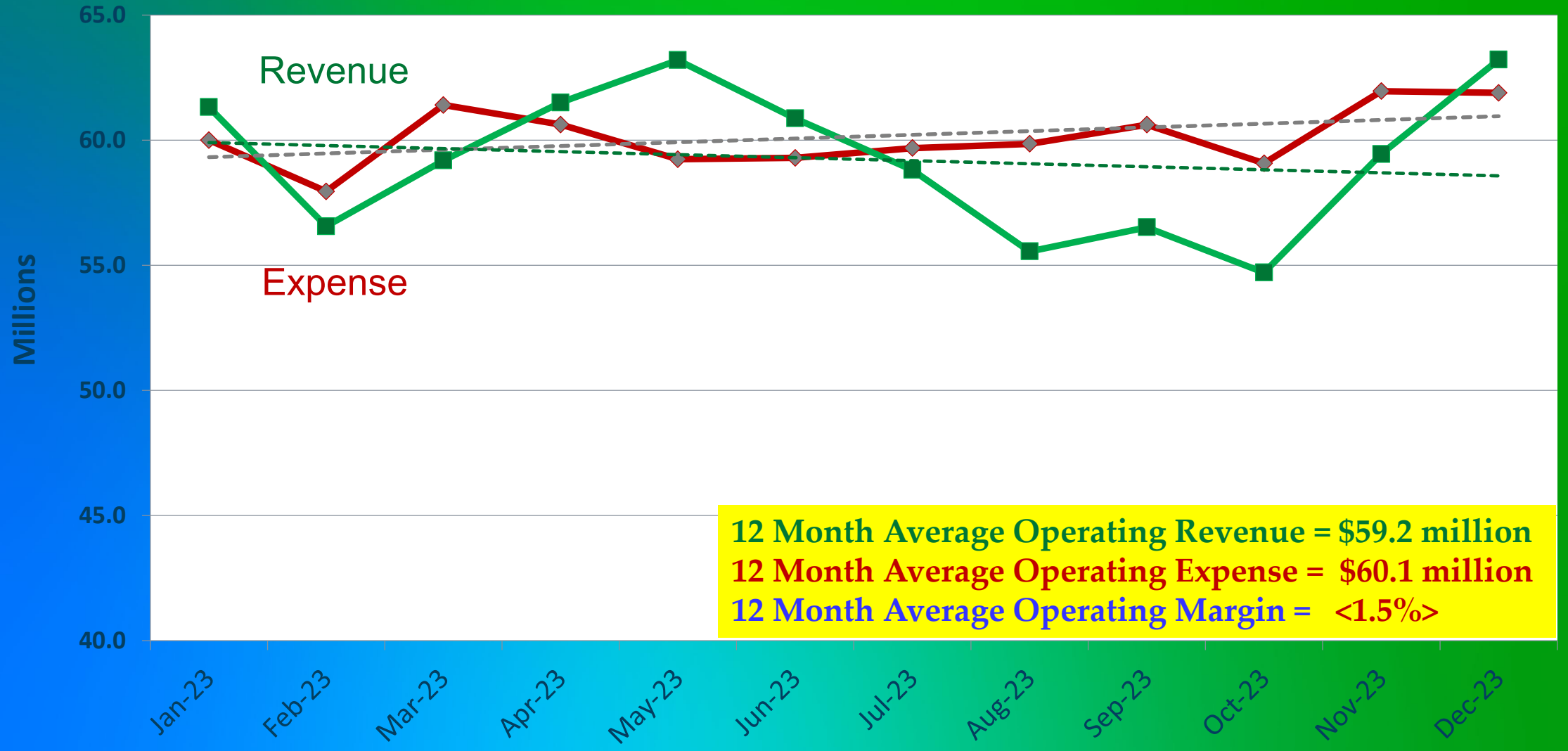
Consolidated Financial Summary
YTD December 2023

$ in Millions	FY 2023 YTD December			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue (*)	$ 347.5	$ 359.2	$ (11.7)	-3.3%
Operating Expense	$ 362.7	$ 357.8	$ (4.9)	-1.4%
Income from Operations	**$ (15.2)**	**$ 1.4**	**$ (16.6)**	**-1185.7%**
Operating Margin %	*-4.4%*	*0.4%*	*-4.8%*	*-1200.0%*
Non Operating Income	$ 22.0	$ 11.5	$ 10.5	91.3%
Net Income	**$ 6.8**	**$ 12.9**	**$ (6.1)**	**-47.3%**
Net Income Margin %	*2.0%*	*3.6%*	*-1.6%*	*-44.4%*

SVHMC Revenues & Expenses Per Adjusted Patient Day
Rolling 12 Months: Jan 23 to December 23



SVH Consolidated Revenues & Expenses
Rolling 12 Months: Jan 23 to December 23



12 Month Average Operating Revenue = $59.2 million
12 Month Average Operating Expense = $60.1 million
12 Month Average Operating Margin = <1.5%>

Salinas Valley Health Key Financial Indicators

Statistic	YTD 12/31/23	SVH Target	+/-	S&P A+ Rated Hospitals	+/-	YTD 12/31/22	+/-
Operating Margin*	-4.4%	5.0%		4.0%		5.1%	
Total Margin*	2.0%	6.0%		6.6%		6.6%	
EBITDA Margin**	-2.3%	7.4%		13.6%		8.9%	
Days of Cash*	342	305		249		340	
Days of Accounts Payable*	47	45		-		55	
Days of Net Accounts Receivable***	56	45		49		49	
Supply Expense as % NPR	14.3%	14.0%		-		12.6%	
SWB Expense as % NPR	57.2%	53.0%		53.7%		52.5%	
Operating Expense per APD*	6,677	6,739		-		6,166	

All metrics above are consolidated for SVH, except Operating Expense per APD is hospital only

*These metrics have been adjusted for normalizing items

**Metric based on Operating Income (consistent with industry standard)

***Metric based on 90 days average net revenue (consistent with industry standard)

Questions/Comments

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
December 31, 2023

	Month of December,		Six months ended December 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 52,888,045	$ 58,241,312	$ 289,771,990	$ 316,158,303
Other operating revenue	1,612,340	671,870	7,246,740	4,478,457
Total operating revenue	54,500,385	58,913,182	297,018,730	320,636,760
Total operating expenses	48,572,361	49,166,829	284,564,849	282,868,063
Total non-operating income	472,100	(3,259,018)	(5,819,773)	(17,083,714)
Operating and non-operating income	$ 6,400,124	$ 6,487,335	$ 6,634,108	$ 20,684,983

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
December 31, 2023

	Current year	Prior year
ASSETS:		
Current assets	$ 342,219,681	$ 408,623,383
Assets whose use is limited or restricted by board	163,788,499	154,427,973
Capital assets	249,761,627	241,345,738
Other assets	287,888,357	182,741,537
Deferred pension outflows	116,911,125	95,857,027
	$ 1,160,569,289	$ 1,082,995,658
LIABILITIES AND EQUITY:		
Current liabilities	92,243,404	106,984,890
Long term liabilities	21,647,807	18,514,233
Lease deferred inflows	1,926,317	1,911,058
Pension liability	118,792,064	79,111,485
Net assets	925,959,697	876,473,992
	$ 1,160,569,289	$ 1,082,995,658

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
December 31, 2023

	Month of December,		Six months ended December 31,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,997	2,249	10,703	11,972
Medi-Cal	990	1,395	6,136	6,952
Commercial insurance	501	937	3,670	4,863
Other patient	158	169	643	674
Total patient days	3,646	4,750	21,152	24,461
Gross revenue:				
Medicare	$ 112,377,689	$ 106,785,458	$ 657,549,723	$ 602,700,098
Medi-Cal	70,432,469	75,079,954	406,910,614	405,008,481
Commercial insurance	59,382,383	57,176,529	316,400,725	320,847,404
Other patient	10,336,945	10,060,136	53,583,998	51,045,256
Gross revenue	252,529,486	249,102,077	1,434,445,060	1,379,601,238
Deductions from revenue:				
Administrative adjustment	319,397	360,029	1,625,910	1,602,757
Charity care	339,919	461,311	4,552,671	4,056,276
Contractual adjustments:				
Medicare outpatient	34,517,144	28,314,767	202,962,520	174,865,499
Medicare inpatient	54,614,027	48,597,232	279,174,418	265,824,676
Medi-Cal traditional outpatient	4,254,832	2,803,692	18,044,276	18,896,956
Medi-Cal traditional inpatient	4,739,170	5,176,451	28,116,409	28,555,230
Medi-Cal managed care outpatient	32,420,424	27,123,702	178,533,675	160,178,882
Medi-Cal managed care inpatient	25,988,563	31,092,983	143,882,158	151,382,850
Commercial insurance outpatient	14,355,511	17,666,708	131,435,634	107,367,125
Commercial insurance inpatient	21,057,656	22,836,214	123,803,543	120,172,026
Uncollectible accounts expense	4,205,137	3,993,962	25,312,290	23,548,018
Other payors	2,829,661	2,433,713	7,229,566	6,992,640
Deductions from revenue	199,641,441	190,860,765	1,144,673,070	1,063,442,936
Net patient revenue	$ 52,888,045	$ 58,241,312	$ 289,771,990	$ 316,158,303
Gross billed charges by patient type:				
Inpatient	$ 135,188,320	$ 142,841,344	$ 730,087,117	$ 739,753,559
Outpatient	87,759,834	77,957,202	528,127,246	466,609,743
Emergency room	29,581,331	28,303,531	176,230,695	173,237,936
Total	$ 252,529,485	$ 249,102,077	$ 1,434,445,058	$ 1,379,601,238

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
December 31, 2023

	Month of December,		Six months ended December 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 52,888,045	$ 58,241,312	$ 289,771,990	$ 316,158,303
Other operating revenue	1,612,340	671,870	7,246,740	4,478,457
Total operating revenue	54,500,385	58,913,182	297,018,730	320,636,760
Operating expenses:				
Salaries and wages	17,051,771	17,415,693	99,337,719	104,507,717
Compensated absences	2,233,673	2,691,799	17,970,675	16,932,625
Employee benefits	9,018,730	8,341,694	49,746,211	45,644,042
Supplies, food, and linen	7,673,685	7,178,051	42,911,259	40,771,325
Purchased department functions	3,300,976	3,943,870	21,541,822	24,704,973
Medical fees	2,198,126	2,189,854	15,138,980	11,741,809
Other fees	2,538,676	3,891,520	13,240,492	17,780,631
Depreciation	2,391,193	1,897,841	14,385,247	11,368,073
All other expense	2,165,531	1,616,507	10,292,444	9,416,868
Total operating expenses	48,572,361	49,166,829	284,564,849	282,868,063
Income from operations	5,928,024	9,746,353	12,453,881	37,768,697
Non-operating income:				
Donations	0	(442,031)	1,333,552	859,346
Property taxes	333,333	333,333	2,000,000	2,000,000
Investment income	4,705,508	(470,856)	17,286,322	(1,978,318)
Taxes and licenses	0	0	0	0
Income from subsidiaries	(4,566,741)	(2,679,464)	(26,439,647)	(17,964,742)
Total non-operating income	472,100	(3,259,018)	(5,819,773)	(17,083,714)
Operating and non-operating income	6,400,124	6,487,335	6,634,108	20,684,983
Net assets to begin	919,559,573	869,986,657	919,325,589	855,789,009
Net assets to end	$ 925,959,697	$ 876,473,992	$ 925,959,697	$ 876,473,992
Net income excluding non-recurring items	$ 6,400,124	$ 6,487,335	$ 6,634,108	$ 20,684,983
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	0	0	0	0
Operating and non-operating income	$ 6,400,124	$ 6,487,335	$ 6,634,108	$ 20,684,983

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
December 31, 2023

	Month of December,		Six months ended December 31,	
	current year	prior year	current year	prior year
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	$ (220,489)	$ 23,371	$ (1,199,679)	$ (885,331)
Neurological Clinic	(77,633)	(59,807)	(438,228)	(364,178)
Palliative Care Clinic	(87,747)	(89,481)	(518,552)	(416,496)
Surgery Clinic	(175,981)	(133,589)	(1,090,961)	(824,203)
Infectious Disease Clinic	(41,327)	(28,030)	(212,536)	(174,440)
Endocrinology Clinic	(231,840)	(124,629)	(1,354,971)	(931,598)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(650,667)	(319,912)	(3,397,421)	(2,426,117)
OB/GYN Clinic	(407,702)	(249,211)	(2,368,237)	(1,696,081)
PrimeCare Medical Group	(734,479)	(386,633)	(5,057,924)	(2,780,806)
Oncology Clinic	(372,590)	(276,033)	(1,935,226)	(1,574,785)
Cardiac Surgery	(304,486)	(273,354)	(1,909,249)	(1,476,512)
Sleep Center	(53,347)	(60,227)	(289,014)	(159,823)
Rheumatology	(80,654)	(65,279)	(415,328)	(365,832)
Precision Ortho MDs	(493,193)	(374,293)	(2,820,572)	(2,149,554)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(39,991)	(43,964)	(254,396)	(225,510)
Vaccine Clinic	0	0	16	(683)
Dermatology	(33,683)	(10,238)	(236,505)	(87,636)
Hospitalists	0	0	0	0
Behavioral Health	(47,319)	(39,105)	(254,301)	(189,269)
Pediatric Diabetes	(38,577)	(62,693)	(281,264)	(291,073)
Neurosurgery	(53,521)	(29,904)	(208,661)	(176,495)
Multi-Specialty-RR	(4,829)	(3,356)	18,563	60,690
Radiology	(436,182)	(167,404)	(1,883,797)	(1,034,036)
Salinas Family Practice	(136,425)	(143,088)	(832,953)	(597,464)
Urology	(170,575)	(199,094)	(1,006,574)	(656,284)
Total SVHC	(4,893,237)	(3,115,953)	(27,947,770)	(19,423,516)
Doctors on Duty	51,461	73,634	293,960	471,409
Vantage Surgery Center	0	0	0	0
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	150,197	246,940	741,903	843,083
Coastal	53,298	65,995	235,686	(66,127)
Apex	0	0	0	0
21st Century Oncology	17,790	(1,448)	(11,393)	(47,658)
Monterey Bay Endoscopy Center	53,750	51,368	247,967	258,067
Total	$ (4,566,741)	$ (2,679,464)	$ (26,439,647)	$ (17,964,742)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
December 31, 2023

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 222,703,090	$ 297,265,223
Patient accounts receivable, net of estimated uncollectibles of $35,035,613	98,096,773	91,267,037
Supplies inventory at cost	8,196,095	7,713,311
Current portion of lease receivable	1,347,190	534,201
Other current assets	11,876,533	11,843,610
Total current assets	342,219,681	408,623,383
Assets whose use is limited or restricted by board	163,788,499	154,427,973
Capital assets:		
Land and construction in process	72,486,366	47,308,745
Other capital assets, net of depreciation	177,275,261	194,036,993
Total capital assets	249,761,627	241,345,738
Other assets:		
Right of use assets, net of amortization	7,151,987	7,137,296
Long term lease receivable	723,298	1,462,610
Subscription assets, net of amortization	8,530,817	0
Investment in Securities	252,336,815	137,538,263
Investment in SVMC	2,772,040	12,815,563
Investment in Coastal	1,917,327	1,577,573
Investment in other affiliates	21,846,598	23,406,844
Net pension asset	(7,390,525)	(1,196,612)
Total other assets	287,888,357	182,741,537
Deferred pension outflows	116,911,125	95,857,027
	$ 1,160,569,289	$ 1,082,995,658
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	$ 60,654,038	$ 68,219,630
Due to third party payers	5,505,983	17,556,458
Current portion of self-insurance liability	19,095,466	18,272,834
Current subscription liability	4,451,874	0
Current portion of lease liability	2,536,043	2,935,968
Total current liabilities	92,243,404	106,984,890
Long term portion of workers comp liability	13,027,333	14,058,922
Long term portion of lease liability	4,836,895	4,455,311
Long term subscription liability	3,783,579	0
Total liabilities	113,891,211	125,499,123
Lease deferred inflows	1,926,317	1,911,058
Pension liability	118,792,064	79,111,485
Net assets:		
Invested in capital assets, net of related debt	249,761,627	241,345,738
Unrestricted	676,198,070	635,128,254
Total net assets	925,959,697	876,473,992
	$ 1,160,569,289	$ 1,082,995,658

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
December 31, 2023

	Month of December,				Six months ended December 31,			
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:								
Gross billed charges	$ 252,529,486	$ 235,748,845	16,780,641	7.12%	$ 1,434,445,060	$ 1,399,225,517	35,219,543	2.52%
Dedutions from revenue	199,641,441	186,136,607	13,504,834	7.26%	1,144,673,070	1,101,130,000	43,543,070	3.95%
Net patient revenue	52,888,045	49,612,238	3,275,807	6.60%	289,771,990	298,095,517	(8,323,527)	-2.79%
Other operating revenue	1,612,340	1,332,540	279,800	21.00%	7,246,740	7,995,240	(748,500)	-9.36%
Total operating revenue	**54,500,385**	**50,944,778**	**3,555,607**	**6.98%**	**297,018,730**	**306,090,757**	**(9,072,027)**	**-2.96%**
Operating expenses:								
Salaries and wages	17,051,771	16,833,291	218,480	1.30%	99,337,719	101,372,814	(2,035,095)	-2.01%
Compensated absences	2,233,673	3,465,241	(1,231,568)	-35.54%	17,970,675	19,140,939	(1,170,264)	-6.11%
Employee benefits	9,018,730	7,367,941	1,650,789	22.41%	49,746,211	46,593,864	3,152,347	6.77%
Supplies, food, and linen	7,673,685	6,899,278	774,407	11.22%	42,911,259	40,956,453	1,954,806	4.77%
Purchased department functions	3,300,976	3,539,230	(238,254)	-6.73%	21,541,822	21,235,376	306,446	1.44%
Medical fees	2,198,126	2,359,060	(160,934)	-6.82%	15,138,980	14,154,361	984,619	6.96%
Other fees	2,538,676	2,269,528	269,148	11.86%	13,240,492	13,523,743	(283,251)	-2.09%
Depreciation	2,391,193	2,077,263	313,930	15.11%	14,385,247	12,665,409	1,719,838	13.58%
All other expense	2,165,531	1,841,330	324,201	17.61%	10,292,444	10,969,047	(676,603)	-6.17%
Total operating expenses	**48,572,361**	**46,652,162**	**1,920,199**	**4.12%**	**284,564,849**	**280,612,006**	**3,952,843**	**1.41%**
Income from operations	**5,928,024**	**4,292,616**	**1,635,408**	**38.10%**	**12,453,881**	**25,478,751**	**(13,024,870)**	**-51.12%**
Non-operating income:								
Donations	0	166,667	(166,667)	-100.00%	1,333,552	1,000,000	333,552	33.36%
Property taxes	333,333	333,333	(0)	0.00%	2,000,000	2,000,000	0	0.00%
Investment income	4,705,508	1,185,806	3,519,702	296.82%	17,286,322	7,114,833	10,171,489	142.96%
Income from subsidiaries	(4,566,741)	(4,053,998)	(512,743)	12.65%	(26,439,647)	(23,817,514)	(2,622,133)	11.01%
Total non-operating income	**472,100**	**(2,368,193)**	**2,840,293**	**-119.94%**	**(5,819,773)**	**(13,702,681)**	**7,882,908**	**-57.53%**
Operating and non-operating income	**$ 6,400,124**	**$ 1,924,423**	**4,475,701**	**232.57%**	**$ 6,634,108**	**$ 11,776,070**	**(5,141,962)**	**-43.66%**

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

	Month of Dec		Six months to date		
	2022	2023	2022-23	2023-24	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	36	32	231	215	(16)
Other Admissions	86	87	529	499	(30)
Total Admissions	122	119	760	714	(46)
Medi-Cal Patient Days	60	51	363	346	(17)
Other Patient Days	138	144	876	847	(29)
Total Patient Days of Care	198	195	1,239	1,193	(46)
Average Daily Census	6.4	6.3	6.7	6.5	(0.3)
Medi-Cal Average Days	1.8	1.5	1.7	1.7	0.0
Other Average Days	0.9	1.6	1.7	1.7	0.0
Total Average Days Stay	1.7	1.5	1.7	1.7	0.0
ADULTS & PEDIATRICS					
Medicare Admissions	424	427	2,382	2,247	(135)
Medi-Cal Admissions	375	276	1,802	1,573	(229)
Other Admissions	419	349	1,908	1,791	(117)
Total Admissions	1,218	1,052	6,092	5,611	(481)
Medicare Patient Days	1,929	1,678	10,017	9,079	(938)
Medi-Cal Patient Days	1,436	1,063	7,202	6,327	(875)
Other Patient Days	1,179	904	6,297	4,559	(1,738)
Total Patient Days of Care	4,544	3,645	23,516	19,965	(3,551)
Average Daily Census	146.6	117.6	127.8	108.5	(19.3)
Medicare Average Length of Stay	4.5	4.2	4.2	4.1	(0.1)
Medi-Cal AverageLength of Stay	3.7	3.3	3.5	3.5	(0.0)
Other Average Length of Stay	2.9	2.1	2.6	2.0	(0.6)
Total Average Length of Stay	3.7	3.1	3.5	3.2	(0.3)
Deaths	32	30	135	156	21
Total Patient Days	4,742	3,840	24,755	21,158	(3,597)
Medi-Cal Administrative Days	3	0	41	5	(36)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	3	0	41	5	(36)
Percent Non-Acute	0.06%	0.00%	0.17%	0.02%	-0.14%

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

	Month of Dec		Six months to date		
	2022	2023	2022-23	2023-24	Variance
PATIENT DAYS BY LOCATION					
Level I	388	257	1,745	1,429	(316)
Heart Center	388	348	2,096	1,962	(134)
Monitored Beds	748	675	3,958	3,694	(264)
Single Room Maternity/Obstetrics	337	293	2,107	1,923	(184)
Med/Surg - Cardiovascular	1,028	923	5,541	4,976	(565)
Med/Surg - Oncology	324	302	1,602	1,658	56
Med/Surg - Rehab	593	546	3,189	2,720	(469)
Pediatrics	158	159	818	808	(10)
Nursery	198	195	1,239	1,193	(46)
Neonatal Intensive Care	207	142	956	795	(161)
PERCENTAGE OF OCCUPANCY					
Level I	96.28%	63.77%	72.95%	59.74%	
Heart Center	83.44%	74.84%	75.94%	71.09%	
Monitored Beds	89.37%	80.65%	79.67%	74.36%	
Single Room Maternity/Obstetrics	29.38%	25.54%	30.95%	28.25%	
Med/Surg - Cardiovascular	73.69%	66.16%	66.92%	60.10%	
Med/Surg - Oncology	80.40%	74.94%	66.97%	69.31%	
Med/Surg - Rehab	73.57%	67.74%	66.66%	56.86%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	28.32%	28.49%	24.70%	24.40%	
Nursery	38.71%	38.12%	20.41%	19.65%	
Neonatal Intensive Care	60.70%	41.64%	47.23%	39.28%	

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

	Month of Dec		Six months to date		
	2022	2023	2022-23	2023-24	Variance
DELIVERY ROOM					
Total deliveries	116	116	733	651	(82)
C-Section deliveries	51	37	232	228	(4)
Percent of C-section deliveries	43.97%	31.90%	31.65%	35.02%	3.37%
OPERATING ROOM					
In-Patient Operating Minutes	23,855	17,688	122,771	96,693	(26,078)
Out-Patient Operating Minutes	27,526	26,842	160,494	177,793	17,299
Total	51,381	44,530	283,265	274,486	(8,779)
Open Heart Surgeries	18	18	86	68	(18)
In-Patient Cases	137	111	825	694	(131)
Out-Patient Cases	271	274	1,650	1,758	108
EMERGENCY ROOM					
Immediate Life Saving	38	33	172	220	48
High Risk	595	870	3,397	4,335	938
More Than One Resource	2,974	2,926	17,998	17,153	(845)
One Resource	2,467	1,998	13,880	11,843	(2,037)
No Resources	97	64	561	594	33
Total	6,171	5,891	36,008	34,145	(1,863)

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

	Month of Dec		Six months to date		
	2022	2023	2022-23	2023-24	Variance
CENTRAL SUPPLY					
In-patient requisitions	16,780	13,803	90,131	78,342	-11,789
Out-patient requisitions	9,058	9,707	56,478	61,810	5,332
Emergency room requisitions	695	548	3,448	4,455	1,007
Interdepartmental requisitions	7,698	7,278	42,798	39,603	-3,195
Total requisitions	34,231	31,336	192,855	184,210	-8,645
LABORATORY					
In-patient procedures	45,626	40,917	239,429	217,890	-21,539
Out-patient procedures	8,581	33,927	61,972	126,637	64,665
Emergency room procedures	13,588	13,411	79,788	78,182	-1,606
Total patient procedures	67,795	88,255	381,189	422,709	41,520
BLOOD BANK					
Units processed	360	325	2,005	1,862	-143
ELECTROCARDIOLOGY					
In-patient procedures	1,309	1,244	6,669	6,461	-208
Out-patient procedures	309	409	2,060	2,394	334
Emergency room procedures	1,193	1,245	6,719	7,193	474
Total procedures	2,811	2,898	15,448	16,048	600
CATH LAB					
In-patient procedures	107	121	572	731	159
Out-patient procedures	57	130	486	672	186
Emergency room procedures	0	0	1	0	-1
Total procedures	164	251	1,059	1,403	344
ECHO-CARDIOLOGY					
In-patient studies	414	446	2,346	2,237	-109
Out-patient studies	245	302	1,345	1,625	280
Emergency room studies	3	0	8	7	-1
Total studies	662	748	3,699	3,869	170
NEURODIAGNOSTIC					
In-patient procedures	143	144	877	794	-83
Out-patient procedures	14	14	98	115	17
Emergency room procedures	0	0	0	0	0
Total procedures	157	158	975	909	-66

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

	Month of Dec		Six months to date		
	2022	2023	2022-23	2023-24	Variance
SLEEP CENTER					
In-patient procedures	0	0	1	0	-1
Out-patient procedures	131	225	850	1,364	514
Emergency room procedures	0	0	1	0	-1
Total procedures	131	225	852	1,364	512
RADIOLOGY					
In-patient procedures	1,777	1,538	8,612	7,828	-784
Out-patient procedures	354	378	2,126	2,385	259
Emergency room procedures	1,650	1,488	9,437	8,962	-475
Total patient procedures	3,781	3,404	20,175	19,175	-1,000
MAGNETIC RESONANCE IMAGING					
In-patient procedures	132	133	916	841	-75
Out-patient procedures	72	97	613	698	85
Emergency room procedures	2	6	39	43	4
Total procedures	206	236	1,568	1,582	14
MAMMOGRAPHY CENTER					
In-patient procedures	3,548	4,021	24,314	24,939	625
Out-patient procedures	3,502	3,957	24,111	24,625	514
Emergency room procedures	3	0	5	9	4
Total procedures	7,053	7,978	48,430	49,573	1,143
NUCLEAR MEDICINE					
In-patient procedures	10	17	115	113	-2
Out-patient procedures	96	134	545	647	102
Emergency room procedures	0	1	1	2	1
Total procedures	106	152	661	762	101
PHARMACY					
In-patient prescriptions	115,027	93,636	575,754	497,415	-78,339
Out-patient prescriptions	14,157	14,682	88,604	94,024	5,420
Emergency room prescriptions	8,983	9,532	54,519	55,877	1,358
Total prescriptions	138,167	117,850	718,877	647,316	-71,561
RESPIRATORY THERAPY					
In-patient treatments	24,664	18,874	103,116	96,812	-6,304
Out-patient treatments	1,009	1,231	6,417	6,447	30
Emergency room treatments	482	606	2,599	3,224	625
Total patient treatments	26,155	20,711	112,132	106,483	-5,649
PHYSICAL THERAPY					
In-patient treatments	2,680	2,436	15,342	15,161	-181
Out-patient treatments	131	265	1,020	1,577	557
Emergency room treatments	0	0	0	0	0
Total treatments	2,811	2,701	16,362	16,738	376

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

	Month of Dec		Six months to date		
	2022	2023	2022-23	2023-24	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,463	1,189	9,498	8,442	-1,056
Out-patient procedures	109	212	905	1,411	506
Emergency room procedures	0	0	0	0	0
Total procedures	1,572	1,401	10,403	9,853	-550
SPEECH THERAPY					
In-patient treatments	482	611	2,616	3,056	440
Out-patient treatments	10	58	136	232	96
Emergency room treatments	0	0	0	0	0
Total treatments	492	669	2,752	3,288	536
CARDIAC REHABILITATION					
In-patient treatments	0	0	1	9	8
Out-patient treatments	449	462	3,021	2,945	-76
Emergency room treatments	0	0	0	0	0
Total treatments	449	462	3,022	2,954	-68
CRITICAL DECISION UNIT					
Observation hours	577	385	2,423	1,798	-625
ENDOSCOPY					
In-patient procedures	72	84	523	442	-81
Out-patient procedures	65	67	370	358	-12
Emergency room procedures	0	0	0	0	0
Total procedures	137	151	893	800	-93
C.T. SCAN					
In-patient procedures	810	820	4,348	4,256	-92
Out-patient procedures	390	299	2,373	2,127	-246
Emergency room procedures	628	675	4,049	4,381	332
Total procedures	1,828	1,794	10,770	10,764	-6
DIETARY					
Routine patient diets	22,308	14,690	149,474	104,972	-44,502
Meals to personnel	25,414	30,741	152,408	170,705	18,297
Total diets and meals	47,722	45,431	301,882	275,677	-26,205
LAUNDRY AND LINEN					
Total pounds laundered	108,949	101,270	603,030	584,027	-19,003

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: January 17, 2024

Re: Policies Requiring Approval

As required under Title 22, CMS, and The Joint Commission (TJC), please find below a list of

	Policy Title	Summary of Changes	Responsible VP
1.	Blood Borne Pathogen Exposure Guidelines	Updated language, updated attachments (flow charts) to include new logo, updated information in references to the most up to date. Format corrected to procedure. Minor updates to job matrix. Rebranding.	Clement Miller, COO
2.	Capital Equipment	Regularly schedule review. Formatting changes only.	Augustine Lopez, CFO
3.	Capitalization of Interest Cost	Regularly schedule review. No changes noted.	Augustine Lopez, CFO
4.	College of American Pathologists Terms of Accreditation	Updated to policy format, updated to current version of CAP standard GEN.26791, added CAP contact information, added CAP reference standard	Clement Miller, COO
5.	Disclosure of Unanticipated Outcomes	Regularly schedule review. No changes noted.	CMO
6.	Disinfection of Instruments/Scopes	Template corrected, rebranded.	Clement Miller, COO
7.	Education and Staff Development	Updated fees and no show language, removed simulation fee and language regarding hospital right to cancel courses and individuals based on a business need.	Michelle Barnhart-Childs, CHRO
8.	Emergency Management for Mass Casualty Incidents (MCI)	Separated decontamination section, expanded definitions, reorganized content to follow the phases of response, added a phase IV for recovery, updated to include	Clement Miller, COO

		references to using Everbridge, added job cards and created a map as a guide (attachment).	
9.	Fan Use / Cleaning	Definition added, reference updated.	CMO
10.	Hand Hygiene	Rebranded, references updated, template corrected, rearranged statements	CMO
11.	Isolation - Standard and Transmission Based Precautions	Updated language and attachments, cleaned up/improved language. Added new "Respiratory protective isolation" language. Format corrected.	CMO
12.	Latex Allergy-Surgery	Template corrected.	Clement Miller, COO
13.	Leave of Absence	Updated CFRA + Bereavement, template corrected, links corrected, updated with reproductive loss leave	Michelle Barnhart-Childs, CHRO
14.	Outbreak Investigation	References updated.	CMO
15.	Paid Time Off (PTO) - Non-Affiliated Employees	Made adjustments focused on current practice including movement away from the former standard pto request form and toward email and department specific protocols. Removed PTO cash out, removed attachment. Updated to omit PTO cashout due to separate policy.	Michelle Barnhart-Childs, CHRO
16.	RC POCT Lab Arterial Blood Gas Quality Management Plan	Edited format, removed attachment, updated to reflect current practice.	Clement Miller, COO
17.	Reprocessing Single Use Devices	Template corrected to procedure. References updated.	Clement Miller, COO

18.	Scope of Service: Employee Health	Regularly schedule review. No changes noted.	Michelle Barnhart-Childs, CHRO
19.	Scope of Service: Nursing Administration	Regularly schedule review. No changes noted.	Lisa Paulo, CNO

Status Pending PolicyStat ID 14287988

Last Approved	N/A
Last Revised	01/2024
Next Review	3 years after approval
Owner	Jill Peralta Cuellar: Director Employee Health
Area	Infection Control

Blood Borne Pathogen Exposure Guidelines

I. POLICY STATEMENT:

A. **HEALTHCARE WORKER (HCW)** and Reporting Blood and Body Fluid Exposures:

"HCW" includes employees, contract providers, MD, and specific Medical providers at Salinas Valley Health Medical Center (SVHMC). Exposures to BBP are to be reported to Employee Health Services (EHS) for immediate investigation. Off hours and holidays, exposures are to be referred to the Administrative Supervisor with communication to EHS/Infection Prevention (IP). Emergency Department (ED) referrals would be at the discretion of the Administrative Supervisor. **Contract providers including contract LIPS may have the initial workup through Employee Health with follow up through their contracting agency/provider.**

B. **FIRST RESPONDERS**

Emergency Medical Services (EMS), Police, Fire, and other Law Enforcement Officers are who are exposed to BBP during transport, monitoring, guarding a shared patient are to report immediately to their supervisor to follow city/county Workers' Compensation exposure policy and procedure.

1. Infection Prevention Manager/designee, is to be notified immediately (759-1858) for all post exposure follow up, dissemination of information to Police Department (PD), Fire Department (FD) or Monterey County Public Health Department (MCPHD) Designated Officer / Watch Commander and to assure appropriate follow up treatment and within compliance with California State Senate Bill 1239.
    a. Information from ED to IP: call ext. 1858 and communicate the following information for IP follow up with First Responder Designated Officer/Watch Commander:
        - Individuals name and medical record number
    b. Source patient name and medical record number, Chief of Emergency Services will fulfill the role of certifying physician.
    c. Infection Prevention Manager / designee, in collaboration with SVHMC Chief Medical Officer (CMO) will act as medical facility contact.

~~C.~~ ~~**VISITORS**~~

~~Visitor exposure to BBP to be evaluated immediately in the SVHMC Emergency Department (ED).Visitor exposure to BBP or other infectious disease is to be reported immediately to Infection Prevention Manager and is addressed in a case-by-case basis, with collaboration with CMO and others as indicated.~~

~~a. Immediately cleanse the affected area(s) with soap and water, if eye splash: locate eyewash station to flush affected with saline or rinse with tap water for several minutes.~~

~~b. Administrative Supervisors are to be contacted to escort the visitor to the ED for immediate evaluation~~

~~D.~~ ~~**PATIENTS**~~

~~IF BBP exposure, thoroughly cleanse affected area as directed above first. Primary RN or Director is to immediately contact Manager IP (x 1858 or via operator) for process. If unable to reach IP Manager 1.) call /page SVHMC operator to contact IP via cell phone. 2.) CMO / Infectious Disease MD to determine immediate course of treatment.~~

A. N/A

II. PURPOSE~~:~~

A. To provide guidance and direction for testing, counseling, treatment and follow-up of healthcare workers who have sustained exposure to blood or body fluid.

B. ~~To guide the staff in the process and care of healthcare workers (HCW),~~Provide guidance and direction in the event of a blood or body fluid exposure to a first responders (i.e., police, fire, EMT, etc.) patients ~~and visitors that are exposed to blood borne pathogens (BBP)~~or visitor. Exposure may occur prior to arrival (first responders) of a shared patient, or patient or visitor exposure while physically admitted to or visiting Salinas Valley Health Medical Center. (SVHMC)~~.~~

C. To ensure appropriate follow up post exposure, and for trending of exposure data related to staff.

III. DEFINITIONS~~:~~

A. **Certifying Physician**: A designated physician who will determine that a significant exposure has occurred. SVHMC: Emergency Department MD, Infectious Disease MD, or CMO

B. **CDC**: Centers for Disease Control and Prevention

C. **Designated Officer /Watch Commander**: an individual designated by a first responder employee to interact with medical facilities regarding infectious disease exposures.

D. **Exposure**: Circumstances in which there is a significant risk of becoming infected with a communicable disease.

E. **Exposure Types**;

- **BBP** is contact with blood or other body fluids that contain pathogenic microorganism that can cause disease in humans, to which standard precautions apply. ~~Direct needle stick, injury with other types of sharps or splash to non-intact skin, open, uncovered wound, or mucus membrane.~~
- 1. Direct needle stick, injury with other types of sharps. a. **High Risk Exposure**:

Percutaneous exposures that cause deep puncture, intramuscular injection, and large gage, hollow bore needle, or mucus membrane or non-intact skin exposure with blood. Any exposure from known HIV, HBV or HCV patient.

- 2. Splash to non-intact skin, open, uncovered wound, or mucus membrane.

F. ~~**High Risk Exposure**: Percutaneous exposures that cause deep puncture, intramuscular injection, and large gage, hollow bore needle, or mucus membrane or non-intact skin exposure with blood. Any exposure from known HIV, HBV or HCV patient.~~

G. **Medical Facility**: the facility that receives patients via EMS, police or law enforcement.

H. **Medical Facility Officer /designee**: individual designated facility administrative body to assume responsibility for fulfilling the provisions under the Ryan White Act. SVHMC has designated Infection Prevention to collaborate care, treatment and to communicate with Designated Officer / Watch Commander.

I. **Senate Bill 1239 (Russell)**: permitting HIV testing and disclosure of a patient's HIV status, even without the patient's consent, where there has been a significant exposure of healthcare personnel.

J. **Source patient /individual**: a patient who potentially has a blood borne disease of which the healthcare provider has risk of exposure

IV. GENERAL INFORMATION:

~~A. N/A~~

A. **HEALTHCARE WORKER (HCW)** and Reporting Blood and Body Fluid Exposures:

"HCW" includes employees, contract providers, MD, and specific Medical providers at SVHMC. Exposures to BBP are to be reported to Employee Health Services (EHS) for immediate investigation. Off hours and holidays, exposures are to be referred to the Administrative Supervisor with communication to EHS/Infection Prevention (IP). Emergency Department (ED) referrals would be at the discretion of the Administrative Supervisor. **Contract providers including contract LIPS may have the initial workup through Employee Health with follow up through their contracting agency/provider.**

B. **FIRST RESPONDERS**

Emergency Medical Services (EMS), Police, Fire, and other Law Enforcement Officers are who are exposed to BBP during transport, monitoring, guarding a shared patient are to report immediately to their supervisor to follow city/county Workers' Compensation exposure policy and procedure.

1. Infection Prevention Manager/designee, is to be notified immediately (759-1858/ 759-3161) for all post exposure follow up, dissemination of information to Police Department (PD), Fire Department (FD) or Monterey County Public Health Department (MCPHD) Designated Officer / Watch Commander and to assure appropriate follow up treatment and within compliance with California State Senate Bill 1239.
    a. Information from ED to IP: call ext. 1858/3161 and communicate the following information for IP follow up with First Responder Designated Officer/Watch Commander:
        i. Individuals name and medical record number
    b. Source patient name and medical record number, Chief of Emergency Services

will fulfill the role of certifying physician.

c. Infection Prevention Manager / designee, in collaboration with SVH Chief Medical Officer (CMO) will act as medical facility contact.

C. **VISITORS**

Visitor exposure to BBP to be evaluated immediately in the SVHMC Emergency Department (ED). Visitor exposure to BBP or other infectious disease is to be reported immediately to Infection Prevention Manager and is addressed in a case-by-case basis, with collaboration with CMO and others as indicated.

1. Administrative Supervisors are to be contacted to escort the visitor to the ED for immediate evaluation

D. **PATIENTS**

If exposed to a BBP, Primary RN or Department Director is to immediately contact Manager IP (x 1858/3161 or via operator) for process. If unable to reach IP Manager 1.) call /page SVH operator to contact IP via cell phone. 2.) CMO / Infectious Disease MD to determine immediate course of treatment.

V. PROCEDURE:

A. Blood borne pathogens: Pathogenic blood or body fluids that can be directly linked to the transmission of Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV) and others.

- Blood
- Semen
- Vaginal secretions
- Cerebrospinal fluid
- Synovial fluid
- Pleural fluid
- Peritoneal fluid
- Pericardial fluid
- Amniotic fluid
- Breast milk

Note: NOTE: Saliva, sputum, urine, nasal secretions, sweat, tears, vomit and stool are not considered infectious unless blood is present. This type of exposure will be evaluated by EHS / IP to determine exposure risk. (~~Phone consultation with the~~ PEP ~~Line~~Consultation Services for Clinicians: 888-448-4911 ~~can also be done~~9 am - 8 pm ET Monday through Friday and 11 am to 8 pm EST on the weekends and holidays.~~)~~ For more information: http://nccc.ucsf.edu/

B. **First Aid: Clean area that was contaminated.** 1. Needle stick/cuts/broken skin: Wash wounds and contaminated skin with soap and water for 3-5 minutes. 2. Eye Splash: Remove contact lenses if worn and rinse with copious amounts of water or saline for 3-5 minutes. 3. Splash to Mouth/Nose: Rinse mouth with water or saline for 3-5 minutes. HCW: Know where the eye wash stations are on

the unit you are working.

C. **Healthcare Worker Responsibilities**

1. BBP exposure is considered ***urgent***; ***immediately*** notify direct supervisor ~~and thoroughly wash area with soap and water~~. ~~If eye splash exposure: go to eyewash station (portable or fixed—know location on your unit!) and flush affected eye(s) with water for several minutes~~Follow the First Aid instructions listed above.
2. Notify EHS or Administrative Supervisor during off hours. Referral to ED for follow up at their discretion.
3. ~~Complete "Employee Injury/Illness/Exposure Report~~Complete "Employee Injury/Illness/Exposure Report located on "EHS My Health" on STAR net. Instructions on how to report electronically: https://starnet.svmh.com/Departments/EmployeeHealth/Pages/News/How-to-report-an-Injury-Illness-or-Exposure.aspx
4. ~~Have~~If exposure to blood has been identified, have baseline labs drawn of source patient (if known) and exposed HCW as soon as possible and preferably within 1 hour of exposure to ensure adequate time for PEP if indicated.
5. High risk exposures will be considered for immediate prophylaxis IF the source patient HIV, HBV status is unknown, testing / results are to be delayed for several days AND the exposure is determined high risk by MD, EHS or IP and /or PEP Hotline (see definition: High Risk Exposure)

D. **First Responder Responsibility**

1. All the above will apply for First Responder, with the exception that they are to notify their Designated Officer immediately.
2. Identify source patient
3. Cleanse area affected as indicated above.
4. Complete "Monterey County Exposure report"
5. All labs will be drawn as stated above.
6. Post exposure prophylaxis will be determined as stated above / algorithm / PEP Hotline.
7. Follow up will be set up as needed/ coordination with Designated Officer / Watch Commander and communication will be via IP Manager.

E. **Visitor Exposure**

1. BBP exposure: assist visitor as able to cleanse / flush area immediately.
2. Notify Administrative Supervisor to ***escort visitor to SVHMC ED for evaluation***.
3. Notify IP Manager (759-1858/759-3161) to *determine exposure*, others that may be affected, etc.
4. IP will notify Risk / Patient Safety Officer, CMO as determined.

F. **Emergency Department Responsibilities**

1. Assess / evaluate exposed individual
2. Counsel individual on BBP exposure process. Document counseling.
3. Order / draw **STAT** labs from exposed individual. All others: HepBAb, HepBAg, HepCAb, HIV stat, CBC, ALT, AST.

4. Order **STAT** labs for source patient [if not already done by Administrative Supervisor] For all others: HIV rapid, HepBAg, and HepCAb.
5. ED MD: order Preventative Exposure Prophylaxis (PEP) **IF** indicated per algorithm. Follow up appt. with ED (except SVHMC employees) in 72 hours **IF** PEP given to exposed individual. *All* SVHMC employees are to follow up with EHS the next business day.
6. **Notification**: 1.) EHS~~:~~ for SVHMC employee / MD exposures 2.) IP Manager~~:~~ for all first responder, visitor and patient exposures.
7. Consult with Infection Prevention or EHS for clarification of process as needed.

G. **The Employee Health Services/Administrative Supervisor (after hours):** will be responsible to follow up with the SVHMC staff member. Staff that have had a high-risk exposure will be offered referral to SVHMC Infection Prevention MD for review and PEP follow up, if after hours, may refer to ED MD.

H. Documentation for staff exposures:
   1. SVHMC healthcare worker's exposure will be documented in Employee Health Services record, maintained by EHS.
   2. Follow up with staff will be per EHS ~~procedures~~procedure and documented accordingly in the employees ~~EH~~EHS file.
   3. Sharps injuries will be documented by EHS according to OSHA / ~~CALOSHA~~CAL OSHA guidelines.

VI. EDUCATION/TRAINING~~:~~

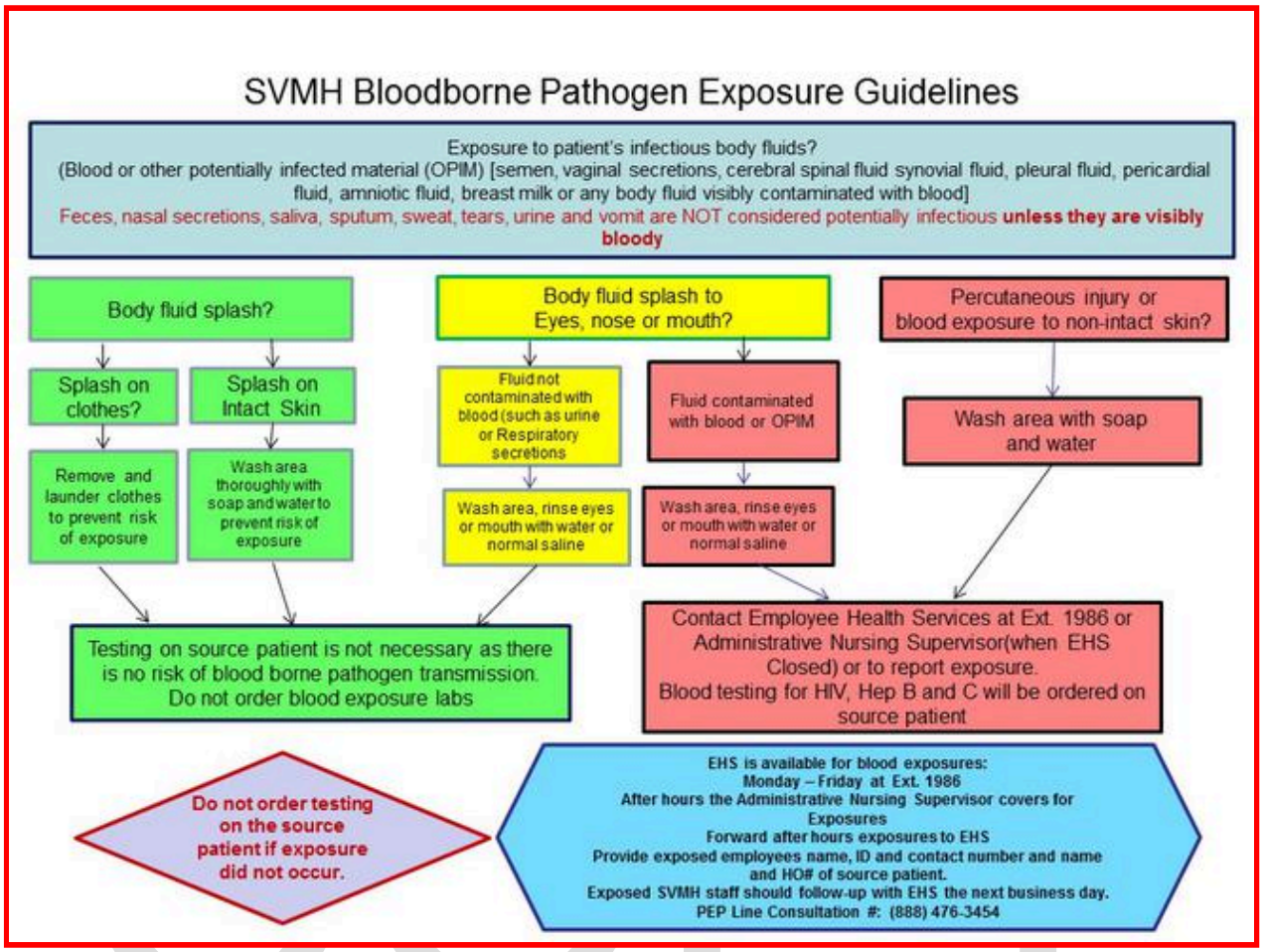
A. Education and/or training will be provided ~~upon hire and~~ as needed ~~and required~~.

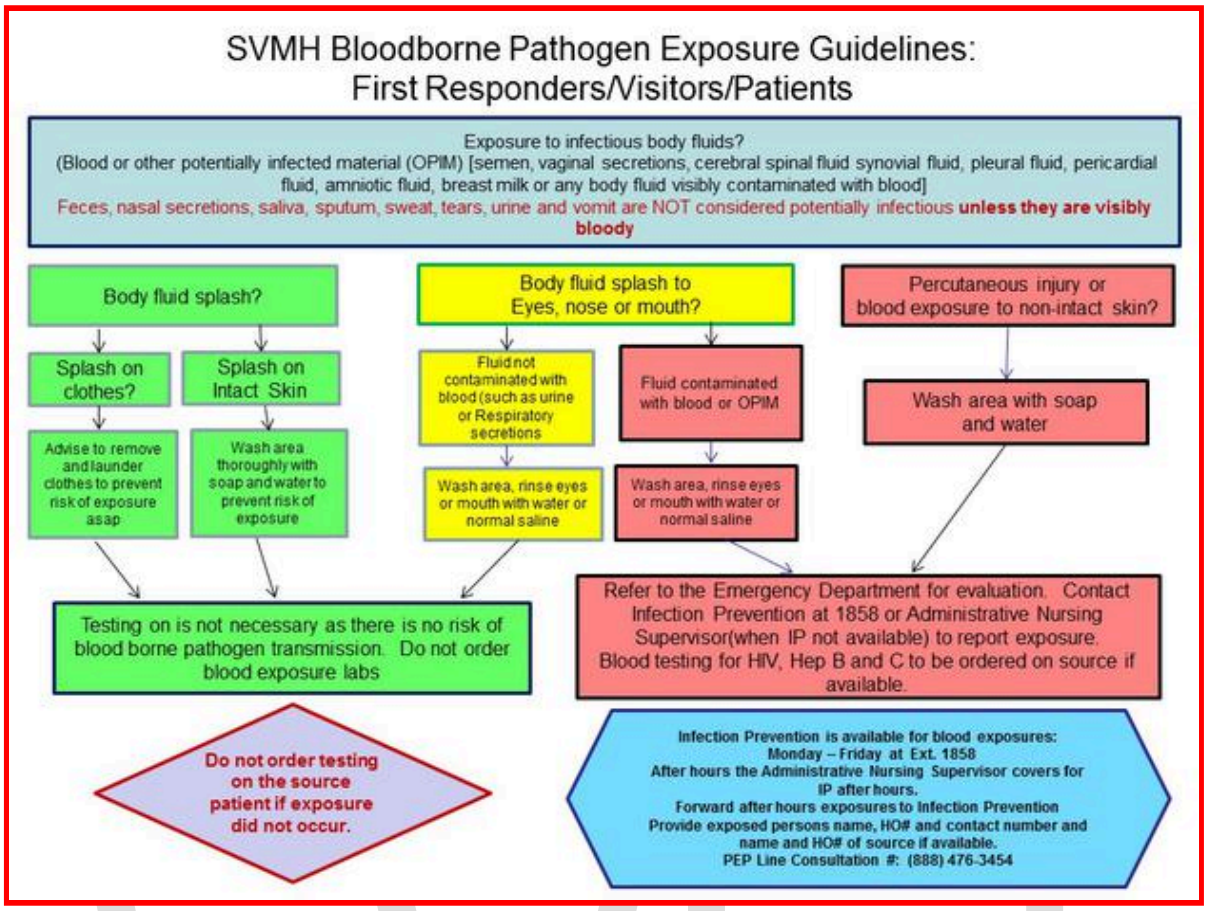
VII. REFERENCES~~:~~

A. Centers for Disease Control and Prevention:Occupational Safety and Health Administration. Bloodborne Pathogen Standard, 29 CFR 1910.1030

B. ~~Centers for Disease Control and Prevention (2017). NIOSH; Management and Treatment Guidelines~~Centers for Disease Control and Prevention (May 12, 2023). NIOSH; Bloodborne Infectious Diseases: HIV/AIDS, Hepatitis B, Hepatitis C: https://www.cdc.gov/niosh/topics/bbp/default.html

C. National Clinician Consultation Center (~~2020~~June 18, 2021): PEP Quick Guide for Occupational Exposures; https://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide-for-occupational-exposures/





Attachments

BLOOD BORN (10877)_Attachment_858_Bloodborne Pathogen Exposure Guidelines Information Non-Employee.pptx

BLOOD BORNE PATHOG (10877)_Attachment_835_Bloodborne Pathogen Exposure Guidelines Information.pptx

BLOODBORNE (12561)_Attachment_1390_Attachment B_Bloodborne Pathogens_Matrix of Department related Tasks_proced_2.pdf

Image 1

Image 2

Approval Signatures

Step Description	Approver	Date

Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	01/2024
P&T/IPC	Genevieve delos Santos: Director Pharmacy	12/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Jill Peralta Cuellar: Director Employee Health	10/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14931299

Last Approved	N/A	Owner	Scott Cleveland: Controller
Last Revised	01/2024	Area	Administration
Next Review	3 years after approval		

Capital Equipment

I. POLICY STATEMENT

A. It is Salinas Valley Health Medical Center (SVHMC) policy to capitalize all equipment that meet the following requirements:

- Equipment has a useful life in excess of one year as defined in the AHA Guideline for Useful Life of Equipment.
- Computer Systems and Copiers/Printers costing over $1,000 (computer system include monitor and computer; copiers/printers include any accessories) including taxes and freight.
- Equipment costing over $2,000 including taxes and freight.
- Groups of similar equipment costing over $10,000 but less than $2,000 individually including taxes and fright. (eg 10 desks costing $1,500 each equals $15,000).

II. PURPOSE

A. To provide guidance on implementing GASB 34 - Fixed Asset Accounting System as it relates to Capital Equipment.

~~III. POLICY~~

~~A. It is Salinas Valley Health Medical Center (SVHMC) policy to capitalize all equipment that meet the following requirements:~~

- ~~Equipment has a useful life in excess of one year as defined in the AHA Guideline for Useful Life of Equipment~~
- ~~Computer Systems and Copiers/Printers costing over $1,000 (computer system include monitor and computer; copiers/printers include any accessories) including taxes and freight.~~
- ~~Equipment costing over $2,000 including taxes and freight.~~

- ~~Groups of similar equipment costing over $10,000 but less than $2,000 individually including taxes and fright. (eg 10 desks costing $1,500 each equals $15,000)~~

IV. DEFINITIONS

A. N/A

V. GENERAL INFORMATION

A. N/A

VI. PROCEDURE

A. Once the equipment has been determined to be Capital Equipment, the requesting party must complete the Budgeting and Approval of Capital Purchases Form (see Policy #1040 CAPITAL BUDGET PLANNING PURCHASE).

B. Any equipment costing over $25,000 individually or in a group is required to obtain at least three bids when appropriate. ECRI report must also be attached.

C. Any special construction/accommodation necessary to install the equipment must be included in the request.

VII. EDUCATION/TRAINING

~~A. N/A~~

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

VIII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2024
Policy Owner	Scott Cleveland: Controller	12/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14931232**

Last Approved	N/A	Owner	Scott Cleveland: Controller
Last Revised	06/2017	Area	Administration
Next Review	3 years after approval		

Capitalization of Interest Cost

I. POLICY STATEMENT

A. It is Salinas Valley Health Medical Center (SVHMC) policy to capitalize construction period interest cost when appropriate based on the average balance of open construction projects.

II. PURPOSE

A. To provide guidance on implementing FASB 34, Capitalization of Interest Cost during a construction period.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. Identify construction projects that have an average monthly balance of at least $1,000,000 in Construction In Process (CIP).

B. Calculate the weighted average interest rate for the debt outstanding during the year and multiply this rate times the amount spent on the qualifying projects identified in the first step. Capitalized interest will be the lesser of this amount and actual interest expense incurred.

C. If actual interest expense exceeds the calculation of capitalizable interest, interest will be capitalized in the projects identified in the first step at the average interest rate calculated in the second step. If actual interest expense is less than the calculation of capitalizable interest, actual interest will be allocated to the projects identified in the first step based on their relative average balances.

D. Capitalized interest will cease at the completion of the project. If the project is delayed more than three months, capitalized interest will cease until the project restarts.

E. When the project is completed, capitalized interest will become a part of the completed project cost and will be depreciated using the same life as the underlying project.

F. To minimize differences between unaudited and audited expenses, if Salinas Valley Health Medical Center determines that interest capitalization will be required at year end, monthly interest expense will be capitalized. Instead of allocating to actual construction projects as described above, a separate construction in process account will be created. This account will be closed out at year end to the qualifying project.

G. If Salinas Valley Health Medical Center decides to borrow funds utilizing tax exempt debt, it will follow FASB 62 requirements – Capitalization of Interest Cost in Situations Involving Certain Tax-Exempt Borrowings and Certain Gifts and Grants.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. FASB 34 – Capitalization of Interest Cost

B. FASB 62 – Capitalization of Interest Cost in Situations Involving Certain Tax-Exempt Borrowings and Certain Gifts and Grants

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2024
Policy Owner	Scott Cleveland: Controller	12/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14361189

Last Approved	N/A	Owner	Lori Orosco: Director Laboratory Services
Last Revised	12/2023	Area	Laboratory
Next Review	2 years after approval		

College of American Pathologists Terms of Accreditation

I. POLICY STATEMENT

The Medical Director of the Laboratory must attest to the Laboratory's compliance with applicable federal, state and local laws to maintain accreditation with the College of American Pathologists.

~~The Medical Director attests that:~~

~~a. All Laboratory personnel are appropriately licensed, if required.~~

~~b. The Laboratory is in compliance with all other applicable federal, state and local laws and regulations.~~

~~c. There have been no investigations of the Laboratory by any state, federal, or other regulatory body~~

~~d. There have been no instances of adverse media attention in the past two years that have not been reported to CAP.~~

~~e. All information provided to the college is truthful and complete~~

~~1. The Laboratory Management will notify the CAP Office whenever the Laboratory finds itself the subject of an investigation by a government entity or adverse media attention related to Laboratory performance. A list of agencies and dates of each occurrence will be provided.~~

~~2. All employees have the ability to communicate concerns about the quality and safety to management, who will investigate employee complaints. The Hospital Quality Reporting system is used by employees to report concerns and for management follow-up. Any form of harassment or punitive action against an employee regarding a communication is prohibited. All reviews are evaluated by Risk Management and may be sent on to the Hospital Quality and Safety Committee. Any corrective and/or preventive actions are included in the Laboratory Quality Management Plan.~~

~~3. The Laboratory will provide an inspection team comparable in size and scope to that required for its own inspection, if requested by the regional and/or State commissioner, at least once during the two-year accreditation period.~~

4. ~~The Laboratory will participate annually in the CAP proficiency testing program.~~
5. ~~The Laboratory will notify the CAP Office in writing of changes in directorship, Laboratory location or ownership.~~
6. ~~The Laboratory will notify the CAP Office when there is a change in the Laboratory's test menu prior to beginning that testing.~~
7. ~~The Laboratory has signed a form authorizing the CAP to release its inspection and proficiency testing data to the appropriate regulatory or oversight agencies.~~
8. ~~The Laboratory will conduct an interim self-inspection. The Supervisor, Lead or designee will record any deficiencies found on the CAP self-inspection form. The form will be dated and initialed by the Supervisor, Lead or designee and submitted to the Laboratory Director. The Supervisor, Lead or designee will then make the corrective actions necessary and record the corrective actions on a separate form which will include the date of the corrective actions and the initials of the Supervisor, Lead or designee. All forms will be submitted to the Laboratory Director and copies of all forms will also be kept within the individual departments.~~
9. ~~The Laboratory will notify CAP of any discovery of actions by laboratory personnel that violate national, state or local regulations.~~
10. ~~The Laboratory will cooperate with CAP and HHS when the laboratory is subject to a CAP or HHS complaint investigation or validation inspection.~~
11. ~~The Laboratory will adhere to the Terms of Use for the CAP Certification Mark of accreditation.~~

II. PURPOSE

It is a requirement of accreditation that all standards and laws are followed and prompt notification of any changes or adverse events be reported to the College of American Pathologists for review and follow up.

III. DEFINITIONS

A. CAP: College of American Pathologists accreditation agency for clinical laboratories

IV. GENERAL INFORMATION

A. The CAP can be contacted by phone 800-323-4040 or online at www.cap.org
B. Online users need to have a validated sign in username and password.

V. PROCEDURE

A. The Medical Director attests that:
    1. All Laboratory personnel are appropriately licensed, if required.
    2. The Laboratory is in compliance with all other applicable federal, state and local laws and regulations.
    3. There have been no investigations of the Laboratory by any state, federal, or other regulatory body

4. There have been no instances of adverse media attention in the past two years that have not been reported to CAP.
5. All information provided to the college is truthful and complete.
6. The Laboratory Management will notify the College of American Pathologists (CAP) promptly for the following events:
    a. Whenever the Laboratory finds itself the subject of an investigation by a government entity (including national, federal, state, local or foreign) or by another accrediting organization.
    b. A validation inspection
    c. Adverse media attention related to laboratory performance.
    d. A list of agencies and dates of each occurrence will be provided.
7. The Laboratory will provide an inspection team comparable in size and scope to that required for its own inspection, if requested by the regional and/or State commissioner, at least once during the two-year accreditation period.
8. The Laboratory will participate annually in the CAP proficiency testing program.
9. The Laboratory will notify the CAP in writing of changes in directorship, laboratory location or ownership within 30 days prior to the change.
10. The Laboratory will notify the CAP when there is a change in the Laboratory's test menu prior to beginning that testing.
11. The Laboratory has signed a form authorizing the CAP to release its inspection and proficiency testing data to the appropriate regulatory or oversight agencies.
12. The Laboratory will conduct an interim self-inspection.
    a. The Supervisor, Lead or designee will record any deficiencies found on the CAP self-inspection form.
    b. The form will be dated and initialed by the Supervisor, Lead or designee and submitted to the Laboratory Director.
    c. The Supervisor, Lead or designee will then make the corrective actions necessary and record the corrective actions on a separate form which will include the date of the corrective actions and the initials of the Supervisor, Lead or designee.
    d. All forms will be submitted to the Laboratory Director and copies of all forms will also be kept within the individual departments.
    e. The forms will be reported to the CAP electronically or via mail if electronic delivery is not available.
13. The Laboratory will notify CAP of any discovery of actions by laboratory personnel that violate national, state or local regulations.
14. The Laboratory will cooperate with CAP and HHS when the laboratory is subject to a CAP or HHS complaint investigation or validation inspection.
15. The Laboratory will adhere to the Terms of Use for the CAP Certification Mark of

accreditation.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. College of American Pathologists Accreditation Standards, GEN.26791; current version.

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
COO	Clement Miller: Chief Operating Officer	12/2023
Laboratory Medical Director	Johnny Hu: PHYSICIAN	12/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2023
Policy Owner	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14854895

Last Approved	N/A	Owner	Brenda Bailey: Manager Risk
Last Revised	11/2020	Area	Administration
Next Review	3 years after approval		

Disclosure of Unanticipated Outcomes

I. POLICY STATEMENT

A. Salinas Valley Health Medical Center (SVHMC) supports a commitment to transparency and honest communications in relation to unanticipated outcomes. Communication should when able occur as soon as possible (within hours, not days) of an unanticipated outcome. Adverse events should be communicated to patients/families when the event may result in a change in treatment, either now or in the future.

II. PURPOSE

A. To provide guidelines in responding and preserving a patient-centered organizational response to unanticipated outcomes and any reporting obligations to regulatory entities.

III. DEFINITIONS

A. **Adverse Event:** An adverse result that differs significantly from the anticipated result of a treatment or procedure and results in harm to the patient. Harm includes, but is not limited to, death, permanent disability, temporary disability, the need for transfer to a higher level of care, the prolongation of hospitalization, or the need for additional diagnostic studies or therapeutic intervention. Not all adverse events are the result of medical error and may be a recognized complication associated with the treatment/procedure.

B. **Disclosure:** Communication to patients or patient's families of information regarding the unanticipated results of a diagnostic test, medical treatment, or surgical intervention.

C. **Informed Consent:** A process to establish a mutual understanding between the patient/family and the physician who will be providing the care, treatment and services to a patient. Information given will include: the nature of the procedure, the risks, complications and expected benefits or effects of the procedure, and any alternatives to the treatment and their risks and benefits.

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. **Reporting an Unanticipated Outcome**

1. The individual identifying an unanticipated adverse outcome will:
    a. Take the necessary action to mitigate the harm to the patient.
    b. Immediately notify the patient's treating physician, the nurse manager/ department manager or nursing supervisor, administration, and risk management and/or patient safety.
    c. Enter an occurrence report.
2. Risk management/designee will:
    a. Conduct an immediate investigation of the events surrounding the unanticipated outcome.
    b. Discuss the event with patient's physician.
    c. Coach/prepare the physician in providing initial disclosure to the patient/ family if needed.
    d. Notify accreditation and regulatory of event for determination of reporting.
3. Initial Disclosure-preparing to communicate with the patient and family.
    a. The physician with the direct support of risk management and/or patient safety officer will inform the patient/family of the unanticipated outcome. Disclosure should not be done alone, and should include a colleague, and/ or a nurse.
    b. Present just the facts as they are known at that point. Do not go into details about how and why until information is clearly known. Avoid speculation.
    c. Show empathy and compassion for the patient/family member. Listen actively, allow for silence and be sensitive to the family's readiness to talk.
    d. Assure the patient/family that the hospital;
        i. Will continue to care for the patient.
        ii. Is committed to discovering what happened (if not known).
        iii. Will keep them informed as to the understanding of the events becomes clear following an investigation and review of care.

B. **Documenting The Event And The Outcome Of The Meeting**

1. Document in the patient's medical record;
    a. The facts as they are presently known.

b. Details and results of the communication of the event to the patient/ family, and the participants involved in the communication.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. California Disclosure Evidence Code §1160

B. CDPH Reporting Requirements (SB 1301/Health and Safety Code 1279.1)

C. Joint Commission Sentinel Events

D. Communication and Resolution Program (CRP) model by BETA HEART

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2023
Policy Owner	Brenda Bailey: Manager Risk	12/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13486141**

Last Approved	N/A	Owner	Carla Knight: Director Perioperative Services
Last Revised	01/2024	Area	Infection Control
Next Review	3 years after approval		

Disinfection of Instruments/Scopes

I. POLICY STATEMENT:

A. Articles prepared for high-level disinfection are meticulously decontaminated utilizing an enzymatic cleaner and mechanical friction that eliminates bio-burden and enhances the effectiveness of the disinfectant.

II. PURPOSE:

A. To guide the staff with a standard method for high-level disinfection of instruments/scopes and to render them free of microorganisms, (excluding spores).

III. DEFINITIONS:

A. High level disinfection: exposure of instruments/devices to a chemical disinfectant for the purpose of destroying all microorganisms except spores.

IV. GENERAL INFORMATION:

A. The disinfectant solution is a hospital approved high-level disinfectant.

B. The solution may be used with a ventilator/hood system.

C. Effectiveness of the disinfectant solution is tested daily with concentration-testing strips.

D. The Monterey Water Pollution Control Agency has approved discarding of outdated -testing strips.

E. High level disinfection may be used for instruments/scopes/devices as an alternative to sterilization when sterilization processes are unsuitable due to heat, length and internal diameter of instrument, and chemical sensitivity plasma. ~~Salinas Valley Health Medical Center (SVHMC)~~SVMHS has elected to designate Plasma Sterilization only, for flexible laryngoscopes and bronchoscopes.

F. Gluteraldehyde is maintained in surgery for use in the rare event that a patient with diagnosed

bladder cancer presents for an ureteroscopy. The scope needs to be high level disinfected. Rationale is there is a higher occurrence of anaphylaxis with Cidex OPA in this group of patients.

G. Staff is protected from unnecessary chemical exposure through the provision of personal protective articles.

V. PROCEDURE:

A. Decontamination process, maximizing the effectiveness of the disinfectant.
    1. Disassembling and scrubbing articles and brushing and irrigating lumens prior to disinfection assure exposure to an enzymatic cleaner and reduction of bioburden.
    2. After cleaning, the articles are rinsed and dried to prevent dilution of the disinfectant solution. All channels should be blown dry with compressed air.

B. High-level disinfection:
    1. Articles to be disinfected are totally immersed in disinfectant.
    2. For items with cable plugs that cannot be immersed, as much of the cable as possible is immersed and the lid is lowered on the cable with the plug outside the container.
    3. Lumens and channels are opened and irrigated to ensure removal of air and thorough contact with the disinfectant.
    4. The articles are soaked for 12 minutes in Cidex OPA, which is in accordance with manufacturer's recommendations and AAMI guidelines.
    5. When using the ventilator/hood the lid is closed during the soaking process.
    6. The articles that are to be used in a sterile field are rinsed thoroughly in three (3) sterile water rinses. The channels are flushed thoroughly in each rinse.
    7. Articles that are being terminally disinfected are rinsed thoroughly and dried before placement in storage. The channels are dried with compressed air.
    8. Terminally disinfected flexible endoscopes are rinsed with water followed by alcohol, dried and then hung in storage without the valves in place.
    9. The effectiveness of the high-level disinfection is demonstrated by daily testing with a chemical monitoring device and recording the results. Refer to the Cidex OPA Testing Competence.

C. Endoscopy High Level Disinfectant:
    1. Processor flushes with alcohol and dries scope at end of the cycle

D. Minimizing exposure to high-level disinfectants:
    1. Unless articles are being loaded into or removed from the disinfectant solution, the lid remains closed.
    2. Staff using chemical disinfectants are to wear splash protective eyewear, gowns, gloves, and skin protection.

3. The product Safety Data sheet is available on the hospital intranet.

E. Documentation: Daily testing is recorded in the Cidex OPA Testing Log Book.

VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

A. Cidex OPA product insert.

B. AAMI, Association for the Advancement of Medical Instrumentation.

C. AORN Recommended Practices for Perioperative Nursing, *Disinfection, high level*.

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	01/2024
P&T/IPC	Genevieve delos Santos: Director Pharmacy	12/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2023
Policy Owner	Carla Knight: Director of Perioperative Services	06/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14778787**

Last Approved	N/A
Last Revised	01/2024
Next Review	3 years after approval
Owner	Michelle Barnhart Childs: Chief Human Resources Officer
Area	Human Resources

Education and Staff Development

I. POLICY STATEMENT

A. Employees who do not attend ***required*** or ***mandatory*** education programs may be subject to a First Written Warning level of discipline, unless progressive discipline is warranted, and/or the employee is unable to work until education is completed.

II. PURPOSE

A. Provide, coordinate and document Education Programs at Salinas Valley Health Medical Center (SVHMC). Education Programs include, but are not limited to: Orientation, Simulation, Competencies, eLearning, and Continuing Education Classes. Staff's abilities to learn (including but not limited to language spoken, grade level, etc.) are routinely assessed to assure appropriate educational programs are defined.

B. Education Programs are provided to meet:

1. Requirements of regulatory agencies (i.e. The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS), California Occupational Safety and Health Administration (CAL-OSHA).
2. Required/mandatory education for specific department(s).
3. Identified need(s) (individual & group)
4. New equipment, products, practice, technology or procedures.
5. Continuing education, licensure, certification, or recertification requirements

III. DEFINITIONS

A. **Pre-Approved Mandatory:** If an employee must attend a **specific education program at a specific date and time**, this education program is defined as "***mandatory***". Overtime

compensation rules will apply as outlined in the appropriate union/non-affiliated handbook.

B. **Required:** An Education Program is "***required"*** when there is more than one (1) opportunity to attend the Education Program.

C. **Optional (Non Mandatory):** Optional ***(non-mandatory***) education programs are paid at the base hourly rate ONLY when it has been pre-approved by the Department Director. No overtime or other premium compensation will apply.

IV. GENERAL INFORMATION

A. The departments of Education and Human Resources are responsible for the provision, coordination and documentation of educational programs.

B. Employees attend General Orientation that covers key safety content with emphasis in provision of care, treatment, in-services, Environment of Care, and infection control or complete Self Study Orientation within 30 days of their date of hire.

C. Nursing staff complete New Hire Nursing Orientation prior to receiving a patient care assignment.

D. New employees and transfers receive department specific orientation. Department specific orientation competencies will be satisfactorily completed within sixty to ninety days of hire unless otherwise authorized by Administration.

E. The hospital orients staff on, but not limited to, the following:

1. Relevant hospital-wide and unit-specific policies and procedures. Completion of this orientation is documented.
2. Their specific job duties, including those related to infection prevention and control and assessing and managing pain. Completion of this orientation is documented. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7; IC.02.04.02, EP 2; RI.01.01.01, EP 8).
3. Sensitivity to cultural diversity based on their job duties and responsibilities. Completion of this orientation is documented.
4. Patient rights, including ethical aspects of care, treatment, and services and the process used to address ethical issues based on their job duties and responsibilities. Completion of this orientation is documented.

F. Staff will attend/complete education programs deemed **required** or **mandatory**.

G. An employee on a leave of absence is not eligible to take Hospital-sponsored classes.

H. The employee is responsible to notify the Education Department of an absence or ~~cancelation~~cancellation for scheduled education programs.

I. Attendees who arrive 10 minutes late will not receive continuing education hours (CE hours) and may lose their seat in the course.

J. The hospital reserves the right to cancel educational programs. In addition, the hospital acknowledges that employees may be canceled from an educational program based on business need.

V. PROCEDURE

A. ~~Attendance~~**Attendance**:

1. It is the responsibility of the employee to obtain authorization from the Department Director/Designee prior to class attendance.
2. It is the responsibility of the attendee to badge in/out and sign in to confirm attendance.
3. A make-up class may be offered to individuals who did not attend ***required*** or ***mandatory*** education. In the event an employee does not attend the ***required or mandatory*** make-up class as scheduled, discipline will be progressed to the appropriate level. Continued non-compliance may result in termination of employment.

B. ~~Registration~~**Registration**:

1. It is the responsibility of the employee to register for classes.
2. The number of participants for any program may be limited due to space restrictions and/or course requirements.
3. SVHMC employees are given priority enrollment over non-employees.
4. Employees who are required to have a specific class for assigned patient care areas have priority registration.

C. ~~Completion timelines (due dates):~~ **Completion timelines (due dates):**

1. Education Programs will be completed by the identified due date (completion date).
2. There is no "grace period".
3. Delinquent staff will receive a First Written Warning (or progressive discipline as appropriate)..
4. Staff on an approved Leave of Absence (LOA) will have 30 days upon their return to complete required education programs or, if necessary, will complete required education prior to reporting to work. Staff is paid for this time.

D. ~~**Late Arrival (Continuing Education and Simulations):**~~

~~1. **CE Classes:** Any registrant who arrives more than ten (10) minutes after the scheduled start time of the class will not be issued CE hours. Registrants who arrive more than ten (10) minutes after the posted time of the class may lose their seat.~~

~~2. **Simulations:** Registrants who arrive more than ten (10) minutes after the scheduled start time of the simulation will not be allowed to participate.~~

Late Arrival (Education Programs):

1. **Education Programs:** Registrants who arrive more than ten (10) minutes after the posted time of the class is deemed a "No Show". The employee will be charged the education program fees through the payroll deduction program. See education program fees below.
2. Any registrant who arrives more than ten (10) minutes after the scheduled start time

of the class will not be issued CE hours.

E. **Failure to Report (No Show):**

1. Failure to report for Education Programs without appropriate notice (Refer to ATTENDANCE GUIDELINES Policy) is an occurrence of unscheduled time off.
2. Failure to attend an educational program without appropriate notice is deemed a "No Show". The employee will be charged the education program fees through the payroll deduction program. See education program fees below.

F. **Appropriate Notice:**

1. Sick call: Scheduled registrant must call the Department of Education (755-0744) at least two (2) hours prior to the start of the education program.
2. Cancellation: Cancellation must be received by noon of the business day prior to the Education Program. (NOTE: By noon Friday for an education program on Monday or by noon Tuesday if Monday is a holiday.)

G. **Education Program No Show Fees** assessed through the payroll deduction program are as follows:

- American Heart Association courses: (Provider) ACLS, PALS, NRP = $~~250~~350.00
- American Heart Association courses: (Renewal): ACLS PALS, NRP = $~~160~~200.00
- American Heart Association courses: (Provider/Renewal): ASLS = $200.00
- HCP (BLS) renewal: = $ 75.00
- CEU programs = $10.00 per 1 hour of CEU
- ~~Simulation courses = $75.00~~

H. **Life Safety Courses (Refer to Attachment A)**

1. Life Safety Courses (i.e., BLS, PALS, ACLS, and NRP) are provided at no cost for those whose job description states such course is required or preferred, or course is approved by the Nursing Director/Manager for potential cross-training needs. (See LICENSURE/CERTIFICATION PROCEDURES FOR NEW HIRES AND STAFF).
2. If the course is NOT required or preferred, the employee shall pay the established fee unless the staff member has received approval in advance that the staff member needs the class for anticipation of cross training to another job which requires the certification. The Nursing Director/Manager may approve paid time for the class using optional education hours as appropriate. If no prior authorization is obtained, employee may attend the class on their own time.

I. **Documentation:**

1. The Education Department maintains employee attendance information in a computerized database.
2. The employee or former employee may request a copy of their Education Record from their department secretary or Education Department.
3. Employee's supervisor may request a copy of the employee's education record for annual performance appraisal review purposes.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. California Code of Regulations. Title 16, division 14, article 5. Continuing Education.

B. California Board of Registered Nursing; ttp://www.rn.ca.gov/licensees/ce-renewal.shtml

C. California Board of Registered Nursing Continuing Education Program Instructions for Providers: California Department of Consumer Affairs: https://www.rn.ca.gov/applicants/cep-lic.shtml#intro

Attachments

A: Life Safety Courses (BLS, PALS, ACLS, NRP) Payment Algorithm

Approval Signatures

Step Description	Approver	Date
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2024
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	01/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14032070**

Last Approved	N/A
Last Revised	11/2023
Next Review	1 year after approval
Owner	Earl Strotman: Director Facilities Management & Construction
Area	Emergency Management

Emergency Management for Mass Casualty Incidents (MCI)

I. POLICY STATEMENT

A. N/A

II. PURPOSE

~~A. To assure readiness for a mass casualty event.~~

A. To guide the response to a mass casualty incident.

III. DEFINITIONS

~~A. MCI Plan - The Emergency Management Plan for Mass Casualty Incidents (MCI plan) is for events occurring inside and outside the hospital requiring additional staff, resources, communication, and preparation and/or extraordinary expansion of services.~~

A. MCI Plan - The Emergency Management Plan for Mass Casualty Incidents (MCI plan) is for events occurring inside and outside the hospital requiring additional staff, resources, communication, and preparation and/or extraordinary expansion of services.

B. Volunteer - In the Hospital Incident Command System (HICS) framework, this refers to an individual who arrives to help with the incident. They are referred to Labor Pool for an appropriate assignment. Not to be confused with the Salinas Valley Health Volunteer Department.

C. Incident Command Team- The team leading the response to the incident, under the direction of the Incident Commander.

D. Public Information Officer (PIO) - the member of the Incident Command Team who is responsible for interfacing with the public, media, various agencies, and the private sector to meet incident-related information needs. The PIO gathers, verifies, coordinates, and disseminates accessible, meaningful, and timely information about the incident for internal and external audiences.

E. Liaison Officer- the member of the Incident Command Team who functions as the incident contact person for representatives from other agencies.

F. MHOAC - Medical and Health Operational Area Coordinator. Responsible for monitoring, ensuring, and procuring medical and health resources during a local emergency or disaster. The MHOAC is authorized to work with the Regional Disaster Medical Health Program to submit and respond to medical and health requests for resources outside of the Operational Area. The county Health Officer and the Local Emergency Medical Services Agency Administrator may act jointly as the MHOAC, or they may jointly appoint an individual to serve in this role.

G. HICS - Hospital Incident Command System. The roles assigned during incident response that align with the National Incident Management System

H. Casualty Care Area - the alternate care area established to manage an influx of patients to the Emergency Department.

I. Job Cards - a guide for individuals assuming roles in MCI response to assist them in supporting the event.

IV. GENERAL INFORMATION

A. The Emergency Management of Mass Casualty Incidents follows the Salinas Valley Health Medical Center (SVHMC) Emergency Operations Program Plan.

B. The Emergency Management Plan for Mass Casualty program is developed, approved and maintained in consultation with representatives of the medical staff, nursing staff, administration and fire and safety experts.

C. The program covers disasters occurring in the community and widespread disasters. It provides for at least the following:

1. Availability of adequate basic utilities and supplies, including gas, water, food and essential medial and supportive materials.
2. An efficient system of notifying and assigning personnel.
3. Unified ~~medical~~ command.
4. Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.
5. Prompt transfer of casualties, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definite care.
6. A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved.
7. Procedures for the prompt discharge or transfer of patients already in the hospital at the time of the disaster who can be moved without jeopardy.
8. Maintaining security in order to keep relatives and curious persons out of the triage area.
9. Establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will be made to provide organized dissemination of information.

D. The program is in conformity with the California Emergency Plan of October 10, 1972 developed by the State Office of Emergency Services and the California Emergency Medical Mutual Aid Plan of March 1974 developed by the Office of Emergency Services, Department of Health.

E. This plan is reviewed at least annually and includes all areas of the Salinas Valley Health Medical

Center (SVHMC) campus and surrounding buildings and offices where SVHMC staff and/or services are present.

F. There is evidence in the personnel/education files, e.g., orientation checklist or elsewhere, indicating that all new employees have been oriented to the program and procedures within a reasonable time after commencement of their employment.

V. PROCEDURE

A. **Phases**

1. The MCI plan consists of four distinct phases:
    a. Phase I: Alert of a possible event
    b. Phase II: Activation and Management of the MCI Plan
    c. Phase III: Demobilization
    d. Phase IV: Recovery

B. ~~**Obtaining and relaying information**~~**Phase I: Alert of a Possible Event**

1. Any employee who learns of an occurrence that might constitute a Mass Casualty Incident (MCI) should attempt to obtain the following information:
    a. What was the occurrence?
    b. What is the location of the occurrence?
    c. How many casualties are estimated?
    d. What type of injuries?
    e. How many victims should the hospital expect and when?
    f. The goal of Code Triage MCI is to be prepared to receive patients within 15 minutes.

2. An employee who learns of the occurrence must notify the Emergency Department at ext. 4355, Hospital Administration ~~at ext~~, or, during off hours and weekends, the on-duty Administrative Nursing Supervisor. ~~1241 or during off hours and weekends the Administrative Supervisor on duty through the operator.~~ After -hours, it is the responsibility of the Administrative Supervisor to consult with the emergency department physician and charge nurse to determine if the event requires activation of the MCI plan. ~~The following people have the authority to activate the MCI plan: Emergency Department physician, Emergency Department Director/Manager, Administrative Supervisor, Executive on site or on call. Any activation of the MCI plan should also call for an activation of the Hospital Incident Command System (HICS).~~

C. **Phase II: Activation of the MCI plan**

~~1. Activation of the MCI plan should be done by overhead page as "Code Triage External, MCI."~~

~~2. Activation of the MCI plan can be done in 3 levels depending on the nature and significance of the event.~~

~~**Level 1:**~~ Unusual event, MCI with either mostly stable, low acuity victims or limited number of

victims. Minimal to moderate response is needed. Portions of HICS may be activated.

~~**Level 2:**~~ Large scale event or hospital emergency that will be involving multiple departments and will necessitate additional staff and resources. A level 2 event will likely involve multiple critical or unstable patients (or the potential for), and complicating factors such as decontamination. Moderate to full response is needed including partial to full activation of HICS.

~~**Level 3:**~~ Major disaster that requires full activation of HICS and an "all hands on deck" response from the organization. A level 3 event will include an overwhelming number of patients, many of which will be traumas, critical, medically complicated, and worried well. It will likely include other complicating factors such as decontamination, alternate triage sites, and expanding treatment areas into other departments or outside. Assembly of tents in adjacent parking lots may also be necessary to accommodate the expansion of triage and treatment areas and staging areas. A level 3 event will likely include multiple outside agencies such as EMS, law enforcement, fire departments, media, etc. A Joint Incident Command may also be necessary in the Incident Command Center (ICC).

~~**Phases:**~~
The MCI plan consists of three distinct phases:
Phase I: Alert of a possible event
Phase II: The actual event when parts, or all of the plan, is activated
Phase III: Demobilization

1. The following people have the authority to activate the MCI plan:
    a. Emergency Department physician,
    b. Emergency Department Director/Manager,
    c. Administrative Supervisor,
    d. Executive on site or on call.
2. Any activation of the MCI plan should also call for an activation of the Hospital Incident Command System (HICS).
3. Activation of the MCI plan may be done at 3 levels depending on the nature and significance of the event.
    a. **Level 1:** Unusual event, MCI with either mostly stable, low acuity victims or limited number of victims. Minimal to moderate response is needed. Portions of HICS may be activated.
    b. **Level 2:** Large scale event or hospital emergency that will be involving multiple departments and will necessitate additional staff and resources. A level 2 event will likely involve multiple critical or unstable patients (or the potential for), and complicating factors such as decontamination. Moderate to full response is needed including partial to full activation of HICS.
    c. **Level 3:** Major disaster that requires full activation of HICS and an "all hands on deck" response from the organization. A level 3 event will include an overwhelming number of patients, many of which will be traumas, critical, medically complicated, and worried well. It will likely include other complicating factors such as decontamination, alternate triage sites, and expanding treatment areas into other departments or outside. Assembly of

tents in adjacent parking lots may also be necessary to accommodate the expansion of triage and treatment areas and staging areas. A level 3 event will likely include multiple outside agencies such as EMS, law enforcement, fire departments, media, etc. A Joint Incident Command may also be necessary in the Incident Command Center (ICC).

D. ~~**MCI MANAGEMENT**~~

1. ~~Once the MCI plan has been activated, the emergency notification system will be activated at the direction of the Incident Command Center (ICC). Each department will then activate their emergency response plans under administrative control of the ICC.~~

    a. ~~The **Casualty Care Unit Leader** or appointee will remain in command of all available medical and surgical personnel and like resources during the event. The on duty Emergency Department physician will act as the Casualty Care Unit Leader until the ICC is operational.~~

    b. ~~The **Administrative Supervisor** on duty will be responsible for establishing the ICC, assuming the role of incident commander, and initiating necessary protocols.~~

        i. ~~The Administrative Supervisor on duty shall remain in the ICC and remain in the role of the incident commander until relieved.~~

        ii. ~~This role will include management of disaster operations as outlined in the Emergency Operations Plan (EOP) and Emergency Management Plan (EMP). This role shall not be superseded by an authority or directive from outside agencies involved with the event without consent from hospital administration.~~

        iii. ~~The role of the incident commander may be assumed by the CEO or other Executive upon arrival to the hospital.~~

    c. ~~**Decontamination**~~

    ~~Upon notification or suspicion that the event has a hazardous materials component and patients will need decontamination, the decontamination trailer will be utilized for all patient decontamination needs.~~

    ~~The Liaison Officer or designee will contact the Monterey County EMS hazardous response team (911) or other applicable agency to obtain the identity of the hazardous material involved, and attempt to obtain a copy of the Safety Data Sheet (SDS).~~

    ~~If SDS has been received, or the material identified through other means, review with all SVHMC responders before patient decontamination is initiated to ensure responding staff are aware of the potential hazards of the material involved, and have ensured they have donned the appropriate PPE to ensure their safety.~~

    ~~The trailer should be opened and assembled on notification. Engineering will be notified to assist with infrastructure needs to support decontamination.~~

    ~~Security will be notified for access control needs and patient belonging documentation.~~

The Environmental Health and Safety Manager will coordinate waste water management in collaboration with the Monterey County Environmental Health and Safety Hazardous Materials Department and Monterey One Water.

Patients contaminated with hazardous materials shall be decontaminated to the best of the hospital's ability and supplemented by one of Monterey County's EMS hazardous materials response teams if needed and available.

At this time the responding agency must be represented in the ICC, if applicable, or a liaison from the ICC should be appointed to represent outside agencies under the Liaison Officer.

At no time shall contaminated patients enter the Emergency Department until they have been decontaminated as this will compromise other patients, staff, and treatment areas inside.

All contaminated patient belongings will be stored in the patient belonging bags, labeled, and secured in the locking storage box. Cleaning and return of patient belongings will be subject to the safety officer or designee discretion.

If necessary, the decontamination certified Emergency Department team members can perform resuscitation efforts simultaneously with decontamination.

d. **Emergency Department MCI carts, Surge Kit and Triage Tags**
Upon activation of the MCI plan the MCI carts will be brought to the front entrance of the Emergency Department and immediately deployed. The MCI cart is located in the "MCI Response" storage shed near the front entrance of the Emergency Department. The MCI carts contain the Surge Kit (including treatment area equipment and assignments), Triage Ribbons and Tags.

Treatment Area Assignments
Red: MD, RN, RN, CA/Tech
Yellow: MD, RN, RN, CA/Tech
Green: PA, RN, CA/Tech

Emergency Department Surge Kit

i. The Surge Kit contains the equipment for the pre-designated color coded treatment areas (Red, Yellow, Green, Black). It also contains specific duties and responsibilities to be accomplished immediately when the MCI plan is activated. Refer to the EOP for fatality management. Corresponding color coded vests and job action sheets are included for the following:

    a. Triage Unit Leader
    b. Casualty Care Unit Leader
    c. Transportation Unit Leader
    d. Immediate Treatment Manager

e. Delayed Treatment Manager
f. Minor Treatment Manager
g. Expectant Manager
h. Incident Commander
i. Safety Officer
j. Patient Registration Unit Leader
k. Access Control Unit Leader
l. Family Unification Unit Leader
m. Patient Tracking Manager

Triage Tags and Ribbons

i. Triage Ribbons are to given to the Triage Unit Leader to assign incoming patients to an acuity category based on the START/ JumpSTART model.
ii. The Triage Tags are to be opened and given to assigned personnel in the designated treatment areas.
iii. The Triage Ribbons and Tags are to be deployed and ready at the time of notification and activation of the MCI plan, ideally before patients arrive to the emergency department.

START and JumpSTART Triage

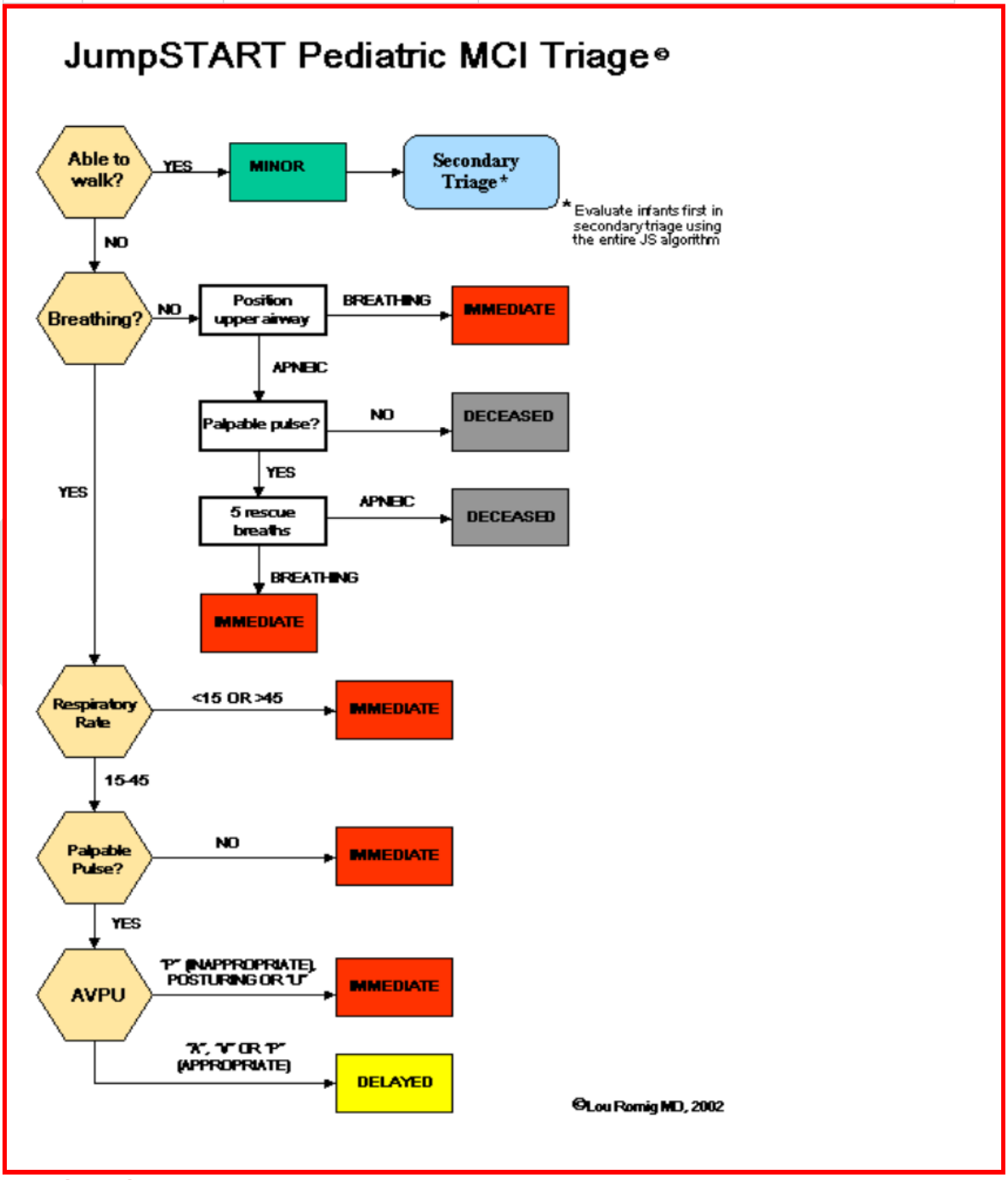
The Simple Triage And Rapid Treatment (START) and JumpSTART (pediatric version) models may be used. The Triage Unit Leader and team of triage nurses will assign patients on arrival to one of the standard four color categories and dispatched them accordingly:

i. **Green:** minor injuries that can wait for appropriate treatment. "Green" patients will be placed in the minor treatment area.
ii. **Yellow:** significant injuries but relatively stable patients that can wait for medical attention. No life threatening conditions. "Yellow" patients will be placed in the delayed treatment area.
iii. **Red:** critical patients in need of immediate intervention and/or resuscitation. "Red" patients will be placed in the immediate treatment area.
iv. **Black:** deceased patients or those who have little to no chance of survival. "Black" patients will be taken to the morgue

START Triage (adult)

Color	Acuity	Treatment	Description/Comments
Red	Emergent	Immediate	Threat to life, limb, or organ
Yellow	Urgent	Delayed	Significant injury or illness but can tolerate a delay

~~Green~~	~~Non-Urgent~~	~~Minimal/Non-urgent~~	~~Can safely wait for treatment~~
~~Black~~	~~Deceased or Expected~~	~~No treatment expected: Treat only if resourced available~~	~~Consider transport and care for expectant patients after "Reds" are cleared, if resources exist and does not delay care of "Yellows"*~~



~~Neurological Assessment~~

"A" =Alert

"V"= Responds to verbal stimuli

"P" =Responds to painful stimuli

"U" =Unresponsive to noxious stimuli

SVHMC offers palliative care services and should be requested through the ICC or Medical Staff Office.

E. ~~**ROLES AND RESPONSIBILITIES**~~

1. ~~**Security**~~
   ~~When the MCI plan is activated hospital security officers should secure the perimeter around the event. In the event of a hazardous material exposure this will help ensure safety of other patients, visitors and hospital personnel and avoid contamination of the treating facility. No passersby or media shall be allowed to enter the perimeter unless instructed by the ICC or unless someone is seeking medical attention. Anyone seeking medical attention shall be directed to the designated triage area. All entrances to the emergency department should be secured. All family and visitors seeking information or wishing to see loved ones should be directed to the Family Reunification Unit Leader. The ICC will assign a family reunification location and a liaison to provide information to family and visitors.~~

2. ~~**Registration of Patients**~~
   ~~During a declared MCI (activation of the MCI plan) patients involved in the MCI, regardless of their involvement, should not be registered on arrival in Meditech. Patients are sorted according to the START and JumpSTART model and tagged as appropriate with triage tags. They are to be tracked using the tracking log located in the surge kit. Patients that have been determined stable for discharge are to be discharged from the discharge area adjacent to the treatment areas. These patients should be fully registered then discharged in Meditech at this time. Patients that need ongoing complicated medical care should be moved into the Emergency Department and registered into Meditech.~~

3. ~~**Nursing Services**~~
   ~~An assigned Nursing director or, during off hours, an additional administrative supervisor or director, will be responsible for coordinating and dispatching nursing and support services to all routine and disaster care-related hospital areas, per the priorities established through the ICC. Specific initial duties include:~~

   a. ~~Conduct accurate bed count for available Med/Surg beds~~
   b. ~~Conduct accurate count of available ICU/Progressive Care/ Isolation beds~~
   c. ~~Contact the Director of Perioperative service to assess readiness of OR and recovery rooms~~
   d. ~~Coordinate with inpatient services the evaluation of patients who can be rapidly discharged from inpatient services.~~
   e. ~~Ensure ED Charge nurse has needed staff and resources including transporters, interpreters, registration clerks, volunteers, etc.~~

4. ~~**Support Services**~~
   ~~The Incident Commander will be responsible to ensure the departmental disaster plans are activated and appropriate staff and supplies are brought to the ED, OR and other areas as needed.~~

   a. ~~**Materials Management:** Additional supplies will likely be needed to the ED. Assign dedicated Materials Management personnel to the ED to bring required supplies and equipment to the ED.~~

b. **Blood Bank:** The Blood Bank is alerted to the MCI by the overhead paging system and will coordinate the distribution of blood and contact outside blood banks if necessary.

c. **Pharmacy:** Dispatches required personnel and medications to the ED. Also prepares for use of possible antidotes in Hazmat and Biohazard incidents.

d. **Radiology:** Dispatches two technicians to the ED with portable equipment if available. Also postpones non emergent diagnostic imaging requests to accommodate the MCI response. Ensures rapid availability of CT scanner, including the outside CT scanner, ultrasound and other diagnostic imaging services.

e. **Transport Services:** Bring all available gurneys and wheel chairs to ED.

f. **Respiratory:** A Respiratory Care Practitioner reports to the ED and the supervisor should compile a list of available ventilators, additional oxygen tanks and nebulizer sets and report this information to the ICC.

g. **Lab services:** Should be prepared to receive a large influx of requests and should deploy available phlebotomists to the treatment areas.

5. **Discharge Planning**
   A discharge staging area will be established adjacent to the Minor (Green) treatment area. Patients determined to be stable for discharge will be moved to this area and will be discharged by a discharge planner. Taxi vouchers and bus passes should be considered to decongest the area. A discharge planning kit is assembled and available in the MCI shed.

6. **Public Relations and News Media**
   At no time will the media be allowed unescorted through any patient care or treatment area. Hospital security will direct all media to the designated media area in the Nancy Ausonio Mammography Center parking lot, or an alternate site will be designated by the ICC. If multiple agencies and/or facilities are involved a joint information center will likely need to be established by the Monterey County Office of Emergency Services. SVHMC's Liason officer can request this by contacting the Monterey County MHOAC ("Mowak") via the on-duty EMS officer at 831-235-0163.

7. **Volunteer and Labor Pool Management**

   a. Medical volunteers (physicians, surgeons, physician assistants) will be screened for emergency credentialing and coordinated through the medical staff office.

   b. All other clinical and ancillary volunteers will be screened for emergency credentialing and coordinated through Human Resources which is represented under the Operations section of the Hospitals Incident Command System.

   c. Refer to the Salinas Valley Health Medical Center EMERGENCY OPERATIONS PLAN for more detailed labor pool management plans.

8. **De-escalation**
   The ICC will authorize telecommunications to give the "Code Triage, all clear" via the overhead paging system when the event has been declared over. It is the incident commander's responsibility to call for de-escalation and to deactivate the EOP and MCI plans. The Triage/Receiving area and MCI treatment areas will be deactivated at the

~~direction of the ICC. This shall be done only after consultation with the ED physician and ED charge nurse.~~

9. ~~**Recovery Phase**~~

   a. ~~Continue to assist employees and community with psychological needs~~

   b. ~~Assist employees with employee assistance programs through Human Resources department~~

   c. ~~Collect MCI documentation sheets and return to ICC~~

   d. ~~Perform debriefing (involve staff and outside agencies). This is the responsibility of the Incident Command team~~

   e. ~~Submit written evaluation of incident to Emergency Management Committee for review~~

   f. ~~Integrate improvements into the Emergency Operations Plan and into departmental plans or procedures as needed.~~

F. **Phase II, continued: MCI Management**

1. **Incident Commander Assignment & Code Notification**

   a. Once the MCI plan has been activated, the emergency notification system will be activated at the direction of the Incident Command Team.

      i. Activation of the MCI plan should be done by overhead page as "Code Triage External, MCI." It may also be announced via Everbridge mass-texting platform.

   b. The on-duty Emergency Department physician, or designee, will take the lead as the **Casualty Care Unit Leader.** They will direct the response at the Casualty Care Area.

   c. The **Administrative Supervisor** on duty will assume the role of Incident Commander, appoint an Incident Command Team, initiate protocols, and set objectives as appropriate.

      i. A summary of suggested supporting roles and objectives is attached in **ATTACHMENT A: MCI Roadmap.** Note: objectives and roles needed may vary depending on the incident.

      ii. The Administrative Supervisor on duty shall remain in the role of incident commander until relieved.

      iii. This role will include management of disaster operations as outlined in the Emergency Operations Plan (EOP). This role shall not be superseded by an authority or directive from outside agencies involved with the event without consent from hospital administration.

      iv. The role of the incident commander may be assumed by the CEO or other authorized On-Call Administrator upon arrival to the hospital.

2. **MCI Casualty Care Area Setup**

   a. **Equipment**

      i. The "MCI Response" trailer is parked near the Emergency

Department and contains supplies needed to establish an alternate care area outside the facility for a patient surge. This kit is designed such that it can be set up in approximately 15 minutes, and creates a casualty care area with a capacity of approximately 50 patients.

a. Color-coded Tents that correspond to the level of care determined at triage.

b. Color-coded carts that correspond to the level of care determined at triage. These contain PPE, materials to support documentation of patient care, triage ribbons and tags, color-coded tarps to place under the tents.

c. Job Cards Kit for MCI-specific roles in the casualty care area.

ii. Upon activation of the MCI plan the MCI supplies will be brought to the casualty care area and immediately deployed.

iii. A map showing setup configuration is attached and may be used to guide for casualty care area setup. See **ATTACHMENT B: Code External Triage MCI 15-to-50 Set Up Map.**

b. **Casualty Care Area Job Assignments**

i. Treatment Areas are anticipated to require the following direct care providers:

a. **Red:** MD, RN, RN, CA/Tech

b. **Yellow:** MD, RN, RN, CA/Tech

c. **Green:** PA, RN, CA/Tech

ii. Additional Supporting Roles (see Job Cards Kit from MCI Supply) may include:

a. Casualty Care Unit Leader (On duty ED physician)

b. Triage Unit Leader

c. Immediate Treatment Manager (Red)

d. Delayed Treatment Manager (Yellow)

e. Minor Treatment Manager (Green)

f. Expectant Manager (Black)

g. Incident Commander (Nurse Administrative Supervisor, or Admin-on-Call)

h. Safety Officer

i. Patient Registration Unit Leader (Registration department, if available)

j. Access Control Unit Leader (Security department, if available)

k. Family Reunification Unit Leader

l. Patient Tracking Manager

m. Transportation Unit Leader

iii. Individuals will familiarize themselves with their role by using job cards, by receiving information from the Incident Command Team, and reading the entirety of this procedure.

a. Note: MCI job cards are available on Starnet.

iv. Casualty Care Leader, or designee, may contact Incident Command Team if more personnel are needed to fill Casualty Care Job Assignments. The Incident Command Team may need to appoint a Labor Pool lead to provide adequate personnel to assigned roles. For more information, see "Labor Pool section", below.

c. **Triage Setup**

i. **Deploy Triage Ribbons and Triage Tags**

a. Triage Ribbons are to given to the Triage Unit Leader to assign incoming patients to an acuity category based on the START (Simple Triage and Rapid Treatment)/JumpSTART (pediatric version) models.

b. Note: the Triage Tags are to be opened and given to assigned personnel in the designated treatment areas. These tags are used for patient tracking and documenting care.

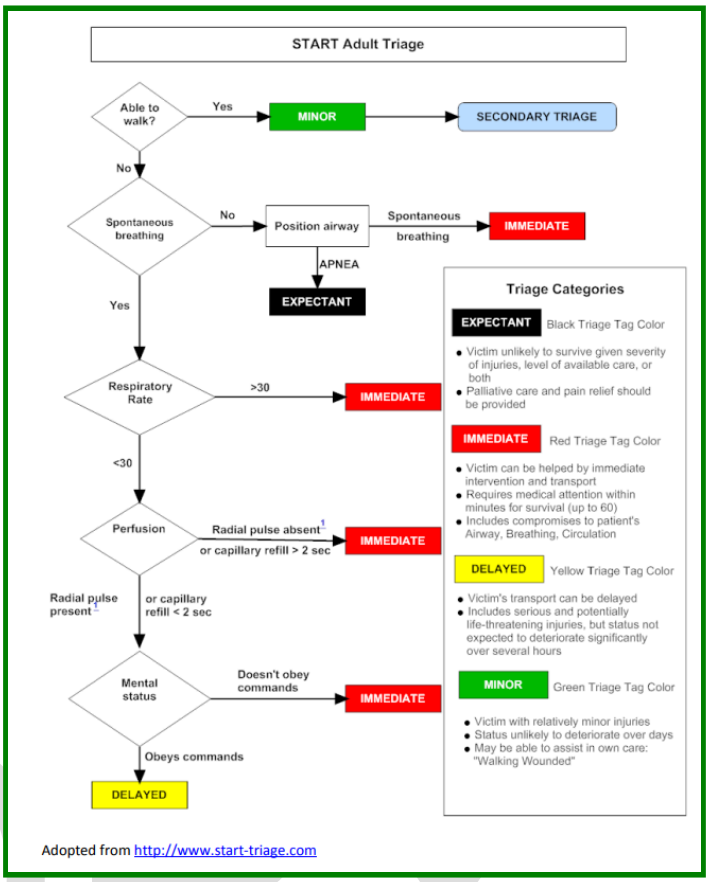
c. The Triage Ribbons and Tags are to be deployed and ready at the time of notification and activation of the MCI plan, ideally before patients arrive to the emergency department.

d. The Triage Unit, with the support of the most experienced ER physician on duty appropriate, will identify patient status and whether patients require immediate, delayed, minor, or expectant care.

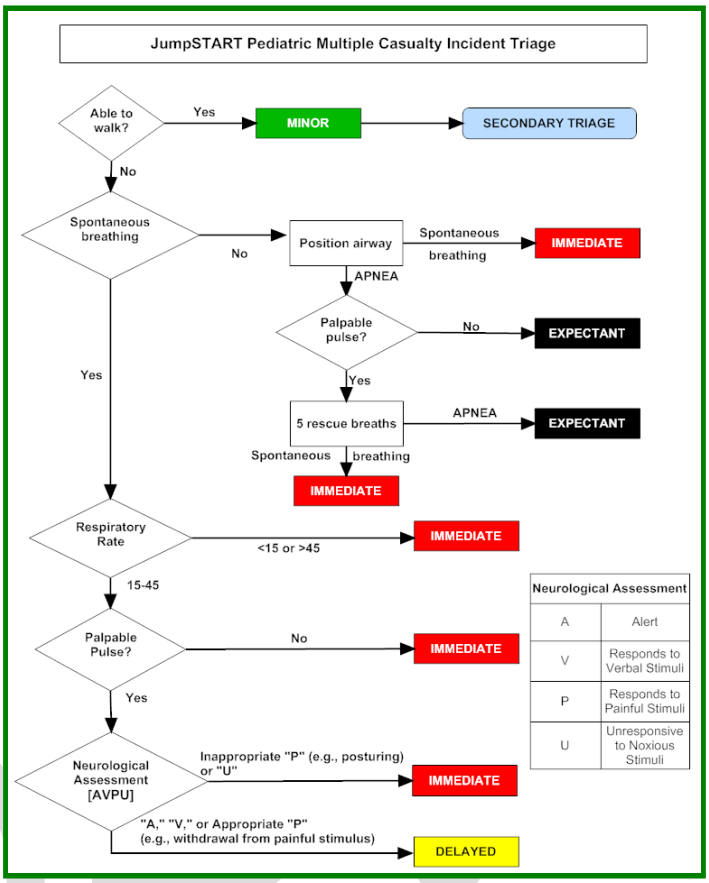
ii. **START and JumpSTART Triage Algorithms**

a. **START Triage (Use if the patient appears to be an adult or young adult):**

b.



c. **JumpSTART (Use if the patient appears to be a child):**



d. **Establish Perimeter and Control Access: Security Access Control Unit Leader**

i. When the MCI plan is activated hospital security officers should secure the following:

a. Blocking traffic to San Jose street, except for ambulance traffic and persons seeking emergency care.

b. The perimeter around the event, particularly in the event of a hazardous material exposure. This will help ensure safety of other patients, visitors and hospital personnel and avoid contamination of the treating facility.

c. Level 3 Lockdown will be initiated, unless the Incident Command Team determines another level is more appropriate for the incident.

ii. Anyone seeking medical attention shall be directed to the designated triage area.

iii. No passersby or media shall be allowed to enter the perimeter unless instructed by the Public Information Officer or designee. Media should be directed to the Media Area, located in the MRI parking lot or as designated by the Incident Command Team.

iv. All family and visitors seeking information or wishing to see loved ones should be directed to the Family Reunification Unit Leader in the Family Assistance Center, located in DRC ABC or as assigned by

Incident Command.

e. **Registration of Patients: Registration Unit Leader**

i. During a declared MCI (activation of the MCI plan) patients involved in the MCI, regardless of their involvement, should not be registered on arrival in Meditech. Patients are sorted according to the START and JumpSTART model and tagged as appropriate with triage tags. They are to be tracked using the tracking log located in the surge kit.

ii. Therefore, assign individuals to support patient registration at the following locations:

a. MCI Discharge Area: Patients that have been determined stable for discharge are to be discharged from the discharge area adjacent to the treatment areas. These patients should be fully registered then discharged in Meditech at this time.

b. Inside the ED: Patients that need ongoing complicated medical care should be moved into the Emergency Department and registered into Meditech there.

f. **Staging Area**

i. The Casualty Care Unit leader, or designee, will identify a staging area, to which incoming equipment, materials, support staff and providers will arrive before being assigned where needed.

g. **Supporting Departments bring resources needed to support the MCI:**

i. The following departments are encouraged to bring resources immediately to the staging area, before receiving requests from Incident Command.

a. **Materials Management:** Additional supplies will likely be needed to the ED. Assign dedicated Materials Management personnel to the ED to bring required supplies and equipment to the ED. Materials Management has a pre-termined pick list.

b. **Blood Bank:** The Blood Bank is alerted to the MCI by the overhead paging system and will coordinate the distribution of blood and contact outside blood banks if necessary.

c. **Pharmacy:** Dispatches required personnel and medications to the ED. Also prepares for use of possible antidotes in Hazmat and Biohazard incidents. See job card in:

i. **ATTACHMENT C: Pharmacy Job Card**

d. **Radiology:** Dispatches two technicians to the ED with portable equipment if available. Postpones non-emergent diagnostic imaging requests to accommodate the MCI response. Ensures rapid availability of CT scanner,

including the outside CT scanner, ultrasound and other diagnostic imaging services.

e. **Transport Services:** Bring all available gurneys and wheel chairs to ED. See job cards in:

   i. **ATTACHMENT D: Transporter Manager Job Card**

   ii. **ATTACHMENT E: Transporter Job Card**

f. **Respiratory:** A Respiratory Care Practitioner reports to the ED and the supervisor should compile a list of available ventilators, additional oxygen tanks and nebulizer sets and report this information to the Incident Command Team.

g. **Lab services:** Should be prepared to receive a large influx of requests and deploy available phlebotomists to the treatment areas.

h. **Palliative care services, Chaplain:** may be requested through the Incident Command.

i. **Volunteer Department:** any on-duty volunteers already on-site as part of the Salinas Valley Health volunteer program will bring available wheelchairs to the staging area. For more information, see job cards in:

   i. **ATTACHMENT F: Volunteer Manager Job Card**

   ii. **ATTACHMENT G: Volunteer Department Job Card**

j. Inpatient Nursing Unit Charge Nurses: Assess staffing and resources available on the unit that may be reallocated to the Casualty Care Area or Emergency Department. Assess for potential discharges. Report to the HICS-assigned Inpatient Unit Leader. See job card in:

   i. **ATTACHMENT H: Inpatient Unit Charge Nurse Job Card**

k. The Incident Command Team, under the direction of the Incident Commander, will ensure appropriate staff and supplies are brought to the Casualty Care Area, ED, OR and other areas as needed.

h. **Establish a Discharge Staging Area**

   i. A discharge staging area may be established adjacent to the Minor (Green) treatment area, and a Discharge Planner will be appointed. Patients determined to be stable for discharge will be moved to this area and will be discharged by a discharge planner. Taxi vouchers and bus passes should be considered to decongest the area. A copy of Sam's Guide to local resources is available in the MCI trailer.

3. **Open Inpatient and Surgery Capacity**

a. Under the Operations Chief, a Medical Care Branch Director will be appointed to ensure the inpatient and procedure areas are prepared to take on an influx of patients. This may include the following activities:

i. Conduct bed count for available inpatient beds

ii. Work with procedure area leaders to assess readiness of OR and recovery rooms. Assess for potential cancellations.

iii. Coordinate with inpatient units or Case Management the evaluation of patients who can be rapidly discharged from inpatient services.

iv. If needed, open an inpatient discharge waiting area, for patients who have already been discharged and are waiting for a ride. The second floor surgery waiting room has been flagged as a suitable location for this. Staff will be assigned to the discharge lounge as appropriate to maintain patient and staff safety.

4. **Deploy Additional Support Functions**

a. **Public Relations and News Media**

i. At no time will the media be allowed un-escorted through any patient care or treatment area. Hospital security will direct all media to the designated media area in the Mammography parking lot, or other area as determined by the Incident Command Team. If multiple agencies and/or facilities are involved, a joint information center may be established by the Monterey County Office of Emergency Services. SVHMC's Liaison officer can request this by contacting the Monterey County MHOAC via the on-duty EMS officer at 831-235-0163.

b. **Volunteer and Labor Pool Management**

i. Medical volunteers (physicians, surgeons, physician assistants) will be screened for emergency credentialing and coordinated through Medical Staff Services department.

ii. All other clinical and ancillary volunteers will be screened for emergency credentialing and coordinated through Human Resources which is represented under the Logistics section of the Hospitals Incident Command System. For more information, see policy Disaster Privilege for Clinical Volunteers, SVHMC Volunteers, Non-Clinical Volunteers, and Non-SVHMC Volunteers

iii. Everbridge, or other communication systems, may be used to request labor pool volunteers.

c. **Family Reunification Center**

i. Details for establishing a Family Reunification Center are in the Emergency Management Program Plan.

G. **Phase III: De-mobilization**

1. The Incident Command Team, under the direction of the Incident Commander, will evaluate the status of individual units/sections and will demobilize each when deemed appropriate.

2. The Incident Command Team will authorize telecommunications to give the "Code External Triage MCI, all clear" via the overhead paging system when the event has been declared over. It is the incident commander's responsibility to call for de-escalation and to deactivate the EOP and MCI plans. The Triage/Receiving area and MCI treatment areas will be deactivated at the direction of the Incident Command Team. This shall be done only after consultation with the ED physician and ED charge nurse.
3. Clean, sanitize, return or dispose of equipment and materials as appropriate.
4. Conduct hot-wash debrief with response team. If possible, include Code Lavender Team to assess for responders' needs post incident.
5. Collect MCI documentation sheets and return to Incident Command.

H. **Phase IV: Recovery**

1. Continue to assist employees and community with psychological needs.
2. Assist employees with employee assistance programs through Human Resources department.
3. Route purchases, labor hours information to Finance Section Chief for potential FEMA reimbursement.
4. Incident Command Team will conduct a formal debrief, and will include outside agencies as appropriate.
5. Submit written evaluation of incident to Emergency Management Committee for review.
6. Replenish supplies as appropriate.
7. Integrate improvements into the Emergency Operations Plan and into departmental plans or procedures as needed.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

~~A. Title 22 70413 and 70741 45~~

A. Title 22 70413 and 70741

B. CDPH "15 'til 50 Mass Casualty Incident Toolkit". Accessed July 2023. https://cdphready.org/15-til-50-mass-casualty-incident-toolkit/

Attachments

ATTACHMENT A: MCI Roadmap

ATTACHMENT B: Code External Triage MCI 15-to-50 Set Up Map

ATTACHMENT C: Pharmacy Job Card

ATTACHMENT D: Transporter Manager Job Card

ATTACHMENT E: Transporter Job Card

ATTACHMENT F: Volunteer Manager Job Card

ATTACHMENT G: Volunteer Department Job Card

ATTACHMENT H: Inpatient Unit Charge Nurse Job Card

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
EM Committee	Sophia Sanchez: Emergency Preparedness Coordinator	01/2024
Emergency Management Specialist	Sophia Sanchez: Emergency Preparedness Coordinator	01/2024
EOCC	James Hively: Manager Environmental Health & Safety	11/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Owner	Earl Strotman: Director Facilities Management & Construction	10/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13669007**

Last Approved	N/A	Owner	Melissa Deen: Manager Infection Prevention
Last Revised	01/2024	Area	Infection Control
Next Review	3 years after approval		

Fan Use / Cleaning

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To give direction on cleaning oscillating fans within the Salinas Valley Health Medical Center (SVHMC), which includes hospital in-patient rooms and licensed off-site locations.

III. DEFINITIONS

~~A. N/A~~

A. Licensed off site locations - Includes clinical units that are under the facility license and are not on the main hospital campus.

IV. GENERAL INFORMATION

A. While in most cases, fan use is fine, the safety of patients and staff is paramount with the use of fans within the healthcare setting.

B. All fans cleared for electrical safety prior to use.

C. Personal fans brought from home are not allowed.

D. SVHMC has fans available for patient use.

E. Fans shall not be used in negative pressure environments.

V. PROCEDURE

A. CLEANING:

1. Fans are cleaned between every patient use using the following procedure:

a. Remove protective cage
b. Remove blades
c. Wipe all of the following with hospital-approved disinfectant wipe, keeping the surface wet for the duration noted by the manufacturer:
d. Protective cage
e. Blades
f. Blade attachment
g. Body, buttons & knobs
h. Electrical cord
i. Reassemble
j. Plug into an outlet and confirm fan functions on low, high and oscillate options
k. Bag the fan and place in storage to signal ready for next use

B. HANDLING:

1. All fans will be removed from in-patient rooms by EVS during the discharge cleaning. Engineering will be sanitizing, bagging and storing all fans. Upon request, Engineering will deliver fan to unit for each individual patient.
2. EVS staff: upon discharge cleaning, take room fans to the soiled utility room or as otherwise instructed by your supervisor. If you find that space is a problem, please let your supervisor know.
3. Nursing staff can request fans for patients any time of day by calling x1723.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

1. Bartley, J. Heating, Ventilation, and Air Conditioning. *APIC Text of Infection Control and Epidemiology, ~~published October 3, 2014~~updated 2022*. Retrieved from journal URL: http://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending

Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	01/2024
P&T/IPC	Genevieve delos Santos: Director Pharmacy	12/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2023
Policy Owner	Melissa Deen: Infection Prevention Manager	05/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13712304

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Last Revised	01/2024	Area	Infection Control
Next Review	3 years after approval		

Hand Hygiene

I. POLICY STATEMENT

~~A. Any Salinas Valley Health Medical Center (SVHMC) staff member, which includes but is not limited to clinical staff, contracted staff, volunteers and medical staff , when having direct contact with patients, the patients environment, or when working in a patient care area/ department;~~

1. ~~Are prohibited to wear **any type** of artificial fingernails or extensions. Keep natural nail tips less than ¼ inch long and well maintained (No chipped polish).~~
2. ~~Use only hospital approved hand lotions; others may negate the effectiveness of our sanitizer / soaps.~~
3. ~~No jewelry on hands and wrists, except wedding/commitment rings and watches needed for patient care.~~
4. ~~Examine hands for any breaks in the skin or irritation from frequent hand washing. See Employee Health Services for assistance in available alternative products if severe irritation noted.~~
5. ~~Apply SVHMC approved hand lotion regularly to help maintain skin integrity.~~
6. ~~Always cover cuts /abrasions with a waterproof dressing.~~
7. ~~Healthcare workers who have exudative lesions or weeping dermatitis are referred to Employee Health Services for evaluation.~~

A.

II. PURPOSE

A. ~~Effective hand hygiene results in a significant reduction in the carriage of potential pathogens on the hands, and therefore can decrease the incidence of preventable infection in patients, and in those providing care.~~

B. To improve adherence to evidence based hand hygiene guidelines. HCW, volunteers, contract workers, visitors and others that come into the SVHMC.

C. ~~SVHMC has certain clinics under its license and these clinics, while not operated by SVHMC, adhere to this policy.~~

D. To promote evidence based hand hygiene with hand sanitizer, antisepsis, and hand washing utilizing guidelines from the Centers for Disease Control and Prevention (CDC).

III. DEFINITIONS

1. ***Alcohol-based hand sanitizer***. An alcohol-containing preparation designed for application to the hands for reducing the number of viable microorganisms on the hands. In the United States, such preparations usually contain 60%--95% ethanol or isopropanol.
2. ***Antiseptic agent*.** Antimicrobial substances applied to the skin to reduce the number of microbial flora. Examples: alcohols, chlorhexidine, chlorine, hexachlorophene, iodine, chloroxylenol (PCMX), quaternary ammonium compounds, triclosan.
3. ***Artificial nails*** also known as fake nails, false nails, fashion nails, nail enhancements, acrylic nails, wraps, or nail extensions are extensions placed over finger nails; another popular alternative to acrylic or gel are fiberglass or silk nails wraps (CDC).
4. ***Decontaminate hands***. To reduce bacterial counts on hands by performing antiseptic hand rub or antiseptic hand wash.
5. ***Detergent***. Detergents (i.e., surfactants) are compounds that possess a cleaning action. They are composed of both hydrophilic and lipophilic parts and can be divided into four groups: anionic, cationic, amphoteric, and nonionic detergents. Although products used for hand washing or antiseptic hand wash in health-care settings represent various types of detergents, the term "soap" is used to refer to such detergents in this guideline.
6. ***Direct patient care***. Direct contact with patients, the patients environment, or when working in a patient care area/department
7. ***Hand hygiene***. A general term that applies to hand washing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis.
8. ***Surgical hand antisepsis***. Antiseptic hand wash or antiseptic hand rub performed pre-operatively by surgical personnel to eliminate transient and reduce resident hand flora. Antiseptic detergent preparations often have persistent antimicrobial activity.
9. ***Visibly soiled hands***. Hands showing visible dirt or visibly contaminated with proteinaceous material, blood, or other body fluids (e.g., fecal material or urine).
10. ***Food and Drug Administration (FDA) product categories***. The 1994 FDA Tentative Final Monograph for Health-Care Antiseptic Drug Products divided products into three categories and defined them as follows:
11. ***Patient preoperative skin preparation***. A fast-acting, broad-spectrum, and persistent antiseptic-containing preparation that substantially reduces the number of microorganisms on intact skin.
12. ***Antiseptic hand wash or HCW hand wash***. An antiseptic-containing preparation designed for frequent use; it reduces the number of microorganisms on intact skin to an initial baseline level after adequate washing, rinsing, and drying; it is broad-spectrum, fast-acting, and if possible, persistent.

13. ***Surgical hand scrub***. An antiseptic-containing preparation that substantially reduces the number of microorganisms on intact skin, it is broad-spectrum, fast acting, and persistent.

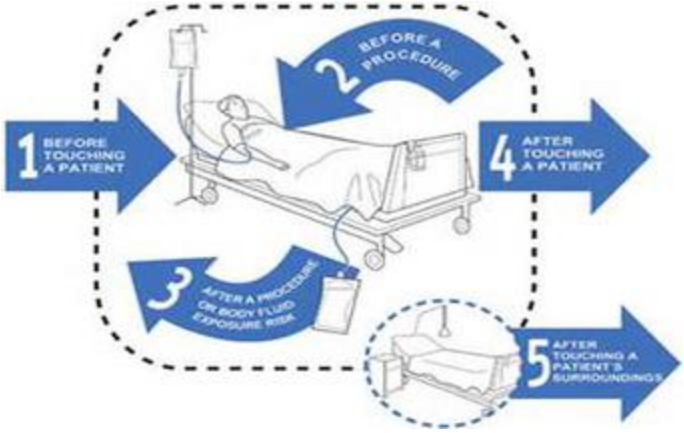
IV. GENERAL INFORMATION

A. Any type of artificial nails /extenders provide an avenue for growth, especially gram negative bacteria's that may contribute to hospital acquired infections.

B. Hands should be washed with soap and water:

1. When hands are visibly dirty or contaminated or are visibly soiled with blood or other body fluids.
2. Before and after eating, and after using a restroom.
3. After caring for a patient with Clostridium difficile or other enteric viral /bacterial infections.
4. Hands should be cleansed with alcohol-based sanitizer if hands are not visibly soiled.
5. SVHMC has adopted The World Health Organizations (WHO) "My *5 Moments for Hand Hygiene"* which aims to:
    a. Reduce unnecessary hand hygiene
    b. Stress the importance of the correct location and time for hand hygiene
    c. Ensure the chain of transmissible infection is broken by proper hand hygiene to prevent healthcare acquired infections (HAI)

    The 5 moments for hand hygiene are to be carried out when HCW is in the **patient zone**, which is an area in the immediate vicinity of the patient where care is provided (e.g. patient room, procedure room / area, etc.).



i. Clean your hands ***before*** touching patient when approaching him / her. (Blood pressure, lifting patient, etc.).

ii. Clean your hands immediately *before* any aseptic task (IV or catheter insertion, etc.).

iii. Clean your hands from a contaminated site /care to clean site / care (ex: wound care, then change IV for example)

iv. Clean your hands immediately *after* an exposure risk to body fluids (wound care, Foley care, etc.).

v. Clean your hands *after* removal of gloves.

vi. Clean your hands *after* touching a patient and his or her immediate surroundings, any object or furniture in the patient room and *before* leaving the room…*even if you did not touch the patient*.

C. Effective hand hygiene results in a significant reduction in the carriage of potential pathogens on the hands, and therefore can decrease the incidence of preventable infection in patients, and in those providing care.

D. SVHMC has certain clinics under its license and these clinics, while not operated by SVHMC, adhere to this procedure.

V. PROCEDURE

A. Hand-hygiene technique

1. When decontaminating hands with an alcohol-based hand rub,
    a. Apply product to palm of one hand and
    b. Rub hands together, covering all surfaces of hands and fingers,
    c. Rub hands until completely dry approximately 15-20 seconds.
2. When washing hands with soap and water:
    a. Wet hands first with water,
    b. Apply product to hands.
    c. Rub hands together vigorously for at least 15- 20 seconds, covering all surfaces of the hands and fingers, making sure to focus on commonly missed areas (finger tips, center of palm between thumb and first finger, and wrists).
    d. Rinse hands with water and dry thoroughly with a disposable towel.
    e. Use towel to turn off the faucet if applicable.
    f. Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis.
3. Lotions
    a. Hospital approved lotions can be applied after hand hygiene or to minimize the occurrence of irritant contact dermatitis.

B. Surgical hand antisepsis

1. Remove rings, watches, and bracelets before beginning the surgical hand scrub.
2. Remove debris from underneath fingernails:
    a. Using a nail cleaner under running water or an alcohol based hand rub.

3. Surgical hand antisepsis using either an antimicrobial soap or an alcohol-based hand rub with persistent activity is recommended before donning sterile gloves when performing surgical procedures.
    a. When performing surgical hand antisepsis using an antimicrobial soap,
        i. Wash hands and forearms for the length of time recommended by the manufacturer, usually 2-6 minutes.
    b. When using an alcohol-based surgical hand-scrub product with persistent activity.
        i. Apply the alcohol-based antiseptic product as recommended.
        ii. Allow hands and forearms to dry thoroughly before donning sterile gloves.

C. Monitoring of Hand Hygiene
    1. Monitoring of hand hygiene will be facilitated by the Infection Prevention Department or their designee, with co-operation of SVHMC leadership teams.

D. Any Salinas Valley Health Medical Center (SVHMC) staff member, which includes but is not limited to clinical staff, contracted staff, volunteers and medical staff , when having direct contact with patients, the patients environment, or when working in a patient care area/ department;
    1. Are prohibited to wear **any type** of artificial fingernails or extensions. Keep natural nail tips less than ¼ inch long and well maintained (No chipped polish).
    2. Use only hospital approved hand lotions; others may negate the effectiveness of our sanitizer / soaps.
    3. No jewelry on hands and wrists, except wedding/commitment rings and watches needed for patient care.
    4. Examine hands for any breaks in the skin or irritation from frequent hand washing. See Employee Health Services for assistance in available alternative products if severe irritation noted.
    5. Apply SVHMC approved hand lotion regularly to help maintain skin integrity.
    6. Always cover cuts /abrasions with a waterproof dressing.
    7. Healthcare workers who have exudative lesions or weeping dermatitis are referred to Employee Health Services for evaluation.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Association of Professionals in Infection Control & Epidemiology (~~2014~~APIC) ~~*Chapter 27:*~~ *Hand hygiene, updated 2022.*~~. APIC Text of Infection Control and Epidemiology.~~

B. Center for Disease Control and Prevention (2014).*Guidelines for Hand Hygiene in Health-Care*

Settings: Recommendations of the Healthcare Infection control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDS Hand Hygiene Task Force : Retrieved from: http://www.cdc.gov/handhygiene/providers/index.html

C. World Health Organization (2009). *WHO guidelines on hand hygiene in healthcare*. Retrieved from : http://www.who.int/gpsc/tools/Five_moments/en/

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	01/2024
P&T/IPC	Genevieve delos Santos: Director Pharmacy	12/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2023
Policy Owner	Melissa Deen: Infection Prevention Manager	05/2023

Standards

No standards are associated with this document

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Last Approved	N/A	Owner	Melissa Deen: Manager Infection Prevention
Last Revised	01/2024	Area	Infection Control
Next Review	3 years after approval		

Isolation - Standard and Transmission Based Precautions

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the medical, nursing and ancillary staff that may, in the course of routine work have contact with blood and/or other potentially infectious materials (OPIM) in the implementation of Standard Precautions and Transmission Based Precautions.

~~III. POLICY~~

IV. DEFINITIONS

A. N/A

V. GENERAL INFORMATION

A. Role of the Nurse and Other Direct Patient Care Providers in Implementation of Standard Precautions and Transmission Based Precautions:

1. Each nurse/direct care provider needs to evaluate his/her own interactions with the patient and use barriers as appropriate, based on anticipated contact with body substances, as opposed to the patient's diagnosis. The guidelines may be used to assist in making these judgments. There is no signage required for Standard precautions.
2. If the patient has a disease that is transmitted in whole or in part by the Airborne, Droplet, or Contact routes, the nurse or clinical staff when feasible will evaluate and educate persons/visitors wishing to enter that patient's room. Use the attached guidelines to assist with these judgments.

3. All nursing/direct care providers must know their own chickenpox, rubella and measles status, and participate as required in Hospital's TB control program.
4. All staff that have frequent contact with blood or body fluids should be immunized against Hepatitis B. Hepatitis B vaccine is offered free of charge for Hospital employees in ~~a job~~jobs identified as bloodborne pathogen category I or II

B. The Physician's Role in Implementing Standard Precautions and Transmission-Based Precautions:

1. It is not necessary to wait for an order "isolation precautions" enter the order in the EMR per policy. If the patient has a disease or is being ruled out for a disease that requires measures beyond Standard Precautions, then an Airborne, Droplet, or Contact precautions sign will be placed on a patient's door. Patients in Reverse or Protective isolation also need a sign placed.
2. Each physician needs to evaluate his/her own interactions with the patient and must use appropriate barriers, based on anticipated contact with body substances, not the patient's diagnosis.
3. All physicians should know their own chickenpox, rubella and measles status, and it is recommended that physicians have yearly TB screening.
4. It is recommended that all physicians who have contact with blood/body fluids be immunized against Hepatitis B.

VI. PROCEDURE

A. **STANDARD PRECAUTIONS**

To provide effective Infection Prevention & Control guidelines for personnel and to prevent the spread of infection, Standard Precautions will be followed by all persons at all times, regardless of the patient's diagnosis. All hospital personnel and medical staff are required to utilize the precautions as described in these guidelines.

1. Health care providers should utilize individual judgment at all times to determine when, and what kind of, barriers are required. Individuals must establish his/her own standards for consistent barrier use: these standards should be based upon the individual's skills and interactions with the patient's body substances, non-intact skin or mucous membranes.
2. **Hand Hygiene**:
   Hand hygiene should be performed frequently and always under the following circumstances:
   a. Before having direct contact with patients.
   b. Before donning gloves and performing an invasive procedure.
   c. After removing gloves or other personal protective equipment.
   d. After contact with body substances or articles/surfaces contaminated with body substances.
      After contact with patient's intact skin (i.e. taking a pulse, blood pressure, or lifting a patient).

e. Between tasks and procedures on the same patient to prevent cross contamination of different body sites.

f. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.

g. Before preparing or eating food

h. After personal contact that may contaminate hands (covering sneeze or cough, blowing nose, using the bathroom).

i. If hands are not visibly soiled, use an alcohol based hand gel for routinely decontaminating hands.

j. When hand are visibly soiled or contaminated, wash hands with soap and water.

3. **Gloves**:

    a. Wear gloves (clean/non-sterile) when touching blood, body fluids, secretions, excretions, and contaminated items. **Put on clean gloves before contact with a patient's mucous membranes or non-intact skin.**

    b. Change gloves during patient care if the hands will move from a contaminated body site (~~i.~~e.g . perineum) to a clean body site (~~i.~~e.g. face).

    c. Remove gloves promptly after use, before touching clean items and environmental surfaces, and before going to another patient

    d. Perform hand hygiene immediately after removing gloves.

4. **Gowns/aprons**:

    a. Wear a gown (clean/non-sterile) to protect skin and prevent soiling of clothing during procedures or patient-care activities that are likely to generate splashes/sprays of blood, body fluids, secretions, or excretions.

    b. Remove a soiled gown as soon as possible, before exiting the patient's room and decontaminate hands to avoid the transfer of microorganisms to other patients or the environment.

5. **Face shields, masks, goggles**:

    a. Masks and/or eye protection or a face shield to protect mucous membranes of the eyes, nose, mouth during procedures and patient-care activities that are likely to generate splashes/sprays of blood, body fluids, secretions, and excretions such as trauma, surgery, delivery of newborns, intubation/suctioning, bronchoscopy, patient care of coughing patient with suspected etiology.

6. **Hoods, caps, shoe covers/boots**:

    a. Use of this type of personal protective equipment is usually limited to the O.R., trauma and/or pathology department. Shoe covers should not be worn out of the work area.

    b. All single-use PPE's will be discarded in the appropriate container prior to leaving the work area.

c. Reusable PPE's will be cleaned, laundered and/or decontaminated as needed.

7. **Removal of PPE**:

a. PPE must be removed in such a manner as to avoid touching the outside of the mask, goggles, gown and gloves, because they may be contaminated with infectious secretions from the patient.

b. Do not touch face or eyes while wearing or removing PPE. This includes not reaching up to adjust goggles or mask. Do not touch surfaces in the patient's room before leaving.

c. Removal of PPE is initiated while you are **INSIDE** the patient's room. Do not leave dirty PPE outside of the patient's room. Follow the steps below:

- ~~Break the ties of the gown by grasping the front of the gown with contaminated gloves at the waist of the gown and pull forward which will pop and release the back waist and neck of gown. If the neck closure is not released, place contaminated gloved hands at front shoulder area and gently pop the neck closure open. If the ties do not break, carefully untie the gown, taking care to NOT contaminate skin or clothing~~
- ~~Using a peeling motion, pull the gown from the shoulders. The gown will begin to turn inside out.~~
- ~~Continue to pull the gown off, again inside out, and remove your gloves as the gown is pulled over your hands.~~
- ~~Hold the removed gown and gloves away from your body and roll into a ball ensuring the potentially contaminated surface is on the inside.~~
- ~~Discard into a waste receptacle inside the patient's room.~~
- ~~Remove face shield/goggles~~
- ~~Decontaminate hands by washing or using alcohol based hand hygiene.~~

i. Break the ties of the gown by grasping the front of the gown with contaminated gloves at the waist of the gown and pull forward which will pop and release the back waist and neck of gown. If the neck closure is not released, place contaminated gloved hands at front shoulder area and gently pop the neck closure open. If the ties do not break, carefully untie the gown, taking care to NOT contaminate skin or clothing

ii. Using a peeling motion, pull the gown from the shoulders. The gown will begin to turn inside out.

iii. Continue to pull the gown off, again inside out, and remove your gloves as the gown is pulled over your hands.

iv. Hold the removed gown and gloves away from your body and roll

into a ball ensuring the potentially contaminated surface is on the inside.

v. Discard into a waste receptacle inside the patient's room.

vi. Remove face shield/goggles

vii. Decontaminate hands by washing or using alcohol based hand hygiene.

8. **Patient-Care Equipment**:
    a. All patient care equipment that comes in contact with skin or body fluids is to be disinfected between patients.
    b. Handle used patient-care equipment soiled with blood, body fluids, sections, and excretions in a manner that prevents contact with skin, clothing, or other surfaces.
    c. Reusable equipment is returned to Sterile Processing for decontamination. If the equipment needs to be used immediately, then use hospital approved disinfectant according to the manufacturer's instructions. Most disinfectants require the solution to be applied and allowed to sit for a specified period of time before drying.
    d. Contaminated disposable (single-use) items are disposed of in regular trash unless there is blood or body fluids in a free flowing or dripping state, in which case it is disposed of as biohazardous or medical waste (i.e. red bag).
    e. If complete decontamination of equipment is not possible, the equipment must be labeled with a biohazard tag with a description of the contaminated portion of that equipment.

9. **Linen:**
    a. Although soiled linen may be contaminated with microorganisms, the risk of disease transmission is minor if it is handled, transported, and laundered in a manner that avoids transfer of these microorganisms to other patients or personnel.
    b. All linen will be bagged inside the patient's room and then transported to the dirty utility room for pick-up by Environmental Services.
10. **Dishes**:
    a. There are no special precautions needed for dishes, cups, or eating utensils. The combination of hot water and detergents used in hospital dishwashers is sufficient to decontaminate them. Food service personnel use gloves when handling dirty dishes.
11. **Biohazardous Waste / Specimens**:
    a. All specimens from the human body are considered potentially infectious. Employees are required to use Standard precautions when handling specimens.

b. Specimens will be placed in a leak-~~resistant~~proof container for transport. All specimens being sent to the lab via the pneumatic tube system will be prepared according to Laboratory policy.

c. If the outside of the specimen container is contaminated, or if there is potential for leakage, the specimen shall be placed into a second container prior to transport.

d. All body substance spills shall be cleaned promptly with a hospital-approved disinfectant.

e. Standard precautions will be used by all personnel cleaning the spill, including the use of appropriate barriers.

12. **Reporting of Illness and Injury**:

    a. Open wounds, skin irritations, etc. must be properly dressed and/or treated if the employee is to remain on duty.

    b. All infections and wounds must be reported to the supervisor, and any significant infections should be reported to Employee Health Nurse and/or Infection Prevention. Employees should not come to work when ill.

13. **Reporting of Exposures to Blood/Body Fluids (Other Potential Infectious Materials -OPIM)**:

    a. All employees shall report exposure to blood and/or OPIM to ~~the~~ Employee Health ~~Nurse~~Department.

14. **Sharps Safety & Disposal**:

    a. Utilize safety engineered sharps when available.

    b. Needles shall not be recapped, purposely bent, broken or removed by hand.

    c. Recapping shall be accomplished only when necessary: this shall be accomplished by a one-handed scoop method and/or mechanical recapping device. No two-handed recapping is allowed.

    d. Used sharps will be disposed of in a safe manner in a rigid, puncture-proof container, which shall be labeled with a biohazardous sign. Sharps containers will be changed when ¾ full according to Environmental Services policy.

    e. Sharps containers are located in each patient room and shall be readily available in patient care areas. Sharps containers will be placed to assure that visibility of contents allows for safe disposal.

    f. The physician, nurse or technician using the needle, syringe or other sharp is responsible for placing it properly into the sharps box after use.

    g. The contracted reusable sharps container company and Environmental Services are responsible for collecting, storing and disposing of any sharps and pharmaceutical waste per Environmental Services policy.

15. **Employee Practices**:

a. Employees shall not eat, apply lip balm or cosmetics, nor adjust their contact lenses in their immediate patient care areas or nursing stations or work stations designated as patient care related.

b. Clean up shall be performed in a manner so as to minimize splashing or aerosolization of body substances.

16. **The isolation patient, and procedures in O.R. and Imaging**.

    a. For certain types of isolation, attempts should be made to schedule procedures for the last procedure of the day. If this is not possible, then time is allotted for cleaning of the room post-procedure.

B. **Transmission-Based ~~Diseases~~Precautions (Airborne, Droplet & Contact) and Protective~~/Reverse~~**:

1. Patients with known and/or suspected Airborne, Droplet, or Contact-spread diseases should be placed in the appropriate isolation. Refer to the attached guideline, "Isolation Precautions for Selected Infections." This guideline will enable staff to select an infection or condition and determine which precautions are needed (Airborne, Droplet, Contact, or a combination), what the infective material is, the duration of isolation, and any special information needed. Enter the order per policy.
2. When the patient is suspected and/or known to have a disease which is transmitted in whole or in part by the Airborne, Droplet, or Contact route, the nurse will place the proper sign on the patient's door, indicating personal protective equipment required by staff/visitors to enter the patient's room.
3. The Airborne, Droplet, or Contact sign becomes the prompt for visitors/staff to check with nursing before entering. It be the responsibility of the nurse/clinical support staff to monitor staff and visitors for proper use of PPE.
4. If a patient has a low WBC count or is a transplant patient, then the patient might need to be in Protective or Reverse isolation.

    a. **Airborne Precautions:**
    Airborne-diseases require isolation in a room capable of having negative pressure ventilation. This type of isolation is for patients known or suspected to have illnesses transmitted by Airborne Droplet nuclei (small-particle residue, 5 microns or smaller in size). Common organisms isolated in Airborne Precautions for example are: TB, Chicken Pox, and Measles.

        i. **Patient Placement:**

            a. Place the patient in a negative air pressure room in the appropriate level of care. Designated rooms are 329, 429, 529 & 537.

            b. Use the isolation sign indicating "Airborne Precautions".

            c. Keep the door closed at all times.

        ii. **Respiratory Protection:**

a. Wear respiratory protection N95 when entering the room of a patient with known or suspected airborne disease. (PAPR for any Aerosol Generating Procedure)

b. Susceptible persons should not enter the room of patients known or suspected to have measles (rubeola) or varicella (chicken pox).

iii. **Patient Transport:**

a. Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize the spread of organisms from the patient by placing a **regular surgical mask** on the patient.

b. ~~**Airborne Precautions:**~~
Airborne, Contact and Eye Protection: Airborne-diseases require isolation in a room capable of having negative pressure ventilation. This type of isolation is for patients known or suspected to have illnesses transmitted by Airborne Droplet nuclei (small-particle residue, 5 microns or smaller in size). ~~Common~~This also includes patients known or suspected to be infected or colonized with epidemiologically important organisms ~~isolated in Airborne Precautions are: TB, Chicken Pox, and Measles~~that can be transmitted by direct contact with the patient (hand or skin-to-skin contact) or indirect contact with environmental surfaces or patient care items in the patient's environment.

~~1. **Patient Placement:**~~

- ~~Place the patient in a negative air pressure room in the appropriate level of care. Designated rooms are 329, 429, 529 & 537.~~
- ~~Use the isolation sign indicating "Airborne Precautions".~~
- ~~Keep the door closed at all times.~~

~~2. **Respiratory Protection:**~~

- ~~Wear respiratory protection (N95 or PAPR (when entering the room of a patient with known or suspected airborne disease).~~
- ~~Susceptible persons should not enter the room of patients known or suspected to have measles (rubeola) or varicella (chicken pox).~~

~~3. **Patient Transport:**~~

- ~~Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize the spread of~~

~~organisms from the patient by placing a **regular surgical mask** on the patient.~~

Common organisms isolated in Airborne, Contact and Eye Protection examples: SARS-COV-2, Ebola, Monkeypox, disseminated Varicella (chicken pox or disseminated shingles), etc.

i. **Patient Placement**:

a. Place the patient in a negative air pressure room in the appropriate level of care. Designated rooms are 329, 429, 529 & 537.

b. Use the isolation sign indicating "Airborne, Contact & Eye Protection Precautions".

c. Keep the door closed at all times.

ii. **Personal Protective Equipment**:

a. Fluid impenetrable gown

b. Gloves

c. N95 mask (PAPR for any Aerosol Generating Procedure)

d. Goggles or Full Face Shield

e. Use above precautions for any contact with patient, secretions, surfaces or equipment that is anticipated.

f. Remove mask, gown, gloves, goggles and wash hands or use alcohol hand gel before leaving this room.

iii. **Patient Transport**:

a. Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize the spread of organisms from the patient by placing a **regular surgical mask** on the patient.

b. Special transport considerations for patients on "high flow" and/or aerosolized respiratory support/ intervention. (i.e. BiPAP/CPAP, Intubation, High Flow Nasal Cannula over 6 L, etc)

c. Reference link: Aerosol Transmitted Diseases Exposure Control Plan

c. **Droplet Precautions:**
This type of isolation is for patients known or suspected to have illnesses transmitted by large-particle Droplets. Organisms isolated in Droplet Precautions may include~~:~~ bacterial meningitis or meningitis cause unknown, seasonal influenza, pertussis, pneumonic plague, mumps, rubella, etc.

~~1. **Patient Placement:**~~

- ~~Place patient in a private room~~
- ~~Place a "Droplet Precautions" sign on the door. Partially close the door so the sign is visible.~~

~~2. **Personal Protective Equipment:**~~

- ~~Wear a regular surgical mask, gown, and gloves for every entry into the room~~

~~3. **Patient Transport:**~~

- ~~Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize dispersal of droplets by putting a regular surgical mask on the patient.~~

i. **Patient Placement:**

a. Place patient in a private room

b. Place a "Droplet Precautions" sign outside the patient room.

ii. **Personal Protective Equipment:**

a. Wear a regular surgical mask, gown, and gloves for every entry into the room

iii. **Patient Transport:**

a. Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize dispersal of droplets by putting a regular surgical mask on the patient.

d. **Contact Precautions:**
This isolation is for patients known or suspected to be infected or colonized with epidemiologically important organisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact) or indirect contact with environmental surfaces or patient care items in the patient's environment. Organisms isolated in Contact Precautions may include~~:~~ multi-drug resistant bacteria (MRSA, VRE, Acinetobacter), Clostridium difficile, Hepatitis A, E. coli 0157:H7, Rotavirus, major abscesses that cannot be contained by a dressing, and Chicken Pox. Scabies and Lice are also isolated in contact precautions until treatment has been completed. Note: Chicken pox and disseminated (full body) shingles also require Airborne Precautions.

~~1. **Patient Placement:**~~

- ~~Place patient in a private room.~~

- ~~Place a "contact precautions" sign on the door. Partially close the door so the sign is visible~~

2. ~~**Hand Hygiene:**~~
   - ~~During patient care, change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material or wound drainage).~~
   - ~~Remove gloves inside the room, and immediately decontaminate hands.~~
3. ~~**Personal Protective Equipment:**~~
   - ~~Wear a gown every time you enter the patient's room. You must wear a gown and gloves whether they are colonized or infected. If the patient has MRSA in their sputum **AND** they are coughing **AND** you will be in close contact with them, a regular mask will also be appropriate. For MRSA colonized patients, a mask is not necessary.~~
4. ~~**Patient Transport:**~~
   - ~~Limit the movement and transport of the patient from the room for essential purposes only. If the patient is transported out of the room, ensure that precautions are maintained to minimize the risk of transmission of organisms to other patients or the environment.~~
     i. ~~place a clean sheet or other physical barrier over gurney or wheelchair before transporting patient~~
     ii. ~~if possible, have patient put on a clean gown prior to transport~~
     iii. ~~The transporter should wear gown and gloves to assist the patient into and out of the wheelchair/gurney. The PPE should then be removed prior to leaving the patient's room and hands decontaminated.~~
     iv. ~~When transportation is complete, thoroughly clean all surfaces of the wheelchair/gurney with a hospital approved disinfectant.~~

i. **Patient Placement:**
   a. Place patient in a private room.
   b. Place a "contact precautions" sign outside the patient room.

ii. **Hand Hygiene:**

a. During patient care, change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material or wound drainage).

b. Remove gloves inside the room, and immediately decontaminate hands.

iii. **Personal Protective Equipment:**

a. Wear a gown every time you enter the patient's room. You must wear a gown and gloves whether they are colonized or infected. If the patient has MRSA in their sputum **AND** they are coughing **AND** you will be in close contact with them, a regular mask will also be appropriate. For MRSA colonized patients, a mask is not necessary.

iv. **Patient Transport:**

a. Limit the movement and transport of the patient from the room for essential purposes only. If the patient is transported out of the room, ensure that precautions are maintained to minimize the risk of transmission of organisms to other patients or the environment.

i. place a clean sheet or other physical barrier over gurney or wheelchair before transporting patient

ii. if possible, have patient put on a clean gown prior to transport

iii. The transporter should wear gown and gloves to assist the patient into and out of the wheelchair/gurney. The PPE should then be removed prior to leaving the patient's room and hands decontaminated.

iv. When transportation is complete, thoroughly clean all surfaces of the wheelchair/gurney with a hospital approved disinfectant.

e. ~~**Protective/Reverse Precautions**~~
~~This type of isolation is for patients known to have an immunocompromising situation such as a low WBC or being a transplant patient on immunosuppressive medications.~~

~~1. **Patient Placement**:~~

- ~~Place patient in a private room~~
- ~~Place a "Protective Isolation" sign on the door. Partially~~

~~close the door so the sign is visible.~~

~~2. **Personal Protective Equipment**:~~

- ~~Wear a regular surgical mask, and gloves for every entry into the room~~

~~3. **Patient Transport**:~~

- ~~Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize exposure to the patient by putting a regular surgical mask on the patient.~~

Protective Respiratory Isolation:

i. This type of isolation is for patients known to be immunocompromised and at risk for developing a serious illness if they acquire a respiratory infection. This can be ordered at the physicians discretion based on patient history and co-morbidities

a. **Patient Placement:**

i. Place patient in a private room with door closed

ii. Place a "Protective Respiratory Isolation" sign outside the patient room.

b. **Personal Protective Equipment:**

i. Regular “ear loop” Face Mask or N95

c. **Strict Handwashing**

d. **Patient Transport:**

i. Limit the movement and transport of the patient from the room to essential purposes only.

ii. If transport or movement is necessary, minimize exposure to the patient by putting a regular “ear loop” mask on the patient.

f. **Protective "Neutropenic" Precautions**
This type of isolation is for patients known to have an immunocompromised condition such as a low WBC and/or low ANC, or being a transplant patient, or on immunosuppressive medications.

i. **Patient Placement**:

a. Place patient in a private room

b. Place a "Protective Isolation" sign outside the patient room.

ii. **Personal Protective Equipment**:

a. Wear a regular surgical mask, and gloves for every entry into the room

iii. **Patient Transport**:

a. Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize exposure to the patient by putting a regular surgical mask on the patient.

iv. **Special Considerations**:

a. Neutropenic precautions when Absolute Neutrophil Count (ANC) reaches 500-650, or provider preference.

b. Avoid patient exposure to all sources of stagnant water. Stagnant water provides an excellent medium for the growth of microorganisms.

c. Avoid use of respiratory therapy equipment with water reservoirs whenever possible.

d. Do not place fresh cut flowers, plants or fresh fruit baskets in the patient's room. Soil/water is a potential source of microorganisms

C. Supporting Plans/Polices:

1. Aerosol Transmitted Diseases Exposure Control Plan
2. Tuberculosis (TB) Prevention and Control
3. Bloodborne Pathogen Exposure Control Plan
4. Injury and Illness Prevention Program Plan
5. BIOMEDICAL WASTE FROM THE PATIENT ENVIRONMENT
6. MEDICAL EQUIPMENT CARE, CLEANING AND MAINTENANCE
7. Soiled Linen Handling
8. Handling Clean Linen
9. Hand Hygiene
10. Nutrition Services Infection Control
11. BIOTERRORISM READINESS PLAN
12. Infection Prevention Pandemic Plan Emerging Infectious Diseases

VII. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VIII. REFERENCES:

1. APIC Text of Infection Control and Epidemiology, ~~4th edition June 2014~~updated 2022.
2. CDC Guidelines for Isolation Precautions for Hospitals. HICPAC Infection Control Hospital Epidemiology 2006; 17:53-80.
3. CAL-OSHA State Standard, Title 8, Chapter 4, Section 5193, January 1999.
4. CDC Guidelines for Environmental Infection Control in Healthcare Facilities, 2003.
5. CMS/JCAHO Standards
6. CDC. Management of Multidrug-Resistant Organisms In Healthcare Settings,~~2006~~ 2022.~~http://www.cdc.gov/ncidod/dhqp/pdf/ar/MDROGuideline2006.pdf~~ Multidrug-Resistant TB (MDR TB)
7. ~~Isolation Guidelines for Mother Baby- https://starnet.svmh.com/Departments/Quality/Documents/Infection Prevention/Isolation_Guidelines_Matrix_Mother_Baby.doc~~

Attachments

2023_Attachment G_General Conditions and Specific Organisms for Transmission Based Isolation.docx

A: Donning & Doffing PPE

Adult Isolation Guidelines Matrix_2023.pdf

Attachment B_Contact Isolation Criteria.pdf

Attachment H_Out Pateint Surgical Services_Isolation workflow.pdf

C: Diarrhea Decision Tree

E: SVMHS References Sheet for Isolation

F: Patient Placement Guidelines

Mother_BabyIsolation_Guidelines_Matrix_2023.pdf

Pediatric Isolation Guidelines Matrix_2023.pdf

Respiratory Viral Illnesses_2023.pdf

Approval Signatures

Step Description	Approver	Date

Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	01/2024
P&T/IPC	Genevieve delos Santos: Director Pharmacy	12/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Melissa Deen: Infection Prevention Manager	10/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13486139**

Last Approved	N/A	Owner	Carla Knight: Director Perioperative Services
Last Revised	01/2024	Area	Infection Control
Next Review	3 years after approval		

Latex Allergy-Surgery

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To guide the staff in providing a latex-safe environment for surgical patients.

III. DEFINITIONS:

A. N/A

IV. GENERAL INFORMATION:

A. When a latex allergy patient is scheduled for surgery, the pre-operative assessment nurse will be notified, through the surgery booking sheet of the need to discuss latex exposure history with the patient. The OR schedule will reflect the patient as latex sensitive and all staff associated with the care of the patient will be notified.

B. The Intra-Operative surgery schedule will reflect that the patient has a latex allergy.

C. Latex precautions will be initiated for all latex sensitive/allergic patients.

D. Where possible, the Department of Surgery will endeavor to use latex safe products as a standard routine on all surgical patients.

V. PROCEDURE:

A. During the pre-operative interview, the pre-operative Nurse will notify the Surgeon about the latex sensitivity assessment. A latex sensitivity test can be ordered to confirm sensitivity. This test generally takes 5 – 10 days for results to be reported. In an extreme situation the surgery may need to be rescheduled.

B. The Operating Room environment will be crosschecked for all potential latex contact points. All packs are latex-free except for the CABG pack, as some of the components within the pack are not made latex-free.

C. The Perioperative staff will follow AORN recommended practices while in the peri-operative phase of care. The nursing units will be notified of the latex sensitivity if the patient is admitted.

D. Documentation:

1. Surgery Schedule
2. Intra Operative Nursing Record

VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

A. AORN (2011) Perioperative Standards and Recommended Practices, Section III: Guidelines & Guidance

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	01/2024
P&T/IPC	Genevieve delos Santos: Director Pharmacy	12/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2023
Policy Owner	Carla Knight: Director of Perioperative Services	06/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **12853714**

Last Approved	N/A	Owner	Robert Andersen: Manager Human Resources
Last Revised	01/2024	Area	Human Resources
Next Review	3 years after approval		

Leave of Absence

I. POLICY STATEMENT

A. N/A

II. PURPOSE

~~A. The purpose of this policy is to outline the guidelines under which employees of Salinas Valley Health Medical Center (SVHMC) may be granted leaves of absence.~~

~~B. This Policy identifies and explains leaves of absence available to eligible employees of the Hospital. Employees are encouraged to read this entire policy to determine which leave or leaves apply to their particular situation. Employees covered by a Collective Bargaining Agreement (CBA) may have different leave rights. This policy will govern leaves of absence for employees covered by a CBA except to the extent this policy and the CBA conflict, in which case the CBA will control.~~

~~III. POLICY~~

A. To outline the guidelines under which employees may be granted leaves of absence

IV. DEFINITIONS

A. N/A

V. GENERAL INFORMATION

A. Employees are encouraged to read this entire policy to determine which leave or leaves apply to their particular situation. Employees covered by a Collective Bargaining Agreement (CBA) may have different leave rights. This policy will govern leaves of absence for employees covered by a CBA except to the extent this policy and the CBA conflict, in which case the CBA will control

B. **HOSPITAL MEDICAL LEAVE ~~POLICY~~:**

- ~~Medical leaves shall be granted as necessary to full-time and part-time employees with six months or more of continuous service, based upon proper application and adherence to the respective CBA if applicable. Per Diem employees will be granted leaves of absence as provided, if at all, by their respective CBA/employee handbook.~~
- ~~Absences of more than 7 days will be deemed to be a leave of absence under this policy.~~
- ~~Medical leaves run concurrently with the Family Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) to the extent an employee is eligible for FMLA/ CFRA.~~

~~1. Health Insurance Coverage will remain intact in accordance with an employee's CBA and applicable Federal and State laws.~~

~~a. If an employee's right to health insurance coverage expires, at that time, the employee will have the option of electing COBRA or dropping insurance coverage. In the event insurance coverage is dropped, it is the employee's responsibility to re-enroll upon return from the leave. Benefit coverage will commence according to appropriate waiting periods following re-enrollment.~~

~~2. **Reinstatement Rights**:~~

~~a. Unless otherwise provided by applicable law non-affiliated employees who return from a medical leave within 6 months of the start of the leave, within a rolling12-month period, may, when possible, be placed in the same position as they held prior to the leave. If an employee's position is no longer available, s/he shall be given an opportunity to apply for available positions for which s/he is qualified.~~

~~b. For affiliated employees, please refer to the respective CBA for detailed information on returning to work.~~

~~c. Non-Affiliated Key Employees: Employees whose loss of time due to a medical Leave of Absence is detrimental to the operations of the department, as determined by administration, may have their position posted. This in no way supersedes applicable State and Federal laws.~~

1. Medical leaves shall be granted as necessary to full-time and part-time employees with six months or more of continuous service, based upon proper application and adherence to the respective CBA if applicable. Per Diem employees will be granted leaves of absence as provided, if at all, by their respective CBA/employee handbook.
2. Absences of more than 7 days will be deemed to be a leave of absence under this policy.
3. Medical leaves run concurrently with the Family Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) to the extent an employee is eligible for FMLA/

CFRA.

a. Health Insurance Coverage will remain intact in accordance with an employee's CBA and applicable Federal and State laws.

i. If an employee's right to health insurance coverage expires, at that time, the employee will have the option of electing COBRA or dropping insurance coverage. In the event insurance coverage is dropped, it is the employee's responsibility to re-enroll upon return from the leave. Benefit coverage will commence according to appropriate waiting periods following re-enrollment.

b. **Reinstatement Rights**:

i. Unless otherwise provided by applicable law non-affiliated employees who return from a medical leave within 6 months of the start of the leave, within a rolling12-month period, may, when possible, be placed in the same position as they held prior to the leave. If an employee's position is no longer available, s/he shall be given an opportunity to apply for available positions for which s/he is qualified.

ii. For affiliated employees, please refer to the respective CBA for detailed information on returning to work.

iii. Non-Affiliated Key Employees: Employees whose loss of time due to a medical Leave of Absence is detrimental to the operations of the department, as determined by administration, may have their position posted. This in no way supersedes applicable State and Federal laws.

C. ~~**FEDERAL AND STATE FAMILY MEDICAL LEAVES**~~

- ~~**FMLA/CFRA**~~

1. ~~**Leaves Run Concurrently:** Benefits provided pursuant to the Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) will run concurrently with any other leave rights to the fullest extent of the law. To the extent FMLA and CFRA rights differ, the employee is eligible for the most generous benefits available under the applicable law.~~

2. ~~**Qualifying Employees**: In order to qualify for any leave pursuant to FMLA and/or CFRA, employees must have been employed for at least one year, and have at least 1,250 hours worked during the preceding 12-month period.~~

3. ~~**Qualifying Reasons**: An eligible employee may be granted a total of 12 weeks (during a backward rolling 12-month period) of leave for the following reasons:~~

~~a. The birth or placement of a child with the employee for adoption or foster care;~~

~~b. To care for a spouse (including a registered domestic partner~~

under the CFRA), dependent child or parent who has a serious health condition; or

c. A serious health condition that renders the employee incapable of performing the functions of his or her job.

4. **Pregnancy, Childbirth/Placement and Related Conditions**:

   a. The entitlement to leave for the birth or placement of a child for adoption or foster care will expire 12 months from the date of the birth or placement.

   b. Time off work because of the employee's disability due to pregnancy, childbirth or related medical condition in most cases is not counted as time used for CFRA leave, but is counted as time used for FMLA leave. See section below for information related to Pregnancy Disability Leave.

   c. Family leave taken under CFRA for purposes of the birth of a child (so-called "bonding" leave) may not be taken until after the birth of the child (unless approved by Administration). If both parents are employed by SVHMC, the two employees generally are limited to a combined 12 weeks of CFRA/FMLA leave for bonding.

   d. Family leave may be taken under CFRA (not FMLA) to care for a registered domestic partner who has a serious health condition.

5. **Military FMLA Entitlement – Qualifying Exigency**

   a. Qualifying Exigency Leave is a type of FMLA leave and may be taken for up to 12 workweeks in the normal 12-month period established by SVHMC for other types of FMLA leave. All time off that qualifies as Qualifying Exigency Leave will be counted against your federal family and medical leave entitlement to the fullest extent permitted by law.

   b. This leave is available to a family member of a military member in the National Guard, Reserves, or regular armed forces.

   c. Employees who are eligible for FMLA may request leave to attend to an exigency or emergency situation arising out of the fact that a spouse, son, daughter, or parent is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces. The term "covered active duty" means: (1) in the case of a member of the armed forces, duty during the deployment of the member with the armed forces to a foreign country; and (2) in the case of a member of the Reserves, duty during the deployment of the member with the armed forces to a foreign country under a call or order to active duty.

   d. Qualifying exigencies include issues arising from a covered military members' short notice deployment (i.e., deployment on

seven or fewer days of notice) for a period of seven days from the date of notification; military events and related activities that are related to the covered active duty or call-to-active-duty status of a covered military member; certain childcare and related activities; making financial or legal arrangements; attending counseling; taking up to five days of leave to spend time with a covered military member who is on short-term temporary rest and recuperation leave during deployment; and attending to certain post-deployment activities.

6. **Military FMLA Entitlement – military caregiver**

    a. Employees who are eligible for FMLA may request leave if their spouse, child, parent, or next of kin meets the definition of an injured or recovering "covered service member." "Next of kin" is defined as the closest blood relative of an injured or recovering covered service member.

    b. "Covered service member" is defined as: (1) any member of the armed forces, including the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status; or is otherwise on the temporary-disability retired list for a serious injury or illness; or (2) who is a veteran who is undergoing medical treatment, recuperation or therapy, for a serious injury or illness and who was a member of the Armed Forces, (including a member of the National Guard or Reserves) at any time during the period of five (5) years preceding the date on which the veteran undergoes the medical treatment, recuperation, or therapy. For the purposes of determining the five (5) year period for covered veteran status, the period between October 28, 2009 and March 8, 2013 is excluded.

    c. Military Caregiver Leave is a type of FMLA leave and may be taken for up to 26 work weeks in a 12-month period. The 12-month period begins on the first day that you take Military Caregiver Leave and ends 12 months after that date. Any other FMLA leave taken during the same 12-month period will be counted against your leave entitlement under this policy. All time off that qualifies as Military Caregiver Leave or any other FMLA leave will be counted against your statutory family and medical leave entitlements to the fullest extent permitted by law.

    d. If spouses are both employed by SVHMC, the spouses are permitted to take only a combined total of 26 weeks of Military Caregiver Leave, or any combination of such leave and other FMLA leave, in a 12-month period.

7. **Intermittent Leave**: When medically necessary, employees may take FMLA leave intermittently or on a reduced schedule basis for their own serious health condition, the serious health condition of a family member or for

military caregiver or qualifying exigency leave. To the extent allowed by law, employees are required to cooperate with the Hospital to arrange reduced work schedules or intermittent leave so as to minimize disruption of Hospital operations.

8. **Medical Certification**: Employees will be required to provide a physician's certification if the leave request is for the employee's own serious health condition, to care for a family member with a serious health condition, or for military caregiver leave. Separate certification may also be required regarding the nature of the family member's military service and/or the existence of a qualifying military exigency.
    a. The head of Human Resources/Designee may contact the health care provider directly to clarify or authenticate a medical certification, including certifications for military caregiver leave after the employee has been given an opportunity to cure any deficiencies.
    b. If the Hospital questions the validity of the medical certification provided by the employee in support of the employee's own serious health condition, the Hospital may, at its expense, require the employee to undergo a medical examination by a health care provider of the Hospital's choosing and at the Hospital's cost.
    c. If the second opinion differs from the first opinion, the Hospital may require the employee or the employee's family member to obtain certification from a third health care provider, again at the Hospital's expense. The third opinion will be final and binding. The health care provider must be jointly designated or approved by the Hospital and the employee in good faith. If the employer does not attempt in good faith to reach agreement, the employer will be bound by the first certification. If the employee does not attempt in good faith to reach agreement, the employee will be bound by the second certification.
    d. Failure to provide the required certifications in a timely manner may result in denial of the leave until the certifications are provided. If an employee refuses to provide the certifications, the request for leave may be denied and the employee may be disciplined.

9. **Employment**: Upon return from an approved FMLA or CFRA leave of absence, employees will be reinstated to their former position or an equivalent position, subject to any exceptions allowed by law. Any employee returning from FMLA/CFRA leave for his/her own serious health condition must provide a fitness for duty certification signed by his/her treating physician. Any employee who fails to provide such certification may not return to work until one is provided. An employee who fails to provide a fitness for duty certification may be disciplined, up to and including termination of employment.

10. **Health Insurance:** Existing group medical insurance coverage for employees who take a leave of absence under FMLA or CFRA will be maintained by the Hospital for 12 work weeks (up to 26 work weeks for FMLA military caregiver leave or up to 29.33 weeks for PDL and CFRA leave) from the beginning of the leave of absence. Thereafter, the employee will have the option of electing COBRA or dropping insurance coverage. In the event insurance coverage is dropped, it is the employee's responsibility to re-enroll upon return from the leave. Benefit coverage will commence on the first of the month following re-enrollment.

    Sick Leave and PTO: Employees may utilize accrued sick leave and/or PTO, in compliance with applicable sick or PTO policies, during an otherwise unpaid FMLA/CFRA leave of absence. Please refer to Section II.C. for the method by which State Disability Insurance (SDI) benefits may be integrated with paid leave benefits.

- **PREGNANCY DISABILITY LEAVE (PDL)/MATERNITY LEAVE**

    1. **Eligibility**: PDL shall be granted as necessary to any employee disabled on account of pregnancy, childbirth, or a related medical condition. Leave will be granted for the period of disability, for up to a maximum of four months. Time off may be requested for other pregnancy-related conditions, including, but not limited to prenatal care, severe morning sickness, doctor-ordered bed rest, gestational diabetes, pregnancy-induced hypertension, loss or end of pregnancy, childbirth and recovery from childbirth. PDL runs concurrently with FMLA leave and any other company-provided leave to the extent allowed by law.

        Leave provided for pregnancy disability is treated separately from leaves required by the state family and medical leave law. However, the first 12 work weeks of a pregnancy disability leave will be treated concurrently as a leave pursuant to the federal FMLA for all eligible employees.

    2. **Health Insurance**: During a pregnancy disability leave, group health benefits will be maintained for the duration of the leave as if the employee were actively working.

    3. **Sick Leave and PTO**: Employees may utilize accrued sick leave and/or PTO, in compliance with applicable sick or PTO policies, during an otherwise unpaid PDL leave of absence

- **INDUSTRIAL LEAVE**

    1. **Certification**: Employees who have suffered an on-the-job injury or illness may be provided with a leave of absence in accordance with the FMLA/CFRA and/or the Medical Leave policies.

    2. **Notification**: In the event of an on-the-job injury or illness, employees are required to immediately notify the Department Director and complete an Employee Injury/Illness/Exposure Report (Form 8655-6323). This form is available in the employee's department or Employee Health Department. If

~~medical treatment is determined to be necessary, the employee is required to immediately contact the Employee Health Nurse or the Nursing Supervisor after hours.~~

3. ~~**Workers' Compensation Benefits/PTO/Sick**: Workers' Compensation benefits begin on the 4th calendar day off work, or first day hospitalized, whichever occurs first. If an employee is off work more than 14 days or is hospitalized, the first three days will be paid by Workers' Compensation.~~

FEDERAL AND STATE FAMILY MEDICAL LEAVES

1. **FMLA/CFRA**
2. **Leaves Run Concurrently:** Benefits provided pursuant to the Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) will run concurrently with any other leave rights to the fullest extent of the law. To the extent FMLA and CFRA rights differ, the employee is eligible for the most generous benefits available under the applicable law.
3. **Qualifying Employees**: In order to qualify for any leave pursuant to FMLA and/or CFRA, employees must have been employed for at least one year, and have at least 1,250 hours worked during the preceding 12-month period.
    a. **PREGNANCY DISABILITY LEAVE (PDL)/MATERNITY LEAVE**
        i. **Eligibility**: PDL shall be granted as necessary to any employee disabled on account of pregnancy, childbirth, or a related medical condition. Leave will be granted for the period of disability, for up to a maximum of four months. Time off may be requested for other pregnancy-related conditions, including, but not limited to prenatal care, severe morning sickness, doctor-ordered bed rest, gestational diabetes, pregnancy-induced hypertension, loss or end of pregnancy, childbirth and recovery from childbirth. PDL runs concurrently with FMLA leave and any other company-provided leave to the extent allowed by law.

            Leave provided for pregnancy disability is treated separately from leaves required by the state family and medical leave law. However, the first 12 work weeks of a pregnancy disability leave will be treated concurrently as a leave pursuant to the federal FMLA for all eligible employees.

        ii. **Health Insurance**: During a pregnancy disability leave, group health benefits will be maintained for the duration of the leave as if the employee were actively working.

        iii. **Sick Leave and PTO**: Employees may utilize accrued sick leave and/or PTO, in compliance with applicable sick or PTO policies, during an otherwise unpaid PDL leave of absence

    b. **INDUSTRIAL LEAVE**
        i. **Certification**: Employees who have suffered an on-the-job injury or illness may be provided with a leave of absence in

accordance with the FMLA/CFRA and/or the Medical Leave policies.

ii. **Notification**: In the event of an on-the-job injury or illness, employees are required to immediately notify the Department Director and complete an Employee Injury/Illness/Exposure Report (Form 8655-6323). This form is available in the employee's department or Employee Health Department. If medical treatment is determined to be necessary, the employee is required to immediately contact the Employee Health Nurse or the Nursing Supervisor after hours.

iii. **Workers' Compensation Benefits/PTO/Sick**: Workers' Compensation benefits begin on the 4th calendar day off work, or first day hospitalized, whichever occurs first. If an employee is off work more than 14 days or is hospitalized, the first three days will be paid by Workers' Compensation.

4. **Qualifying Reasons**: An eligible employee may be granted a total of 12 weeks (during a backward rolling 12-month period) of leave for the following reasons:
    a. The birth or placement of a child with the employee for adoption or foster care;
    b. To care for a spouse, dependent child or parent (including a registered domestic partner, grandchild, grandparent, sibling or designated person under CFRA) who has a serious health condition; or
    c. A serious health condition that renders the employee incapable of performing the functions of his or her job.
    d. **Pregnancy, Childbirth/Placement and Related Conditions**:
        i. The entitlement to leave for the birth or placement of a child for adoption or foster care will expire 12 months from the date of the birth or placement.
        ii. Time off work because of the employee's disability due to pregnancy, childbirth or related medical condition in most cases is not counted as time used for CFRA leave, but is counted as time used for FMLA leave. See section below for information related to Pregnancy Disability Leave.
        iii. Family leave taken under CFRA for purposes of the birth of a child (so-called "bonding" leave) may not be taken until after the birth of the child (unless approved by Administration). If both parents are employed by SVMHS, the two employees generally are limited to a combined 12 weeks of CFRA/FMLA leave for bonding.
        iv. Family leave may be taken under CFRA (not FMLA) to care for a registered domestic partner who has a serious health condition.
    e. **Military FMLA Entitlement – Qualifying Exigency**

i. Qualifying Exigency Leave is a type of FMLA leave and may be taken for up to 12 workweeks in the normal 12-month period established by Salinas Valley Health Medical Center (SVHMC) for other types of FMLA leave. All time off that qualifies as Qualifying Exigency Leave will be counted against your federal family and medical leave entitlement to the fullest extent permitted by law.

ii. This leave is available to a family member of a military member in the National Guard, Reserves, or regular armed forces.

iii. Employees who are eligible for FMLA may request leave to attend to an exigency or emergency situation arising out of the fact that a spouse, son, daughter, or parent is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces. The term "covered active duty" means: (1) in the case of a member of the armed forces, duty during the deployment of the member with the armed forces to a foreign country; and (2) in the case of a member of the Reserves, duty during the deployment of the member with the armed forces to a foreign country under a call or order to active duty.

iv. Qualifying exigencies include issues arising from a covered military members' short notice deployment (i.e., deployment on seven or fewer days of notice) for a period of seven days from the date of notification; military events and related activities that are related to the covered active duty or call-to-active-duty status of a covered military member; certain childcare and related activities; making financial or legal arrangements; attending counseling; taking up to five days of leave to spend time with a covered military member who is on short-term temporary rest and recuperation leave during deployment; and attending to certain post-deployment activities.

f. **Military FMLA Entitlement – military caregiver**

i. Employees who are eligible for FMLA may request leave if their spouse, child, parent, or next of kin meets the definition of an injured or recovering "covered service member." "Next of kin" is defined as the closest blood relative of an injured or recovering covered service member.

ii. "Covered service member" is defined as: (1) any member of the armed forces, including the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status; or is otherwise on the temporary-disability retired list for a serious injury or illness; or (2) who is a veteran who is undergoing medical treatment, recuperation or therapy, for a serious injury or illness and who was a member of the Armed Forces, (including a member of the National Guard or

Reserves) at any time during the period of five (5) years preceding the date on which the veteran undergoes the medical treatment, recuperation, or therapy. For the purposes of determining the five (5) year period for covered veteran status, the period between October 28, 2009 and March 8, 2013 is excluded.

iii. Military Caregiver Leave is a type of FMLA leave and may be taken for up to 26 work weeks in a 12-month period. The 12-month period begins on the first day that you take Military Caregiver Leave and ends 12 months after that date. Any other FMLA leave taken during the same 12-month period will be counted against your leave entitlement under this policy. All time off that qualifies as Military Caregiver Leave or any other FMLA leave will be counted against your statutory family and medical leave entitlements to the fullest extent permitted by law.

iv. If spouses are both employed by SVMH, the spouses are permitted to take only a combined total of 26 weeks of Military Caregiver Leave, or any combination of such leave and other FMLA leave, in a 12-month period.

g. **Intermittent Leave**: When medically necessary, employees may take FMLA leave intermittently or on a reduced schedule basis for their own serious health condition, the serious health condition of a family member or for military caregiver or qualifying exigency leave. To the extent allowed by law, employees are required to cooperate with the Hospital to arrange reduced work schedules or intermittent leave so as to minimize disruption of Hospital operations.

h. **Medical Certification**: Employees will be required to provide a physician's certification if the leave request is for the employee's own serious health condition, to care for a family member with a serious health condition, or for military caregiver leave. Separate certification may also be required regarding the nature of the family member's military service and/or the existence of a qualifying military exigency.

i. The head of Human Resources/Designee may contact the health care provider directly to clarify or authenticate a medical certification, including certifications for military caregiver leave after the employee has been given an opportunity to cure any deficiencies.

ii. If the Hospital questions the validity of the medical certification provided by the employee in support of the employee's own serious health condition, the Hospital may, at its expense, require the employee to undergo a medical examination by a health care provider of the Hospital's choosing and at the Hospital's cost.

iii. If the second opinion differs from the first opinion, the Hospital

may require the employee or the employee's family member to obtain certification from a third health care provider, again at the Hospital's expense. The third opinion will be final and binding. The health care provider must be jointly designated or approved by the Hospital and the employee in good faith. If the employer does not attempt in good faith to reach agreement, the employer will be bound by the first certification. If the employee does not attempt in good faith to reach agreement, the employee will be bound by the second certification.

iv. Failure to provide the required certifications in a timely manner may result in denial of the leave until the certifications are provided. If an employee refuses to provide the certifications, the request for leave may be denied and the employee may be disciplined.

i. **Employment**: Upon return from an approved FMLA or CFRA leave of absence, employees will be reinstated to their former position or an equivalent position, subject to any exceptions allowed by law. Any employee returning from FMLA/CFRA leave for his/her own serious health condition must provide a fitness for duty certification signed by his/her treating physician. Any employee who fails to provide such certification may not return to work until one is provided. An employee who fails to provide a fitness for duty certification may be disciplined, up to and including termination of employment.

j. **Health Insurance:** Existing group medical insurance coverage for employees who take a leave of absence under FMLA or CFRA will be maintained by the Hospital for 12 work weeks (up to 26 work weeks for FMLA military caregiver leave or up to 29.33 weeks for PDL and CFRA leave) from the beginning of the leave of absence. Thereafter, the employee will have the option of electing COBRA or dropping insurance coverage. In the event insurance coverage is dropped, it is the employee's responsibility to re-enroll upon return from the leave. Benefit coverage will commence on the first of the month following re-enrollment.

k. **Sick Leave and PTO:** Employees may utilize accrued sick leave and/or PTO, in compliance with applicable sick or PTO policies, during an otherwise unpaid FMLA/CFRA leave of absence. Please refer to Section II.C. for the method by which State Disability Insurance (SDI) benefits may be integrated with paid leave benefits.

D. **INTEGRATION OF BENEFITS FOR ALL MEDICAL LEAVES**

- ~~**State Disability Insurance**: SDI pays a weekly benefit for non-work-related injuries or illnesses suffered by employees. All employees contribute to the SDI program through payroll deductions. SDI benefits begin on the 8th calendar day off work due to the injury or illness, regardless of hospitalization. SDI benefits may be integrated with any PTO or sick leave used during an employee's absence under this section. It is the employee's responsibility to file a State Disability Insurance Claim form. Information regarding benefits under the SDI program is available in the Human~~

~~Resources Department.~~

- ~~**Paid Family Leave**: Paid Family Leave provides benefits to individuals who need to take time off work to care for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner. Benefits are also available to new parents who need time to bond with a new child entering their life either by birth, adoption, or foster care placement.~~

  ~~PFL does not provide job protection, only monetary benefits. Additional information regarding the PFL program is available from the Human Resources Department.~~

1. **State Disability Insurance**: SDI pays a weekly benefit for non-work-related injuries or illnesses suffered by employees. All employees contribute to the SDI program through payroll deductions. SDI benefits begin on the 8th calendar day off work due to the injury or illness, regardless of hospitalization. SDI benefits may be integrated with any PTO or sick leave used during an employee's absence under this section. It is the employee's responsibility to file a State Disability Insurance Claim form. Information regarding benefits under the SDI program is available in the Human Resources Department.
2. **Paid Family Leave**: Paid Family Leave provides benefits to individuals who need to take time off work to care for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner. Benefits are also available to new parents who need time to bond with a new child entering their life either by birth, adoption, or foster care placement.
3. PFL does not provide job protection, only monetary benefits. Additional information regarding the PFL program is available from the Human Resources Department.

E. PERSONAL AND EDUCATIONAL LEAVES

- ~~**Personal leaves**:~~
  1. ~~**Local 39 and Non-Affiliated Employees**: May be granted after six months of service, based upon proper application by the employee and Administrative approval.~~
  2. ~~**NUHW and CNA Employees**: May be granted based upon proper application by the employee, according to CBA guidelines and Administrative approval.~~
  3. ~~**Use of PTO**: Personal leaves require the use of PTO benefits, if available.~~
- ~~**Educational Leaves**:~~
  1. ~~**Local 39 and Non-Affiliated Employees**: may be granted to Local 39 and Non-Affiliated employees after six months of service; based upon proper application by the employee and Administrative approval.~~
  2. ~~**NUHW and CNA Employees**: may be granted based upon proper application by the employee, according to CBA guidelines and Administrative approval.~~
  3. ~~**Use of PTO**: Educational leaves require the use of PTO benefits, if available.~~

- ~~**Employment:**~~
    1. ~~Employees who return from a Personal or Educational leave within the approved leave period shall be placed in the same classification, shift and department as held prior to the leave.~~

1. **Personal leaves**:
    a. **Local 39 and Non-Affiliated Employees**: May be granted after six months of service, based upon proper application by the employee and Administrative approval.
    b. **NUHW and CNA Employees**: May be granted based upon proper application by the employee, according to CBA guidelines and Administrative approval.
    c. **Use of PTO**: Personal leaves require the use of PTO benefits, if available.
2. **Educational Leaves**:
    a. **Local 39 and Non-Affiliated Employees**: may be granted to Local 39 and Non-Affiliated employees after six months of service; based upon proper application by the employee and Administrative approval.
    b. **NUHW and CNA Employees**: may be granted based upon proper application by the employee, according to CBA guidelines and Administrative approval.
    c. **Use of PTO**: Educational leaves require the use of PTO benefits, if available.
3. **Employment:**
    a. Employees who return from a Personal or Educational leave within the approved leave period shall be placed in the same classification, shift and department as held prior to the leave.

F. **BEREAVEMENT LEAVE**

- ~~In cases of bereavement, full time and part time employees may be granted a leave of absence due to the death of a family member, as defined below:~~
    1. ~~**Non-Affiliated Employees**: Full and part-time non-affiliated employees may be absent with pay for up to three (3) normally scheduled days because of death in the family. Family includes current spouse, mother, step-mother, father, step-father, sister, step-sister, sister-in-law, brother, step-brother, brother-in-law, child, step-child, daughter-in-law, son-in-law, current father-in-law, current mother-in-law, grandparents, grandchildren, registered domestic partner and children of registered domestic partner.~~
    2. ~~**Per diem or Temporary Employees**: Employees may be allowed to take unpaid bereavement leave up to three days with written approval of their supervisor.~~
    3. ~~For all other employees refer to CBA.~~
    4. ~~**Timing**: Bereavement leave must be taken within a reasonable time frame~~

~~of the death of the family member.~~

1. In cases of bereavement, full time and part time employees may be granted a leave of absence due to the death of a family member, as defined below:
    a. **Full-Time and Part-Time Employees**: Full and part-time employees may be absent with pay for up to three (3) normally scheduled days because of death in the family. Family includes current spouse, mother, step-mother, father, step-father, sister, step-sister, sister-in-law, brother, step-brother, brother-in-law, child, step-child, daughter-in-law, son-in-law, current father-in-law, current mother-in-law, grandparents, grandchildren, registered domestic partner and children of registered domestic partner. Upon request, employees may be absent an additional two (2) normally scheduled days with the option to use PTO or go unpaid.
    b. **Per diem or Temporary Employees**: Upon request, employees may be absent without pay for up to five (5) normally scheduled days.
    c. **Timing**: Bereavement leave must be taken within three (3) months of the death of the family member.
    d. **Documentation:** Documentation of the death of the family member may be required within 30 days of the first day of bereavement leave. Documentation includes: Death Certificate, Published Obituary or Written Verification of Death, Burial, or Memorial Services from a Mortuary, Funeral Home, Burial Society, Crematorium, Religious Institution or Governmental Agency.
    e. Represented employees: refer to your CBA for more information.
2. In cases of a reproductive loss event, employees may be granted a leave of absence due to the death of a family member, as defined as "the day or, for a multiple-day event, the final day of a failed adoption, failed surrogacy, miscarriage, stillbirth, or an unsuccessful assisted reproduction."
    a. The employee may take up to five days of leave for reproductive loss events.
    b. The law limits the amount of reproductive loss leave to a maximum of 20 days within a 12-month period.
    c. Eligible employees:
        i. Must be employed at least 30 days to be eligible for reproductive loss leave.
        ii. Must take the leave within three months of the event triggering the leave (*i.e.*, reproductive loss events), but need not be taken on consecutive days.
        iii. Have the option to use PTO or go unpaid.

G. **OTHER STATUTORY LEAVES**

- ~~**LEAVE AND ACCOMMODATION FOR VICTIMS OF STALKING, DOMESTIC VIOLENCE AND SEXUAL ASSAULT**~~

1. ~~Unpaid time off is available to victims of stalking, domestic violence or sexual assault for the purpose of appearing in court to obtain legal relief; seeking medical attention; obtaining services from a domestic violence shelter, program, or rape crisis center; obtaining psychological counseling or participating in safety planning. Victims of domestic violence or sexual assault should provide reasonable advance notice when possible; otherwise, they must provide, within a reasonable time, evidence from the court, prosecuting attorney, police or medical professional, domestic violence advocate or advocate for victims of sexual assault, health care provider or counselor, as appropriate.~~
2. ~~In addition to unpaid time off, the Hospital will also provide reasonable accommodation to an employee who has disclosed his or her status as a victim of domestic violence, sexual assault, or stalking, unless doing so would pose an undue hardship.~~
3. ~~Any employee needing reasonable accommodation should notify **Human Resources or the employee's supervisor**. An employee requesting a reasonable accommodation may be required to provide a certification to the Hospital regarding his or her need for accommodation. Additionally, if the need for accommodation ceases, the employee must notify the Hospital that the accommodation is no longer needed.~~
4. ~~Employees may use any accrued PTO or paid sick leave for such absences if they wish.~~

- ~~**LEAVE TO APPEAR IN COURT**. Employees may take unpaid time off to appear in court to comply with a subpoena or other court order as a witness in any judicial proceeding.~~
    1. ~~Reasonable Notice: Affected employees must give the Hospital reasonable documented notice that they will be absent due to one of the above purposes. In the event of an emergency court appearance or other incident that does not allow for prior notice, the employee must provide the Hospital with documentary evidence that their absence was required for any of the above reasons such as police report, court order or documentation from a medical professional, counselor or advocate.~~
    2. ~~Employees may use any accrued PTO for such absences, if they wish.~~
- ~~**LEAVE FOR VICTIMS OF CRIME**. Any employee who is the victim of a crime, an immediate family member of a victim, a registered domestic partner of a victim, or the child of a registered domestic partner of a victim, may be absent from work to attend judicial proceedings related to that crime.~~
    1. ~~**Reasonable Notice**: Prior to the absence, the employee must provide the employer with a copy of the notice of each scheduled proceeding unless advance notice is not feasible. If notice is not feasible, the employee must provide the Hospital with documentary evidence that their absence was required to attend these judicial proceedings, such as notice from the court or government agency setting the hearing, the district attorney or prosecuting attorney's office, or the victim/witness office advocating on~~

behalf of the victim.

2. Employees may use any accrued PTO for such absences, if they wish.

- **LEAVE TO PERFORM EMERGENCY DUTY AS A VOLUNTEER FIREFIGHTER, RESERVE PEACE OFFICER, OR EMERGENCY RESCUE PERSONNEL**. Any employee who volunteers to perform emergency duty as a firefighter, reserve peace officer or emergency rescue personnel may take time off work from the Hospital while engaged in providing such emergency service.

    1. The Hospital can deny the requested leave if it determines that the employee's absence would hinder the availability of public safety or emergency medical services.

    2. A "voluntary firefighter" is person registered as a volunteer member of a regularly organized fire department of a city, county or district.

    3. "Emergency rescue personnel" means any person who is an officer, employee or member of a fire department, sheriff's department, police department, or a private fire department, whether that person is a volunteer or partly paid or fully paid, while he or she is actually engaged in providing emergency services.

    4. Any employee who is a volunteer firefighter, reserve peace officer or emergency rescue personnel may take temporary leaves of absence, not to exceed an aggregate of 14 days per calendar year, for the purpose of engaging in applicable training.

- **LEAVE TO ATTEND CHILD'S SCHOOL OR DAYCARE** - Please see HR#850 - FAMILY SCHOOL PARTNERSHIP.
- **SCHOOL DISCIPLINE LEAVE**. Any employee who is the parent or guardian of a child and is actually living with the child or grandparent who has custody of a grandchild is eligible for a school-discipline leave. The employee must have received a written notice from the school principal requesting his or her attendance at a conference to discuss the child's/grandchild's suspension from school. School-discipline leave is not available to employees who voluntarily consult with school administrators regarding a child's/grandchild's performance in school. The Hospital may require the employee to provide a copy of the notice received from the school, prior to granting school-discipline leave, and may require documentation from the school as proof that the visit took place. The Hospital may ask the employee or the principal to briefly reschedule the conference if the employee's attendance at work is essential at the time originally scheduled. There is no limit to how frequently employees may be provided school-discipline leave. Employees may use accrued PTO during school-discipline leave. If an employee does not have any PTO time available, the employee may take unpaid leave.
- **MILITARY LEAVE** - Please see HR#873 - MILITARY LEAVE AND RE-EMPLOYMENT RIGHTS.
- **CIVIL AIR PATROL LEAVE**. The Hospital will provide eligible employees with up to ten days of leave per year for Civil Air Patrol duty. Each leave for a single emergency mission cannot exceed three days, unless the emergency is extended by the entity in

~~charge of the operation and the extension is approved by the employer. In order to be eligible for this leave, the employee must meet the following criteria: The employee must have been employed by the Hospital for a 90-day period before the start of the leave; and must be a volunteer member of the California Wing of the civilian auxiliary of the United States Air Force (Civil Air Patrol), responding to an emergency operation mission. Employees are required to provide documentation of the need for the leave. The Hospital may deny an employee's request for leave if documentation is not provided. Employees are not required to exhaust any other accrued leaves or PTO in order to take Civil Air Patrol leave. Upon return from Civil Air Patrol leave, employees will be reinstated to the position held when the leave began, or to an equivalent position.~~

- ~~**ORGAN AND BONE MARROW DONORS' LEAVE**. Any employee who chooses to donate organs to another person will be given a paid leave of up to 30 workdays in any one year period. Any employee who chooses to donate bone marrow to another person will be given a paid leave of up to five workdays in any one year. Employees requesting such leave must provide written verification to the Hospital of 1) the need for the leave; and 2) the medical necessity for the donation. The Hospital will continue and pay for existing health insurance coverage during the entire leave of absence. Employees taking leave for bone marrow donation must first use up to five days of accrued PTO; those taking leave for organ donation must use up to two weeks of accrued PTO. Leave for either purpose may be taken in one or more periods of time. Employees returning from donor leave pursuant to this section will be restored to the position held by him/her when the leave began or to a position with equivalent seniority status, employee benefits, pay and other terms and conditions of employment. Leave for organ donation or bone marrow donation may not be taken concurrently with any leave taken pursuant to the federal Family and Medical Leave Act or the California Family Rights Act.~~

1. **LEAVE AND ACCOMMODATION FOR VICTIMS OF STALKING, DOMESTIC VIOLENCE AND SEXUAL ASSAULT**

    a. Unpaid time off is available to victims of stalking, domestic violence or sexual assault for the purpose of appearing in court to obtain legal relief; seeking medical attention; obtaining services from a domestic violence shelter, program, or rape crisis center; obtaining psychological counseling or participating in safety planning. Victims of domestic violence or sexual assault should provide reasonable advance notice when possible; otherwise, they must provide, within a reasonable time, evidence from the court, prosecuting attorney, police or medical professional, domestic violence advocate or advocate for victims of sexual assault, health care provider or counselor, as appropriate.

    b. In addition to unpaid time off, the Hospital will also provide reasonable accommodation to an employee who has disclosed his or her status as a victim of domestic violence, sexual assault, or stalking, unless doing so would pose an undue hardship.

    c. Any employee needing reasonable accommodation should notify **Human Resources or the employee's supervisor**. An employee requesting a

reasonable accommodation may be required to provide a certification to the Hospital regarding his or her need for accommodation. Additionally, if the need for accommodation ceases, the employee must notify the Hospital that the accommodation is no longer needed.

d. Employees may use any accrued PTO or paid sick leave for such absences if they wish.

2. **LEAVE TO APPEAR IN COURT**. Employees may take unpaid time off to appear in court to comply with a subpoena or other court order as a witness in any judicial proceeding.

    a. Reasonable Notice: Affected employees must give the Hospital reasonable documented notice that they will be absent due to one of the above purposes. In the event of an emergency court appearance or other incident that does not allow for prior notice, the employee must provide the Hospital with documentary evidence that their absence was required for any of the above reasons such as police report, court order or documentation from a medical professional, counselor or advocate.

    b. Employees may use any accrued PTO for such absences, if they wish.

3. **LEAVE FOR VICTIMS OF CRIME**. Any employee who is the victim of a crime, an immediate family member of a victim, a registered domestic partner of a victim, or the child of a registered domestic partner of a victim, may be absent from work to attend judicial proceedings related to that crime.

    a. **Reasonable Notice**: Prior to the absence, the employee must provide the employer with a copy of the notice of each scheduled proceeding unless advance notice is not feasible. If notice is not feasible, the employee must provide the Hospital with documentary evidence that their absence was required to attend these judicial proceedings, such as notice from the court or government agency setting the hearing, the district attorney or prosecuting attorney's office, or the victim/witness office advocating on behalf of the victim.

    b. Employees may use any accrued PTO for such absences, if they wish.

4. **LEAVE TO PERFORM EMERGENCY DUTY AS A VOLUNTEER FIREFIGHTER, RESERVE PEACE OFFICER, OR EMERGENCY RESCUE PERSONNEL**. Any employee who volunteers to perform emergency duty as a firefighter, reserve peace officer or emergency rescue personnel may take time off work from the Hospital while engaged in providing such emergency service.

    a. The Hospital can deny the requested leave if it determines that the employee's absence would hinder the availability of public safety or emergency medical services.

    b. A "voluntary firefighter" is person registered as a volunteer member of a regularly organized fire department of a city, county or district.

    c. "Emergency rescue personnel" means any person who is an officer, employee or member of a fire department, sheriff's department, police

department, or a private fire department, whether that person is a volunteer or partly paid or fully paid, while he or she is actually engaged in providing emergency services.

d. Any employee who is a volunteer firefighter, reserve peace officer or emergency rescue personnel may take temporary leaves of absence, not to exceed an aggregate of 14 days per calendar year, for the purpose of engaging in applicable training.

5. **LEAVE TO ATTEND CHILD'S SCHOOL OR DAYCARE** - Please see HR#850 - FAMILY SCHOOL PARTNERSHIP.

6. **SCHOOL DISCIPLINE LEAVE**. Any employee who is the parent or guardian of a child and is actually living with the child or grandparent who has custody of a grandchild is eligible for a school-discipline leave. The employee must have received a written notice from the school principal requesting his or her attendance at a conference to discuss the child's/grandchild's suspension from school. School-discipline leave is not available to employees who voluntarily consult with school administrators regarding a child's/grandchild's performance in school. The Hospital may require the employee to provide a copy of the notice received from the school, prior to granting school-discipline leave, and may require documentation from the school as proof that the visit took place. The Hospital may ask the employee or the principal to briefly reschedule the conference if the employee's attendance at work is essential at the time originally scheduled. There is no limit to how frequently employees may be provided school-discipline leave. Employees may use accrued PTO during school-discipline leave. If an employee does not have any PTO time available, the employee may take unpaid leave.

7. **MILITARY LEAVE** - Please see HR#873 - MILITARY LEAVE AND RE-EMPLOYMENT RIGHTS.

8. **CIVIL AIR PATROL LEAVE**. The Hospital will provide eligible employees with up to ten days of leave per year for Civil Air Patrol duty. Each leave for a single emergency mission cannot exceed three days, unless the emergency is extended by the entity in charge of the operation and the extension is approved by the employer. In order to be eligible for this leave, the employee must meet the following criteria: The employee must have been employed by the Hospital for a 90-day period before the start of the leave; and must be a volunteer member of the California Wing of the civilian auxiliary of the United States Air Force (Civil Air Patrol), responding to an emergency operation mission. Employees are required to provide documentation of the need for the leave. The Hospital may deny an employee's request for leave if documentation is not provided. Employees are not required to exhaust any other accrued leaves or PTO in order to take Civil Air Patrol leave. Upon return from Civil Air Patrol leave, employees will be reinstated to the position held when the leave began, or to an equivalent position.

9. **ORGAN AND BONE MARROW DONORS' LEAVE**. Any employee who chooses to donate organs to another person will be given a paid leave of up to 30 workdays in any one year period. Any employee who chooses to donate bone marrow to another person will be given a paid leave of up to five workdays in any one year. Employees requesting such leave must provide written verification to the Hospital of 1) the need

for the leave; and 2) the medical necessity for the donation. The Hospital will continue and pay for existing health insurance coverage during the entire leave of absence. Employees taking leave for bone marrow donation must first use up to five days of accrued PTO; those taking leave for organ donation must use up to two weeks of accrued PTO. Leave for either purpose may be taken in one or more periods of time. Employees returning from donor leave pursuant to this section will be restored to the position held by him/her when the leave began or to a position with equivalent seniority status, employee benefits, pay and other terms and conditions of employment. Leave for organ donation or bone marrow donation may not be taken concurrently with any leave taken pursuant to the federal Family and Medical Leave Act or the California Family Rights Act.

H. **GENERAL INFORMATION REGARDING LEAVES**

- ~~**Payroll Deductions**: Payroll deductions required by law will continue to be deducted while in paid status. Employee authorized deductions will continue to be deducted while in paid status, unless directed otherwise by the employee. If an employee has a payroll deduction for health care coverage and goes into an unpaid status, he/she will be directed to pay this premium to HR to maintain coverage.~~
- ~~**Pension/Defined Contribution Plan**: Years of service will continue to accrue towards Pension/Defined Contribution Plan benefits for each plan year in which an eligible benefited employee is paid 1,000 or more hours in accordance with the provisions of the pension and Defined Contribution Plans.~~
- ~~**Fringe Benefits Accruals**: Paid Time Off (PTO) and Sick Leave will continue to accrue on a pro-rated basis while an employee remains in a paid status.~~

1. **Payroll Deductions**: Payroll deductions required by law will continue to be deducted while in paid status. Employee authorized deductions will continue to be deducted while in paid status, unless directed otherwise by the employee. If an employee has a payroll deduction for health care coverage and goes into an unpaid status, he/she will be directed to pay this premium to HR to maintain coverage.
2. **Pension/Defined Contribution Plan**: Years of service will continue to accrue towards Pension/Defined Contribution Plan benefits for each plan year in which an eligible benefited employee is paid 1,000 or more hours in accordance with the provisions of the pension and Defined Contribution Plans.
3. **Fringe Benefits Accruals**: Paid Time Off (PTO) and Sick Leave will continue to accrue on a pro-rated basis while an employee remains in a paid status.

VI. PROCEDURE

A. **Requesting Leave**:

- ~~Employees anticipating a leave of absence are directed to contact the Human Resources Leave Specialist 30 days in advance of the leave, whenever possible, to review the details of the approval process and how the leave may affect insurance, benefits accruals, position, etc. Details of the leave (including, but not limited to, start and end dates) shall be identified on the Leave of Absence Request form. Once the HR Leave Specialist has received supporting medical documentation, if~~

~~applicable, the form will be submitted to the Department Director for approval. The approved leave form is then returned to HR for processing.~~

1. Employees anticipating a leave of absence are directed to contact the Human Resources Leave Specialist 30 days in advance of the leave, whenever possible, to review the details of the approval process and how the leave may affect insurance, benefits accruals, position, etc. Details of the leave (including, but not limited to, start and end dates) shall be identified on the Leave of Absence Request form. Once the HR Leave Specialist has received supporting medical documentation, if applicable, the form will be submitted to the Department Director for approval. The approved leave form is then returned to HR for processing.

B. **Interactive Process**:

- ~~Should a medical leave of absence be due to a disability as defined in the Fair Employment and Housing Act (FEHA) or the Americans With Disabilities Act (ADA), the Hospital will engage in a timely, good faith interactive process pursuant to HR#68, REASONABLE ACCOMMODATION FOR INDIVIDUALS WITH A DISABILITY prior to making a final decision regarding the employee's employment status.~~
- ~~The purpose of the interactive process is to discuss the employee's needs and identify an appropriate reasonable accommodation that will enable the employee to perform the essential functions of the job. During the meeting, the Hospital representative may ask the employee relevant questions about the disabling condition and what limitations the employee has, as well as what the employee wants as an accommodation. The Hospital will consider the employee's request, and may offer to discuss available alternatives. The employee does not have to specify the precise accommodation requested, but does need to describe the problems posed by the workplace barrier. Suggestions from the employee may assist the Hospital in determining the type of reasonable accommodation to provide; however, the Hospital is not required to accept the employee's suggestion if there are multiple viable accommodations available.~~

1. Should a medical leave of absence be due to a disability as defined in the Fair Employment and Housing Act (FEHA) or the Americans With Disabilities Act (ADA), the Hospital will engage in a timely, good faith interactive process pursuant to HR#68, REASONABLE ACCOMMODATION FOR INDIVIDUALS WITH A DISABILITY prior to making a final decision regarding the employee's employment status.
2. The purpose of the interactive process is to discuss the employee's needs and identify an appropriate reasonable accommodation that will enable the employee to perform the essential functions of the job. During the meeting, the Hospital representative may ask the employee relevant questions about the disabling condition and what limitations the employee has, as well as what the employee wants as an accommodation. The Hospital will consider the employee's request, and may offer to discuss available alternatives. The employee does not have to specify the precise accommodation requested, but does need to describe the problems posed by the workplace barrier. Suggestions from the employee may assist the Hospital in determining the type of reasonable accommodation to provide; however, the Hospital is not required to accept the employee's suggestion if there are multiple

viable accommodations available.

C. **Return to Work**:

- ~~Unless a written request for a leave extension is received and approved, the employee will be expected to return to work on the original date indicated on the leave form. Employees returning from a Medical or Industrial leave must first report to Employee Health Services with a fit for duty release signed by their physician. Employee Health Services will then send the Department Director and HR a Status Report indicating return to work date.~~

1. Unless a written request for a leave extension is received and approved, the employee will be expected to return to work on the original date indicated on the leave form. Employees returning from a Medical or Industrial leave must first report to Employee Health Services with a fit for duty release signed by their physician. Employee Health Services will then send the Department Director and HR a Status Report indicating return to work date.

D. **Computer Access**:

- ~~Individuals on Leave of Absence may not access the Hospital computer systems; however, LaborWorkx ("Portal") only may be accessed from the Human Resources Department.~~

1. Individuals on Leave of Absence may not access the Hospital computer systems; however, LaborWorkx ("Portal") only may be accessed from the Human Resources Department.

E. **Access to Payroll Deduction**

- ~~Individuals on Leave of Absence may not use their identification badge for payroll deduction. Upon return to work, identification badge will be re-activated.~~

1. Individuals on Leave of Absence may not use their identification badge for payroll deduction. Upon return to work, identification badge will be re-activated.

F. **Failure to Follow Procedures**:

- ~~Employees who fail to follow these procedures, or who accept other employment during a leave which is inconsistent with the need for leave, may be considered to have voluntarily terminated their employment with the Hospital.~~
- ~~License and Certification Expiration While on Leave: Employees whose license or certification expires during the time of his or her Leave of Absence will have 30 calendar days from the expiration date in order to get a renewal. A copy of the renewed license or certification must be provided to the employee's manager or supervisor and to the Education Department within 30 days from the expiration. Failure to provide a copy of the current certification within this time period will result in immediate termination of employment if the license/certification is a requirement for the employee's position.~~

1. Employees who fail to follow these procedures, or who accept other employment during a leave which is inconsistent with the need for leave, may be considered to

have voluntarily terminated their employment with the Hospital.

2. License and Certification Expiration While on Leave: Employees whose license or certification expires during the time of his or her Leave of Absence will have 30 calendar days from the expiration date in order to get a renewal. A copy of the renewed license or certification must be provided to the employee's manager or supervisor and to the Education Department within 30 days from the expiration. Failure to provide a copy of the current certification within this time period will result in immediate termination of employment if the license/certification is a requirement for the employee's position.

G. **Documentation**:

1. Leave of Absence Request – internal HR form
2. Return to Work Assessment Sheet – internal Employee Health form
3. SVHMC Employee Health Service Visit Report – internal Employee Health form

VII. EDUCATION/TRAINING

~~A. Staff meetings by Department Director/Designee~~

~~B. Employment law poster~~

~~VIII. DOCUMENTATION~~

~~A. Leave of Absence Request – internal HR form~~

~~B. Return to Work Assessment Sheet – internal Employee Health form~~

~~C. SVHMC Employee Health Service Visit Report – internal Employee Health form~~

A. Education and/or training is provided as needed

IX. REFERENCES

A. Family Medical Leave Act (FMLA)

B. California Family Rights Act (CFRA)

C. ~~FAMILY SICK POLICY (HR#861)~~FAMILY SICK POLICY

D. Pregnancy Disability Leave (FEHA)

E. Domestic Violence/Sexual Assault Leave (Labor Code §230(c))

F. Leave to Appear in Court (Labor Code §230(a))

G. Leave for Victims of Crime (Labor Code §230(b))

H. Leave to Perform Emergency Duty as a Volunteer Firefighter, Reserve Peace Officer or Emergency Rescue Personnel (Labor Code §230.3)

I. School Discipline Leave (Labor Code §230.7)

J. Leave to Attend Child's School or Daycare (Labor Code §230.8)

K. ~~MILITARY LEAVE AND RE-EMPLOYMENT RIGHTS (HR#873)~~

L. Civil Air Patrol Leave (Labor Code §1501)

M. Organ and Bone Marrow Donors' Leave (Labor Code §1510)

Approval Signatures

Step Description	Approver	Date
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
HR Director	Michelle Barnhart Childs: Chief Human Resources Officer	01/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2024
Policy Owner	Robert Andersen: Manager Human Resources	01/2024

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13678164

Last Approved	N/A	Owner	Melissa Deen: Manager Infection Prevention
Last Revised	01/2024	Area	Infection Control
Next Review	3 years after approval		

Outbreak Investigation

I. POLICY STATEMENT

A. Outbreak Investigation is to determine and confirm the existence of an epidemic. The investigation is to be performed by those individuals that are epidemiologically trained and educated as defined by the Association for Professions in Infection Control and Epidemiology (APIC).

II. PURPOSE

A. To define the process that the Infection Prevention Manager, in conjunction with the Employee Health Manager, Infection Prevention Medical Director, and /or Chief Medical Officer will conduct epidemiological surveillance, investigation and reporting to appropriate authorities, hospital units, clinics and Committees.

III. DEFINITIONS

A. **Outbreak**

1. An outbreak is the occurrence of more cases of a disease or event than expected during a specified period of time in a given area or among a specific group of people. In a health care facility, an outbreak may be suspected when routine surveillance activities detect an unusual microbial isolate, a cluster of case, or an apparent increase in the usual number or incidence of cases; when a clinician diagnoses an uncommon disease; or when an alert physician, nurse, or laboratory worker notices a cluster of cases.

B. **Cluster**

1. A cluster is a group of cases of a disease or other health-related event that occurs closely related in time and place. In a cluster, the number of cases may or may not exceed the expected number—frequently the expected number is not known.

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. Many steps in an outbreak investigation will occur simultaneously; however, whenever an outbreak or cluster is suspected, the investigator must first conduct an initial evaluation of the reported cases to confirm that a potential epidemic exists, and then decide whether to initiate a basic or a full-scale investigation.

1. **Initial Evaluation**

   The purpose of the initial evaluation is to provide a quick analysis of the likelihood that an important excess of cases has occurred and to determine if a potential problem exist. The steps are as follows:

   a. Verify the diagnosis of the reported cases. The diagnosis will be verified by reviewing laboratory reports and medical records. In addition, clinical findings can be discussed with physician and or the Infection Prevention Medical Director, especially when there appears to be a discrepancy between the clinical findings and the laboratory findings. If the clinical findings do not support the laboratory finding then a pseudo infection or misdiagnosis will be suspected.

   b. Evaluate the severity of the problem. If the condition is severe, a full-scale investigation may be needed. If it is mild or only affects a few people, then a basic investigation may be all that is needed with appropriate units and Directors notified.

   c. Conduct a retrospective review of surveillance records, laboratory reports, and clinical records to identify if there are other cases.

   d. Develop a line listing of cases per APIC protocols.

   e. Review the existing information and determine if a potential problem exists (i.e., does the incidence rate appear to be greater than expected).

   f. If a potential outbreak exists, decide whether to begin a basic or a full-scale investigation. Because the initial steps for both investigations are similar, no time will be lost if started with a basic investigation and subsequently finds that a full-scale study is warranted.

2. **Outbreak Investigation**

   a. To identify and verify the diagnosis of newly reported cases. The IP Manager will conduct prospective surveillance for new cases by monitoring laboratory results, clinical records and reports from attending healthcare providers. All new suspected cases will be added to the line listing.

   b. Develop a case definition that will be used to identify affected persons. A case definition utilizes epidemiologic, clinical, and laboratory criteria to

define and classify cases and usually restricts cases to a specific time, place and person. The definition may categorize cases as possible, probably, and definite. The case definition may initially be broad to ensure that all those who have the disease or condition are included in the study. Salinas Valley Memorial Hospital Infection Prevention Department will utilized the Centers for Disease Control (CDC) definitions for infectious conditions that are reportable to the California Department of Public Health and / or Monterey County Health Department (See attachment A: CDPH / MCDH Reportable Diseases)

c. Review clinical and laboratory findings. If the outbreak is of infectious etiology, clinical and laboratory findings will be reviewed early in the investigation to determine if the cases are infected or colonized or if they represent pseudo infection.

d. Confirm the existence of an epidemic. This is done by determining if the incidence rate or the number of cases is above the endemic or expected rated if the rate is known. It is important during this phase to rule out the possibility of surveillance techniques; equipment, new ways of specimen collection, etc. can all lead to an increase number of reported infections.

e. The IP Department will conduct a literature search as needed to assist with identifying risk factors, sources, reservoirs, modes of transmission, and effective control measures.

f. If the outbreak is of infectious etiology, the IP Department will notify the microbiologist of the likelihood of an outbreak and will be instructed to save all isolates of the suspected agent as appropriate.

g. Essential personnel will be notified (per CAL OSHA & CDPH requirements) as soon as the likelihood of an outbreak has been determined by the IP Manager and IP Medical Director / Chief Medical Officer. Salinas Valley Memorial Hospital VP/COO, VP/CNO, Manager of Risk, Manager of Quality, affected units, clinics or departments and affected staff will be alerted as well. The CDPH / MCDH will be notified as determined by the Manager of Risk Management.

h. Institute early control measures. Personnel in the affected areas will be notified of the appropriate infection prevention and control measures to utilize including appropriate personal protective equipment to be utilized.

i. An investigation team will be assembled by the IP Manager and a member will be appointed primary contact person to answer questions and communicate findings and recommendations. (Usually the IP Manager or IP Medical Director). The team will be composed of the IP Manager, Employee Health, Quality Manager, Risk Manager, Laboratory, Pharmacy and CNO and /or COO. Spokesperson for any outside reporters will be determined by the Communications Director (Public Information Officer).

j. The IP Manager will record all actions taken for final reporting once outbreak has resolved. Line listing will be completed on all cases suspected or confirmed. Data collection will be collected in a uniform

manner and data elements will be determined and epidemic curve will be graphed.

k. During the outbreak interim reports will be prepared as needed. When the outbreak has resolved the IP Manager will prepare a formal report that will be submitted to the Pharmacy & Therapeutics / Infection Control Committee..

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Association for Professionals in Infection Control and Epidemiology (~~2014~~APIC). ~~*APIC text of infection control & epidemiology* (4th Ed).~~ **Outbreak Investigation. 12: 1-10**. Washington DC~~:~~ ~~APIC publishing~~. Updated 2022.

B. ~~Outbreak Investigation: A Cheat Sheet. CDC, 09/07/2011. https://blogs.cdc.gov/publichealthmatters/2011/09/outbreak-investigation-a-cheat-sheet/~~CDC Outbreak Resource Page: https://www.cdc.gov/outbreaks/; updated December 3, 2022

C. Principles of Epidemiology in Public Health Practice (October 2006, updated May 2012). An Introduction to Applied Epidemiology and Biostatistics (Third Edition). **Lesson Six: Investigating an Outbreak. 6-1-75**. Atlanta, GA., U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Centers for Disease Control and Prevention (CDC), Office of Workforce and Career Development

Attachments

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5- 2643.20, and §2800-2812 Reportable Diseases and Conditions*

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	01/2024
P&T/IPC	Genevieve delos Santos: Director Pharmacy	12/2023

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2023
Policy Owner	Melissa Deen: Infection Prevention Manager	05/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13951403**

Last Approved	N/A	Owner	Robert Andersen: Manager Human Resources
Last Revised	10/2023	Area	Human Resources
Next Review	3 years after approval		

Paid Time Off (PTO) - Non-Affiliated Employees

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. The following Paid Time Off (PTO) benefits are described for eligible Non-Affiliated employees.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. Paid Time Off (PTO) combines vacation, holidays, and sick leave into one account of Paid Time Off. PTO may be used for vacation, holidays, illness, emergencies, religious observances, routine health or dental care, personal business, California Paid Sick Leave (PSL) compliance, or other elective excused absences (except for some education leaves, bereavement leave, and jury duty, which shall be paid in addition to PTO). With the exception of PSL, PTO must be scheduled with the immediate supervisor, in advance, except in the case of illness or emergency ("Unscheduled Time Off"). In the event of illness or emergency, PTO will be granted, provided notification of the illness or emergency is given to the supervisor prior to the start of the shift (as per department policy) for which the PTO is to be used. "Emergency" for the purposes of this policy shall be defined as a circumstance for which the employee could not have provided advance notice and be of such compelling and sufficient reason to cause the employee's absence from a scheduled shift. If notice or reason given is not sufficient according to department policy, PTO may be denied. As noted in the California Paid Sick Leave policy, up to 3 days of PTO may be used for California PSL purposes in accordance with applicable law. Please see the PSL Policy (HR# 6087 CALIFORNIA PAID SICK LEAVE) for more information about accrual, scheduling and usage of PTO for PSL purposes. In the event there is a conflict between the PSL Policy and the PTO policy, the PSL policy will control with regard

to PTO which is used to meet California paid sick requirements.

B. All full-time and part-time non-affiliated employees who average at least ~~thirty-two~~forty (~~32~~40) hours per pay period are eligible for the PTO Program.

C. All non-affiliated eligible employees who do not use Unscheduled Time Off (See ~~APM / Human Resources -~~ ATTENDANCE GUIDELINES) for that calendar quarter will receive a bonus of an additional eight (8) hours of PTO. This will be prorated for part time employees.

D. Any employee who has been removed from the work scheduled because his/her required license/certification/registry has expired will not qualify for the PTO Bonus/Unscheduled Time Off Incentive Program ~~(see Section I.C above) as described in the Non-Affiliated Handbook.~~

E. PTO accrual for full-time employees is calculated according to this table effective January 1, 2017:

Non-Affiliated	Accrual/per pay period
0-1.999 Years	8.46 hours
2-4.999 Years	10.00 hours
5 – 13.999 Years	13.08 hours
14 – 18.999 Years	13.70 hours
19 – 28.999 Years	14.62 hours
29+ Years	16.15 hours

F. The maximum number of PTO hours that may be accrued is two (2) years' accrual based on length of service as set forth in the following table. Once the accrual maximum is achieved, the accrual will cease until the balance drops below the maximum accrual.

Non Affiliated	Maximum Accrual
0 – 1.999 Years	439.92 hours
2 – 4.999 Years	520 hours
5 – 13.999 Years	680.16 hours
14 – 18.999 Years	712.40 hours
19 – 28.999 Years	760.24 hours
29+Years	839.80 hours

G. The following holidays are observed. All holidays are included in the accrual calculations above.

Nationally Recognized Holidays

1. New Year's Day
2. President's Day
3. Memorial Day
4. Independence Day (4th of July)
5. Labor Day
6. Thanksgiving Day

7. Christmas Day

H. Administration may at its sole discretion determine hours of work. Administration may determine that a department will be closed and that its staff must utilize PTO for time that the department is closed, except that staff will never be forced to use PTO which is set aside for PSL usage.

I. Use of PTO on or after the 90th day of employment will be limited to the employee's earned PTO balance. During the first eighty-nine (89) days of employment, PTO will be allowed only for nationally recognized holidays listed above.

J. At time of separation of employment, employees will be paid the balance of PTO hours not used at the time of separation. If an employee separates employment during the first 90 days of employment and has a negative PTO balance, the negative balance is subject to review.

K. PTO hours must be available in the employee's accrual bank at the time the PTO is to be taken in order for the employee to be allowed to take approved vacation. PTO with no accrual in the bank will be denied, even though it was approved prior to the scheduled date it was to be taken.

L. ~~Per Diem Employees transferring to benefited positions – for accrual information, refer to OPM HR.5 – Employees Who Transfer To and From Per Diem and Benefited Positions.~~

M. ~~**PTO CASH OUT**~~:

~~In compliance with IRS guidance on PTO cash-outs, employees will be allowed to cash out PTO only in the event of an unforeseen financial emergency. An unforeseen financial emergency is one in which:~~

1. ~~an employee can demonstrate s/he has a real financial emergency caused by an event beyond his/her control,~~
2. ~~it would result in serious financial hardship if the cash payment were not made, and~~
3. ~~the amount of cash payment is limited to the amount necessary to meet the emergency.~~
    a. ~~At least 16 hours of accrued PTO must be cashed out at one time and the employee must be left with a balance of at least 40 hours in PTO accruals.~~
    b. ~~The request for PTO cash out must be made on a PTO Cash Out Request Form and submitted, with substantiating documentation as outlined on the form, to the Human Resources department for approval.~~
    c. ~~The PTO cash out monies will be available in a separate check on regular paydays. There will be no handwritten checks or "rush" checks for PTO cash out.~~
    d. ~~PTO may not be cashed out if the request is made in the same pay period that a disciplinary action has occurred.~~
    e. ~~No shift differential shall be paid on PTO cash outs.~~

N. **EXTENDED SICK LEAVE (ESL):**

1. The ESL accrual will be as follows:

Employed	Accrual
0-5 years	1.85 hours per pay period / 48.10 per year
5+ years	1.65 hours per pay period / 42.90 per year

2. These hours will be placed in an ESL account and may be used if the employee:
    a. Qualifies for State Disability Insurance (SDI) or Workers' Compensation benefits; and
    b. Has completed the first ninety (90) days of employment.
3. ESL will be used to supplement SDI or Workers' Compensation benefits during an extended illness or injury period. PTO will be used when ESL has been exhausted.
4. ESL may not be cashed out.
5. In any calendar year, ESL may be used by an employee at his or her request for leave to attend to an illness of a child, parent or spouse of the employee, provided that:
    a. The employee has completed the first ninety (90) days of employment. The employee may use only the amount of ESL that would be accrued during six (6) months at the employee's then current rate of entitlement at the time the leave is requested for this purpose.

V. PROCEDURE

A. Requests for use of ~~Paid Time Off (~~PTO~~), other than PSL, require completion of the **Request For Paid Time Off** form, which is available on the Hospital intranet and in Human Resources. Employees~~ should ~~make such requests~~be made to the Department Director/Supervisor who has authority and responsibility for review and approval of such requests. Please follow departmental standards for requesting PTO.

B. Paid Time Off may be granted only for hours accrued, with the exception of Section I. ~~I.~~ If verification of hours is necessary, review the employee's API report.

C. All applicable provisions of Hospital ~~policy~~ and Departmental ~~Policy~~Policies must be followed. Individual departments/units have policies that determine core staffing and the number of individuals that could be utilizing PTO during any given ~~timeframe~~time frame.
    1. Cancellation of PTO must occur 48 hours prior to actual date of requested PTO. Once employee is back on the schedule he/she may pick up additional shift.
    2. If PTO is ~~cancelled~~canceled the employee will be placed back on the schedule at the unit ~~Director's~~leaders discretion.
    3. If a person has scheduled a PTO day and takes the PTO day off, it will remain deducted from their PTO bank, regardless of the number of hours worked during the pay period.
    4. If a person has scheduled a PTO day and they meet their FTE requirement by picking up additional shifts prior to the scheduled PTO day, they may cancel the scheduled PTO.
    5. Cancellations must be in writing to the department Director/designee.

D. All applicable provisions of Hospital ~~policy~~ and Departmental ~~Policy~~Policies must be followed for PTO utilization for exchanges with fellow staff members.

1. Approval of exchanges must occur 48 hours prior to actual date of requested exchange.
2. Only one swap per employee per pay period is authorized, unless otherwise approved by the Department Director/designee.
3. Premium Pay must be waived on the schedule exchange form.
    a. Copy of completed form sent to individual reconciling payroll.
    b. Ensure API deducts premium pay.
    c. Ensure the employee affected and his/her director sign the API form prior to being sent to payroll.
4. First priority for swaps given by time submitted.
5. No schedule exchanges occur in staffing without approval from Director.

E. An employee may split his/her PTO period subject to the requirements of efficient operation. ~~Request for Paid Time Off forms may be obtained from Department Directors, the Human Resource Department, and the Hospital intranet.~~

F. If an employee responds to a call-in request to work while he/she is out on PTO, he/she will be paid at his/her regular straight-time rate.

G. It is the employee's responsibility to monitor their PTO balance. A **First Warning Notice** will be issued to any employee who takes time off when there are insufficient hours in their PTO bank to cover the time off unless the time off is otherwise protected by law.

H. Documentation:

1. ~~PTO Cash Out Request form~~
2. Request for Paid Time Off

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Human Resources policy – ATTENDANCE GUIDELINES

Approval Signatures

Step Description	Approver	Date

Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
HR Director	Michelle Barnhart Childs: Chief Human Resources Officer	12/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Robert Andersen: Human Resources Manager	10/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14016076**

Last Approved	N/A	Owner	Louis Villaneda Sr.: Respiratory Care Manager
Last Revised	11/2023	Area	Plans and Program
Next Review	1 year after approval		

RC POCT Lab Arterial Blood Gas Quality Management Plan

SCOPE

1. The Respiratory Care Point-of-Care Testing (POCT) Lab (referenced to as the 'RC Lab' in this document) Arterial Blood Gas (ABG) Quality Management Plan provides a systematic means to ensure the delivery of quality POCT blood gas services and outlines the organizational structure, regulatory compliance, and processes and tools utilized to ensure the continual improvement of the quality and performance of services provided, including an Individualized Quality Control Program (IQCP).

OBJECTIVES/GOALS

1. **Individualized Quality Control Program (IQCP):** The Medical Director is responsible for the IQCP. IQCP is a total quality assurance approach comprised of three phases: **Risk Assessment (RA), Quality Control Plan (QCP) and Quality Assurance (QA)** and is utilized to:
    1. Review the pre-analytic (before testing), analytic (testing), and post-analytic (after testing) phases of the testing process.
    2. Break down each phase into steps, so that potential failures and errors can be identified.
    3. Analyze the information gathered to determine what control activities can be put into place to reduce the identified potential failures and errors.
2. **Risk Assessment:** The **RA** process will be utilized to assist in the process of identifying, evaluating, and reducing potential sources of failures and errors that could occur during the pre-analytical, analytical and post-analytical phases of testing. The RA will evaluate testing process components including, but not limited to:
    1. Specimen
    2. Test system
    3. Reagent

4. ~~Environment~~
5. ~~Testing personnel~~

~~RA will be supported with applicable resources including, but not limited to:~~

1. ~~Test performance specifications~~
2. ~~Hospital and RC Lab policies and procedures~~
3. ~~Manufacturer's instructions and package inserts~~
4. ~~Manufacturer's alerts and bulletins~~
5. ~~Instrument and troubleshooting manuals~~
6. ~~Proficiency Testing (PT) results and performance data~~
7. ~~Quality Control (QC) logs/data~~
8. ~~Specimen receipt and rejection logs~~
9. ~~Calibration data~~
10. ~~Data obtained through verification of establishment of performance specifications~~
11. ~~FDA alerts~~
12. ~~Historical QC data, including data from previously conducted equivalent quality control study~~
13. ~~Instrument correlations data~~
14. ~~Records of complaint and corrected records~~
15. ~~Regulatory and accreditation requirements~~
16. ~~Scientific publications~~
17. ~~Test process flow charts or maps~~
18. ~~Testing personnel training and competency records~~

~~The Medical Director attests that:~~

1. ~~All RC POCT laboratory personnel are appropriately licensed.~~
2. ~~The Laboratory is in compliance with all other applicable federal, state and local laws and regulations.~~
3. ~~There have been no investigations of the Laboratory by any state, federal, or other regulatory body.~~
4. ~~The Laboratory Management will notify the CAP Office whenever the Laboratory finds itself the subject of an investigation by a government entity or adverse media attention related to Laboratory performance.~~
5. ~~All employees have the ability to communicate concerns about the quality and safety to management, who will investigate employee complaints.~~
6. ~~All technical personnel must be assessed for competency to perform patient testing.~~

Competency assessment records **(Attachment A)** must include all six elements described below for each individual on each test system during each assessment period, unless an element is not applicable to the test system. Elements of competency assessment include but are not limited to:

a. Direct observation of routine test performance, including, as applicable, patient/sample identification and preparation: And specimen collection, handling, processing and testing.

b. Monitoring the record and reporting of test results, including, as applicable, reporting critical results.

c. Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventive maintenance records.

d. Direct observation of performance of instrument maintenance and function checks.

e. Assessment of test performance through testing previously analyze specimens, internal blind testing samples or external proficiency testing sample; and

f. Evaluation of problem solving skills.

7. After initial assessment, all non-waived testing personnel semiannually the first year and annually thereafter. Documentation of testing by department is maintained by the supervisor and evidence of compliance is documented on the Annual Competency Assessment form. The Laboratory Director or designee ensures that Competencies are performed on schedule by reviewing status on a regular basis. The Medical Director designates the following individual to assess competency in the Respiratory Care Laboratory (Brandon Reed CLS Laboratory Technical Supervisor).

3. **Quality Control (QCP):** The Medical Director (or Respiratory Care Coordinator as designated by the Medical Director) is responsible for the development, implementation, continuous updating and signing and dating of the QCP.

The QCP provides a process for the immediate detection of errors that occur due to test system failure, adverse environmental conditions, and operator performance. The QCP includes activities and tools to reduce the likelihood of failures and errors identified from RAs, and incident reports. The QCP helps assure the accuracy and reliability of test results and that the quality of testing is adequate for patient care and is aligned with CAP (College of American Pathologists) and manufacturer minimum standards.

The RC Lab Director (or designee) will be responsible for maintaining and reviewing the QCP with staff. The designee will review the QCP with the Medical Director and will serve as the primary point of contact for meeting and reporting completion of QC requirements as outlined in the QCP.

Support materials include, but not limited to: policies and procedures, competencies, checklists, E-learning, manufacturer's instructions, electronic database information/reports, and other training materials. These materials will be made available to staff and records of all

documents will be maintained in the Respiratory Care management office.

4. **Quality Assessment (QA):** The Medical Director is responsible for providing a continuous QA process of verifying the effectiveness of the QCP including monitoring, assessing and correcting performance involved in the pre-analytical, analytical, and post-analytical testing process including, but not limited to, components such as: specimen, test system, reagents, environment, and testing personnel. QA activities may include, but are not limited to:
    1. QC reviews
    2. PT records (scores, testing failures, trends)
    3. Chart reviews
    4. Specimen rejection logs
    5. Turnaround time reports
    6. Complaint/Incident records
    7. Observation of staff and competency records
    8. Laboratory data reports (QML, Meditech)
    9. Temperature logs
    10. Records of preventative measures, corrective actions, & follow-up
    11. FDA alerts

DEFINITIONS

1. N/A

PLAN MANAGEMENT

1. **Organization Structure and Authority**: The Medical Director has the overall responsibility for the Quality Management Program. The Medical Director (and/or Designee) approves all policy and procedures including the RC Lab's Individualized Quality Control Program (IQCP) and consults and provides direction for the RC Lab's Risk Assessment (RA), Quality Control Plan (QCP), and Quality Assessment (QA) activities in conjunction with the Program's Administrative Director, RC Lab Director, Supervisors/Lab Coordinator, and staff.
2. **Regulatory Compliance**: The Medical Director is responsible for coordinating the Quality Improvement activities of the Lab - ensuring the program is documented and that the findings, conclusions from monitoring, evaluation, and problem solving activities are discussed and documented and that evidence-based and best practice standards and thresholds are set and observed which are derived from various sources including, but not limited to:
    1. California State Accreditation Requirements
    2. College of American Pathologists (CAP) & Clinical Laboratory Improvement Amendments (CLIA) Accreditation Requirements
    3. Joint Commission (JC) Accreditation Requirements
    4. Policies, procedures and protocols of Salinas Valley Health Medical Center (SVHMC)
    5. Policies, procedures and protocols are established by the RC Department

6. Manufacturer's instructions

3. **Actions and Reporting:** The Lab Director and Supervisors/Lab Coordinator will document any investigations and resolution of incidents or problems and conduct root cause analysis of any unexpected events involving death or serious physical or psychological injury, or risk (including "near misses" sentinel events) per Hospital policy. Actions include: monitoring, collecting information, formulating corrective actions, documenting, and follow-up actions to improve patient care.

   Actions must be taken which are appropriate, acceptable to the hospital and the patient community and which result in improved patient care. Actions may include, but are not limited to:

   1. Education/training
   2. Implementing new or revised procedures
   3. Staffing changes
   4. Counseling/guidance

   The Lab Medical Director, or designee, is responsible for reporting quality improvement activities to the Medical Director and to the Quality Management Department (statement form or graphs to trend the information) in quarterly reports including:

   1. Criteria used in monitoring and evaluation process
   2. Outcome of review
   3. Actions taken to improve patient care
   4. Effectiveness of the indicators and plan for improvement

4. **Interdisciplinary Teams**: The Medical Director, RC Lab Director, Supervisors/Lab Coordinator, Admin. Director, and staff participate in interdisciplinary teams including, but not limited to:

   1. Pharmacy and Therapeutics Committee
   2. Code Blue/Rapid Response Committee
   3. Clinical Interdisciplinary Advisory (CIA) Committee
   4. NICU Interdisciplinary Committee
   5. Emergency Management Committee

5. **Plan Elements**
6. **Plan Management**
7. **Plan Responsibility**
8. **Performance Measurement**

   1. Evaluations of the Quality Management Plan and program will be conducted annually, and as need arises, under the direction of RC POCT Lab Medical Director (referred to as 'Medical Director' in this document) in consult with the Administrative Director, RC Lab Director, Supervisors/Lab Coordinator and staff.

2. ~~Evaluation should include any trends or challenges to service or quality. Findings should be objectively assessed in terms of cause and options for correction. Cost and magnitude of the effect on patient care should be considered and problems or recommended actions referred to the appropriate sources for resolution. All documents are archived for a minimum of two years.~~

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

~~REFERENCES~~

1. ~~N/A~~

I. SCOPE

A. The Respiratory Care Point-of-Care Testing (POCT) Lab (referenced to as the 'RC Lab' in this document) Arterial Blood Gas (ABG) Quality Management Plan provides a systematic means to ensure the delivery of quality POCT blood gas services and outlines the organizational structure, regulatory compliance, and processes and tools utilized to ensure the continual improvement of the quality and performance of services provided, including an Individualized Quality Control Program (IQCP).

II. OBJECTIVES/GOALS

A. **Individualized Quality Control Program (IQCP):** The Medical Director is responsible for the IQCP. IQCP is a total quality assurance approach comprised of three phases: **Risk Assessment (RA), Quality Control Plan (QCP) and Quality Assurance (QA)** and is utilized to:

    1. Review the pre-analytic (before testing), analytic (testing), and post-analytic (after testing) phases of the testing process.
    2. Break down each phase into steps, so that potential failures and errors can be identified.
    3. Analyze the information gathered to determine what control activities can be put into place to reduce the identified potential failures and errors.

B. **Risk Assessment:** The **RA** process will be utilized to assist in the process of identifying, evaluating, and reducing potential sources of failures and errors that could occur during the pre-analytical, analytical and post-analytical phases of testing. The RA will evaluate testing process components including, but not limited to:

    1. Specimen
    2. Test system
    3. Reagent
    4. Environment

5. Testing personnel

C. RA will be supported with applicable resources including, but not limited to:

1. Test performance specifications
2. Hospital and RC Lab policies and procedures
3. Manufacturer's instructions and package inserts
4. Manufacturer's alerts and bulletins
5. Instrument and troubleshooting manuals
6. Proficiency Testing (PT) results and performance data
7. Quality Control (QC) logs/data
8. Specimen receipt and rejection logs
9. Calibration data
10. Data obtained through verification of establishment of performance specifications
11. FDA alerts
12. Historical QC data, including data from previously conducted equivalent quality control study
13. Instrument correlations data
14. Records of complaint and corrected records
15. Regulatory and accreditation requirements
16. Scientific publications
17. Test process flow charts or maps
18. Testing personnel training and competency records

D. The Medical Director attests that:

1. All RC POCT laboratory personnel are appropriately licensed.
2. The Laboratory is in compliance with all other applicable federal, state and local laws and regulations.
3. There have been no investigations of the Laboratory by any state, federal, or other regulatory body.
4. The Laboratory Management will notify the CAP Office whenever the Laboratory finds itself the subject of an investigation by a government entity or adverse media attention related to Laboratory performance.

5. All employees have the ability to communicate concerns about the quality and safety to management, who will investigate employee complaints.

6. All technical personnel must be assessed for competency to perform patient testing. Competency assessment records **(Attachment A)** must include all six elements described below for each individual on each test system during each assessment period, unless an element is not applicable to the test system. Elements of competency assessment include but are not limited to:

    a. Direct observation of routine test performance, including, as applicable, patient/sample identification and preparation: And specimen collection, handling, processing and testing.

    b. Monitoring the record and reporting of test results, including, as applicable, reporting critical results.

    c. Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventive maintenance records.

    d. Direct observation of performance of instrument maintenance and function checks.

    e. Assessment of test performance through testing previously analyze specimens, internal blind testing samples or external proficiency testing sample; and

    f. Evaluation of problem solving skills.

7. After initial assessment, all non-waived testing personnel semiannually the first year and annually thereafter. Documentation of testing by department is maintained by the supervisor and evidence of compliance is documented on the Annual Competency Assessment form. The Laboratory Director or designee ensures that Competencies are performed on schedule by reviewing status on a regular basis. The Medical Director designates the following individual to assess competency in the Respiratory Care Laboratory (Brandon Reed CLS Laboratory Technical Supervisor).

E. **Quality Control (QCP):** The Medical Director (or Respiratory Care Coordinator as designated by the Medical Director) is responsible for the development, implementation, continuous updating and signing and dating of the QCP.

1. The QCP provides a process for the immediate detection of errors that occur due to test system failure, adverse environmental conditions, and operator performance. The QCP includes activities and tools to reduce the likelihood of failures and errors identified from RAs, and incident reports. The QCP helps assure the accuracy and reliability of test results and that the quality of testing is adequate for patient care and is aligned with CAP (College of American Pathologists) and manufacturer minimum standards.

2. The RC Lab Director (or designee) will be responsible for maintaining and reviewing the QCP with staff. The designee will review the QCP with the Medical Director and will serve as the primary point of contact for meeting and reporting completion of QC requirements as outlined in the QCP.
3. Support materials include, but not limited to: policies and procedures, competencies, checklists, E-learning, manufacturer's instructions, electronic database information/ reports, and other training materials. These materials will be made available to staff and records of all documents will be maintained in the Respiratory Care management office.

F. **Quality Assessment (QA):** The Medical Director is responsible for providing a continuous QA process of verifying the effectiveness of the QCP including monitoring, assessing and correcting performance involved in the pre-analytical, analytical, and post-analytical testing process including, but not limited to, components such as: specimen, test system, reagents, environment, and testing personnel. QA activities may include, but are not limited to:

1. QC reviews
2. PT records (scores, testing failures, trends)
3. Chart reviews
4. Specimen rejection logs
5. Turnaround time reports
6. Complaint/Incident records
7. Observation of staff and competency records
8. Laboratory data reports (QML, Meditech)
9. Temperature logs
10. Records of preventative measures, corrective actions, & follow-up
11. FDA alerts

III. DEFINITIONS

A. N/A

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. See Scope

B. **Plan Responsibility**

1. See F. Regulatory Compliance

C. **Performance Measurement**

1. Evaluations of the Quality Management Plan and program will be conducted annually, and as need arises, under the direction of RC POCT Lab Medical Director (referred to as 'Medical Director' in this document) in consult with the Administrative Director, RC Lab Director, Supervisors/Lab Coordinator and staff.
2. Evaluation should include any trends or challenges to service or quality. Findings should be objectively assessed in terms of cause and options for correction. Cost and magnitude of the effect on patient care should be considered and problems or recommended actions referred to the appropriate sources for resolution. All documents are archived for a minimum of two years.

D. **Orientation and Education**

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

E. **Organization Structure and Authority**: The Medical Director has the overall responsibility for the Quality Management Program. The Medical Director (and/or Designee) approves all policy and procedures including the RC Lab's Individualized Quality Control Program (IQCP) and consults and provides direction for the RC Lab's Risk Assessment (RA), Quality Control Plan (QCP), and Quality Assessment (QA) activities in conjunction with the Program's Administrative Director, RC Lab Director, Supervisors/Lab Coordinator, and staff.

F. **Regulatory Compliance**: The Medical Director is responsible for coordinating the Quality Improvement activities of the Lab - ensuring the program is documented and that the findings, conclusions from monitoring, evaluation, and problem solving activities are discussed and documented and that evidence-based and best practice standards and thresholds are set and observed which are derived from various sources including, but not limited to:

1. California State Accreditation Requirements
2. College of American Pathologists (CAP) & Clinical Laboratory Improvement Amendments (CLIA) Accreditation Requirements
3. Joint Commission (JC) Accreditation Requirements
4. Policies, procedures and protocols of Salinas Valley Health Medical Center (SVHMC)
5. Policies, procedures and protocols are established by the RC Department
6. Manufacturer's instructions

G. **Actions and Reporting:** The Lab Director and Supervisors/Lab Coordinator will document any investigations and resolution of incidents or problems and conduct root cause analysis of any unexpected events involving death or serious physical or psychological injury, or risk (including "near misses" sentinel events) per Hospital policy. Actions include: monitoring, collecting

information, formulating corrective actions, documenting, and follow-up actions to improve patient care.

H. Actions must be taken which are appropriate, acceptable to the hospital and the patient community and which result in improved patient care. Actions may include, but are not limited to:

1. Education/training
2. Implementing new or revised procedures
3. Staffing changes
4. Counseling/guidance

I. The Lab Medical Director, or designee, is responsible for reporting quality improvement activities to the Medical Director and to the Quality Management Department (statement form or graphs to trend the information) in quarterly reports including:

1. Criteria used in monitoring and evaluation process
2. Outcome of review
3. Actions taken to improve patient care
4. Effectiveness of the indicators and plan for improvement

J. **Interdisciplinary Teams**: The Medical Director, RC Lab Director, Supervisors/Lab Coordinator, Admin. Director, and staff participate in interdisciplinary teams including, but not limited to:

1. Pharmacy and Therapeutics Committee
2. Code Blue/Rapid Response Committee
3. Clinical Interdisciplinary Advisory (CIA) Committee
4. NICU Interdisciplinary Committee
5. Emergency Management Committee

V. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date

Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Sr. Admin Director	Christianna Kearns: Associate Chief Operating Officer	12/2023
Respiratory Medical Director	Christianna Kearns: Associate Chief Operating Officer	12/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2023
Policy Owner	Louis Villaneda Sr.: Respiratory Care Manager	11/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13486142

Last Approved	N/A	Owner	Carla Knight: Director Perioperative Services
Last Revised	01/2024	Area	Infection Control
Next Review	3 years after approval		

Reprocessing Single Use Devices

I. POLICY STATEMENT:

~~A. SVMH is committed to complying with all federal regulations, including the Food and Drug Administration's Enforcement Priorities for Single Use Devices Reprocessed by Third Parties and Hospitals.~~

~~B. SUDs are reprocessed by an FDA approved/ registered reprocessing facility upon approval of that facility by the Infection Control/Risk Management, Surgical Executive, and Medical Executive Committees.~~

~~C. SUDs are not reprocessed in the Surgical Sterile Reprocessing Department at SVMH.~~

~~D. The reprocessor will submit confirmation of FDA annual inspection and certification to the Directors of Materials Management, Surgery, and Infection Prevention and Control.~~

~~E. The Materials Management Director functions as the liaison between SVMH and the reprocessor to promote coordination of the program/problem resolution.~~

~~F. Reprocessed device failures are reported as described in the procedure section.~~

~~G. Neurosurgical single use devices (SUDs) are excluded from reprocessing.~~

A. N/A

II. PURPOSE:

A. To provide guidelines in utilizing a 3rd party for reprocessing/remanufacturing single use devices.

III. DEFINITIONS:

A. FDA: US Food and Drug Administration.

B. Reprocessing: an FDA regulated manufacturing process by which medical devices labeled for single use are cleaned, refurbished, tested, and sterilized resulting in a device safe for reuse.

C. Reprocessing company: a company registered with the FDA to reprocess single use medical devices for patient use during sterile procedures. The reprocessors are subject to the regulatory requirements applicable to the original manufacturer and follow the FDA Guidance Document, *Enforcement priorities for single use devices reprocessed by third parties and hospitals*.

D. SUD: single use medical device.

E. 510(k) – Section 510(k) of the Food, Drug, and Cosmetic Act requires device manufacturers, who must register, to notify FDA of their intent to market a medical device in advance, in order for the FDA to review and clear that device for marketing.

IV. GENERAL INFORMATION:

~~A. N/A~~

A. Salinas Valley Health Medical Center (SVHMC) is committed to complying with all federal regulations, including the Food and Drug Administration's Enforcement Priorities for Single Use Devices Reprocessed by Third Parties and Hospitals.

B. SUDs are reprocessed by an FDA approved/ registered reprocessing facility upon approval of that facility by the Infection Control/Risk Management, Surgical Executive, and Medical Executive Committees.

C. SUDs are not reprocessed in the Surgical Sterile Reprocessing Department at SVHMC.

D. The reprocessor will submit confirmation of FDA annual inspection and certification to the Directors of Materials Management, Surgery, and Infection Prevention and Control.

E. The Materials Management Director functions as the liaison between SVHMC and the reprocessor to promote coordination of the program/problem resolution.

F. Reprocessed device failures are reported as described in the procedure section.

G. Neurosurgical single use devices (SUDs) are excluded from reprocessing.

V. PROCEDURE:

A. Reprocessing vendor responsibilities

1. Assistance with identification of SUDs approved for reprocessing is provided upon request.
2. An updated list of the reprocessor's FDA approved 510k SUDs should be provided annually to the Directors of Materials Management, Surgery, and Infection Prevention and Control.
3. SUD rigid "biohazardous/reprocessing only" labeled collection receptacles are provided by the reprocessor's account service representative for use at predetermined locations.
    a. Used device bins: in procedure rooms and other areas as requested by the department directors.
    b. Opened/unused device bins: in a centralized location on each unit.

c. Shipping containers:
    i. In one centralized location for ease of collection and identification.
    ii. Labeled as required by the FDA: "BIOHAZARD Medical Device Collection Only".
    iii. The reprocessor's account service representative will collect and ship the collection bins.

4. Collection and shipping should occur on an agreed upon schedule.
5. Reprocessed SUDs packaging will be clearly labeled with the vendor's identification.
6. The reprocessing vendor will send a list of reprocessed items available and rejected to the Materials Management Director on a mutually acceptable schedule.
7. A detailed summary utilization report for SUDs sent for reprocessing should be sent to each director of the user departments and Materials Management.
8. A quality assurance program should be maintained for the following:
    a. Tracking the number of reprocessing cycles undergone by each device.
    b. Logging complaints and reporting to the user, the results of the assessment of device failure or process problems.
9. A summary of the 510k clearance for a specific device will be sent to the department directors when requested.
10. Upon introduction of the reprocessing program, education for ~~SVMH~~SVHMC staff and physicians related to the science, safety, and processes associated with reprocessing will be provided when requested by ~~SVMH~~SVHMC.

B. ~~SVMH~~SVHMC responsibilities
1. Staff should use the provided collection bins as indicated on the bins
    a. For opened/unused SUDs.
    b. For collection of used SUDs. Other metal and plastic devices may be placed in this container and will be sent by the reprocessor for recycling.
        i. Needles and knife blades are excluded.
        ii. Neurosurgical devices are excluded.
    c. Bins should be maintained free of trash
2. Staff should encourage use of reprocessed SUDs before opening original manufacturer supplied products.
3. The Infection Control Committee oversees the reprocessing program.
    a. The Directors of Materials Management, Infection Prevention and Control and departments utilizing reprocessed SUDs e.g. Surgery, Cath Lab, and DI report utilization, occurrences, and additions to the SUDs program.
    b. Summaries of Infection Control Committee activities, related to

reprocessed SUDs, should be provided to physician and leadership committees.

4. The designation of which SUDs will be reprocessed is made by the directors of individual departments and Materials Management.
    a. Only devices listed by the reprocessor as having FDA 510k approval and pre-determined cost effectiveness are selected.
    b. Individual directors maintain records of rationale for approval or rejection of devices considered for the SUDs reprocessing program.
5. The Materials Management Director provides guidance for the following:
    a. Coordination and execution of the reprocessing program.
    b. Facilitation of system problem resolution.
6. The department directors collaborate with the reprocessor regarding
    a. Timely removal and shipment of SUDs by the reprocessor.
    b. Maintenance of stock of reprocessed SUDs.

C. Reprocessed SUD failure
1. Failure without patient injury.
    a. The staff involved with the procedure save the SUD and packaging in a bag labeled infectious material.
    b. The circulating RN/designee completes an occurrence report and notifies the charge person who alerts the Materials Management Purchaser.
    c. Materials Management notifies the reprocessor and obtains a device complaint form, which is completed by Materials Management and returned with the SUD to the reprocessor.
2. Failure with patient injury.
    a. The staff members involved with the procedure save the SUD and packaging.
    b. The circulating RN/designee completes an occurrence report and notifies the charge person who alerts the directors of the department in which the injury occurred and Risk Management.
    c. The circulating RN/designee quarantines the SUD until release has been authorized by Risk Management.
    d. Risk Management notifies the reprocessor.

D. Documentation: N/A

VI. EDUCATION/TRAINING:

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

~~B. Updates are communicated by the OR Educator via medical and nursing staff publications.~~

A. Education and/or training is provided as needed

VII. REFERENCES:

A. AORN. (2011). Guidance statement: Reuse of single use devices (2006), *Perioperative Standards and Recommended Practices*, (pp. 645-651). Denver, CO: AORN.

B. U.S. Department of Health and Human Services, FDA U.S. Food and Drug Administration. (Document issued: July 30, 2001). Labeling recommendations for single-use devices reprocessed by third parties and hospitals; Final guidance for industry and FDA. Retrieved on 07/11/11 from http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm071058.htm

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D. U.S. Government Accountability Office. (January 2008). Report to the Committee on Oversight and Government Reform, House of Representatives. Reprocessed single-use medical devices. GSAO 08-147. Retrieved on 07/15/11 from http://www.gao.gov/htext/d08147.html

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	01/2024
P&T/IPC	Genevieve delos Santos: Director Pharmacy	12/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2023
Policy Owner	Carla Knight: Director of Perioperative Services	06/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14931231**

Last Approved	N/A	Owner	Jill Peralta Cuellar: Director Employee Health
Last Revised	08/2022	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Employee Health

I. SCOPE OF SERVICE

Employee Health supports the Mission, Vision, Values and Strategic Plan of Salinas Valley Health Medical Center (SVHMC).

The purpose of Employee Health is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of Employee Health is to ensure that all customers will receive high quality care / service in the most expedient and professional manner possible.

II. GOALS

In addition to the overall SVHMC goals and objectives, Employee Health develops goals to direct short term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital goals.

The goal(s) of Employee Health is to:

A. Provide services to support the health and well-being of our staff.

III. DEPARTMENT OBJECTIVES

A. To support SVHMC objectives.

B. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.

C. To plan for the allocation of human/material resources.

D. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions though patient/significant other education and to restore the patient to the highest level of wellness as possible.

E. To support the provision of a therapeutic environment appropriate for the population in order

to promote healing of the whole person.

F. To evaluate staff performance on an ongoing basis.

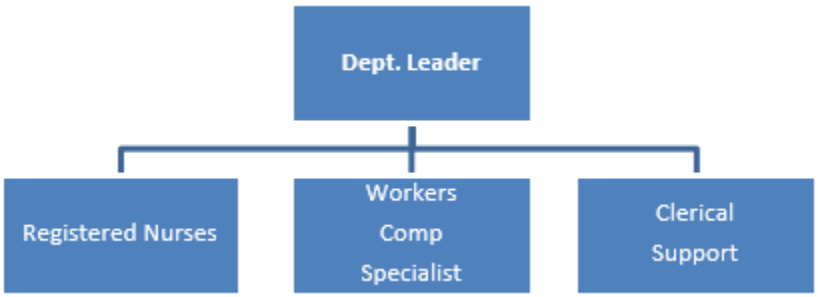
G. To provide appropriate staff orientation and development.

H. To monitor Employee Health function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED at SVHMC

1. All Departments
2. Active Medical Staff/LIP's
3. Active Volunteers
4. Active Travelers/Contractors
5. Students actively working within the hospital for training purposes during their training period.

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation
Occupational/Employee Health Services is open Monday through Friday 07:30 to 16:30. Open clinic hours are:

Monday, Wednesday, Thursday: 0730 – 1630
Tuesday and Friday: 0730-1200

Hospital Administrative Supervisors are available to serve the needs of employees after hours and on week-ends and holidays. EHS leadership is available as needed through the hospital operator

B. Location of department (s) 440 East Romie Lane, Salinas, CA 93950

VI. DEFINITION OF PRACTICE AND ROLE IN MULTIDISCIPLINARY CARE /SERVICE

A. The Occupational/Employee Health Services Department provides access to all staff, and volunteers for the initiation and maintenance of wellness and safety.
Primary services include:

- First aid and triage for injury and illness
- Post offer Pre-placement assessment
- Physical tasks evaluation
- Initial and Annual TB screening
- Immunization program
- Annual health assessment/screening
- Medical Clearance for fit testing
- Annual fit testing and training for N95 Respirator and Portable Air Purifying Respirator (PAPR)
- Temporary/Transitional Return to work programs
- Ergonomic program including work place and work task assessments, recommendations and education.
- Job shadowing and recommendations to department leadership to support a culture of safety.
- Case Management for both industrial and non-industrial injuries and illness
- Industrial injury management of employees of SVHMC
- Worker Compensation benefits coordination
- Tracking of illness and injury trends and report out to The Worker Safety Committee.
- Staff exposure follow up. This done in collaboration with Infection Prevention and under the Employee Health Medical Director's guidance.
- Safe Patient Handling collaboration with the Safe Patient Handling Committee including evaluation and implementation of patient mobility equipment.

VII. REQUIREMENTS FOR STAFF

Occupational/Employee Health Services follows guidelines of national, state and local regulatory bodies. Standards of practices are consistent with standards of practice.

A. Licensure / Certifications:

The basic requirements for ***Registered Nurse*** include:

1. Current state licensure
2. BLS
3. Completion of competency-based orientation
4. COHN, COHN-S strongly recommended
5. Completion of annual competencies

The basic requirements for ***Workers Comp Specialist*** include:

1. 3-5 years' experience in workers' compensation or a course of completion in workers compensations or RN with Workers Compensation/Case Management experience

2. Knowledge of OSHA, Cal OSHA and Ergonomics

The basic requirements for Department Coordinators include:

1. Ability to perform administrative duties and support the Employee Health Department.
2. Strong Computer skills
3. Strong and professional phone skills
4. Proficient in Excel
5. Ability to handle fast pace, high stress situation

B. Competency:

Staff are required to have routine competence assessments in concert with the unit's ages of the population and annual performance appraisals. The assessment could be in a written, demonstrated, observed or verbal form. The required competency for staff depends primarily on their work areas and duties. Once a year staff are required to complete the online education modules that have been defined by the organization.

Department personnel who attend educational conferences will in-service other EHS staff regarding the information learned at the conferences. Other internal and external continuing education opportunities are communicated to staff members.

Staff are encouraged to participate in organizations that support the work done in Employee Health.

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

- Employee educational needs assessment at the time of hire and annually as part of developmental planning
- Performance improvement planning, data collections and activities
- Staff input
- Evaluation of patient population needs
- New services/programs/technology implemented
- Change in the standard of practice/care
- Change in regulations and licensing requirements
- Needs assessment completed by Education

The educational needs of the department are assessed through a variety of means, including:

- STAR Values
- Quality Assessment and Improvement Initiatives

- Strategic Planning (Goals & Objectives)
- New / emerging products and/or technologies
- Changes in Practice
- Regulatory Compliance

Feedback and requests for future topics are regularly solicited from staff via e-mail, surveys, in-service evaluation forms, and in person.

D. Continuing Education

Continuing education is required to maintain licensure / certifications. Additional in-services and continuing education programs are provided to staff in cooperation with the Department of Education.

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The unit is staffed with an appropriate number of professional, technical and clerical personnel to permit coverage of established hours of care / service, to provide a safe standard of practice and meet regulatory requirements. General Staffing Plan:

Assignments made by the leadership of Employee Health Services are based on hospital needs, competencies of the staff, the degree of supervision required, and the level of supervision available.

In the event of a severe emergency, the minimum amount of staff required to safely operate this unit will be determined and staffed accordingly.

IX. EVIDENCED BASED STANDARDS

The SVHMC staff will correctly and competently provide the right service, do the right procedures, treatments, interventions, and care by following evidenced based policies and practice standards that have been established to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

The SVHMC staff will design, implement and evaluate systems and services for care / service delivery which are consistent with a "Patient First" philosophy and which will be delivered:

- With compassion, respect and dignity for each individual without bias.
- In a manner that best meets the individualized needs of the patient.
- In a timely manner.
- Coordinated through multidisciplinary team collaboration.
- In a manner that maximizes the efficient use of financial and human resources.

X. CONTRACTED SERVICES

Contracted services under this Scope of Service are maintained in the electronic contract management system.

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Employee Health supports the SVHMC's commitment to continuously improving the quality of patient care to the patients we serve and to an environment which encourages performance improvement within all levels of the organization. Performance improvement activities are planned in a collaborative and interdisciplinary manner, involving teams/committees that include representatives from other hospital departments as necessary. Participation in activities that support ongoing improvement and quality care is the responsibility of all staff members. Improvement activities involve department specific quality improvement activities, interdisciplinary performance improvement activities and quality control activities.

Systems and services are evaluated to determine their timeliness, appropriateness, necessity and the extent to which the care / service(s) provided meet the customers' needs through any one or all of the quality improvement practices / processes determined by this organizational unit.

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure, Employee Health Department will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Unit based measurement indicators are found within the Quality dashboard folder.

Attachments

Organization of the Department

Approval Signatures

Step Description	Approver	Date
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2024

Policy Owner	Jill Peralta Cuellar: Director Employee Health	01/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14900824**

Last Approved	N/A	Owner	Lisa Paulo: Chief Nursing Officer
Last Revised	02/2023	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Nursing Administration

I. SCOPE OF SERVICE

Nursing Administration supports the Mission, Vision, Values and Strategic Plan of Salinas Valley Health Medical Center (SVHMC) and has designed services to meet the needs and expectations of patients, families and the community.

The purpose of Nursing Administration is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of Nursing Administration is to ensure that all customers will receive high quality care / service in the most expedient and professional manner possible. Nursing Administration provides nursing leadership on premise 24 hours per day 7 days a week. The Administrative Supervisor under the direction of the Chief Nursing Officer/Designee is responsible for the operations of services, including determining the types and numbers of nursing personnel and staff necessary to provide nursing are for all areas of the hospital.

II. GOALS

A. The goal of Nursing Administration is to provide support and oversight for the all Nursing Services and non-clinical functions that effect patient care throughout the hospital.

B. In addition to the overall SVHMC goals and objectives, Nursing Administration develops goals to direct short term and long-term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital and Department of Nursing goals. The goals will be reviewed quarterly as part of the Unit's Performance Improvement Program and will include input from Physicians, Department Directors, Clinical Nurse Managers, Staff Nurses (RN).

III. DEPARTMENT OBJECTIVES

A. To support SVHMC and Department of Nursing objectives.

B. To support the delivery of safe, effective, and appropriate care / service in a cost-effective

manner.

C. To plan for the allocation of human/material resources.

D. To support the provision of high-quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions though patient/significant other education and to restore the patient to the highest level of wellness as possible.

E. To support the provision of a therapeutic environment appropriate for the population to promote healing of the whole person.

F. To evaluate staff performance on an ongoing basis.

G. To provide appropriate staff orientation and development.

H. To monitor Nursing Administration function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Nursing Administration through the Administrative Supervisor provides support for all clinical and non-clinical departments and is the Hospital Designee for Department Heads after hours.

V. ORGANIZATION OF THE DEPARTMENT

(Nursing Organization Chart for Nursing)

A. Hours of Operation:
Nursing Administration provides services provides 24 hours/day, 7 days/week administrative supervisor coverage and support to all hospital departments/directors in their absences.

B. Location of departments:
The Nursing Administration offices are in the basement of the Cisilini Plaza.

C. Major Services / Modalities of care may include:
Administrative Supervisor in Nursing Administration in collaboration with the nursing leaders oversees the allocation of resources to all departments on a day to day bases.

Nursing Administration consist of the Administrative Supervisor that oversees provision of resources resource department to facilitate Patient Care Resources when needed as follow but not limited to:

- Patient Care Resources (Float Pool)
- Administrative Supervisor
- Interpreting Services

Staffing Office supports the Unit Directors in their staffing responsibility to ensure safe staffing levels are maintained as patient volumes and acuities fluctuate throughout the day. The Staffing office maintains and replaces staff on a day to day shift by shift basis under the direction of the Administrative Supervisor. The Administrative Supervisor ensures compliance with regulatory statutes and reallocates resources meet the standards of safe patient care. In

addition, the staffing office provides resources needed for clinical and non-clinical resources when needed.

VI. DEFINITION OF PRACTICE AND ROLE IN MULTIDISCIPLINARY CARE /SERVICE

The Chief Nursing Officer assumes twenty-four (24) hour responsibility of the Department.

The Chief Nursing Officer is directly responsible to the Chief Operations Officer. It is the CNO's duty to attend all administrative and technical functions within the department and throughout the hospital as needed. All personnel within the department are under the guidance and direction of the CNO. In the CNO's absence, the position is filled by their designee.

The Administrative Supervisor facilitates problem solving, patient flow and placement, staffing oversight, and operational management.

Systems, services and patient care are evaluated to determine their timeliness, appropriateness, clinical necessity, and the extent to which the level of care or services provided meets the patients' needs through any one or all of the following quality improvement practices:

1. Multidisciplinary Performance Improvement Teams
2. Patient Family Surveys
3. Focused Studies
4. Patient Relations Services
5. Employee Forums
6. Collaboration with Medical Staff

VII. REQUIREMENTS FOR STAFF (applicable to department)

All individuals who provide patient care services are certified, licensed or registered (according to applicable state law and regulation) and have the appropriate training and competence.

A. Licensure / Certifications:

The basic requirements for ***Registered Nurses*** include:

1. Current state licensure
2. Current BLS
3. CCRN Certification preferred
4. Completion of competency-based orientation
5. Completion of annual competency

The basic requirements for ***Interpreters*** include:

1. Certification in the hospital approved certification training program.

B. Competency

Staff are required to have routine competence assessments in concert with the unit's ages of the population and annual performance appraisals. The assessment could be in a written, demonstrated, observed or verbal form. The required competency for staff depends primarily on their work areas and duties. Once a year staff are required to complete the online education modules that have been defined by the organization.

During the year in-services are conducted routinely. The in-services are part of the department's on-going efforts to educate staff and further enhance performance and improve staff competencies. These in-services are in addition to the annual competency assessments. Department personnel who attend educational conferences are strongly encouraged to share pertinent information from the conferences with other staff members at in-services. Additional teleconferences, video conferences, and speakers are scheduled for staff on occasion. Other internal and external continuing education opportunities are communicated to staff members.

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

- Employee educational needs assessment at the time of hire and annually as part of developmental planning
- Performance improvement planning, data collections and activities
- Staff input
- Evaluation of patient population needs
- New services/programs/technology implemented
- Change in the standard of practice/care
- Change in regulations and licensing requirements
- Needs assessment completed by Nursing Education

The educational needs of the department are assessed through a variety of means, including:

- STAR Values
- Quality Assessment and Improvement Initiatives
- Strategic Planning (Goals & Objectives)
- New / emerging products and/or technologies
- Changes in Practice
- Regulatory Compliance

Feedback and requests for future topics are regularly solicited from staff via e-mail, surveys,

in-service evaluation forms, and in person.

D. Continuing Education

Continuing education is required to maintain licensure / certifications. Additional in-services and continuing education programs are provided to staff in cooperation with the Department of Education.

VIII. STAFFING PLAN

The department is staffed with one Administrative Supervisor 24 hours per day and 7 days a week.

Interpreter services are always staffed with a minimum of one interpreter certified in Spanish. If other interpreters are needed the Interpreter on Wheels is utilized.

IX. EVIDENCED BASED STANDARDS

The SVHMC staff will correctly and competently provide the right service, do the right procedures, treatments, interventions, and care by following evidenced based policies and practice standards that have been established to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

The SVHMC staff will design, implement and evaluate systems and services for care / service delivery which are consistent with a "Patient First" philosophy and which will be delivered:

- With compassion, respect and dignity for each individual without bias.
- In a manner that best meets the individualized needs of the patient.
- In a timely manner.
- Coordinated through multidisciplinary team collaboration.
- In a manner that maximizes the efficient use of financial and human resources.

SVHMC has developed administrative and clinical standards for staff practice and these are available on the internal intranet site.

X. CONTRACTED SERVICES

Contracted services under this Scope of Service are maintained in the electronic contract management system.

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Nursing Administration supports the SVHMC's commitment to continuously improving the quality of patient care to the patients we serve and to an environment which encourages performance improvement within all levels of the organization. Performance improvement activities are planned in a

collaborative and interdisciplinary manner, involving teams/committees that include representatives from other hospital departments as necessary. Participation in activities that support ongoing improvement and quality care is the responsibility of all staff members. Improvement activities involve department specific quality improvement activities, interdisciplinary performance improvement activities and quality control activities.

Systems and services are evaluated to determine their timeliness, appropriateness, necessity and the extent to which the care / service(s) provided meet the customers' needs through any one or all the quality improvement practices / processes determined by this organizational unit.

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure Nursing Administration Department will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Unit based measurement indicators are found within the Quality dashboard folder.

Approval Signatures

Step Description	Approver	Date
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2023
Policy Owner	Lisa Paulo: Chief Nursing Officer	12/2023

Standards

No standards are associated with this document

Status Draft PolicyStat ID 14765813

Last Approved	N/A	Owner	Pedro Delgado Jr: President/ Chief Executive Officer
Last Revised	N/A	Area	Administration
Next Review	N/A		

Board Member Compensation and Expenditure Reimbursement

I. POLICY STATEMENT

A. Pursuant to the requirements of California AB1234, California Government Code, California Health and Safety Code and the Bylaws of Salinas Valley Healthcare System (dba Salinas Valley Health), compensation and expenditure reimbursement paid to members of the Board of Directors of Salinas Valley Health for district-related expenses shall be made in accordance with the following procedure.

II. PURPOSE

A. To set forth the policy and procedure for compensating members of the Board of Directors of Salinas Valley Health and for reimbursement of authorized, district-related expenses incurred by members of the Board of Directors.

III. DEFINITION

A. N/A

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

1. **COMPENSATION**
    - **Compensation for Meetings**. A member of the Board of Directors of Salinas Valley Health shall receive one hundred dollars ($105.00) per meeting, not to exceed six (6) meetings per month for the time period of January 1, 2024 to December 31, 2024.

1. **Findings in Support of Compensation for Meetings.** Pursuant to Health & Safety Code Section 32103(a), the Board finds that the following facts support the need to compensate members of the Board of Directors of Salinas Valley Health for a total of up to six (6) meetings per month:
    a. The Board is comprised of only five (5) members;
    b. Each of the Board Members sit on at least two (2) separate standing committees of the Board which requires monthly meetings of said committees;
    c. Board Members are also members of various ad hoc Board Committees that have met or will be meeting in calendar year 2023, including, ad hoc Committee of Bylaws, President/CEO Search Committee and others;
    d. The Board maintains a close working relationship with Medical Staff that has greatly benefited the District, and such relationship is maintained by regular attendance of Board Members as guests, at Medical Staff meetings;
    e. The organization is in a period of flux, which has required and will continue to require holding Special Meetings of the Board, likely on a monthly basis, to consider items including the selection of a President/CEO.

- **Definition of Meeting**. "Meeting" shall mean regular and annual meetings held pursuant to Article V, Section 5.1, of the SVHMC Bylaws, special meetings held pursuant to Article V, Section 5.3, standing committee meetings held pursuant to Article IV, Section 4.2, ad hoc Board committee meetings, and meetings of the Medical Staff of the hospital.

2. **EXPENDITURE REIMBURSEMENT**

- **Authorized Expenses.** Each member of the Board of Directors shall be allowed his or her actual necessary traveling and incidental expenses incurred in the performance of official business of Salinas Valley Health as assigned by the Board in accordance with the terms and conditions of this policy and procedure. District funds, equipment, supplies, titles, and staff time must only be used for authorized district business. Authorized expenses are, generally, expenses incurred in connection with activities including, but not limited to, the following:
    1. Communicating with representatives of regional, state and national government on district adopted policy positions;
    2. Attending educational seminars designed to improve Board Member's skill and information levels;
    3. Participating in regional, state and national organizations whose activities affect the district's interests;
    4. Participating in an event recognizing service to the district; and
    5. Attending district events.

- **Approval for Other Expenses.** All other expenditures require prior approval by the district board of directors. The following expenses also require prior approval by the district board of directors:
    1. International healthcare/district-related travel expenses; and
    2. Expenses that exceed the annual budgetary limits established for Board and Administrative purposes.
- **Personal Expenses.** Examples of personal expenses that the district will not reimburse include, but are not limited to:
    1. The personal portion of any trip;
    2. Political or charitable contributions or events;
    3. Family expenses when accompanying board member on district-related business;
    4. Entertainment expenses;
    5. Personal losses incurred while on district business; and
    6. Non-mileage personal automobile expenses, including repairs, traffic citations, insurance or gasoline.
- **Questions**. Any question regarding the propriety of a particular type of expense should be resolved by the District Board of Directors before the expense is reimbursed.

3. **COST CONTROL**

To conserve district resources and keep expenses within community standards for public officials, expenditures should adhere to the following guidelines. In the event that expenses are incurred that exceed these guidelines, the cost borne or reimbursed by the district will be limited to the costs that fall within the guidelines.

- **Transportation.** Board members shall utilize the most economical mode and class of transportation reasonably consistent with scheduling requirements and space needs, using the most direct and time-efficient route.
    1. **Rental Vehicles.** Charges for rental vehicles may be reimbursed under this provision if the expense is economical and reasonable for purposes of conducting the business of the district.
    2. **Airfare**. Charges for airfare may be reimbursed under this provision if the expense is economical and reasonable for purposes of conducting the business of the district.
    3. **Automobile**. Automobile mileage is reimbursed at Internal Revenue Service rates in effect at the time the expense is incurred. The IRS mileage reimbursement rate does not include bridge and road tolls, which are also reimbursable. These rates are designed to compensate the driver for gasoline, insurance, maintenance and other expenses associated with operating the vehicle. The Internal Revenue Service rates will not be paid for rental vehicles; only receipted fuel expenses will be reimbursed for

rental vehicles.

4. **Taxis/Shuttles**. Taxis or shuttle fares may be reimbursed, including a fifteen percent (15%) gratuity per fare, when the cost is economical and reasonable for purposes of conducting the business of the district.

- **Lodging**. Lodging expenses will be reimbursed or paid for when travel on official district business reasonably requires an overnight stay.
    1. **Conferences/Meetings.** If lodging is in connection with a conference, lodging expenses may not exceed the group rate published by the conference sponsor for the meeting in question if such rates are available at the time of booking. If the group rate is not available, see next section.
    2. **Other Lodging**. Travelers must request government rates, when available. Lodging rates that are equal or less than government rates are presumed to be reasonable and hence reimbursable for purposes of this policy. In the event that government rates are not available at a given time or in a given area, reimbursement of lodging expense shall be at a reasonable rate for the specific location of lodging.
- **Meals**. Reimbursable meal expenses and associated gratuities will not exceed the Internal Revenue Service rates in effect at the time the expense is incurred. When the meal function is an organized event, the board member shall be reimbursed the amount being charged by the event organizer for the meal, regardless of whether the per person cost exceeds the Internal Revenue Service rates.
- **Phone/Fax/ Internet**. Board members will be reimbursed for actual telephone and fax expenses incurred on district business. Telephone bills should identify which calls were made on district business. Board members will be reimbursed for internet access connection and/or usage fees away from home, not to exceed $15.00 per day, if internet access is necessary for district-related business.
- **Airport Parking**. Board members will be reimbursed for airport parking expenses. Long-term parking must be used for travel exceeding twenty-four (24) hours.

4. **DOCUMENTATION**

- **EXPENSE REPORTS**
    1. **Expense Report**. All expense reimbursement requests must be submitted on an expense report form provided by the district. Expense reports must document that the expense in question met the requirements of this policy.
    2. **Submission Deadline**. Board members must submit their expense reports within sixty (60) days of an expense being incurred, accompanied by receipts documenting each expense.
    3. **Audits.** All expenses are subject to verification that they comply with this policy.
- **COMPLIANCE WITH LAWS**
    1. Board members understand that some expenditures may be subject to

reporting under the Political Reform Act and other laws. All agency expenditures are public records subject to disclosure under the Public Records Act and other laws.

- **VIOLATION OF THIS POLICY**
    1. Under state law, use of public resources or falsifying expense reports in violation of this policy may result in any or all of the following: (1) loss of reimbursement privileges; (2) a demand for restitution to the district; (3) the agency's reporting the expenses as income to the elected official to state and federal tax authorities; and (4) other civil penalties.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. California AB1234
B. California Government Code
C. California Health and Safety Code (Local Health Care District Law)
D. Bylaws of Salinas Valley Health Medical Center

Approval Signatures

Step Description	Approver	Date

Standards

No standards are associated with this document

QUALITY AND EFFICIENT PRACTICES COMMITTEE

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

(CATHERINE CARSON)

PERSONNEL, PENSION AND INVESTMENT COMMITTEE

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

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

(JUAN CABRERA)

a. Committee Chair Report
b. Board Questions to Committee Chair/Staff
c. Motion/Second
d. Public Comment
e. Board Discussion/Deliberation
f. Action by Board/Roll Call Vote

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Najwa Bahu-Baugh, MD, (ii) Contract Terms for Dr. Bahu-Baugh's Recruitment Agreement, and (iii) Contract Terms for Dr. Bahu-Baugh's Internal Medicine Professional Services Agreement**

Executive Sponsor: Allen Radner, MD, Interim President/CEO, Salinas Valley Health
Gary Ray, Chief Legal & Administrative Officer, Salinas Valley Health

Date: January 15, 2024

Executive Summary

In consultation with members of the medical staff, Salinas Valley Health (SVH) executive management has identified the recruitment of physicians specializing in primary care as a recruiting priority for the hospital's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in January 2023, the specialty of primary care/internal medicine was recommended as a top priority for recruitment. In addition, the recruitment of additional primary care physicians will help with patient access and with a reduction in the current average wait time for new patient appointments at Salinas Valley Health Primecare.

The recommended physician, Najwa Bahu-Baugh, MD, attended Medical School at the American University of the Caribbean and completed her Residency and Internship in Internal Medicine at the College of Medicine at the University of Oklahoma. She also completed her Fellowship in Pulmonary and Critical Care Medicine at the University of Oklahoma. Dr. Bahu-Baugh practiced inpatient and outpatient pulmonary and critical care until 2020. She is currently providing outpatient primary care and pulmonary services at her private practice in Oklahoma. Dr. Bahu-Baugh is excited to relocate to the area with her husband and be near extended family. She plans to join SVH Clinics in June 2024.

Terms and Conditions of Agreements

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

1. **Professional Services Agreement**. Essential Terms and Conditions:
   - Professional Services Agreement (PSA). Contracted physician under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics. Pursuant to California law, physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
   - Term: PSA is for a term of two years, with annual compensation reported on an IRS W-2 Form.
   - Base Compensation: $300,000 per year.
   - Productivity Compensation: To the extent it exceeds the base salary, physician is eligible for work Relative Value Units (wRVU) productivity compensation at a $51.00 wRVU conversion factor.
   - Benefits. Physician will be eligible for standard SVH Clinics physician benefits:
     - Access to SVH Health Plan for physician and qualified dependents. Premiums are projected based on 15% of SVH cost.
     - Access to SVH 403(b) and 457 retirement plans. Five percent base contribution to 403(b) plan that vests after three years. This contribution is capped at the limits set by Federal law.
     - Four weeks (20 days) of time off each calendar year.
     - Continuing Medical Education (CME) annual stipend in the amount of $2,400 paid directly to physician and reported as 1099 income.
   - Professional Liability Insurance. Professional liability is provided through BETA Healthcare Group.

2. **Recruitment Agreement** that provides a recruitment incentive of $40,000, which is structured as forgivable loan over two years of service.

Meeting our Mission, Vision, Goals
Strategic Plan Alignment:

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

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

The addition of Dr. Bahu-Baugh to SVH Clinics has been identified as a need for recruitment while also providing additional resources and coverage for SVH Primecare.

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

Recommendation

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

1. **The Findings Supporting Recruitment of Najwa Bahu-Baugh, MD;**
   - That the recruitment of an internal medicine physician to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
   - That the recruitment benefits and incentives the hospital proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;
2. **The Contract Terms of the Recruitment Agreement for Dr. Bahu-Baugh; and**
3. **The Contract Terms of the Internal Medicine Professional Services Agreement for Dr. Bahu-Baugh.**

Attachments

- Curriculum Vitae for Najwa Bahu-Baugh, MD

CURRICULUM VITAE
NAJWA A. BAHU-BAUGH, MD

CITIZENSHIP: USA
MEDICAL LICENSURE:
Oklahoma #20169 (1996)
California #C 171107
Florida #ME 147626
EDUCATION:
1994 MD American University of the Caribbean

BOARD CERTIFICATION:

NBPAS: 2019-Present
ABIM - Internal Medicine 2000-Present
Pulmonary Critical Care eligible 2002-2019

POSTGRADUATE TRAINING AND FELLOWSHIP APPOINTMENTS:

Fellowship, Pulmonary and Critical Care Medicine July 1999 – June 2002
Department of Medicine University of Oklahoma Health Sciences Center
Oklahoma City, Oklahoma

Chief Residency, Internal Medicine July 1998 – June 1999 College of Medicine
University of Oklahoma Health Sciences Center Oklahoma City, Oklahoma

Residency & Internship, Internal Medicine July 1995 – July 1998
College of Medicine University of Oklahoma Health Sciences Center Oklahoma City, Oklahoma

TEACHING RESPONSIBILITIES:

Clinical Rotations;
Great Plains Family Residency Program, 2002 -2020 Preceptor for Second Year Medical Students, 1998 – 2020
Teaching Clinical Medicine III for PA program, 2000 – 2001 1

MEMBERSHIP IN PROFESSIONAL AND SCIENTIFIC SOCIETIES

American College of Physicians / American Society of lnternal Medicine, Member 1995 to Present American College of Chest Physicians, Member 1999 to Present American Thoracic Society, Member 2001 to Present American Society of Women in Medicine, Member 1997 to Present American Medical Association, Member 1995
Society for Critical Care Medicine, Member 1999
Oklahoma Medical Society, Member 1995

LECTURES

When to call the doctor at night – ICU in service April 2008
COPD?'s and answers – Better Breathers Summer 2006
Nocturnal Ventilation -Who Benefits March 2002
ILD -Drug Induced March 2002 TB -Treatment and Prevention December 2001
Pneumonia and Pneumothorax November 2000 and September 2001
Fat Emboli Syndrome June 2001
Pulmonary Manifestations of Collagen Vascular Disease April 2001 Inflammation and Steroids February 2001
NAEPP – Overview of Treatment September 2000
Atypical Pneumonia June 2000
Approach to *HN* Patient with Pulmonary Symptoms May 2000
Bronchoprovocation Testing February 2000
Oxygen Toxicity December 1999
Bronchiectasis February 2023
Overview of Restrictive and Obstructive lung disease February 2023

CLINICAL RESEARCH

COPD Exacerbation and Troponin

STAFF PRIVILEGES

Integris Medical Center July 2018 November 2020
Mercy Health Center July 2002 – 2018
Deaconess Hospital August 2002 – 2020
Select Specialty Hospital August 2002 – 2020
VA Medical Center July 1998 – 2005
Kindred Hospital July 1999 - 2003 OUHSC July 1995 - June 2002 Oklahoma Physician Hospital July 1998 – July 2000 2
Watonga Hospital July 1997 – June 2000
Fairview Hospital July 1998 – July 2000

MEDICAL APPOINTMENTS

Deaconess Hospital - Chief of Medicine 2013-2018
Deaconess Hospital-Medical Director, Respiratory Department January 2008 - January 2009
Mercy Hospital-Section Chief, Pulmonology Department January 2008 -2012
Mercy Hospital -Peer Review, Pulmonology Department January 2008 -January 2010
Mercy Hospital- Physician Reviewer for new pulmonologist January 2007 -2010
Deaconess Hospital- Critical Care Committee March 2006 – Present Deaconess Hospital – P&T Committee January 2004 – Present

FINANCE COMMITTEE

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

(JOEL HERNANDEZ LAGUNA)

TRANSFORMATION, STRATEGIC PLANNING AND GOVERNANCE COMMITTEE

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

(VICTOR REY, JR.)

Medical Executive Committee Summary – January 11, 2024

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Al-Louzi, Omar, MD	Neurology	Medicine	TeleNeurology
Glaser, Anne, MD	Radiology	Surgery	Remote Radiology
Kaur, Gurvinder, MD	Neurosurgery	Surgery	Neurological Surgery:
Kumar, Rajiv, MD	Radiology	Surgery	Remote Radiology
Lekic, Tim, MD	Neurology	Medicine	TeleNeurology
Rincon, Freddy, MD	Neurology	Medicine	TeleNeurology

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Bhat, Arvind, MD	Internal Medicine	Medicine	Adult Hospitalist
Bottari, Brendan, MD	Interventional Radiology	Diagnostic Imaging	Diagnostic Imaging Vascular and Interventional Radiology Peripheral Endovascular Center for Advanced Diagnostic Imaging (CADI)
Castro, Robert, MD	Neonatology	Pediatrics	Neonatal
Chen, Kevin, MD	Ophthalmology	Surgery	Ophthalmology
Fiorenza, Jeffrey, MD	Gastroenterology	Medicine	Gastroenterology General Internal Medicine
Giedt, W. Reid, MD	Pediatrics	Pediatrics	Pediatrics
Gonzalez, Jaime MD	Family Medicine	Medicine	Adult Hospitalist
Kanter, Gregory, MD	Urogynecology	OB/GYN	Urogynecology Robotic Surgery: Gynecology & Urogynecology
Lilja, James, MD	Gynecologic Oncology	Ob/Gyn	Gynecologic Oncology
Locke, Erica, MD	Emergency Medicine	Emergency	Emergency Medicine
Meisner, Nicole, MD	Ob/GYN	OB/GYN	Obstetrics and Gynecology
Nowak, Kenneth, MD	Otolaryngology	Surgery	Otolaryngology
Regwan, Steven, DO	Cardiology	Medicine	Cardiology Cardiac Diagnostic Outpatient Center (CDOC) Center for Advanced Diagnostic Imaging (CADI) Taylor Farms Family Health and Wellness Center: Cardiology core
Rodnick, Jeffrey, MD	Radiation Oncology	Medicine	Radiation Oncology
Ruiz, James, MD	Ob Hospitalist	Ob/Gyn	Ob Hospitalist Obstetrical Ob Hospitalist Gynecology
Wilson, Alison, DO	Family Medicine	Medicine	Adult Hospitalist:

Temporary/Locum Tenens Privileges:

NAME	SPECIALTY	DATES
Tabrizi, Peyman, MD	Neuro Surgery	12/22/2023 – 01/26/2024

Privilege Modifications:

NAME	SPECIALTY	PRIVILEGE	RECOMMENDATION
Silk, Jeremy, MD	Plastic Surgery	Use of Laser	Voluntarily relinquishing Use of Laser privileges, effective January 31, 2024

Staff Status Modifications:

NAME	SPECIALTY	STATUS	RECOMMENDATION
Alvarez, Francisco, MD	Pediatrics	Provisional	Resignation effective 12/31/2023
Atchaneeyasakul, Kunakorn, MD	Neurology	Telemedicine	Resignation effective 11/30/2023
Dogan, Ozge, MD	Pediatrics	Provisional	Resignation effective 12/31/2023
Harkins, Andrew	Pediatrics	Provisional	Resignation effective 12/31/2023
Hasan, Mohamed, MD	Pediatrics	Provisional	Resignation effective 12/31/2023
Hubner, Gwen, MD	Pediatrics	Provisional	Resignation effective 12/31/2023
Hosohama, Misa MD	Radiology	Leave of Absence	Resignation effective 10/31/2023
Indudhara, Ramaiah, MD	Urology	Provisional	Resignation effective 1/1/2024
Kamler, Jan, MD	Gastroenterology	Provisional	Resignation effective 1/31/2024
Kironde, Tendo MD	Pediatrics	Provisional	Resignation effective 12/31/2023
Martin, Sonya, MD	Psychiatry	Telemedicine	Resignation effective 12/15/2023
Mittal, Vikrant, MD	Psychiatry	Telemedicine	Resignation effective 12/31/2023
Oldroyd, Julie, MD	Psychiatry	Telemedicine	Resignation effective 12/15/2023
Pagano, Evan, MD	Pediatrics	Provisional	Resignation effective 12/31/2023
Patel, Saharsh, MD	Pediatrics	Provisional	Resignation effective 12/31/2023
Powell, Carmin, MD	Pediatrics	Provisional	Resignation effective 12/31/2023

Other Items Recommended for Approval: *(Attached)*

Department of Medicine Clinical Privileges Delineation Infectious Disease – Revision	The Committee recommended approval of the revision adding Remote Infectious Disease Privileges.

Interdisciplinary Practice Committee

Modification/Addition of Privileges/Status:

NAME	SPECIALTY	RECOMMENDATION
Gates, Cristina PA	Emergency Medicine	Resignation effective 12/28/2023
Hurst, Sharen, NP	Emergency Medicine	Resignation effective 12/28/2023
McClain. Marguerite, PA-C	Cardiac Surgery	Resignation effective 2/1/2024

Other Items Recommended for Approval: *(Attached)*

Cardiovascular Nursing Standardized Procedure	Revisions/Updates recommended for approval.
Vaginal Bleeding Nursing Standardized Procedure	Revisions/Updates recommended for approval.

Informational Items:

I. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Medical Staff Excellence Committee
d. Quality and Safety Committee Reports:
   - Transitional Care Program
   - Medical Surgical Care Cluster
   - Pediatrics
   - Inpatient Wound Care Program
   - Dialysis Services
   - Pharmacy & Therapeutics/Infection Prevention Committee Report
   - Emergency Department
   - Outpatient Infusion Services
   - Wound Healing Center
   - Social Work and Case Management
   - Diagnostic Imaging and Mammography Center

II. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings
c. Medical Staff Treasury Report
d. Medical Staff Statistics Year to Date
e. Health Information Management (HIM) Update
f. HCAHPS Update

III. Other Items Approved:
a. Practitioner Health and Wellness Committee Chair – Erica Locke, MD appointed
b. Order Set Approved: Oncotherapy: Pembrolizumab 200 mg

Salinas Valley Health Medical Center
Clinical Privileges Delineation
Infectious Disease

Applicant Name: _____

Qualifications:

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

- Successful completion of an ACGME- or AOA-accredited post-graduate training program in internal medicine and successful completion of a training program in infectious disease.

And

- Documentation of the provision of inpatient or consultative services for at least 24 infectious disease patients or documented participation in a hospital-affiliated formalized residency or special clinical fellowship in infectious disease during the past 12 months.

New applicants will be required 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 Privilege Statement

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

Infectious Disease Core Privileges:

Admit, evaluate, diagnose, treat, and provide consultation to patients, with infectious or immunologic diseases of all types and in all organs. Privileges include, but are not limited to: management of an unusually severe infection such as tuberculosis, meningitis, disseminated tuberculosis, system mycosis, and unusual infections in the immune-compromised host, aspiration of superficial abscess; interpretation of Gram stain; and management of investigational anti-infective agents.

General Internal Medicine Core Privileges:

☐ **Check if Requesting**

Admit, evaluate, diagnose, treat and provide consultation to patients with common and complex illnesses, afflictions, diseases, and functional disorders of the circulatory, respiratory, digestive, endocrine, metabolic, musculoskeletal, hematopoietic, and eliminative systems of the human body. 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.

Remote Teleradiology/Radiology:

☐ **Check if Requesting**

Includes Infectious Disease privileges above under current contractual agreement with Salinas Valley Health to provide remote services.

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 5 patient contacts per year in the hospital, and cannot provide documentation of current competence from another facility, will not qualify to reapply.

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
				Ventilator Management Uncomplicated <48 hours	For uncomplicated ventilator cases (up to 48 hours), successful completion of an accredited residency that provided the necessary cognitive and technical skills for full ventilator management.	**1**	Successful management of at least five (5) mechanical ventilation cases within the past 24 months.

Internal Medicine: 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

- Arthrocentesis
- Arterial Line Placement - Percutaneous
- Biopsy of superficial lymph nodes
- Burns, superficial and partial thickness
- Central Venous Line Placement
- Excision of skin and subcutaneous lesions
- Excision of cutaneous and subcutaneous tumors and nodules
- I & D abscess
- Local anesthetic techniques
- Lumbar Puncture
- Nasogastric tube placement
- Paracentesis
- Perform simple skin biopsy or excision
- Preliminary interpretation of electrocardiograms, own patient
- Remove non-penetrating corneal foreign body, nasal foreign body
- Thoracentesis
- Thrombolytic therapy for stroke

Applicant:
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:

Status Pending PolicyStat ID 14740402

Last Approved	N/A	Owner	Darlene Vaughan: Director Nursing
Last Revised	11/2023	Area	Nursing Standardized Procedures
Next Review	3 years after approval		

Cardiovascular Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Wong-Baker Scale: System to rate pain on a numeric scale, zero (0) to ten (10).

B. ER: Emergency Room

C. EKG: Electrocardiogram

D. IV/INT: Intravenous Therapy (saline lock) with intermittent flushes.

E. CBC: Complete Blood Count

F. CMP: Comprehensive Metabolic Panel

G. TROP: Troponin

H. sHCG: Human Chorionic Gonadotropin

I. SOB: Short of Breath

III. PROCEDURE

A. Function

1. To expedite care for patients who present to the Emergency Department (ED) with a chief complaint ~~of chest pain~~ that may be cardiovascular/cardiac in nature.

B. Circumstances

1. Setting Emergency

a. Registered Nurses (RN) assigned to the ED may initiate orders for patients presenting with chest pain or symptoms that may be cardiac in nature prior to physician evaluation **IF:** the ED physician is not immediately available. The RN will obtain an EKG within 10 minutes, ensure blood is drawn, order approved laboratory tests, initiate cardiac monitoring, place oxygen per protocol and place an INT with routine flushes. This will apply to patients with symptoms listed in the PATIENT CONDITIONS section below.

2. Supervision

    a. Registered Nurses who are qualified to perform this standardized procedure may independently order approved laboratory tests , order an EKG, previous EKG, Oxygen Administration, and start/place an IV saline lock with intermittent flushes of 10cc normal saline to patients who present with a chief complaint ~~of chest pain~~that may be cardiac in nature and for whom meet the criteria above. Physician supervision is not required.

3. Patient Conditions

    a. Emergency Department patients who present with **any** of the following symptoms, the procedure will be initiated:

        i. **Chest Pain-** Discomfort in the center of the chest that lasts more than a few minutes, or that goes away and comes back. Patients may describe the pain as uncomfortable pressure, squeezing, fullness or pain.

        ii. **Pain in other areas of the upper body –** Symptoms can included pain in one or both arms, the back, neck, jaw or stomach. Patient may describe the pain as deep aching and throbbing in one or both arms.

        iii. **Shortness of breath –** May occur with or without chest pain/ discomfort. May be described as breathlessness and/or inability to catch breath when waking up.

        iv. **Anxiety –** Unusual nervousness, and/or feelings of impending doom.

        v. **Syncope/Pre-syncope**- feeling light headed, dizziness, or fainting.

        vi. **Irregular heart rhythm**- new onset of irregular rhythm or palpitations.

        vii. **Swollen legs, ankles, or feet**- non-traumatic swelling of the

extremities.

viii. **Other signs –** These may include clammy sweating, nausea, ~~lightheadedness or dizziness, syncope, palpations or irregular heartbeat~~and or fatigue.

b. **NOTE**: Symptoms of heart attack in women are often different than in men. Women are more likely to experience shortness of breath, fatigue, nausea, dizziness and anxiety as presenting symptoms.

C. Data Base

1. Subjective

a. Prioritization and Severity of Illness

i. Patients with a chief complaint of chest pain, syncope, dizziness, SOB with exertion, irregular heart rhythm, palpitations, or non-taumatic swelling of extremities that may be cardiac in nature will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating other medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see TRIAGE ASSESSMENT)

ii. History of present illness/injury/chief complaint

iii. Characteristic of Chest Pain using the Wong-Baker Pain Scale

iv. Consider conditions related to cardiac disease i.e.) pericarditis, cardiomyopathy, or coronary artery disease

v. History of cardiac surgeries/illness

2. Objective

a. Chief complaint of chest pain

i. Signs of hypovolemia

ii. Chest excursion, symmetry and pain upon palpation

iii. Level of consciousness

iv. Color of skin/sclera

v. Presence or absence of peripheral edema

vi. Objective signs of pain

D. Diagnosis

1. ~~Chest Pain~~Cardiovascular concerns suspect to be cardiac in nature

E. Plan

1. Treatment

    a. The following laboratory tests may be ordered: CBC, CMP, POC I-stats as needed, Troponin I, HCG (<50 years old), Draw Extra, Chest XRay 1 View.

    b. ~~The order must be placed under the name EMERGENCY PHYSICIAN . If a different provider is later assigned to the patient, the orders will be transferred to the provider assigned.~~

    The order must be placed under the name of the supervising ED physician. If no ED provider has signed up for the patient then the order set should be placed under 'Physician, Emergency'

    c. The blood and urine specimens must be labeled accurately with the patient's name and account number. The accuracy of the label must be verified by using the hospital approved patient identification process (see PATIENT IDENTIFICATION policy). The labeling of specimens must occur AT THE PATIENT'S BEDSIDE.

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

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

    f. Cardiac monitor with rhythm interpretation (rhythm strip to be mounted in patient's medical record)

2. Patient conditions requiring consultation/reportable conditions:

    a. Notify an Emergency Department physician immediately of the following:

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

        ii. Change in triage acuity.

            a. Patients presenting with signs and symptoms of possible ACS (acute coronary syndrome).

            b. **Note: If the patient appears unstable and/or a life threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY Conditions requiring immediate treatment include: Expanding or acute aortic abdominal aneurysm, acute myocardial**

infarction, pulmonary embolism or spontaneous pneumothorax.

3. Education - Patient/Family
    a. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy.
4. Follow Up
    a. As needed to maintain continuity of care
5. Documentation of Patient Treatment
    a. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.
    b. ~~Enters "EMERGENCY PHYSICIAN as ordering provider.~~

        If no ED provider has signed up for the patient then the order set should be placed under 'Physician, Emergency'
    c. Navigates to ~~Emergency Department~~ER Nursing ~~Order Sets~~Orders
    d. Selects "~~Chest Pain-~~Cardiovascular Standardized Procedure" as the order source.

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

IV. REQUIREMENTS FOR THE REGISTERED NURSE

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

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

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

D. Evaluation

1. Initial: at 3 months, 6 months, and 12 months by the nurse manager through feedback from colleagues, physicians, and chart review during performance period being evaluated.
2. Routine: annually after the first year by the nurse manager through feedback from colleagues, physicians and chart review.
3. Follow up: areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.
4. Demonstrates knowledge of procedure through clinical performance.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method

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

B. Review schedule

1. Review of policy every three (3) years

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

1. Approval of the standardized procedure is outlined in the electronic policy and procedure system.
2. Nursing
    a. Director of Emergency Department every three (3) years
3. Medicine
    a. Medical Director of Emergency Department every three (3) years
    b. Chair of Interdisciplinary Medical Practice Committee every three (3) years
4. Administration

a. Chief Nursing Officer (Vice President of Patient Care Services) every three (3) years

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

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

VII. REFERENCES

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

B. Emergency Nurses Association: Emergency Nursing Core Curriculum (2016), 7th Edition. *Planning/interventions for myocardial infarction.*

Approval Signatures

Step Description	Approver	Date
IDPC	Katherine DeSalvo: Director Medical Staff Services	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2023
Policy Owner	Darlene Vaughan: Director Nursing	11/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14044098

Last Approved	N/A	Owner	Darlene Vaughan: Director Nursing
Last Revised	11/2023	Area	Nursing Standardized Procedures
Next Review	3 years after approval		

Vaginal Bleeding Standardized Procedure

I. POLICY

A. Function

- This standardized procedure outlines circumstances for which a registered nurse in the Emergency Department may start an IV and order blood work prior to a patient examination by a physician.

B. Circumstances

- ~~Setting~~

1. ~~Registered Nurses (RNs) may order Complete Blood Count (CBC), Serum Human Chorionic Gonadotropin (sHCG), UA, and a Blood Type and Rh factor (Type and Rh) on patients between menarche and menopause who present with a chief complaint of vaginal bleeding (DRAW EXTRA TUBES) **IF:** the ED physician is not immediately available AND the patient is between menarche and menopause.~~
2. ~~Patient to be NPO except for Meds.~~

Setting

- Registered Nurses (RN) assigned to the ED may initiate orders for patients presenting with vaginal bleeding prior to physician evaluation IF: the ED physician is not immediately available. The RN will ensure blood is drawn, order approved laboratory tests, and place an INT with routine flushes. This will apply to patients with symptoms listed in the PATIENT CONDITIONS section below.
- Registered nurses in the ED may order the following labs for patient's thirteen years of age and over with a complaint of vaginal bleeding: CBC, CMP, HCG (non-menopause females only), DRAW EXTRA, Type (ABO/RH Profile), UA and culture if needed, and place INT.

- Supervision
    1. Registered Nurses, who are employed in the Emergency Department and have successfully completed the Patient's with Vaginal Bleeding competency, are qualified to perform this standardized procedure and may order CBC, sHCG, Type and Rh, place a saline lock IV when vital signs are within normal limits or initiate IV resuscitation if vital signs are abnormal, to the patients presenting with the chief complaint of vaginal bleeding and whom meet criteria. Physician supervision is not required.

- ~~Patient Conditions~~
    1. ~~Patients with a history of hysterectomy should only have blood drawn for a CBC.~~
    2. ~~Patients whose Type and Rh can be located in the medical record within the last one (1) year: DO NOT require a Type and Rh.~~

- ~~Other~~
    1. ~~Consider conditions related to vaginal bleeding, chromosomal abnormalities, endocrine dysfunction, abnormal development of the embryo, and trauma.~~
    2. ~~Additional factors that increase risk of spontaneous abortion include maternal infections, advanced maternal age, malnutrition, substance abuse, immunologic incompatibility, surgery during pregnancy, and structural anomalies of the reproductive organs.~~

- Patient Conditions
    1. If the patient has not been seen in the ED within the previous 24 hours for the same complaint and/or the need for blood testing and IV therapy is questionable/concerning.
    2. Patients thirteen years of age and over
    3. Chief complaint of vaginal bleeding
    4. ED provider not immediately available

II. DEFINITIONS

A. CBC: Complete Blood Count

B. CMP: Comprehensive Metabolic Panel

C. sHCG: Serum Human Chorionic Gonadotropin

D. Blood Type and Rh factor (Type and Rh)

E. UA: Urinalysis

III. PROCEDURE

A. Database

- Subjective
    1. Patients with the chief complaint of vaginal bleeding will be triaged and prioritized according to accepted triage policy based on the severity of their vaginal bleeding using the Emergency Severity Index (ESI) 5 Level Triage. (See TRIAGE ASSESSMENT)
        a. Spontaneous abortion (miscarriage) is the loss of a pregnancy before viability of the fetus defined as 20 weeks gestation. Spontaneous abortion should be considered in any woman of childbearing age who presents to the emergency department with vaginal bleeding. Spontaneous abortions are commonly categorized as threatened, inevitable, incomplete, missed, or septic.
        b. An ectopic pregnancy (EP) could cause vaginal bleeding in pregnant women. EP intrudes into the tubal wall too deeply or grows too large, it can rupture the tube and can be life-threatening due to risk of hemorrhage.
        c. Menopausal or women of a geriatric age, malignant disease should always be considered. Postmenopausal hormonal changes may be responsible for dysfunctional uterine bleeding (DUB). Patients in this age group with vaginal bleeding are at increased risk for uterine cancer.
        d. ~~Pediatric patients may have an estrogen and progesterone production imbalance and these do increase with puberty between 8-11 years of age. Vaginal bleeding in pediatric patients could be from maltreatment and the index of suspicion on sexual abuse must be maintained.~~
    2. All patients presenting with chief complaint of vaginal bleeding and characteristics using numerical or Wong Baker pain scale.
        a. Onset of vaginal bleeding and potential cause (what happened)
        b. Last normal menstrual period (LNMP) and location of pain, if present.
        c. Duration of vaginal bleeding
        d. Characteristics of vaginal bleeding: amount, color, presence of clots/tissue. Number of full pads/tampons used (each holds approximately 30 ml of blood).
        e. Alleviating or aggravating factors
        f. Radiation of pain
        g. Treatment before arriving to the Emergency Department.
        h. Positive pregnancy test: date and method (serum or urine).
        i. Fatigue, dizziness, lightheadedness, syncope
        j. Contraceptive history

k. Reproductive history, total number of pregnancies, live births spontaneous/therapeutic abortion(s) (gravida, para, SAB/TAB)
l. Recent trauma or surgery
m. Recent sexual intercourse

- Objective
    1. Patients with vaginal bleeding will be assessed for the following
        a. Level of consciousness, behavior, affect
        b. Abnormal vital signs, obtain orthostatic vital signs (lying, sitting, standing)
        c. Skin, color; moist or dry
        d. Gait
        e. Quality and Quantity of vaginal bleeding, color, amount, passage of clots or tissue
        f. Presence or absence of pain/cramping and location of pain
        g. Palpation of abdomen for tenderness
        h. Auscultation for Fetal Heart Tones

B. Diagnosis
- Vaginal bleeding caused by
    1. Spontaneous abortion from a nonviable fetus
    2. Ectopic pregnancy invading the tubal wall
    3. Uterine dysfunction
    4. Endocrine imbalance
    5. Sexual assault/abuse or maltreatment
    6. Malignant disease
- Potential differential diagnoses
    1. Deficient fluid volume
    2. Acute pain
    3. Anticipatory grieving
- Plan
    1. Treatment
        a. Patient must have an accurate name-band in place before blood work is drawn.
        b. When initiating an IV infusion the RN will label the blood tubes accurately by using the hospital approved patient identification process (see PATIENT IDENTIFICATION POLICY). The labeling of specimens must occur AT THE PATIENT'S BEDSIDE.

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

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

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

f. The ED RN will assess the patient presenting with vaginal bleeding according the standardized policy and procedure of Vaginal Bleeding.

i. The ED RN will initiate IV therapy when the following is present:

1. Moderate to heavy vaginal bleeding present
2. Skin signs are cool, pale, and moist
3. Systolic blood pressure (SPB) of 100 or less and/or heart rate of greater than 100.
4. A female staff member **MUST** be present with the ED physician during the patient's vaginal exam.
5. If specimens are obtained patient label must be taken to the bedside and verified with the patient using the two (2) Patient Identifiers (patient name and medical record number).

2. Patient conditions requiring consultation:

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

b. Heavy bleeding present with skin signs of cool, pale and moist.

c. Vital signs critical less than 100 SBP and heart rate greater than 100.

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

e. Change in triage acuity

3. Education-Patient/Family

a. Educate on processes of the Emergency Department

i. Why patient must remain NPO status until results

ii. Explain the need for blood work and initiation of blood work

iii. Explain the procedure of vaginal exam
iv. Explain what medication given and why
v. Education that patient did not do anything wrong, that miscarriage or threatened miscarriage it is not the patient's fault
vi. Educate on receiving RhoGAM, if woman is Rh-negative

b. Educating for threatened abortion
i. Maintain bed rest for 24 to 48 hours or until bleeding subsides
ii. Educate on the need for bed rest and pelvic rest (no sexual intercourse, do not place anything inside the vagina) until bleeding and cramping stop
iii. Use sanitary pads only; avoid tampons
iv. Return to the Emergency Department if bleeding or pain increases
v. Save any clots or tissue that passes and bring to the emergency department or follow-up physician
vi. Ensure appropriate follow-up care with obstetrician/gynecologist.

c. Education for complete abortion
i. Mild abdominal pain/cramping is common for several days
ii. Use sanitary pads only; avoid tampons
iii. Take temperature four times a day
iv. Pelvic rest
v. Ensure follow-up care with obstetrician/gynecologist.
vi. Activity as tolerated
vii. Return to the emergency department if temperature is higher than 100.6 F, bleeding, pain, or foul-smelling discharge occurs or increases

d. Follow up
i. Reassessment and reevaluation of vaginal bleeding every two (2) hours or more frequently according to the patient severity and amount of vaginal bleeding and accordance with the Emergency Department Policy and Procedure: Assessment/Reassessment (see STANDARDS OF CARE- EMERGENCY DEPARTMENT)

e. Documentation of Patient Treatment

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

1. The ED RN initiating the standardized procedure will document the following: CBC, sHCG, Type and Rh, and IV therapy ordered per "standardized procedure" in the electronic medical record.
2. Enters "supervising ED physician as ordering provider, per policy.
3. Navigates to New Sets.
4. Selects "ER Nursing Orders" order set
5. Selects appropriate order.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education and Training

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

B. Experience

- Current California RN license and designated to work in ED

C. Initial and Ongoing Evaluation

- Demonstrates knowledge of procedure through clinical performance.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method

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

B. Review schedule

- Review of policy every three (3) years

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

- Nursing
    1. Director of Emergency Department every 3 years
- Medicine
    1. Medical Director of Emergency Department every 3 years
    2. Chair of Interdisciplinary Medical Practice Committee every 3 years
- Administration
    1. Chief Nursing Officer (Vice President of Patient Care Services) every 3 years

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. Records are kept electronically in Education Department Computer system and in nursing unit's education file.

VII. REFERENCES

A. Board of Registered Nursing, Title 16, California Code of Regulations (CCR)
B. Section 1474; Medical Board of California, Title 16, CCR Section 1379.
C. Emergency Nurses Association: Emergency Nursing Core Curriculum (2000)
D. 6th Edition. *Vaginal bleeding* 536-564.
E. TRIAGE ASSESSMENT
F. STANDARDS OF CARE- EMERGENCY DEPARTMENT

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	Pending
IDPC	Katherine DeSalvo: Director Medical Staff Services	12/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Owner	Darlene Vaughan: Director Nursing	11/2023

Standards

No standards are associated with this document

EXTENDED CLOSED SESSION
(if necessary)

(VICTOR REY, JR.)

ADJOURNMENT

RECONVENE OPEN SESSION/
CLOSED SESSION REPORT

(VICTOR REY, JR.)