July 18, 2025

TO: Legal Counsel

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

The next regular meeting of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **THURSDAY, JULY 24, 2025, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA.**

(V*isit* https://www.salinasvalleyhealth.com/about-us/healthcare-district-information-reports/board-of-directors/board-committee-meetings-virtual-link/ *for Public Access Information*).

Allen Radner, MD
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, JULY 24, 2025, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C

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

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

	AGENDA	*Presented By*
1.	**CALL TO ORDER / ROLL CALL**	*Joel Hernandez Laguna*
2.	**CLOSED SESSION** *(See Attached Closed Session Sheet Information)*	*Joel Hernandez Laguna*
3.	**RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION** *(Estimated time 4:30 pm)*	*Joel Hernandez Laguna*
4.	**AWARDS & RECOGNITION**	*Allen Radner, M.D.*
5.	**PUBLIC COMMENT**	*Joel Hernandez Laguna*

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

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

A. Minutes of the Regular Meeting of the Board of Directors June 26, 2025

B. Policies/Plans Requiring Approval

1. Breastfeeding the Late Preterm Infant
2. Breastfeeding the Newborn
3. Complete Decongestive Therapy for Management of Lymphedema
4. Contraction Stress Test
5. Cord Blood Specimen Collection for pH Analysis
6. Fetal Heart Rate Monitoring
7. NICU: Consultation & Transfer of Patient
8. Obtaining Daily Weights for Heart Failure Patients
9. Oral Care
10. Peer Feedback
11. Placenta Release
12. Scope of Service: Medical Staff Services

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

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

7. BOARD MEMBER COMMENTS AND REFERRALS *Joel Hernandez Laguna*

8. STATUS UPDATE ON EPIC IMPLEMENTATION *Alysha Hyland*
Josh Rivera

9. REPORTS ON STANDING AND SPECIAL COMMITTEES

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

Minutes of the July 14, 2025 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

B. **PERSONNEL, PENSION & INVESTMENT COMMITTEE** *Catherine Carson*

Minutes of the July 14, 2025 Personnel, Pension & Investment Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

C. **FINANCE COMMITTEE** *Victor Rey, Jr.*

Minutes of the July 21, 2025 Finance Committee meeting have been provided to the Board for their review. The Financial Reports of the Finance Committee have been provided for review (informational). The following recommendation has been made to the Board.

1. **Consider Recommendation for Board Approval of the Short Term Lease Agreement for Epic Inpatient Training Space at 928 East Blanco Road, Suite 121, Salinas Between Salinas Valley Health and Rancho Llano Development, LLC**

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

D. **TRANSFORMATION, STRATEGIC PLANNING & GOVERNANCE COMMITTEE** *Rolando Cabrera, M.D.*

Minutes of the July 16, 2025 Corporate Compliance & Audit Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF JULY 10, 2025, AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS: *Rakesh Singh, M.D.*

A. Reports

1. Credentials Committee Report (Including the following)

- Family Medicine Active Community – Clinical Privileges Delineation – Revision

- General Surgery, Oncology General Surgery and Colorectal Surgery – Clinical Privileges Delineation – Revision
- Urology – Clinical Privileges Delineation – Revision

2. Interdisciplinary Practice Committee Report (Including the following)
   - Amniotomy Nursing Standardize Procedure

B. Policies/Procedures/Plans and Agreements Recommended for Approval:

1. Care of the CRRT Patient

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

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

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

13. ADJOURNMENT *Joel Hernandez Laguna*

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, August 28, 2025, at 4:00 p.m.**

The Salinas Valley Health (SVH) Board packet is available at the Board Meeting, electronically at https://www.salinasvalleyhealth.com/about-/healthcare-district-information-reports/board-of-directors/meeting-agendas-packets/2025/, and in the SVH Human Resources Department located at 611 Abbott Street, Suite 201, Salinas, California, 93901. All items appearing on the agenda are subject to action by the SVH Board.

Requests for a disability related modification or accommodation, including auxiliary aids or Spanish translation services, in order to attend or participate in-person at a meeting, need to be made to the Board Clerk during regular business hours at 831-759-3050 at least forty-eight (48) hours prior to the posted time for the meeting in order to enable the District to make reasonable accommodations.

SALINAS VALLEY HEALTH BOARD OF DIRECTORS
THURSDAY, JULY 24, 2025, 4:00 P.M.

AGENDA FOR CLOSED SESSION

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

CLOSED SESSION AGENDA ITEMS

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

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

1. Report of the Medical Staff Quality and Safety Committee
    - Accreditation and Regulatory (RATCLIFF)
2. Quality and Safety Board Dashboard Review (KUKLA)
3. Consent Agenda:
    - Throughput Committee
    - Sepsis Initiative
    - HIM Health Information Management
    - Critical Care Service Line
    - Supply Chain/Materials Management
    - Volunteer/Community Service
    - Diagnostic Imaging
    - Rehab Services-PT/OT
    - Medical-Surgical Cluster, Pediatrics, Inpatient Wound Care Program
    - Transitional Care

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

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

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

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

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

Additional information required pursuant to Section 54956.9(e): Communications with Department of Justice

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

PUBLIC EMPLOYEE PERFORMANCE EVALUATION
(Government Code §54957)
Title: (Specify position title of employee being reviewed): President/CEO

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)

AWARDS AND RECOGNITION

(Verbal)

(DR. RADNER)

PUBLIC COMMENT

DRAFT SALINAS VALLEY HEALTH[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
JUNE 26, 2025

Board Members Present: President Joel Hernandez Laguna, Vice-President Catherine Carson, Isaura Arreguin, Rolando Cabrera, M.D., and Victor Rey, Jr.

Absent: None;

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

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Hernandez Laguna called the meeting to order at 4:07 p.m. in the Downing Resource Center, Rooms A, B, and C.

2. CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Hearings and Reports and (2) Conference with Labor Negotiator-Local 39, and (3) Public Employee Performance Evaluation: President/CEO*.

The meeting recessed into Closed Session under the Closed Session Protocol at 4:09 p.m.

The Board completed its business of the Closed Session at 5:01 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 5:02 p.m. President Hernandez Laguna reported that in Closed Session, the Board discussed *(1) Hearings and Reports and (2) Conference with Labor Negotiator-Local 39.* The Board received and accepted the reports listed on the Closed Session agenda. No other action was taken.

President Hernandez Laguna announced there is a need for an extended closed session.

4. AWARDS AND RECOGNITION

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

- **STAR Award: James Lewis, MA, CCEP, Clinical Exercise Physiologist:** Clement Miller, COO, stated that after serving our country for two decades in the Navy, James joined Salinas Valley Health eight years ago to serve our community as an Exercise Physiologist with the

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Cardiac Rehab team. He and the colleague who nominated him for the honor, Betzi Grogin, BSN, RN, CCRP (a 2022 DAISY Award recipient herself), have recently passed the exam to become Certified Cardiac Rehab Professionals. The nomination detailed an impeccable work ethic that included attention to detail in charting and valuable support during the last three recertifications (AACVPR). "He is always willing to share with our patients any information he has with regards to services available in our community. And after witnessing the tremendous need for social and psychological counseling services that exists with our patient population he compiled a comprehensive resource booklet for our staff and patients to utilize." James said, "This is a big part of my life to be in this (Cardiac Rehab) unit and that this is the 1st time full time job he's had since he was in the military." James stated that he loves having the opportunity to acknowledge SVH as a great place and that he loves being involved and working here.

- **Mercedes Labindalaua, RN, BSN, CCRN, Retirement:** Clement Miller, COO, introduced Mercedes stating that she is retiring next month after 37 years of service to Salinas Valley Health and was Nurse of the Year in 2016! Mercedes is known as an extraordinary individual who epitomizes the professional role of the nurse. A dedicated patient advocate, she exudes compassion and always manages to remain graceful under pressure. Carla Spencer, CNO, stated that Mercedes was her preceptor when she started at SVH, that Mercedes has a heart of gold and said to Mercedes, "I appreciate you." Mercedes stated it is humbling and a great honor to be invited to the Board meeting. She was honored to have received an email from Dr. Radner. Mercedes has had "so many good memories and met and worked with many wonderful people. The community is so privileged to have all this (healthcare) available without having to leave the area."

5. PUBLIC COMMENT:

None.

6. CONSENT AGENDA – GENERAL BUSINESS

Recommend Board Approval of the Following:

A. Minutes of the Regular Meeting of the Board of Directors May 22, 2025

B. Policies/Plans Requiring Approval
   1. Account Cancellation
   2. Amnioinfusion
   3. Application of Fetal Scalp Electrode
   4. Arterial Catheter Insertion (Assist) Care and Removal
   5. Automated Dispensing Cabinet
   6. Cardiac Cath Lab – Regulations
   7. Care of the Obstetrical Emergency Department Patient
   8. Chargemaster Dictionary Maintenance
   9. Electronic Provider Documentation
   10. Formulary Process
   11. Isolation - Standard and Transmission Based Precautions
   12. RC POCT Laboratory Safety/Chemical Hygiene Plan
   13. Registration Data Accuracy
   14. Scope of Service: Administration

15. Scope of Service: Cardiovascular Diagnostic and Treatment Units
16. Scope of Service: Department of Pharmacy
17. Uses and Disclosures of Protected Health Information (General)

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Director Carson stated that she requested revisions be made to *Uses and Disclosures of Protected Health Information* and *Scope of Service: Administration* which were completed. She stated the *Scope of Service: Department of Pharmacy* is the best she has seen.

MOTION:

Upon motion by Director Dr. Cabrera, second by Director Rey, the Board of Directors approves the Consent Agenda, Items (A) through (B) as listed.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;
Nays: None;
Abstentions: None;
Absent: None.

Motion Carried

7. REQUEST FOR RATIFICATION: SUBSTANTIVE ELEMENTS OF COLLECTIVE BARGAINING AGREEMENT BETWEEN SVMHS AND INTERNATIONAL UNION OF OPERATING ENGINEERS, STATIONARY ENGINEERS LOCAL NO. 39, AFL-CIO

Human Resources Manager Robert Anderson reported that the Salinas Valley Memorial Healthcare System (SVMHS) and International Union of Operating Engineers, Stationary Engineers Local No. 39, AFL-CIO (Local 39) had tentatively agreed on a contract with the following terms.

Term	July 1, 2025 – June 30, 2029
Wages	• 5.00% increase effective 7/7/2025 • 4.25% increase effective 7/6/2026 • 4.15% increase effective 7/5/2027 • 4.00% increase effective 7/3/2028
Pension Plan	• 7% increase effective 7/1/2025 • 7% increase effective 7/1/2026 • 7% increase effective 7/1/2027 • 7% increase effective 7/1/2028
Training Fund	• $40 increase effective 1/1/2026 • $40 increase effective 1/1/2027 • $40 increase effective 1/1/2028 • $40 increase effective 1/1/2029
Health and Welfare	• Increased health insurance contributions by $221 effective 7/1/2025

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera, second by Director Rey, the Board of Directors approves the Request for Ratification of Collective Bargaining Agreement between Salinas Valley Memorial Health Care District, operating as Salinas Valley Health Medical Center (SVHMC) and International Union of Operating Engineers, Stationary Engineers Local No. 39, AFL-CIO.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;
Nays: None;
Abstentions: None;
Absent: None.

Motion Carried

8. BOARD MEMBER COMMENTS AND REFERRALS

Director Rolando Cabrera, M.D.: None

Director Catherine Carson: Director Carson attended the Leukemia & Lymphoma Society Monterey Bay Vision of the Year Grand Finale; the team raised $500K and that it is fun to represent the hospital at events.

Director Victor Rey, Jr.: (1) Director Rey attended the event celebrating 20,000 patients of the SVH Mobile Clinic. Services are provided free of charge to the district and beyond. He stated "Hats off to the entire team." (2) He represented SVH at the Grower-Shipper Association Friday Mixer.

Director Isaura Arreguin: (1) Director Arreguin gave kudos to ER team for great service and stated "I appreciate the SVH ER." (2) She stated she met with Dr. Rodriguez, CMO, to learn about the Mobile Clinic and the impact it has on our community.

Director Joel Hernandez Laguna: (1) Director Hernandez Laguna stated 20K is a lot of patients and commended the Mobile Clinic. (2) He attended the Summer Health Institute last week. He spoke to the students about what the Board does. The high school students are eager and ready to learn. (3) He had a nice conversation with SVH Foundation in April. (4) Some people in Gonzales have asked him if space at the Taylor Farms Family Health and Wellness Clinic is available for classes. Dr. Radner stated there is absolutely space available for that purpose and he will follow up with Director Hernandez Laguna.

9. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Catherine Carson regarding the Quality and Efficient Practices Committee. The minutes of the June 16, 2025 meeting were provided for Board review. Director Carson stated the Committee received: (1) Patient Care Services update on the Perinatal Unit Practice Council, and (2) Reports on Palliative Care, Accreditation/Regulatory, Patient Safety Events/RCAs and Leapfrog. The quarterly Dashboard Report will come to Board next month.

B. PERSONNEL, PENSION & INVESTMENT COMMITTEE

A report was received from Director Carson regarding the Personnel, Pension and Investment Committee. The minutes of the June 16, 2025 meeting were provided for Board review. There was a report on the

Actuary's Pension Valuation of the SVMHS Defined Benefit Pension Plan as of January 1, 2025. The following recommendations were made.

1. **Consider Recommendation for Board Approval to Fund the Required Minimum Contribution to the Salinas Valley Memorial Healthcare District Employees' Pension Plan for Calendar year 2025**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Arreguin, the Board of Directors approves funding the required minimum contribution of $12,000,717 to the Salinas Valley Memorial Healthcare District Employees' Pension Plan for Calendar Year 2025.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;
Nays: None;
Abstentions: None;
Absent: None.

Motion Carried

2. **Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Natalie Friedricks, MD, (ii) Contract Terms for Dr. Friedricks' Recruitment Agreement, and (iii) Contract Terms for Dr. Friedricks' Obstetrics and Gynecology Professional Services Agreement**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Dr. Friedricks speaks Spanish which is important. Incentives are needed for purposes of recruitment in this competitive market and are compliant with fair market value. The recruitment agreements are forgiven after 2 years of service.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Carson, the Board of Directors approves:

1. The Findings Supporting Recruitment of Natalie Friedricks, MD:
   - That the recruitment of an obstetrics and gynecology 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. Friedricks; and
3. The Contract Terms of the Obstetrics and Gynecology Professional Services Agreement for Dr. Friedricks.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;
Nays: None;
Abstentions: None;
Absent: None.

Motion Carried

3. **Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of a Physician to Central Coast Nephrology Medical Corporation, and (ii) Contract Terms for the Recruitment Agreement**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: This agreement is for a community recruitment of a nephrology physician. Central Coast Nephrology is actively recruiting and working with a search firm until recruitment. The SVH $50,000 commitment to assist the group in recruiting a physician is required prior to an offer being made.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Rey, the Board of Directors approves:

1. The Findings Supporting the Recruitment of a Nephrologist to Central Coast Nephrology,
   - The recruitment of a nephrologist is in the best interest of the public health of the communities served by the District;
   - The recruitment incentive SVH proposes for this recruitment is necessary in order to relocate and attract an appropriately qualified physician to practice in the communities served by the District;
2. The Contract Terms of the Recruitment Agreement.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;
Nays: None;
Abstentions: None;
Absent: None.

Motion Carried

C. FINANCE COMMITTEE

A report was received from Director Rey regarding the Finance Committee. The minutes of the June 23, 2025 meeting were provided for Board review. The Financial Reports of the meeting were included in the packet for review (informational). The following recommendations were made.

1. **Consider Recommendation for Board Approval of Purchase of the Stryker MAKO 4 Robotic-Arm Assisted Surgery System**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Carson, and second by Director Arreguin, the Board of Directors approves the purchase of the Stryker Mako 4 at a total cost of $789,090.50. This capital acquisition includes the base equipment price of $549,090.50, which comes with a one-year warranty. Additionally, the agreement encompasses two years of service coverage following initial warranty, valued at $240,000, for the duration of the service term.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;
Nays: None;
Abstentions: None;
Absent: None.

Motion Carried

2. **Consider Recommendation for Board Approval of Awarding a Contract for Design and Engineering Services to HDR Architecture Inc. in Conjunction with the Emergency Department Replacement Project**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: This has been a long time coming and will be a huge project which will take a lot of effort. Clement Miller, COO, and Brad McCoy, Vice President of Facilities, Construction & Real Estate, were thanked for their focus on this project.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Arreguin, the Board of Directors approves the award of the master architect design services to HDR Architecture for the design and engineering of the Emergency Department Replacement project, in the amount of $1,631,742, as presented. Executive Leadership may review and execute additional services not more than 10% of the original contract value or not in excess of $450,000. The total amount is $2,081,742.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;
Nays: None;
Abstentions: None;
Absent: None.

Motion Carried

3. **Consider Recommendation for Board Approval of Competitive Solicitation and Contract Award for Epic Acute Project Go-Live Assistance Engagement with Optimum Health IT**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: There are approximately 14 weeks until go-live. President Hernandez Laguna requested a report on Epic and how we are progressing for the July Board Meeting.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Carson, the Board of Directors approves the Competitive Solicitation and Contract Award for Epic Acute Project Go-Live Assistance Engagement with Optimum Health IT in an amount not to exceed $3,200,000.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;
Nays: None;
Abstentions: None;
Absent: None.

Motion Carried

D. CORPORATE COMPLIANCE AND AUDIT COMMITTEE

A report was received from Director Hernandez Laguna regarding the Corporate Compliance and Audit Committee. The minutes of the June 18, 2025 meeting were provided for Board review. There are no recommendations.

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON JUNE 12, 2025, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING:

Rakesh Singh, M.D., Chief of Staff, reviewed the reports of the Medical Executive Committee (MEC) meeting of June 12, 2025. A full report was provided in the Board packet.

Recommend Board Approval of the Reports as listed on the Agenda.

PUBLIC COMMENT: None.

BOARD DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera, second by Director Arreguin, the Board of Directors receives and accepts the Medical Executive Committee Credentials Committee Report and Interdisciplinary Practice Committee Report as follows:

A. Reports
    1. Credentials Committee Report (Including the following)
        - Surgery – Active Community Clinical Privilege Delineation Revision
    2. Interdisciplinary Practice Committee Report (Including the following)
        - Abdominal Pain Nursing Standardized Procedure
        - Chest Pain/Cardiovascular Nursing Standardized Procedure
        - Glycemic Measurement at Point of Care Standardized Procedure
        - Nausea and Vomiting Nursing Standardized Procedure
        - Vaginal Bleeding Nursing Standardized Procedure

B. Policies/Procedures/Plans and Agreements Recommended for Approval:
    1. Authority Statement – Infection Prevention
    2. Discharge Criteria OB-ED

3. Endoscope Handling, Reprocessing and Storing
4. Induction/Augmentation of Labor and Cervical Ripening
5. Outsourcing Sterile Compounding
6. Reportable Diseases and Conditions

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;
Nays: None;
Abstentions: None;
Absent: None.

Motion Carried

11. EXTENDED CLOSED SESSION

President Hernandez Laguna announced item to be discussed in Extended Closed Session are *(1) Hearings and Reports*, and *(2) Public Employee Performance Evaluation – President/CEO.* The meeting recessed into Closed Session under the Closed Session Protocol at 5:52 p.m. The Board completed its business of the Closed Session at 6:26 p.m.

12. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 6:27 p.m. President Hernandez Laguna reported that in Extended Closed Session, the Board discussed *(1) Hearings and Reports*, and *(2) Public Employee Performance Evaluation–President/CEO*.

No action was taken.

13. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, July 24, 2025, at 4:00 p.m.** There being no further business, the meeting was adjourned at 6:28 p.m.

_____

Rolando Cabrera, MD
Secretary, Board of Directors

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: July 24, 2025

Re: Policies Requiring Approval

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

	Policy Title	Summary of Changes	Responsible Exec
Consent Agenda Policies			
1.	Breastfeeding the Late Preterm Infant	Minor wording changes made as required by Baby-Friendly for increased clarification. Updated references.	Carla Spencer, CNO
2.	Breastfeeding the Newborn	Updates made as required by Baby-Friendly wording changes for increased clarification and to include affiliated prenatal clinics. Updated resource list and minor changes to attachments based on current AAP recommendations. References updated. EMR changed to EHR.	Carla Spencer, CNO
3.	Complete Decongestive Therapy for Management of Lymphedema	Changes made per Dr. Wilson's recommendation: In the contraindications section changed "hypertension" to "uncontrolled hypertension," and "renal failure" to "advanced renal failure" and "Cardiac edema" to "moderate to advanced heart failure."	Clement Miller, COO
4.	Contraction Stress Test	No Changes. Regularly scheduled review.	Carla Spencer, CNO
5.	Cord Blood Specimen Collection for pH Analysis	Meditech replaced with EHR.	Carla Spencer, CNO
6.	Fetal Heart Rate Monitoring	Added verbiage from AWHONN 2024 Position Statement on documentation frequency and contemporaneous summary documentation in the 2nd stage of labor. Formatting changes and updated references.	Carla Spencer, CNO
7.	NICU: Consultation & Transfer of Patient	Minor typos corrected. Regularly scheduled review.	Carla Spencer, CNO
8.	Obtaining Daily Weights for Heart Failure Patients	No Changes. Regularly scheduled review.	Allen Radner, CEO

	Policy Title	Summary of Changes	Responsible Exec
9.	Oral Care	Added oral care frequency to dependent patient section as well as denture section. Revised policy statement, purpose statement and added NV-HAP definition. Added infection risk to general info. Added the procedure name from dynamic health under procedure. Of note- CHG no longer recommended according to AACN, supporting articles and dynamic health. I have not removed this yet as still current practice at SVH.	Carla Spencer, CNO
10.	Peer Feedback	Updated references, cleaned up definitions, added STAR and PRIDE, added links.	Carla Spencer, CNO
11.	Placenta Release	Minor wording changes. Updated references. Request form added.	Carla Spencer, CNO
12.	Scope of Service: Medical Staff Services	Spelled out abbreviations, added OPPE and FPPE references. Changed Chief Medical Officer to Chief Clinical Officer.	Timothy Albert, CCO

MEC			
Nursing Standardized Procedures			
1.	Amniotomy	No Changes	Carla Spencer, CNO
MEC Policies/Plans			
1.	Care of the CRRT Patient	Removed manual return of blood with use of hand crank r/t concern of air embolism if done incorrectly, high risk, low volume.	Carla Spencer, CNO

Status **Pending** PolicyStat ID **18072835**

Origination	03/2020	Owner	Julie Vasher: Director Women's & Children's Services
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Breastfeeding the Late Preterm Infant

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in promoting, supporting and sustaining breastfeeding in the late preterm infant.

B. Heighten staff awareness of difficulties the late preterm infants and their mother's experience with breastfeeding.

C. To guide the staff in maintaining optimal health of the infant and mother.

D. To guide the staff in decreasing the risk of medical problems associated with the late preterm infant (i.e. dehydration, hypoglycemia, hyperbilirubinemia, weight loss, failure to thrive).

III. DEFINITIONS

A. The "Late Preterm Infant" refers to infants born between $34^{0/7}$ to $36^{6/7}$ weeks of gestation.

IV. GENERAL INFORMATION

A. Allow infants born at 34 0/7 to 36 6/7 weeks of gestation to breastfeed and/or breast milk feed to the greatest extent possible.

B. Offer strategies to anticipate, identify promptly, and manage breastfeeding problems that the late preterm infant and mother may experience in the inpatient setting and refer to outpatient services as needed.

C. For the stable infant, encourage immediate and extended skin-to-skin contact after birth to

improve postpartum stabilization of heart rate, respiratory effort, temperature control, metabolic stability, and early breast feeding. Allow free access to the breast.

D. If the mother and infant are separated, the mother should begin hand expression of colostrum within the first hour of birth and at 3 hour intervals.

E. Observe infant closely for twelve (12) to twenty-four (24) hours to assure physiologic stability (e.g., temperature, apnea, tachypnea, and hypoglycemia).

F. Encourage rooming-in twenty-four (24) hours a day.

G. Ensure frequent on demand breastfeeding. It is important that the infant be breastfed (or breast-milk fed) *at least* eight to twelve (8-12) times per twenty-four (24) hour period (at least every three hours). Sometimes it may be necessary to wake the baby within four hours of the previous feed, which is not unusual in the late preterm infant, if he or she does not indicate hunger. A mother may need to express her milk and give it to the baby using an alternative feeding method. Refer to ALTERNATIVE FEEDING METHODS FOR THE BREAST FED INFANT CLINICAL PROCEDURE and BREASTFEEDING THE NEWBORN.

H. Formal evaluation from a lactation consultant or other certified health professional with expertise in lactation management should be completed within twenty-four (24) hours of delivery.

I. Assess and document breastfeeding.

V. PROCEDURE

A. Ongoing care:

1. Communicate daily changes in feeding plan either directly or with use of written bedside tool such as a feeding diary.
2. Educate the mother about breastfeeding her infant (e.g., position, latch, milk transfer, early feeding cues, waking a sleepy baby, etc.).
3. Monitor vital signs per policy, ADMISSION ASSESSMENT - NEWBORN , weight change, stool and urine output, and milk transfer. Pre/post feeding weights may be helpful once lactogenesis II (greater than 4-5 days) has occurred. BREAST MILK CALCULATION/BABY WEIGHT SCALE CLINICAL PROCEDURE.
4. Monitor for frequently occurring problems (e.g., obtain bilirubin test if jaundiced before 24 hours, glucose screen before feeds for the first 24 hours or as ordered by provider. Refer to PERINATAL SERVICE: BLOOD GLUCOSE MANAGEMENT/ TREATMENT STANDARDIZED PROCEDURE and HYPERBILIRUBINEMIA-INFANT MANAGEMENT & TREATMENT.
5. Avoid excessive weight loss or dehydration. Losses greater than 3% of birth weight by Day 1 or greater than 7% by Day 3, less than six voids/three to four sizable yellow seedy stools daily by day 4, ineffective milk transfer, or exaggerated jaundice are considered excessive and merit further evaluation by the physician.
    a. The infant may need to be supplemented after breastfeeding with small quantities (5 to 10 mL per feeding first 24 hours; 10-30 ml per feeding thereafter dependent on infant's metabolic requirements and feeding tolerance) of expressed breast milk or formula. Mothers may supplement

using a supplemental nursing device at the breast, syringe feeds, or bottle depending on clinical situation and mother's preference. Refer to ALTERNATIVE FEEDING METHODS FOR THE BREAST FED INFANT CLINICAL PROCEDURE.

b. If supplementing/poor feedings, the mother should pump/express milk regularly (use of a hospital grade electric pump is recommended when feasible) at least every 2-3 hours (minimum 8 times per 24 hours) until the baby is breastfeeding well or if the mother and infant are separated and unable to breastfeed.

c. Preferred choice of supplement will be colostrum/mother's own milk and if that is not available, ready mixed formula would be used.

6. Avoid thermal stress by using skin-to-skin contact or by double wrapping infant and by dressing the baby in a shirt and hat. Consider intermittent use of an incubator to maintain temperature.

B. Discharge Planning:

1. Assess readiness for discharge; physiologic stability, adequate intake (breast or bottle feeding), weight loss, void and stool pattern.
2. Develop discharge-feeding plan. Consider diet, milk intake (mL/kg/day), and method of feeding (breast, bottle, supplemental device, etc.). If supplementing, determine method most acceptable to mother for use after discharge.
3. Parents should be instructed to make an appointment with infant's follow-up physician within forty-eight (48) hours of discharge to recheck weight, feeding adequacy, jaundice.
4. Communicate discharge-feeding plan to primary care provider.
5. Encourage follow up lactation support through Salinas Valley Health Medical Center (SVHMC) outpatient lactation services, private lactation consultant or WIC lactation services.

C. Order entry

1. Lactation consultant service referral.

D. Documentation

1. Documentation of each breastfeeding session in the EMR (when necessary nurse's notes should reflect feeding plan, education, and discharge instructions).
2. Quality of feeding should be validated by the RN at least one (1) time per shift. LATCH score by RN one time per shift, score <7 lactation consult initiated and RN to view another breastfeeding session.
3. Verbal and written instructions will be given to parents/family discussing "Parent Information Sheet: Late Preterm Infant".

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Academy of Breastfeeding Medicine. (2016). Protocol # 10: Breastfeeding the late preterm infant (34 0/7-36 6/7 weeks gestation). DOI: 10.1089/bfm.2016.29031.egb

B. Meek, J. Y., Noble, L., & Section on Breastfeeding. (2022). Policy statement: breastfeeding and the use of human milk. Pediatrics, 150(1), e2022057988.

C. Walker, M. (2021). *Breastfeeding management for the clinician: Using the evidence*. (5th ed.). Jones & Bartlett Learning.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Chair Dep OBGYN	Katherine DeSalvo: Director Medical Staff Services	06/2025
CNO	Carla Spencer: Chief Nursing Officer	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	Julie Vasher: Director Women's & Children's Services	04/2025
Lactation Supervisor	Holly Shannon: Supervisor Lactation Program	04/2025

Standards

No standards are associated with this document

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Origination	03/2021	Owner	Julie Vasher: Director Women's & Children's Services
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Breastfeeding the Newborn

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To assist the nurse in promoting a philosophy of maternal infant care that advocates breastfeeding and supports the normal physiologic function involved in the establishment of the maternal infant process of breastfeeding.

B. To promote successful breastfeeding by ensuring that, in the absence of contraindications, all mothers who elect to breastfeed will have a successful and satisfying experience.

C. To ensure that care is congruent with the Ten Steps to Successful Breastfeeding as endorsed by the UNICEF/World Health Organization Baby Friendly Hospital Initiative, Baby-Friendly USA.

III. DEFINITIONS

A. Baby Friendly Hospital Initiative: The Baby Friendly Hospital Initiative is an international effort developed by the World Health Organization and UNICEF in 1991 to promote, protect and support breastfeeding in hospitals and birth centers worldwide. The Baby Friendly Hospital Initiative is a program built around a list of 10 research supported practices, the Ten Steps to Successful Breastfeeding, which were developed for maternity facilities. Baby-Friendly USA manages the US Baby Friendly program.

B. Cue-based, or on-demand, feeding: Whenever the infant exhibits hunger cues (body wiggling, hand clasping, hands to mouth, light sucking motion, rooting behavior, tongue extension, light sounds, body flexion, turning head to the side), and the mother responds.

C. Exclusive breastfeeding: Providing breast milk as the sole source of nutrition. No other liquids or solids recommended. Exclusive breastfeeding is recommended for the first six months of

life and after the addition of solids breastfeeding should continue until mother and infant decide they no longer want to breastfeed. The national recommendation for exclusive breastfeeding for the first six months of life and continuing on after introduction of solids, for one to four years.

D. Rooming-in: Infant is encouraged to be in the mother's room 24 hours a day. Regardless of feeding choice rooming-in is encouraged for all families.

E. Skin-to-skin (STS): Infant placed, with only a hat and diaper, against mother's bare chest, between her breasts, and then both are covered with a warm blanket. STS is offered to all mothers and babies regardless of feeding choice or delivery method.

IV. GENERAL INFORMATION

A. Staff will ensure the continuity of care for breastfeeding mothers in the transition from hospital to home by providing information regarding community lactation resources.

B. The health care staff may refer the patient to the Lactation Services as appropriate. See Attachment A regarding Triggers for Lactation Consultation.

C. **Comply fully with the International Code of Marketing of Breastmilk Substitutes and relevant World Health Assembly resolutions.**

1. This facility upholds the World Health Organization (WHO) International Code of Marketing of Breastmilk Substitutes by offering education and materials that support human milk rather than infant food or drinks, and by refusing to accept or distribute free or subsidized supplies of breastmilk substitutes, nipples, bottles, and other infant feeding supplies. This philosophy will be posted in all locations where care is provided to mothers, infants and young children.

2. No employees of manufacturers or distributors of breastmilk substitutes, bottles, nipples, or pacifiers have direct or indirect contact with pregnant women or mothers. Pregnant women, mothers or their families are not given marketing materials or samples/gift packs by SVHMC that include formula, bottles, nipples or other infant feeding equipment or coupons for any of these items. Any educational materials distributed to breastfeeding mothers and the hospital educational videos are free of messages or logos that promote or advertise infant food or drinks other than breastmilk.

3. SVHMC and/or any affiliated prenatal clinics and their staff members may not receive any free gifts, nonscientific literature, materials, equipment, money or support for breastfeeding education or events from manufacturers or distributors of breastmilk substitutes, bottles, nipples or pacifiers.

D. **Have a written breastfeeding policy that is routinely communicated to staff and parents.**

1. The Perinatal Leadership Team (Director, Managers, Supervisors, and Clinical Nurse Educator) is responsible for the development, implementation, evaluation and revision of a written breastfeeding policy. This policy is posted on the StarNet and accessible to all staff at Salinas Valley Health Medical Center (SVHMC) and any affiliated prenatal clinics.

2. All direct care staff and direct care providers that provide prenatal, delivery and/or

newborn care will receive appropriate orientation to the implementation of this policy within the first 12 weeks after hiring. Staff will be expected to read and sign off on the policy. Minimally every 2 years, to sustain safe and effective care, policy reviews/updates will be procided to direct care staff and direct care providers. Changes to the policy will be reviewed with all staff at staff meetings, through email and prior to the implementation of the revisions.

3. SVHMC will maintain a multidiscplinary Breastfeeding Task Force that will meet a minimum of quarterly to assess implementation of the policy and determine how often to assess institutional compliance with the policy. Committee members will define actions needed to remain compliant with the policy and Baby-Friendly USA criteria for evaluation.

E. **Establish ongoing monitoring and data-management systems.**

1. A mechanism for data collection directed to routinely track breastfeeding and mother-infant care indicators and policy implementation will be in place to continually monitor and improve quality of perinatal care. Incorporation of breastfeeding indicators into the facility quality-improvement monitoring system is mandated. The multidisciplinary Breastfeeding Task Force meet at least every 6 months, or more frequently when the data indicates practices are below the expected metrics, to review monitored data.

F. **Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.**

1. The Lactation Program Supervisor, with support from the Director of Women and Childrens' Services, perinatal managers, and educators, is responsible for the development and oversight of the *Direct Care Staff and Direct Care Provider Competency Verification and Training Plan.* The Perinatal Leadership team is responsible for implementing and assuring that all relevant staff in the perinatal units and affiliated prenatal clinics are educated and trained in breastfeeding and lactation management. All staff and providers who assist mothers with infant feeding will have sufficient knowledge, competence and skills in the 16 competencies listed in the Baby-Friendly USA Guidelines and Evaluation Criteria - Step 2, Table 1.
2. All direct care staff/direct care providers who provide education, assessment, support, intervention, assistance and/or follow-up with regards to infant feeding within the affiliated prenatal services will have sufficient knowledge, competence and skills in the *Direct Care Staff and Direct Care Provider Competency Verification and Training Plan.*
3. Staff competency in the critical areas identified in the most current version of the US Baby-Friendly Guidelines and Evaluation Criteria will be verified upon hire and annually.
4. All providers with privileges will receive education and training on the benefits of exclusive breastfeeding, physiology of lactation, how their specific fields of practice impact lactation, and how to find out about safe medications for use during lactation.
5. All staff and providers will be trained within 6 months of hire and this education will

be documented in the employee lactation education file. Documentation of training and competency verification will be maintained by the Lactation Program Supervisor.

6. The Lactation Department will provide annual updates to support continuing education of breastfeeding, incorporating new evidence and areas of identified opportunity/improvement.

G. **Discuss the importance and management of breastfeeding with pregnant women and their families.**

1. SVHMC and affiliated prenatal clinics will foster programs that make education about breastfeeding available to pregnant women whom the facility and clinics provides services. Pregnant women and their support persons (as appropriate) will be educated on the following:
    a. Breastfeeding
        i. The importance of breastfeeding (including a discussion on the importance of direct breastfeeding, as needed)
        ii. Global recommendations for breastfeeding including: exclusive breastfeeding for the first 6 months, the risks of giving formula or other breast-milk substitutes, breastfeeding continues to be important after 6 months when other foods are given.
        iii. The basics of good positioning and attachment
        iv. Recognition of feeding cues
    b. Birth Practices:
        i. The importance of immediate and sustained skin-to-skin contact
        ii. The importance of early initiation of breastfeeding
        iii. The importance of rooming-in.
    c. US Recommended Prenatal Discussion Topics for Anticipatory Guidance include:
        i. Non-pharmacological pain relief during labor
        ii. Creating a safe sleep environment:
            a. Along with the importance of rooming-in, staff should discuss how to create a safe sleep environment while rooming-in at the hospital. Narcotic-induced sleepiness, hormonally driven sleepiness and fatigue are all factors that mothers should be aware of while rooming-in at the hospital.
            b. Risk reduction strategies for SIDS after leaving the hospital including the importance of removing suffocation hazards from the breastfeeding environment and defining hazardous circumstances
        iii. How to have an abundant milk supply

iv. How to prevent sore nipples

v. How to prevent or minimize engorgement after birth

vi. Availability of community resources with staff properly trained to assist with breastfeeding assessment and management

vii. A brief conversation to discuss details about feeding a premature, low birthweight or sick baby that might need to be admitted to the NICU

2. Mothers will be encouraged to exclusively breastfeed unless medically contraindicated. Exclusively breastfed newborns will receive no other liquids or solids with the exception of oral medications prescribed by a medical care provider.
3. SVHMC promotes breastfeeding in the following ways:
    a. Pregnant women will be offered prenatal breastfeeding classes at this facility. The curriculum which includes the key teaching points listed in the current version of the US Baby-Friendly *Guidelines and Evaluation Criteria*. These prenatal breastfeeding classes will not include discussion about the use of formula or infant feeding bottles.
    b. The Lactation Department is responsible for developing, evaluation, and revising a curriculum for breastfeeding education for women receiving prenatal services. The curriculum will include all the required topics identified in the most current version of the US Baby-Friendly *Guidelines and Evaluation Criteria*. A schedule for delivery of this information, beginning in the first trimester, is identified in the curriculum. The providers at Taylor Farms Family Health & Wellness Center are responsible for implementing the education, and documenting the education in the patient's EHR.
    c. The staff at this facility and the affiliated clinic does not distribute to pregnant women educational materials that contain product names, images, or logos of infant formula foods, bottles, feeding devices and other related items.
    d. All affiliated and non-affiliated clinics will be provided with breastfeeding booklets titled, *You & Your Baby*, for all pregnant women. The booklet describes the practices at this facility that support optimal maternity care and infant feeding, including skin-to-skin care and rooming-in. The Lactation Department will be responsible for designing, evaluating, revising the booklet. The booklet will not contain education on the use of formula or infant feeding bottles.
    e. Lactation Department staff members from this facility regularly attend local breastfeeding coalition meetings and collaborate with community-based programs and agencies. The responsibility of staff members who attend these meeting is to develop a relationship with local individuals and organizations that offer prenatal and postpartum breastfeeding education and support, and to coordinate breastfeeding messages with others in the community. It is also the responsibility of the staff to identify prenatal and

postpartum breastfeeding support needs in the community and encourage the development of services to meet these needs. Staff members report highlights of coalition meetings at this facility's perinatal staff meetings.

4. Upon admission to this facility, the admitting nurse will ask the mother about her feeding decision for her infant. If the mother states her intention is to breastfeed her infant, the mother's medical history will be assessed to identify any possible contraindications to breastfeeding. Contraindications to breastfeeding are listed in Attachment B (Supplementation – Medically Acceptable Reasons), which is updated based on the current recommendation of the authorities referenced in the policy. If a contraindication to breastfeeding is identified in the mother's medical history, the mother will be counseled appropriately on her feeding options. The contraindication to breastfeeding and education will be documented in the mother's EHR.
5. If the mother states that her intention is to feed her infant formula, the nurse will talk with the mother to ensure that she has been informed of the benefits of breastfeeding. The nurse will give the mother the opportunity to express her concerns and ask questions about breastfeeding. If, after the discussion, the mother's decision is to feed her infant formula, her decision and the education will be documented by the nurse.

H. **Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.**

1. To facilitate mother-infant bonding, to ensure best practices for breastfeeding support, and to safely transition the infant from intrauterine life, all mothers and infants, regardless of infant feeding method, will be placed in skin-to-skin care after birth. For skin-to-skin care, the infant is placed prone on the mother's chest or abdomen, wearing only a hat and a diaper. The mother will have no clothing between herself and the infant, and there will be no towel or blanket between the mother and infant to disrupt skin-to-skin contact. The infant should be able to access the mother's breasts or no interference from clothing such as a bra or gown. A warm blanket may be placed over the infant and mother once the infant is place skin-to-skin.
2. The primary RN has the responsibility to create the optimal environment for transition of the infant and initiation of the first breastfeeding. This encompasses placing the infant skin-to-skin with the mother immediately after birth, assisting the mother to recognize infant signs of feeding readiness, and allowing the infant to self-attach to the breast.
3. Monitoring of the infant's position and airway should be ongoing throughout skin-to-skin care. To ensure infant safety, the RAPP (respiratory, activity, perfusion and position) assessment will be done every 15 minutes and documented in the infant's EHR.
4. In the case of vaginal birth, the stable infant should be dried and immediately placed skin-to-skin with the mother. In the case of cesarean birth, the stable infant should be placed skin-to-skin with the mother as soon as she is able to respond to her infant.
5. The initial period of skin-to-skin contact will continue uninterrupted for at least 1

hour and through the completion of the first feeding (if breastfeeding), or for at least one hour if not breastfeeding, unless there are documented medically justifiable reasons to interrupt contact. Skin-to-skin contact should continue as long as the mother desires and is feasible for the infant. After the initial period of skin-to-skin contact, mothers should be encouraged to continue this type of care for their infants as much as possible during their hospital stay. Parents will be given education on practicing skin-to-skin care safely.

6. During the initial period of skin-to-skin contact, routine newborn procedures should be postponed until the first breastfeeding has been completed. Monitoring and assessments should be performed while the infant is skin-to-skin with the mother.
7. Unless the mother or infant is medically unstable or the mother declines, all infants should be placed in skin-to-skin contact with their mothers. When a delay of initial skin-to-skin care has occurred, staff should ensure that skin-to-skin care is initiated as soon as medically possible.
8. When it is necessary for an infant to be admitted to the NICU, the nursing staff should educate the mother regarding the importance of skin-to-skin care for her infant and support the implementation of skin-to-skin care as soon as is medically possible.
9. The time that skin-to-skin care begins and ends will be documented in the infant's EHR. If there is a medical contraindication to skin-to-skin care, or the mother refuses skin-to-skin care, this will be documented.

I. **Support mothers to initiate and maintain breastfeeding and manage common difficulties.**

1. The RN caring for the mother-infant couplet is responsible for observing and assessing as many breastfeeds as possible. At least 2 breastfeeds per 12-hour shift or 1 breastfeed per 8-hour shift will be assessed by the RN and documented in the infant's EHR
2. The RN will utilize the assessment time to educate mothers on feeding cues, correct positioning and latch, and signs of an effective feeding. All mothers and infants should be assessed for risk factors for breastfeeding difficulties. Couplets considered "at risk" may need additional assessment and monitoring. A lactation consultation referral should be ordered for all "at risk" couplets.
3. All breastfeeding mothers should be taught by a staff nurse manual expression of breastmilk and the importance of exclusive breastfeeding, how to accomplish exclusivity for the first 6 months, and signs and symptoms of feeding issues that require referral to a health care provider or lactation consultant. Mother will also be educated about how the use of pacifiers, bottles and artificial nipples may interfere with the development of optimal breastfeeding. All of this teaching will be documented in the EHR.
4. Education will be provided to the mother and includes, but is not limited to:
    a. Milk production and release
    b. Frequency of feeding on demand (a minimum of 8-12 feedings in 24 hours)
    c. Proper positioning and latch on

d. The importance of physical contact and bonding during breastfeeding
e. Effectiveness of feeding and signs of milk transfer
f. Preventative management of common problems such as engorgement, sore and cracked nipples
g. Manual expression
h. Handling and storage of expressed breastmilk
i. How to maintain lactation if separated from the infant
j. Maintenance of breastfeeding for the first 6 months
k. Signs/symptoms of infant feeding issues requiring referral to a qualified healthcare provider

5. To support optimal nutrition for the infant and optimal breastmilk production for the mother, special consideration must be taken in the case where the infant is not adequately transferring milk or must be separated from the mother. In the case of inadequate milk transfer, the mother-infant couplet will be assessed individually by the primary RN, lactation staff or healthcare professional for the need of supplementation on the part of the infant or breast stimulation on the part of the mother. When there is evidence that the infant will not be meeting normal newborn feeding expectations, manual expression or pumping will be initiated as soon as this evidence presents itself, and the mother's expressed milk will be offered to the infant, unless medically contraindicated.
6. In the case where it is necessary for the infant to be admitted to the NICU or transferred to another facility, breastfeeding mothers will be taught to express their milk as soon as possible, at least within 6 hours from the time of delivery. The teaching by the nurse will include the frequency with which the mother needs to express her milk as well as how to properly store and handle breastmilk.
7. SVHMC supports safe and adequate nutrition for any infant, regardless of the infant's feeding method. For any infant who is fed formula, regardless of the reason, the mother will be given written instruction (Bottle-Feeding Your Baby handout) and verbal information on safe formula preparation, including appropriate hygiene, cleaning of utensils and equipment, appropriate reconstitution, accuracy of measurement of ingredients, handling, storage, appropriate feeding methods, and that powdered infant formula is not sterile. Safe preparation, feeding, and storage of formula instruction must follow the recommendations of leading international and national authorities. This information will be given on an individual basis to women who are feeding their infants formula. Education given to the mother will be documented in the infant's EHR.

J. **Do not provide breastfed newborns any food or fluids other than breastmilk, unless medically indicated.**

1. When a mother requests her infant be supplemented with formula, staff will empower the mother's informed decision by listening to her specific concerns and personalizing the conversation to explore the challenges and answer any concerns regarding the following evidence-based information: importance of exclusive

breastfeeding and possible risk factors that could influence health outcomes with the introduction of breast-milk substitutes including the possible impact to the success of breastfeeding. As appropriate, options will be offered specific to her concerns. The mother will be given written information (*Supplementing Breast Milk WIth Formula* (risks associated with formula and benefits of breast milk) and the CDC handout *How to Prepare and Store Powedered Infant Formula (*for formula use outside the hospital setting). and taught the negative consequences of feeding an infant formula. This education will be documented. If the mother decides to feed her infant formula after receiving education, her choice will be supported by the staff and documented in the EHR.

2. Formula will be stored in a secure location in all perinatal units and distribution will be monitored. Formula will not be placed in or around the breastfeeding infant's bassinet or in the mother's room.
3. Infants will not be supplemented with infant formula without a medical indication or maternal request. Medical indications to supplement a breastfeeding infant are listed in Attachment B (Supplementation – Medically Acceptable Reasons), which is updated based on the current recommendations from the Academy of Breastfeeding Medicine (ABM), American Academy of Pediatrics (AAP), and the Centers for Disease Control and Prevention (CDC).
4. It is expected that all staff and providers adhere to this protocol with attachments when considering administering a breastmilk substitute to a breastfeeding infant. If it is determined that an infant should be supplemented, there must be a written medical indication for the supplementation and a provider order for formula in the EHR (except in cases where the mother has requested supplementation).
5. Staff will provide anticipatory guidance regarding preventative steps to minimize engorgement to mothers who are planning to exclusively formula feed. Education will be given to parents regarding sighs/symptoms of infant feeding issues that would require referral to a qualified provider. This education will be documented in the EHR.

K. **Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.**

1. All mother-infant couplets will practice rooming-in, regardless of infant feeding method. Rooming-in is defined as keeping the infant in the mother's room 24-hours a day. As is appropriate, all routine newborn procedures should be performed at the mother's beside. If procedures require separation of the mother and infant, the maximum allowable time for separation in any 24-hours period is 1 hour, unless there is a:
    a. medically justifiable reason for a longer separation or,
    b. safety-related reason for a longer separation or,
    c. an informed decision (maternal request for separation).
2. Healthy mother-infant couplets are safest when kept together and cared for as a unit however safe rooming-in information should be given to mother and family. The RN needs to be aware of patient safety concerns such as infant falls. The RN will

complete the maternal fall risk assessment and monitor higher risk couplets more frequently, especially at night or in early morning hours or if mother is alone with infant. The RN will review safety precautions and equipment with mother and family including the call system, bed and how to contact staff directly with any issues or concerns.

3. Any separation of the mother and infant will be documented in the infant's EHR. Documentation will include the time the separation began and ended, the reason for the separation, and the location of the infant during separation.
4. If the mother requests infant to be removed from her room, staff will explore the reason and educate mother/family regarding the benefits of keeping infant in close proximity. If the mother still requests after informed decision the infant will be returned to mother for exclusivity of breastfeeding when showing feeding cues. Informed mother decisions will be honored and documented in the EHR.

L. **Support mothers to recognize and respond to their infants' cues for feeding.**

1. Mothers will be encouraged to breastfeed on demand or when the baby exhibits hunger cues or signals. Mothers will be educated as to these feeding readiness cues (increased alertness/activity, mouthing, or rooting) to be used as indicator of infant's readiness for feeding.
2. No staff member will place any limitation on how often or how long mothers should breastfeed. Mothers and support persons will be educated that infants breastfeed approximately 8 to 12 times in 24 hours and not on a timed schedule. The nurse will discuss the normality of cluster feeding with mothers.
3. Encouraged breastfeeding ad libitum and on demand. For preterm infants on the postpartum unit that are not displaying hunger cues, it may be necessary to wake the infant if he or she does not indicate hunger cures within 4 hours of the previous feed, which is not unusual in the late preterm infant.
4. Education will be provided to the mother and includes, but is not limited to:
    a. Recognition of feeding cues to initiate feedings
    b. Normal newborn feeding expectations
    c. No limits on how often or how long infants should be fed

M. **Counsel mothers on the use and risks of feeding bottles, artificial nipples, and pacifiers.**

1. For all mothers whose breastfeeding infants receive formula, whether for reason of the mother's request or for a medical indication, staff will avoid the routine use of artificial nipple and infant feeding bottles. The mother will have feeding options discussed with her, and she will be taught by the nurse how to use an alternative feeding method of her choice. The supplemental feeding methods used by SVHMC include cup, spoon, Supplemental Nursing System (SNS) and syringe feeding. The education will be documented in the infant's EHR.
2. If a mother requests that her infant be supplemented using an artificial nipple, the nurse will educate her on the possible negative effects on the success of breastfeeding, and will document the education. The mother will be encouraged to use an alternative feeding method.

3. In accordance with evidence-based best practices for optimal breastfeeding outcomes, the staff in Labor & Delivery and Mother-Baby will not routinely distribute pacifiers to breastfeeding couplets. If a breastfeeding mother requests that her infant be given a pacifier, the mother will be counseled by the nurse regarding her concerns and reasons for this request, address the concerns raised, educate her on the possible consequences to the success of breastfeeding, help with any breastfeeding problems, discuss alternative methods for soothing her infant and the appropriate time to introduce a pacifier, once breastfeeding is well established. The nurse will document this education and the mother's decision.
4. If a mother brings in a pacifier for her infant to use, the staff will educate her about the possible negative consequences of pacifier use until breastfeeding is well established.
5. When an infant must undergo a painful medical procedure, a pacifier may be used for pain management. The use of a pacifier for pain management will be discussed with the mother prior to the procedure. The pacifier will be disposed of following the procedure and before the infant is returned to the mother's room.
6. In support of the International Code of Marketing of Breastmilk Substitutes, SVHMC does not accept free or subsidize breastmilk substitutes, infant feeding bottles, or other infant feeding supplies. All of these items are purchased at fair market price.

N. **Coordinate discharge so that parents and their infants have timely access to ongoing support and care.**

1. Prior to discharge, the RN caring for the mother-infant couplet will provide the mother with information on postpartum breastfeeding support services available to her from this facility and in the community.
2. All mothers will be provided with instruction to schedule a visit within 3-5 days of birth and within 48 hours to 72 hours after discharge with a skilled professional to evaluate feeding and jaundice.
3. Staff will provide written breastfeeding information and education so that mothers are be able to recognize maternal and infant warning signs that must receive urgent evaluation along with contact information for health professionals.
    a. Infant: unsually not waking for more than 4 hours or, always awake or, never seeming satisfied or, mother than 12 feeds per day, or no signs of swallowing with at least every 3-4 sucks, too few wet/heavy or soiled diapers per day, fever.
    b. Mother: persistent painful latch or, breast lumps, breast pain, fever, doubts with milk production, aversion to the child, profound sadness and any doubt with breastfeeding self-efficacy.
4. For preterm or at-risk infants begin cared for on the postpartum unit: if the infant is still not latching or feeding well at the time of discharge, a written individualized feeding plan will be devised and depending on the dyad's clinical situation and resources, the infant's discharge may be delayed. Whenever needed, a visit for specifically following up on feeding issues will be arranged. The feeding plan and interventions will be documented in the EHR.

5. Mothers identified prenatally or soon after delivery, as at risk of delayed lactogenesis II, a lactation consultation will be entered as deemed appropriate. A feeding plan and close follow-up of the infant (for adequate hydration and nutrional besides help with expression) will be offered. At discharge, continuum of care will be ensured with a written feeding plan and close follow-up.
6. The Lactation Department staff will be responsible for attending the area breastfeeding coalition meetings in order to stay current with available postpartum breastfeeding resources. They will compile a list of resources that is available for staff to share with mothers. The resources will be updated regularly and shared on the Lactation Board.
7. As representatives of the hospital, those attending coalition meetings will be expected to participate in activities that assess community postpartum breastfeeding support needs, discover what breastfeeding support groups are available to mothers, and encouraged development of breastfeeding support services when needs are identified. By becoming familiar with the support services available to postpartum breastfeeding mothers in the community, those who attend coalition meetings will serve as a resource for recommending appropriate breastfeeding services to mothers and healthcare providers when specific needs arise.

V. PROCEDURE

A. Equipment- N/A

B. Set-up

1. Standard Precautions
2. Breastfeeding mothers will be instructed about:
    a. The benefits of breastfeeding;
    b. The importance of exclusive breastfeeding/breastmilk;
    c. Infant feeding cues;
    d. Proper positioning and latch-on;
    e. Suck and swallow patterns;
    f. Milk production, release and how to assess milk transfer;
    g. Frequency and duration of feeding and feeding cues. No restrictions are placed on mother's regarding frequency and duration of breastfeeding.
    h. Hand expression of breast milk and the use of an electric breast pump if indicated.
    i. Mothers will be encouraged to exclusively breastfeed unless medically contraindicated for the first six months of life and continue as solids are introduced.
    j. No supplemental formula will be given unless specifically ordered by a physician or by mother's documented request: See Attachment B (Supplementation – Medically Acceptable Reasons)

C. Operation

1. Explain breastfeeding management and benefits of breastfeeding to mother (parents).
2. Initiating skin-to-skin and breastfeeding
3. Assessment of the infant's latch and suck at the breast.
    a. Infant's head should be aligned with his/her body. The body is correctly aligned with an imaginary line from the infant's ear to shoulder to iliac crest, "tummy-to-tummy" position.
    b. Mother's hand is supporting her breast with a cupped hand, "C" hold, well back from areola during breastfeeding. *The mother does not have to support her breast throughout the feeding if it is comfortable for her and her infant. *No mother should be instructed to place her finger on her breast by the infant's nose. Assess an appropriate position so that the infant can breathe freely and mother recognizes that the infant is breathing while the infant is breastfeeding.
    c. Assess for proper grasp of areola and suckling by the newborn.
        a. Infant's mouth is opened wide and lips are flanged and visible, not pursed and hidden.
        b. Infant's checks are full, not puckering in.
        c. A complete seal is formed by infant's mouth. It is normal for the infant to take time to learn to breastfeed correctly.
        d. Approximately ½ inch of the areola tissue behind the nipple is in the infant's mouth with appropriate latch-on.
        e. Correct suckling is quiet, no clicking or smacking sounds should be heard.
        f. Adequate milk transfer during the feeding is noted by audible swallowing.

D. Education to mother/family

1. Mother and family will be encouraged to utilize education materials, hospital television presentations, and unit resources (lactation service referral, education handouts) as appropriate.
2. If a feeding at the breast is incomplete or ineffective, the mother should be instructed to begin regular hand expression of her breast milk with assistance by a staff member. The colostrum obtained by expression will be given to the baby.
3. Provide educational materials and community resources to mother/family upon discharge (unit care booklet, community breastfeeding resource guide, SVHMC Lactation Services contact information, and other breastfeeding handouts as appropriate).
4. Recommendation for a routine follow-up visit with the health care provider in 2-4 days is reviewed with all parents.

E. Documentation:
    1. Document feedings in the Newborn Feeding Assessment screen in the infant's EHR.
    2. Infants admitted to the NICU, feedings are documented in the NICU Feeding Assessment screen.
    3. When applicable the RN will chart a nurse's note to further explain the feeding assessment or interventions used during the breastfeeding session.
    4. RN will document any reason/request for bottle, nipple or pacifier use for the breastfed infant in appropriate areas in the infant EHR and teaching materials will be utilized.

F. Order entry:
    A. Lactation consultant service referral.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Academy of Breastfeeding Medicine Clinical Protocol #7: Model Maternity Policy Supportive of Breastfeeding. (2018). *Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine,* 13(9) 559-574, doi: 10.1089/bfm.2018.29110.mha

B. American Academy of Pediatrics. (2022). Policy statement: Breastfeeding and the use of human milk.*Pediatrics.* 150(1), e2022057988, doi: 10.1542/peds.2022-057988

C. Baby-Friendly USA, Inc. (2021). Guidelines and evaluation criteria for facilities seeking Baby-Friendly designation. 6th ed. Albany, NY: Baby-Friendly USA

D. Centers for Disease Control and Prevention (CDC). (2025). Contraindication to breastfeeding or feeding expressed breastmilk to infants. CDC Website. https://www.cdc.gov/breastfeeding-special-circumstances/hcp/contraindications/index.html#print

E. Lawrence, R.A. and Lawrence, R.M. (2022) *Breastfeeding: A Guide for the medical profession.* 9th ed. Philadelphia, PA: Elsevier Mosby.

Attachments

A - Triggers for Lactation Consultation - Breastfeeding the Newborn.docx

B - Supplementation – Medically Acceptable Reasons - Breastfeeding the Newborn.docx

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Women's & Children's Service Line	Katherine DeSalvo: Director Medical Staff Services	06/2025
CNO	Carla Spencer: Chief Nursing Officer	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	Julie Vasher: Director Women's & Children's Services	05/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18059183

Origination	N/A	Owner	Jessica Graziano: Manager Rehab Services
Last Approved	N/A	Area	Rehabilitation
Next Review	3 years after approval		

Complete Decongestive Therapy for Management of Lymphedema

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in providing Complete Decongestive Therapy for the management of Lymphedema.

III. DEFINITIONS

A. PT: Physical Therapist

B. OT: Occupational Therapist

C. MLD: Manual Lymphatic Drainage

D. RN: Nurse

E. CDT: Complete Decongestive Therapy

IV. GENERAL INFORMATION

A. Lymphedema bandaging is a multilayer system of short stretch, non-elastic pure cotton bandages, which are applied over padding to create compression and comfort around the circumference of the involved area.

B. The therapeutic effects of bandaging in the treatment of Lymphedema are;

1. A reduction in the return of lymph to the involved area once mobilized by MLD
2. A reduction in the production of new lymph via ultra-filtration by increasing tissue pressure

3. An increase in re-absorption of other lymphatic loads by increasing tissue pressure
4. An improvement in the efficiency of the muscle and joint pumps as a lymph propellant
5. A mechanical manipulation and improvement in lymphatic fibrosis as movement is performed.

C. PTs and OTs performing CDT and/ or applying multilayer bandaging for lymphedema management as long as the following criteria are met;
    1. An order from the patient's physician is in the medical records
    2. The patient meets the "indications" criteria and clinical assessment does not show evidence of contraindications.

D. The PT and/or OT has received training and education in this process and their certificaton/ training has been documented.

V. PROCEDURE

A. Clinicians providing CDT therapy for patients will follow Evidence based practice

B. Patients being managed and monitored for any evidence of excessive compression (e.g. pallor or cyanosis of toes, complaints of pain, diminished sensation). Patients and/or family members will be educated on these signs/ symptoms as well. If sign/symptoms present, the bandages will be removed promptly

C. The bandaging will be changed as needed per therapists' protocol.

D. Patients will be assessed by the therapists as to whether they benefit from application.
    1. Precautions
        a. Hypertension
        b. Mild Arterial Disease
        c. Limb paralysis
        d. Diabetes
        e. History of Congestive Heart Failure (Seek physician approval)
    2. Contraindications
        a. Acute Infections
        b. Cardiac Edema
        c. Acute Deep Venous Thrombosis
        d. Uncontrolled Hypertension
        e. Advanced arterial disease
        f. Malignancy
        g. Renal Disease

E. Documentation (This will be at the end of the procedure and if there is no specific

documentation then type N/A)

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Tzani I, Tsichlaki M, Zerva E, Papathanasiou G, Dimakakos E. Physiotherapeutic rehabilitation of lymphedema: State-of-the-art. Lymphology. 2018 Jul 2;51(1):1-2.

B. Executive Committee. The diagnosis and treatment of peripheral lymphedema: 2016 consensus document of the International Society of Lymphology. Lymphology. 2016 Mar 21;49(4):170-84.

C. Michopoulos E, Papathanasiou G, Vasilopoulos G, Polikandrioti M, Dimakakos E. Effectiveness and Safety of Complete Decongestive Therapy of Phase I: A Lymphedema Treatment Study in the Greek Population. Cureus. 2020 Jul 19;12(7).

D. Cohen SR, Payne DK, Tunkel RS. Lymphedema: strategies for management. Cancer: Interdisciplinary International Journal of the American Cancer Society. 2001 Aug 15;92(S4):980-7.

E. Norton School of Lymphedema Course Manual for Manual Lymph Drainage/ CDT certification Training 2004-2013

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Rehab Medical Director	Katherine DeSalvo: Director Medical Staff Services	07/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	Jessica Graziano: Manager Rehab Services	05/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18180445

Origination	07/2019	Owner	Daniela Jago: Clinical Manager
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Contraction Stress Test

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To direct nursing in preparation and administration of the oxytocin challenge test.

III. DEFINITIONS

A. Tachysystole – More than five uterine contractions in a ten minute period averaged over 30 minutes.

IV. GENERAL INFORMATION

A. Relative Contraindications:
   1. Preterm labor
   2. Pregnancies associated with a high risk of preterm labor
   3. Preterm premature rupture of membranes
   4. History of classical uterine scar
   5. Known placenta previa

V. PROCEDURE

A. Witness patient signature on consent for contraction stress test

B. Assess and document vital signs.

C. Evaluate fetal heart rate tracing for 10-20 minutes or perform an NST as ordered. If at least three (3) contractions lasting >40 seconds are present in a ten (10) minute period, uterine

stimulation is not necessary. Proceed to interpretation of the test.

D. If contractions are not present, initiate the oxytocin challenge test.

E. Initiate an IV mainline electrolyte solution infusion per physician order.

F. Initiate oxytocin (20 units in 1000ml) via a secondary IV line using an infusion pump. This secondary line should be connected to the most proximal port (to the patient) of the primary line.

G. Initiate infusion at 0.5-1.0 Mu/min. At 15-20 minute intervals the dose may be doubled until there is adequate uterine activity, max dose 20 Mu/Min. Note the difference in titration between this protocol and the oxytocin induction/augmentation protocol.

H. In the event of uterine tachysystole, oxytocin should be reduced or discontinued immediately, and the physician notified. If a Category II tracing with heightened concern is present, initiate intrauterine resuscitation measures and notify physician.

I. When there are three (3) adequate contractions in a ten (10) minute period, discontinue oxytocin infusion and proceed to interpretation of the test. Continue monitoring with the mainline IV at TKO for at least one hour, or until contractions cease.

J. If fetal heart rate decelerations occur in the presence of tachysystole, retesting is appropriate to ensure a correct interpretation.

- Interpretation of the oxytocin challenge test:
    1. **NEGATIVE**: No late or significant variable decelerations.
    2. **POSITIVE**: Late decelerations are identified with 50% or more of contractions, even if the contraction frequency is less than three in 10 minutes.
    3. **EQUIVOCAL**: Intermittent late (late decelerations with fewer than 50% of contractions) or significant variable decelerations.
    4. **UNSATISFACTORY**: Fewer than three contractions within 10 minutes or a tracing that cannot be interpreted.

K. Notify physician of test results.

L. Documentation:
    1. Fetal heart rate monitoring assessment
    2. Results of oxytocin challenge test
    3. Communication with physician

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2017). *Guidelines for perinatal care* (8th ed). Elk Grove, IL: Authors.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Chair Dep OBGYN	Katherine DeSalvo: Director Medical Staff Services	06/2025
CNO	Carla Spencer: Chief Nursing Officer	06/2025
WCS Director	Julie Vasher: Director Women's & Children's Services	06/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2025
Policy Owner	Daniela Jago: Clinical Manager	06/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17392173

Origination	03/2022	Owner	Daniela Jago: Clinical Manager
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Cord Blood Specimen Collection for pH Analysis

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide nursing staff in obtaining umbilical cord blood and proper handling for pH analysis.

III. DEFINITIONS

A. ABG – arterial blood gas

B. TBB – To be born

C. RCP – Respiratory Care Provider

IV. GENERAL INFORMATION

A. The Physician obtains the cord segment for cord blood analysis. The RN sends the specimen to NICU RCP for analysis.

V. PROCEDURE

A. **Equipment**

1. Two (2) 1 ml Arterial Blood Sample Syringes
2. Two (2) 1.5 inch 22 gauge needles
3. Labels with patient's appropriate identification information (with a baby or TBB label only; one marked for venous and one for arterial specimens). See LABELING OF SPECIMENS and PATIENT IDENTIFICATION POLICY policies.
4. Specimen biohazard bag

5. Cup of crushed ice

B. **Obtaining Specimen**

1. An order must be initiated in the electronic health record (EHR) before RCP is contacted in order to analyze samples
2. Identify the umbilical artery and the umbilical vein. In the cord the vein is the larger of the two. Usually a sample is drawn from the umbilical vein in one syringe and another sample from the umbilical artery in a different syringe. Be sure the syringes contain heparin. This will prevent the blood from clotting.
3. Grasp one end of the umbilical cord with your non-dominant hand to prevent it from moving. With the dominant hand, hold the syringe between the thumb, the index finger and the middle finger, similar to how you would hold a pencil.
4. Insert the needle into the umbilical vein slowly at a 45-degree angle. Be careful to avoid going completely through the vein. Pull back slowly on the syringe to allow it to fill with blood. Obtain the required amount of blood according to hospital policy and remove the needle from the umbilical cord.
5. Remove the needle from the syringe and push any air bubbles out of the syringe. The sample and self-contained pre-heparinized syringes should be, appropriately capped and rolled/rotated between the handler's palms to mix the contents of the syringe
6. Bubbles can interfere with accurate results if they are left in the sample. Place a cap on the syringe to prevent the blood from spilling out. Label the syringe according to hospital polices LABELING OF SPECIMENS . Be sure to indicate on the label the sample is from the umbilical vein. Repeat the same procedure in step four on the umbilical artery and label the sample accordingly.
7. Samples should be labeled (with a baby or TBB label- not the mother's label) and placed inside biohazard bag; the bag should be sealed to maintain a dry environment for label identification and scanning
8. Acquire a container filled with ice (e.g. cup, a second biohazard bag, or etc.) and completely submerge the sealed bag containing the samples
9. The sample should be delivered to the NICU to the countertop where the Unit Clerk and/or Charge RN is stationed and RCP should be contacted at extension 5685 by the Labor & Delivery RN.

C. **Documentation**

1. Document collected cord gas and results reported in EHR.

VI. EDUCATION/TRAINING:

A. Education and/or training is provided as needed

VII. REFERENCES

A. American Academy of Pediatrics American College of Obstetricians and Gynecologists, (2017). *Guidelines for Perinatal Care*, (8th ed.), Washington, DC.

B. Simpson, K.R., Creehan, P.A., Obrien-Abel, N., Roth, C., Rohan, A. (2021). Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) *Perinatal Nursing*, (5th Ed.) Philadelphia: Lippincott-Raven.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	06/2025
Women's & Children's Service Line	Katherine DeSalvo: Director Medical Staff Services	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Daniela Jago: Clinical Manager	02/2025

Standards

No standards are associated with this document

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Origination	06/2022	Owner	Daniela Jago: Clinical Manager
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Fetal Heart Rate Monitoring

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in the management of antepartum/intrapartum patients requiring electronic fetal heart rate monitoring.

III. DEFINITIONS

A. NICHD – National Institute for Child Health and Human Development.

IV. GENERAL INFORMATION

A. Registered nurses and physicians who have demonstrated competency in electronic fetal monitoring may initiate and evaluate the ongoing use of EFM (electronic fetal monitoring) in the care of intrapartum and antepartum patients.

B. All registered nurses and physicians with obstetrical privileges who will use EFM in the care of their patients will initially complete a course of study that includes the physiologic interpretation of EFM data and its implications for labor support. This course will include both cognitive and psychomotor skill validation of standardized core competencies used in auscultation, electronic monitoring of the fetal heart rate (FHR) and evaluation of uterine activity. Registered nurses and Physicians with obstetrical privileges who utilize EFM in the care of their patients must participate and complete educational programs within three (3) months of hire or placement on the medical staff. Registered nurses and physicians with obstetrical privileges will also participate in competency maintenance activities as designated.

C. Nurses are responsible for timely communication and collaboration with the physician regarding fetal and maternal status during the use of EFM to ensure that Category II or Category III patterns are managed appropriately.

D. Communication between physicians and nurses will utilize NICHD terminology for standardization of nomenclature for fetal heart rate monitoring and clinical interpretation of FHR tracings.

E. ***Methods***

1. Patients will be monitored by a method that is appropriate to evaluate fetal status and uterine activity, based on gestational age and risk status.
2. Intermittent auscultation during the intrapartum period is encouraged for those patients considered low risk. Low risk includes:
    a. No meconium staining, intrapartum bleeding, or abnormal or undertermined fetal test results
    b. No known risk factors that could increase risk of fetal acidemia during labor (eg, congenital anomalies, intrauterine growth restriction)
    c. No marternal condition that may affect fetal well-being (eg, prior cesarean scar, diabetes, hypertension)
    d. No requirement for oxytocin induction or augmentation of labor
3. Five components will be assessed and documented at each evaluation. These include: baseline rate; baseline variability; presence of accelerations; presence of periodic or episodic decelerations; uterine activity: frequency, duration, intensity and resting tone.
4. A registered nurse who has successfully completed the Fetal Scalp Electrode competency may initiate a fetal scalp electrode for internal monitoring of the fetal heart rate. Registered nurses will be eligible to complete the competency for Fetal Scalp Electrode after six months of continuous nursing care in labor and delivery. However, all registered nurses who have completed the fetal monitoring competency may monitor the intrapartum use of the fetal scalp electrode utilizing appropriate standards of care.
5. Paper fetal heart rate tracings will run only in the event of loss of use of electronic recording and/or downtime. If paper fetal heart rate tracings are used, appropriately label fetal heart rate tracing and place in designated envelope and place in chart.
6. A physician may insert an intrauterine pressure catheter (IUPC) for internal monitoring of uterine activity. However, all registered nurses who have completed the fetal monitoring competency may monitor the intrapartum use of the IUPC utilizing appropriate standards of care.

V. PROCEDURE

A. **Intrapartum Monitoring Assessment and Documentation**

Assess FHR before	Assess FHR after
Amniotomy	Admission of patient
Ambulation	AROM or SROM
Administration of medications	Vaginal exam

Administration of analgesia	Ambulation
Transfer or discharge of patient	Recognition of abnormal uterine activity patterns
	Administration of medications

1. ***Intermittent auscultation****:* Reserved for low risk patients, upon physician orders. Assess and document FHR every 15-30 minutes while in active labor, every 15 minutes in the second stage during passive fetal descent, and every 5-15 minutes during the active pushing phase of the second stage of labor. Should be assessed immediately following uterine contractions for a minimum of 60 seconds. Further guidelines are listed below:
    a. Palpate the maternal abdomen and perform Leopold's maneuver
    b. Assess uterine contractions (frequency, duration, intensity) and uterine tone by palpation
    c. Apply conduction gel to underside of the Doppler device
    d. Palpate the women's pulse
    e. Count the FHR after uterine contractions for at least 30-60 seconds
    f. Interpret FHR findings and document

Category I FHR characteristics for by auscultation include ALL of the following:	Category II FHR characteristics by auscultation include ANY of the following:
• Normal FHR baseline between 110 and 160 bpm • Regular rhythm • Presence or absence of FHR increases or accelerations from the baseline rate • Absence of FHR decreases or decelerations from the baseline	• Irregular rhythm • Presence of FHR decreases or decelerations from the baseline • Tachycardia (baseline >160 bpm >10 minutes in duration) • Bradycardia (baseline <110 >10 minutes in duration)

2. ***Continuous EFM****:* In a patient considered to be low risk FHR should be assessed every 30 minutes while in active labor and every 15 minutes during the second stage. In a patient who presents to the unit with risk factors or develops a need for increased fetal surveillance (Category II and III), FHR should be assessed every 15 minutes while in active labor and every 5 minutes during the second stage.
    a. While evaluation of the FHR and uterine activity may occur every 5-15 minutes depending on patient and fetal status, a summary of findings of fetal status may be documented every 30 minutes.

3. ***Contraction Pattern:*** Quantified as the number of uterine contractions in a 10 minute period, averaged over 30 minutes. Duration, intensity, and resting tone should be assessed with contraction pattern. This should be part of each FHR assessment and/or documentation.
4. ***Documentation:***
    a. Documentation for low risk patients and Category I fetal heart tracing should be completed at a minimum of every hour. Evaluation of and nursing response to changes in fetal or maternal status should be evident in documentation.
    b. If fetal heart rate tracing reflects a Category II, III or patient is considered high risk during the first stage of labor, evaluation should occur every 15 minutes with documentation every 30 minutes.
    c. Documentation for high risk patients or Category II and III fetal heart rate patterns in the second stage of labor should reflect evaluation every five minutes and documented every 30 minutes at a minimum.
        i. During the second stage, contemporaneous summary documentation of fetal and uterine activity status may be utilized for increments of 30 minutes. This should indicate continuous nursing bedside attendance and evaluation; pushing efforts; fetal descent; FHR changes; interventions and communication with provider.
    d. During titration of oxytocin, documentation should occur before each dosage change and at intervals that reflect high risk status**.**
    e. Narrative notes should include; ongoing interventions for Category II or Category III FHR that has not responded to the usual intrauterine resuscitation techniques; nurse-physician communication; changes in maternal status; any patient concerns or requests; and details of emergent situations and the outcomes.

B. **Management of Category II Fetal Heart Rate Tracings (See Attachment B)**
1. Management of Category II Fetal Heart Rate Patterns: Clarifications for use in Algorithm Variability refers to predominant baseline FHR pattern during a 30 minute evaluation period
2. Marked variability is considered same as moderate variability for purposes of this algorithm
3. Significant decelerations are defined as any of the following:
    a. Variable decelerations lasting longer than 60 seconds and reaching a nadir more than 60 bpm below baseline
    b. Variable decelerations lasting longer than 60 seconds and reaching a nadir less than 60 bpm regardless of the baseline
    c. Any late deceleration of any depth
    d. Any prolonged deceleration, as defined by the NICHD. Identification of a

prolonged deceleration should prompt discontinuation of the algorithm until deceleration is resolved

4. Application of algorithm may be initially delayed for up to 30 minutes while attempts are made to alleviate category II pattern with conservative therapeutic interventions
5. Once a category II FHR pattern is identified, FHR is evaluated and algorithm applied every 30 minutes

C. **Antepartum Use of EFM**

1. EFM should be continuous until condition is stable, then 20-30 min every shift with evidence of Category I status, as ordered.

D. **Physiologic Goals & Interventions Associated with Maximizing Fetal Perfusion & Oxygenation**

1. When an indeterminate or abnormal (Category II or III) is identified:
    a. initial assessment may include a cervical exam to rule out umbilical cord prolapse, rapid cervical dilation
    b. review of uterine activity to rule out tachysystole
    c. evaluation of maternal vital signs
2. Initiate fetal resuscitation using the following interventions as needed:
    a. Maternal repositioning
    b. Reduction of uterine activity
    c. Intravenous (IV) fluid bolus
    d. Correction of maternal hypotension
    e. Oxygen administration
    f. Amnioinfusion during first stage of labor
    g. Modification of maternal pushing efforts during the second stage

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. American Academy of Pediatrics & American College of Obstetricians and Gynecologists (2017). *Guidelines for Perinatal Care.*(8th ed). AAP/ACOG.

B. AWHONN. (2021). *Fetal heart monitoring principles and practices*. (6th ed). Lyndon, A., & Wisner, K. IA: Kendall/Hunt.

C. AWHONN. (2024). Fetal heart monitoring: AWHONN position statement. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 53*(3), e5-e9. https://doi.org/10.1016/j.jogn.2024.03.001

D. Macones, G., Hankins, G. Spong, C., Hauth, J. & Moore, T. (2008). The 2008 National institute of child health and human development workshop report on electronic fetal monitoring: Update

on definitions, interpretation, and research guidelines. *Journal of Obstetric, Gynecologic and Neonatal Nurses, 37*, 510-515.

Attachments

A: Operational Principles on Using NICHD Terminololgy

B: Management of Category II Fetal Heart Rate Tracings

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Women's & Children's Service Line	Katherine DeSalvo: Director Medical Staff Services	06/2025
CNO	Carla Spencer: Chief Nursing Officer	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Daniela Jago: Clinical Manager	03/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 16948893

Origination	12/2018	Owner	Karina Kessler: Clinical Manager
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

NICU: Consultation & Transfer of Patient

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide guidance and information regarding management of high-risk infants.

B. To provide for a smooth and coordinated transfer of a sick or convalescing neonate to or from a Neonatal Intensive Care Unit (NICU).

III. DEFINITIONS

A. ECMO – extracorporeal membrane oxygenation.

IV. GENERAL INFORMATION

A. High-risk infants requiring a higher level of neonatal care will be transferred to a regional Tertiary Center. Newborns with, but not limited to the following conditions will be transported:

1. Infants with cyanotic heart disease/major cardiac anomalies requiring further evaluation or Patent Ductus Arteriosus in need of ligation.
2. Term infants with hypoxic-ischemic encephalopathy who may benefit from whole body cooling.
3. Neonatal seizures (including status epilepticus unresponsive to treatment).
4. All conditions requiring immediate surgery (including surgical stages of necrotizing enterocolitis –free air/peritonitis).
5. Infants on mechanical ventilation who may be a candidate for high frequency ventilation and/or ECMO.
6. Infants with a potentially air-borne infectious disease requiring isolation.

7. Infants who are less than 28 weeks gestation and/or less than 1000 grams.

B. TeleHealth ("TeleNeo") or telephone consultation from regional Level III centers will be available to the physicians and nursing staff twenty-four (24) hours a day.

V. PROCEDURE

A. Equipment

1. NICU transport checklist – located in the transport folder.
2. Release of Information and Authority to transfer form (Transport Consent) – located in the transport folder.
3. Consents for all invasive procedures performed.
4. One (1) copy of mother and infant's chart, lab work, x-rays, and ECGs; plus, 2 copies of the infant's face sheet.
5. Photograph and foot printing supplies.
6. Newborn identification Confirmation on Admission and at Discharge. (Band Sheet).

B. Transport of infant to a higher level of care:

1. Physician makes arrangements for transport with an available tertiary care center and receives facility and physician acceptance.
2. Physician will discuss transport and all invasive procedures with parents and obtains informed consent for transfer.
3. NICU charge RN will notify the LD and/or MB charge nurse and administrative supervisor on duty upon determination of arrangement of infant's transport.
4. If a NICU unit assistant is unavailable, the LD and/or MB charge nurse or the nursing supervisor on duty makes arrangements for a unit assistant to be in the NICU immediately and throughout the transport to assist the medical/nursing staff.
    a. Unit assistant transport duties include, but may not be limited to:
        i. Answering the telephone, notifying departments of procedures needed, assisting in obtaining items needed for the infant's stabilization and making or arranging for copies to be sent with transport team, confirming ETA of transport team.
5. Parents should sign the Release of Information and Authority to Transfer Form (i.e. Transfer Consent).
    a. Use the complete name of the receiving hospital (i.e. no abbreviations) on the transport consent.
6. Parents should sign the consents for any invasive procedures to be performed.
    a. Use the correct name for invasive procedures (i.e. no abbreviations) on any consent. Invasive procedures may include: umbilical artery or vein catheterization, lumbar puncture, bladder tap, thoracentesis and placement of chest tube.

b. Unit assistant, or charge nurse to copy mother's and infant's charts and infant's face sheets.

c. Make arrangements for copies of all the results of the diagnostic tests (x-rays, labs, EKGs) to send to receiving NICU.

d. Order genetic screen to be drawn. Draw genetic screen when possible. The State of California prefers the genetic screen to be drawn prior to transport. However, exceptions can be made upon request of the receiving hospital or if the condition of the infant indicates withholding the genetic screen.

e. If possible, take pictures of the infant, obtain the footprints, and give them to the parents.

f. Medical, nursing, and ancillary staff provide all necessary care to stabilize and maintain the infant until the transport team arrives. Once transport team arrives, they assume care.

g. Prior to the infant's departure, complete section III of the Newborn Identification Confirmation on Admission and at Discharge Form (Band sheet), and record the newborn band number on the band sheet. Obtain mother's signature on band form. If the mother is unable to sign the band sheet, the father may sign or legal guardian.

h. Transfer of an infant into SVHMC NICU from another facility may occur when: (Refer to NICU TRANSPORT: CARE PRACTICES FOR TRANSPORT).

    i. Community NICU level of care is appropriate and,

    ii. The NICU medical director (or designee) in collaboration with the Nursing Director of Women/Children Services (or designee), the Administrative Supervisor, and charge RN, approve the transfer. Staffing and bed availability are considered.

i. Upon arrival of infant:

    i. Document arrival time and receive report from transport team.

    ii. Perform admission assessment.

C. Documentation:

1. Transfer to Regional NICU

    a. At time of referral initiate "All California Neonatal Transport Form" (CPeTs).

    b. Document arrival time of transport team and transfer of infant's care to the transport team.

    c. Document discharge time and brief assessment of infant's discharge condition in electronic health record.

    d. Complete Occurrence report.

    e. Unit assistant to enter admission and discharge in NICU statistics log book. Include delivery information, complications, procedures performed, and transport information.

f. Transfer into Salinas Valley Health Medical Center (SVHMC) NICU:
    i. Chart time of infant's arrival at SVHMC and name of transferring hospital.
    ii. Chart baseline assessment in electronic health record.
    iii. Unit assistant enters admission into the NICU statistics logbook. Information should include the transferring hospital, date of birth, birth weight, and day of transfer.
    iv. Identification bands are made and placed on the infant.
    v. Document orientation of parents/guardians to NICU visiting policy and routines.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Guidelines for Perinatal Care (8th Edition, 2015). A Joint Publication of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

B. Lucille Packard Children's Hospital Neonatal Policies Criteria for Admission, Admission and Transfer Criteria and Physician Admitting and Consultation Guidelines.

C. California Children's Services Manual of Procedure. Chapter 3.25.2, Community NICU.

D. Title 22 Licensing and Certification of Health Facilities and Referral Agencies.

Attachments

A: Available Hospitals for Consultation

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	06/2025

Director of Women's and Children's Services	Julie Vasher: Director Women's & Children's Services	06/2025
NICU Medical Director	Robert Castro: PHYSICIAN	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Karina Kessler: Clinical Manager	03/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 16893062

Origination	08/2021	Owner	Lilia Meraz Gottfried: Director Clinical Development
Last Approved	N/A	Area	Patient Care
Next Review	3 years after approval		

Obtaining Daily Weights for Heart Failure Patients

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To standardize the process for obtaining daily weights of hospitalized heart failure patients to promote consistency and accuracy of measurement. Consistency and accuracy in weight measurement is necessary for clinically reliable assessment of fluid balance trends, appropriate drug and treatment dosing, and evaluation of treatment effectiveness.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. Circumstances
    1. Setting
        a. All inpatient and observation patients that have the Nursing Orders for "Weigh Daily0600" or "Standing Weight Daily0600".
    2. Scope
        a. Applies to patients with diagnosis of heart failure and/or patients receiving IV diuretic therapy.
    3. Supervision
        a. Registered Nurses (RN) or Nursing Assistants (NA) may weigh patients.
        b. RN is responsible for ensuring the accurate documentation and monitoring

of the weight.

V. PROCEDURE

A. Obtaining Weights

1. General

a. All possible attempts should be made to weigh patient at the same time of day.

b. All possible attempts should be made to weigh the patient using the same type of scale during the entire hospitalization.

c. If patient is able to ambulate or stand, all possible attempts should be made to weigh the patient using a standing scale for better accuracy.

i. For patient mobility/safety concerns, RN may obtain order to consult Occupational Therapy.

d. Daily weights will be performed prior to breakfast.

e. Daily weights will be performed after patients void or after an empty indwelling catheter collection bag.

2. Using a Built-In Bed Scale

a. Zero the bed prior to admission, flat and unoccupied, and containing only standard linen and equipment. (List per PATIENT WEIGHTS Competency).

i. fitted sheet

ii. flat sheet

iii. patient gown

iv. top blanket (green)

v. 1 pillow

vi. call bell

vii. phone

viii. telemetry transmitter box (if applicable)

b. Weigh patient on a zeroed bed, with only the items on the bed that were on it at the time of zeroing. Note: Any items hanging from the bed or on the patient must be held off the bed or hung adjacent to the bed. (Examples: Drainage bags, wound VACs, compression stocking pumps).

c. Re-zero bed when:

i. The accuracy of the weight is in question.

ii. A low air loss mattress overlay is added (see next step).

d. If a low air loss overlay (with or without an MRS overlay base) is added:

i. Re-zero the unoccupied bed with low air loss overlay (and MRS overlay base, if applicable).

3. Scale/Bed Issues
    a. Contact Biomed if the scale or bed does not seem to be functioning properly or is alarming for servicing. If issues with bed cannot be resolved, obtain and move patient to a properly functioning bed; report and document equipment issues.
        i. Starnet > Quick Links > Biomed Work Order
        ii. Biomedical Department: Extension 1816

B. Education-Patient/Family
    1. During Hospitalization
        a. Purchase a scale, if patient does not already have one.
        b. Purpose and importance of daily weight monitoring.
        c. Proper and safe weighing techniques.
        d. Daily weight tracking.
    2. At Discharge
        a. Confirm patient has a scale at home.
            i. If unable to afford a scale, contact Case Management.
        b. Provide patient with their last weight reading to use as baseline at home.
            i. Provide weight in both kilograms (kg) and pounds (lb).
            ii. Write down weight in Heart Failure Patient Education book.
    3. Review Heart Failure Zones chart.
    4. Weight gain parameters and proper interventions.
        a. Some patients may have order for PRN oral diuretic. Review medication instructions with patient.
    5. Review follow-up appointment instructions and assist with scheduling appointment if necessary.
    6. Confirm patient has contact information for MD office and Home Health agency (if applicable).\

C. Documentation:
    1. The patient's weight will be documented in kilogram (kg) in the EMR.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

REFERENCES

A. Curtis, A., Wood, A., Johnson, K., Walker, J., Dornburg, S., Osser-Burgess, A., Markham, E., & Nack, J. (2012). The importance of daily weight measurements in heart failure patients:

performance improvement project. Heart & Lung, 41, 424-425.

B. Riegel, B., Moser, D., Anker, S., Appel, L., Dunbar, S., Grady, K., Gurvitz, M., Havranek, E., Lee, C., Lindenfield, J., Peterson, P., Pressler, S., Schocken, D., & Whellan, D. (August 009). State of science: Promoting self-care in persons with heart failure: A scientific statement from the American Heart Association. Circulation. 1141-1163. Retrieved from http://circ.ahajournals.org/content/120/12/1141

C. Sherer, A., Freeman, L., Owens, D., Nyako, M., Hunter, L., Buck, N., Ragan, L., Tijani, T., White, C., Hamilton, P., & Pettiford, A. (2012). Weighing in on the facts: Best practices in daily weight monitoring for heart failure patients. Heart & Lung, 41, 432-433.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	07/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2025
Policy Owner	Lilia Meraz Gottfried: Director Clinical Development	07/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 16976912

Origination	04/2013	Owner	Frank Mensah: Interim Director Critical Care Services
Last Approved	N/A	Area	Patient Care
Next Review	3 years after approval		

Oral Care

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To create a standardized oral care practice amongst Salinas Valley Health staff involved in direct patient care, which reflects current, evidence-based practice recommendations to reduce the risk of NV-HAP, improve patient comfort, and support nutrition and communication.

B. To create a systematic approach to providing high-quality, routine oral care.

III. DEFINITIONS

A. Oral cavity: the oral cavity includes the lips, gingivae, teeth, hard palate, buccal surfaces, tongue, and floor of the mouth.

B. Biofilm: a well-organized, cooperative community of microorganisms that form on the surfaces of the cheeks, tongue and teeth comprised of a sticky mass of proteins, lipids, glycoproteins, and glycolipids which house oral microbial communities.

C. Oral care: the assessment of the patient's oral health utilizing the Bedside Oral Health Assessment tool and documentation of the assessment and oral care provided a minimum of every twelve hours. Oral care consists of the mechanical removal of plaque and biofilm from the mouth by gently brushing the palate, buccal surfaces, tongue, gums, and tooth surfaces with a soft-bristled toothbrush; the use of alcohol-free antiseptic mouth rinse; and the application of oral cavity moisturizer.

D. Denture care: the removal of plaque and food debris from dentures or removable dental appliances by gently brushing the appliance with a soft-bristled toothbrush and soaking the appliance in a cleansing solution.

E. NV-HAP: Non-ventilator health care-associated pneumonia

IV. GENERAL INFORMATION

A. Salinas Valley Health is committed to ensuring consistent, evidence-based oral care for all patients to reduce the risk of healthcare-associated infections and improve patient outcomes

B. An oral health assessment will be completed as part of the admission assessment and a minimum of every twelve hours using a standardized assessment tool.

    1. The oral cavity will be assessed using a standardized assessment tool the Bedside Oral Assessment (See Bedside Oral Assessment Tool).

C. All patients will receive oral care while admitted to the hospital.

D. Good oral hygiene, including regular brushing and flossing, is essential to control harmful bacteria and prevent conditions like tooth decay and gum disease.

E. Oral health can influence several serious conditions, including endocarditis. Research suggests a connection between oral bacteria and cardiovascular diseases like heart disease and stroke. Gum disease is linked to complications in pregnancy, such as premature birth and low birth weight, while oral germs can contribute to pneumonia and other respiratory illnesses (Sedghi et al., 2021).

F. Oral pathogens have been directly implicated in health care-associated pneumonia (HAP) , which is the most common health care-assiciated infection in the United States and in intensive care units (ICUs) worldwide (Quinn et al., 2020).

V. PROCEDURE

A. Organization adopted practice standards and procedures can be found on StarNet Quick links-Dynamic Health-Providing Oral Hygiene.

B. Independent patients, able to perform their own oral care:

    1. Provide oral care supplies.
    2. Teeth brushing will be performed a minimum of twice daily.
    3. Instruct the patient how and when to apply mouth moisturizer.

C. Dependent patients, unable to perform their own oral care:.

    1. Follow standard procedure for gathering appropriate oral care supplies.
    2. Oral hygiene will be provided a minimum of twice daily.
    3. Position the patient’s head to the side or in semi-fowlers position.
    4. Provide suctioning as needed while performing oral care.
    5. Oral cavity moisturizer will be applied every four hours and as needed to prevent drying of oral mucosa.

D. Denture wearing patients:

    1. Denture care should be provided a minimum of twice daily; dentures should be removed at night to prevent bacterial buildup and to allow for gums to rest.
    2. Patients should be encouraged to wear dentures while they are awake to facilitate

clear speech and nutrition.

3. At bedtime, dentures should be stored in a patient-labeled cup filled with cool water and effervescent cleaner.
4. Refer to Dynamic Health, Caring for Patients with Dentures, for step-by-step procedure.

E. Pediatric Patients:

1. For infants without teeth, gently wipe all surfaces of the oral cavity with a water moistened soft cloth.
2. For pediatric patients with teeth, brush teeth with a pediatric toothbrush and toothpaste a minimum of twice daily.
    a. Patients 3 years and younger, use a rice-grain sized smear of toothpaste.
    b. Patients older than 3 years, use a pea-sized amount of toothpaste.
3. Refer to Dynamic Health, Providing Oral Care to Hospitalized Pediatric Patients.

F. For intubated patients in the ICU and/or tracheostomy patients in the ICU and 1 Main:

1. Chlorohexidine gluconate (CHG) will be used to provide oral care every twelve hours, in addition to standard oral care.

G. Documentation

1. Nurse Swallow Screen will be performed and documented upon admission and as needed when a change in condition occurs.
2. An Oral health assessment will be performed and documented by the nurse upon admission and a minimum of every twelve hours using the Bedside Oral Assessment tool.
3. Oral Care will be performed and documented in the patient care record a minimum of every twelve hours and as indicated by oral care protocol.
4. Frequency of oral mucosal care is driven by the Bedside Oral Assessment Score and will be documented in patient care record according to protocol frequency.
5. Chlorohexidine Gluconate requires a physician order and is obtained through the pharmacy; CHG is scanned and documented on patient eMAR.
6. Staff members will document refusal of oral care in patient care record.

VI. EDUCATION/TRAINING

A. Education and/or training will be provided as needed.

VII. REFERENCES

A. Abebe GM (2021) Oral Biofilm and Its Impact on Oral Health, Psychological and Social Interaction. Int J Oral Dent Health 7:127. doi.org/10.23937/2469-5734/1510127

B. Ames, Nancy & Sulima, Pawel & Yates, Jan & Mccullagh, Linda & Gollins, Sherri & Soeken, Karen & Wallen, Gwenyth. (2011). Effects of Systematic Oral Care in Critically Ill Patients: A

Multicenter Study. American journal of critical care: an official publication, American Association of Critical-Care Nurses. 20. e103-14. 10.4037/ajcc2011359.

C. Barbara Quinn, Karen K. Giuliano, Dian Baker, Non-ventilator health care-associated pneumonia (NV-HAP): Best practices for prevention of NV-HAP, American Journal of Infection Control, Volume 48, Issue 5, Supplement, 2020, Pages A23-A27, ISSN 0196-6553, https://doi.org/10.1016/j.ajic.2020.03.006. (https://www.sciencedirect.com/science/article/pii/S0196655320301292)

D. Centers for Disease Control and Prevention. (2023). Non-ventilator healthcare-associated pneumonia (NV-HAP) prevention toolkit. Retrieved from: https://www.cdc.gov/hai/prevent/oral-health-toolkit.html

E. Prendergast, V., Kleiman, C., & King, M. (2013). The Bedside Oral Exam and the Barrow Oral Care Protocol: translating evidence-based oral care into practice. Intensive & critical care nursing, 29(5), 282–290. https://doi.org/10.1016/j.iccn.2013.04.

F. Sedghi, L., DiMassa, V., Harrington, A., Lynch, S. V., & Kapila, Y. L. (2021). The oral microbiome: Role of key organisms and complex networks in oral health and disease. Periodontology 2000, 87(1), 107–131. https://doi.org/10.1111/prd.12393

G. Segura A, Boulter S, Clark M, et al. Section on Oral Health. Maintaining and improving the oral health of young children. Pediatrics. 2014;134(6):1224-9. doi:10.1542/peds.2014-2984

H. Virginia Prendergast, Cindy Kleiman, Mary King, The Bedside Oral Exam and the Barrow Oral Care Protocol: Translating evidence-based oral care into practice, Intensive and Critical Care Nursing, Volume 29, Issue 5, 2013, Pages 282-290, ISSN 0964-3397, https://doi.org/10.1016/j.iccn.2013.04.001.

Attachments

Bedside Oral Assessment.docx

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	07/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2025
Policy Owner	Frank Mensah: Interim Director Critical Care Services	06/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18121392**

Origination	04/2019	Owner	Kirsten Wisner: Director Magnet Program
Last Approved	N/A	Area	Patient Care
Next Review	3 years after approval		

Peer Feedback

I. POLICY STATEMENT

A. All registered nurses participate in peer feedback by giving and receiving practice focused feedback. Nurses use peer feedback to set an improvement goal on their annual self-evaluation.

II. PURPOSE

A. The purpose of peer feedback is to:

1. Support peer feedback for nurses at all levels
2. Improve the quality of care and enhance patient outcomes
3. Increase nurses' comfort level with giving and receiving feedback
4. Foster open communication about potential causes of error or harm
5. Monitor quality outcomes and identify opportunities for performance improvement
6. Identify and discuss system process issues

III. DEFINITIONS

A. **Peer Review** – the process by which practicing registered nurses systematically monitor and assess the quality of nursing care provided by peers as measured against professional standards of practice.

B. **Peer** – someone of the same rank.

C. STAR Values: **S**upport, **T**eamwork, **A**ccountability, **R**espect

D. PRIDE Nursing Values:

P We provide professional, patient-centered care.

R We are respectful of our patients, families, and colleagues.

I We serve our patients with integrity. We are honest, ethical, and authentic in our actions.

D We welcome and embrace diversity.

E We provide excellent, evidence-based care.

IV. GENERAL INFORMATION

A. In accordance with Salinas Valley Health Medical Center's Professional Practice Model and professional standards, nurses at all levels are expected to participate in peer review.

B. Peer feedback is a form of peer review that can be used to continuously monitor care, enhance communication, and keep patients and nurses safe.

C. Peer review/feedback will be based on the following 6 evidence-based principles:

1. A peer is someone of the same rank
2. Peer review is practice focused
3. Feedback is timely, routine, and a continuous expectation
4. Peer review fosters a continuous learning culture of patient safety
5. Feedback is not anonymous
6. Feedback incorporates the developmental stage of the nurse

D. Peer feedback involves training for all nurses, a peer feedback focus on each clinical unit, and an annual performance evaluation process. All nurses are expected to use peer feedback regularly.

E. Nurses in direct-care roles, who perform the clinical work of the profession should have oversight for issues related to practice, quality, competence, and knowledge.

V. PROCEDURE

A. The Practice Council oversees peer feedback and general guidelines for the unit and organizational levels.

B. Unit Practice Councils (UPCs) choose specific indicators to focus their peer feedback bi-annually and are encouraged to monitor measurable outcomes as appropriate.

C. Selected indicators will align with the nursing strategic plan and organizational goals.

D. Peer feedback is meant to be used by nurses in all roles and should be continuous and timely. It is expected to support nurses to address issues or improvement opportunities relevant to their role. Peer feedback should be used when a structured and agreed-upon communication framework is needed.

E. Peer feedback conversations are private; however, nurses are expected to use the conversations to generate at least one annual goal that is documented in the annual performance evaluation. (See attachment for more information on peer feedback goals)

F. Feedback may incorporate the Professional Practice Model and PRIDE and STAR values for exemplary patient care and use of effective communication.

G. Training is provided to all nurses and includes the following objectives:

1. Understand how professionals can incorporate feedback to evaluate and regulate their practice.
2. Learn the brain science behind feedback to better understand reactions to feedback.
3. Recognize that *how* feedback is given impacts the success of the interaction.
4. Create a safety culture where mistakes are seen as opportunities to learn.

H. Incident-based Peer Review to be conducted according to the specific procedure NURSING EXCELLENCE / PEER REVIEW

VI. EDUCATION/TRAINING

A. Education and/or training provided as needed.

VII. REFERENCES

1. American Nurses Association. (2025). *Code of ethics for nurses*. Author.
2. American Nurses Association. (2021). *Nursing scope and standards of practice (4th Ed.)*. Author.
3. Haag-Heitman, B., & George, V. (2010). *Peer review in nursing: Principles for successful practice*. Sudbury, MA: Jones & Bartlett Publishers.
4. Rodriguez, R., Hambley, C., & Wisner, K. (2024). Taking the fear out of peer feedback: A brain-friendly peer feedback program. *JONA: The Journal of Nursing Administration, 54*(1), 40-46.
5. Wisner, K., & Lopez, M. (2024). Clinical nurses' perceptions of a "brain-friendly" peer feedback program. *Journal of Nursing Care Quality, 39*(4), 330-336.

Attachments

Peer Feedback Goal Setting for Annual Evaluations.pptx

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	07/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2025
Policy Owner	Kirsten Wisner: Director Magnet Program	07/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18182262

Origination	06/2022	Owner	Daniela Jago: Clinical Manager
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Placenta Release

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide staff in the process of storing, testing and releasing a placenta.

III. DEFINITIONS

A. L&D – Labor and Delivery

B. EHR - Electronic Health Record

IV. GENERAL INFORMATION

A. In an effort to respect and support religious, ethnic, and cultural practices, Salinas Valley Health Medical Center (SVHMC) allows a patient to request the release of their placenta after childbirth. Consideration and proper assurances of public health and safety as evidenced by maternal testing and the absence of communicable diseases as required by law before the placenta can be released.

B. Pathology consultation should be made when there are clinical indications as identified or when the obstetrician or pediatrician believes it is warranted.

C. Obstetrics practitioners should discuss a patient's wishes for placental release during office visits. If a patient wishes to have their placenta released after delivery, testing for HIV, Hepatitis B and Hepatitis C should be completed.

V. PROCEDURE

A. Following delivery, placentas that do not require pathology consultation, will be placed in the

identified refrigerator located in the L&D Unit's soiled utility room.

B. If the placenta meets criteria for further pathology consultation, PLACENTAL EXAMINATION AND NEONATAL CORD BLOOD GAS ANALYSIS CLINICAL PROCEDURE, the placenta will be placed in a hard sided, specimen container and identified with the patient's label on the outside of the specimen container. A fixative agent will be poured over the specimen prior to sealing the container. The placenta will be hand carried to pathology.
    1. Surgical Pathology-Cytology form is to be completed for all specimens sent to the pathology department.
    2. The placenta will not be authorized for release to the patient.

C. Patients requesting to take their placenta home will be allowed to do so upon verification of the absence of maternal communicable diseases by L&D Unit staff.
    1. Patient is required to present current documented evidence of negative HIV, Hepatitis B and Hepatitis C testing. If information is not readily available in the SVHMC EHR, the patient's OB provider will be contacted to request current lab results, which can be faxed by the patient's primary Obstetrical provider to SVHMC L&D Unit.
    2. If no current evidence of negative tests, the test will be ordered while the patient is in the hospital. The placenta will not be released until all required test results are negative.

D. Staff will review the Request for Placenta Release with the patient. The Consent must be completed in order for the placenta to be released (see attachment).

E. The L&D Unit staff will prepare the placenta and process accordingly.
    1. The placenta will be placed in a hard sided specimen container with a patient label placed on the outside of the specimen container PATIENT IDENTIFICATION POLICY , LABELING OF SPECIMENS
    2. The specimen container will be placed in a red biohazard bag.

F. The release of the placenta shall be coordinated with the L&D Unit staff and will be released to the "Requestor" and or designee to be removed from the premises upon receipt. The placenta will not be permitted to stay in the patient's room.

G. Placentas from routine deliveries, vaginal or cesarean section, can be released to birthing patients who are requesting their placenta and whose placentas are not of concern (positive infectious tests) and/or in need of pathological examination per the OB provider.

H. Documentation:
    1. Request for Placenta Release Consent form

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. California Code of Regulations, Title 8, Section 5193. *Bloodborne pathogens*

B. Carreon, C., Ravishankar, S., Parast, M., et al. (2023). Releasing placentas to families: A unified recommendation form the perinatal committee of the society for pediatric pathology. *Archives of Pathology & Laboratory Medicine, 147*(5), 515-517. https://doi.org/10.5858/arpa.2022-0425-LE

Attachments

Request for Placenta Release English.pdf

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Chair Dep OBGYN	Katherine DeSalvo: Director Medical Staff Services	07/2025
Lab Medical Director	Johnny Hu: PHYSICIAN	07/2025
CNO	Carla Spencer: Chief Nursing Officer	07/2025
WCS Director	Julie Vasher: Director Women's & Children's Services	07/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2025
Policy Owner	Daniela Jago: Clinical Manager	06/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18269246**

Origination	06/2022	Owner	Katherine DeSalvo: Director Medical Staff Services
Last Approved	N/A	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Medical Staff Services

I. SCOPE OF SERVICE

Medical Staff Services 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.

II. GOALS

The goals of Medical Staff Services will be to:

A. Administer Medical Staff Bylaws, Rules and Regulations, Credentialing and Recredentialing, Clinical Privileging and Peer Review to ensure regulatory and accreditation compliance.

B. To provide a wide range of support to Physicians and Advanced Practice Providers (APPs) which promote safe and quality health care.

C. Ensure that all Physicians and Advanced Practice Providers receive high quality service in the most expedient and professional manner.

D. To support oversight of the quality of care, treatment, and services delivered by individuals who are credentialed and privileged through the Medical Staff process.

E. To coordinate all Medical Staff functions and affairs within parameters established by Hospital administration and Officers of the Medical Staff and to serve as a resource to the Health System community.

F. Maintain sufficient equipment and supplies to adequately those functions described.

III. DEPARTMENT OBJECTIVES

A. To support the Salinas Valley Health Medical Center goals.

B. To support safe, effective, and appropriate care in a cost effective manner.

C. To plan for the allocation of human/material resources.

D. To support high level medical management with a focus on a collaborative, multi-disciplinary approach.

E. To collect data regarding Medical Staff and Advanced Practice Provider performance and patient care for the purposes of ongoing professional practice evaluation as well as focused professional practice evaluation.

F. To develop/implement/evaluate standards applicable to the Medical Staff Services Department and Medical Library.

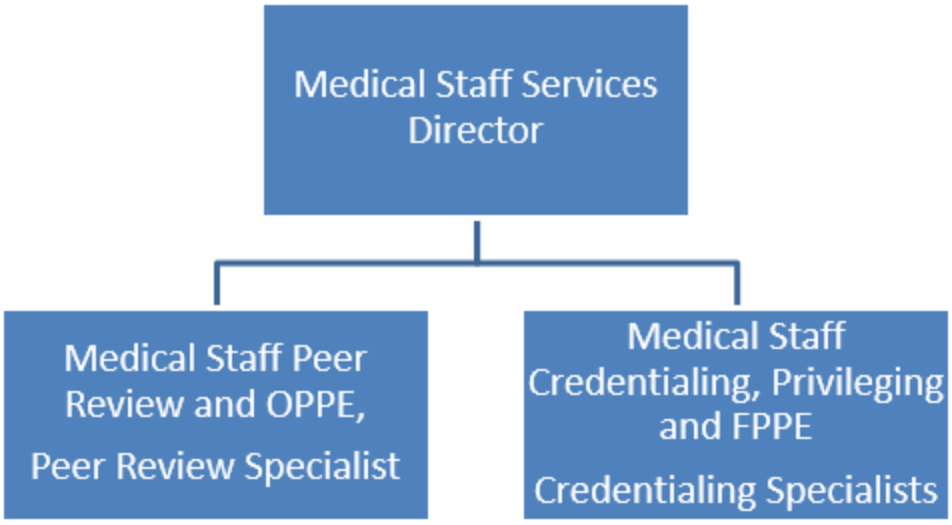
G. To evaluate staff performance on an ongoing basis.

H. To provide appropriate staff orientation and development.

IV. POPULATION SERVED

1. All credentialed Medical Staff and Advanced Practice Providers
2. All clinical and support departments
3. Administration and Board of Directors
4. External regulatory agencies

V. ORGANIZATION OF THE DEPARTMENT



A. Staff includes:
    1. Medical Staff Director
    2. Credentialing Coordinators
    3. Medical Staff Peer Review Specialist

B. Hours of Operation:
Monday – Friday from 7:30 am – 4:30 pm.

C. Location of department:
The hospital's Medical Staff Services Department is located in the Downing Resource Center Room 116.

VI. DEFINITION OF PRACTICE AND ROLE IN MULTIDISCIPLINARY CARE /SERVICE

A. The Medical Staff Services Department assesses, supports, coordinates and educates the Medical Staff and Advanced Practice Providers to support a high standard of patient care provided by credentialed staff within the Health Care System through:
    1. Credentialing
    2. Re-credentialing
    3. Development of privileging criteria
    4. Proctoring (focused professional practice evaluation)
    5. Continuing medical education
    6. Oversight of the Unassigned Emergency Call schedule
    7. Medical staff meetings to include staffing, coordinating and follow-up
    8. Medical Staff Bylaws/Rules and Regulations maintenance
    9. Orientation of new Medical Staff and Advanced Practice Provers
    10. Effective peer review (ongoing professional practice evaluation)

B. The Director of the Medical Staff Services reports to the Chief Clinical Officer.

C. All personnel within the Department are under the guidance and direction of the Medical Staff Services Director. In the Director's absence, the position is filled by the Credentialing Coordinator. It is their responsibility to carry out the duties of the Director in their absence.

VII. REQUIREMENTS FOR STAFF

All individuals who provide services in this Department have the appropriate training and competence.

A. Licensure / Certifications:

The basic requirements for the Credentialing Coordinator include:

Current NAMSS CPCS Certification (National Association of Medical Staff Services Certified Professional Credentialing Specialist)

The basic requirements for the Medical Staff Services Director include:

Current NAMSS CPMSM Certification (National Association of Medical Staff Services Certified Professional in Medical Staff Management)

Current NAHQ CPHQ Certification (National Association of Healthcare Quality Certified

Professional in Healthcare Quality)

B. Competency

Staff are required to have routine competence assessments in concert annual performance appraisals. 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 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

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 may be provided to staff based on applicability.

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The Department is staffed with a sufficient 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 are made based on acuity and needs of the department, competencies of the staff, the degree of supervision required, and the level of supervision available. In the event of employee absences, workloads are shifted to provide that service which cannot wait responsible employee's return.

In the event of an emergency, the minimum amount of staff required to safely operate this unit is: **2**

IX. EVIDENCED BASED STANDARDS

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

Medical Staff Services supports the Salinas Valley Health Medical Center 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 Salinas Valley Health Medical Center Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure, the Medical Staff Services Department will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Attachments

Organization of the Department

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CCO	Timothy Albert: Chief Clinical Officer	06/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2025
Policy Owner	Katherine DeSalvo: Director Medical Staff Services	06/2025

Standards

No standards are associated with this document

BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

STATUS UPDATE ON EPIC IMPLEMENTATION

(VERBAL REPORT)

(Alysha Hyland / Josh Rivera)

QUALITY AND EFFICIENT

PRACTICES COMMITTEE

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

(CATHERINE CARSON)

PERSONNEL, PENSION & INVESTMENT COMMITTEE

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

(CATHERINE CARSON)

FINANCE COMMITTEE

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

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

(VICTOR REY, JR.)

Financial Performance Review
June 2025
Finance Committee

Scott Cleveland
Interim Chief Financial Officer

Consolidated Financial Summary
For the Month of June 2025

$ in Millions	For the Month of June 2025			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 74.3	$ 62.6	$ 11.7	18.7%
Operating Expense	$ 67.1	$ 63.7	$ (3.4)	-5.3%
Income from Operations	**$ 7.2**	**$ (1.1)**	**$ 8.3**	**754.5%**
Operating Margin %	*9.7%*	*-1.8%*	*11.5%*	*638.89%*
Non Operating Income	$ 8.0	$ 3.0	$ 5.0	166.7%
Net Income	**$ 15.2**	**$ 1.9**	**$ 13.3**	**700.0%**
Net Income Margin %	*20.4%*	*3.0%*	*17.4%*	*580.0%*

Normalizing Item included in operating income:
- IGT DHCS MediCal Rate Range Program for FY 2024-25 (net) $2.3 Million

Normalizing Item included in non-operating income:
- FEMA Grant funds recognized (net) $2.1 Million

2

Consolidated Financial Summary
For the Month of June 2025 - Normalized

$ in Millions	For the Month of June 2025			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 72.0	$ 62.6	$ 9.4	15.0%
Operating Expense	$ 67.1	$ 63.7	$ (3.4)	-5.3%
Income from Operations	**$ 4.9**	**$ (1.1)**	**$ 6.0**	**545.5%**
Operating Margin %	*6.8%*	*-1.8%*	*8.6%*	*477.78%*
Non Operating Income	$ 5.9	$ 3.0	$ 2.9	96.7%
Net Income	**$ 10.8**	**$ 1.9**	**$ 8.9**	**468.4%**
Net Income Margin %	*15.0%*	*3.0%*	*12.0%*	*400.0%*

Normalizing Item excluded from operating income:
- IGT DHCS MediCal Rate Range Program for FY 2024-25 (net) $2.3 Million

Normalizing Item excluded from non-operating income:
- FEMA Grant funds recognized (net) $2.1 Million

Executive Summary: Financial Performance

Salinas Valley Health's Income from Operations was $7.2 million for the month which was favorable to budget by $8.3M. After normalizing for the DHCS Rate Range IGT of $2.3 million income from operations was $4.9 million. The favorable financial performance for the month was driven by the following:

- ✓ **Strong Outpatient Revenues -** favorable to budget by $32M (23%), this equates to a favorable variance of $6 million in OP Net Revenue. Key services driving this variance were:
  - ➢ **OP Infusion Program -** cases were over budget by 16% (156 cases or $3M in net revenues)
  - ➢ **OP Surgeries –** cases were over budget by 22% (66 cases, $0.9M in net revenue)
  - ➢ **MRI Procedures** were over budget by 23% (55 cases)
- ✓ **Inpatient Surgeries** were over budget by 7% (8 cases)
- ✓ **Total Admissions** were over budget by 3% (29 cases)
- ✓ **Average Length of Stay** was 12% favorable to budget at 3.6 days
- ✓ Medicare Case Mix Adjusted Average Length of Stay was favorable by 16% at 2.1 days

Executive Summary: Financial Performance – Cont'd

- **Key Unfavorable Performance Highlights:**
  - ✓ **Payor Mix** was varied with higher than expected Commercial revenue, up 5%. However, Medicare and MediCal were over budget by 15% and 10%, respectively.
  - ✓ **Observation cases** were over budget by 59% (79 cases)
  - ✓ **ER Outpatient Visits** were under budget 6% (252 cases)
  - ✓ **All Payor Case Mix** of 1.58 was 2% under target
  - ✓ **Deliveries** were under budget by 4% (4 cases)
  - ✓ **Days in AR** at 68 is still trending over target due to slow paying insurance providers

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Consolidated Financial Summary YTD June 2025

$ in Millions	FY 2025 June YTD			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 849.9	$ 749.1	$ 100.8	13.5%
Operating Expense	$ 794.2	$ 761.9	$ (32.3)	-4.2%
Income from Operations	**$ 55.7**	**$ (12.8)**	**$ 68.5**	**535.2%**
Operating Margin %	*6.6%*	*-1.7%*	*8.3%*	*488.2%*
Non Operating Income	$ 42.0	$ 36.1	$ 5.9	16.3%
Net Income	**$ 97.7**	**$ 23.3**	**$ 74.4**	**319.3%**
Net Income Margin %	*11.5%*	*3.1%*	*8.4%*	*271.0%*

Operating Income includes the Normalizing Items of:

- $4.6M - CCAH Voluntary Rate Range Funds (net) received YTD for CY 2023
- $4.8M - District Hospital Direct Payment (net) for 2023
- $4.3M - HQAF (net) for program year 2024
- $1.4M – Medi-Cal Supplemental OP (net) for CY 2023-24
- $2.3M – DHCS Medi-Cal Rate Range (net) for CY 2024-25
- **$17.4M – Total YTD**

Non Operating Income includes Normalizing Items of:

- $6.3M - FEMA Grant funds (net) received YTD
- $12.9M - FEMA Grant funds received inception to date

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Consolidated Financial Summary
YTD June 2025 - Normalized

$ in Millions	FY 2025 June YTD			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 832.5	$ 749.1	$ 83.4	11.1%
Operating Expense	$ 794.2	$ 761.9	$ (32.3)	-4.2%
Income from Operations	**$ 38.3**	**$ (12.8)**	**$ 51.1**	**399.2%**
Operating Margin %	*4.6%*	*-1.7%*	*6.3%*	*370.6%*
Non Operating Income **	$ 35.8	$ 36.1	$ (0.3)	-0.8%
Net Income	**$ 74.1**	**$ 23.3**	**$ 50.8**	**218.0%**
Net Income Margin %	*8.9%*	*3.1%*	*5.8%*	*187.1%*

Operating Income excludes the Normalizing Items of:

- $4.6M - CCAH Voluntary Rate Range Funds (net) received YTD for CY 2023
- $4.8M - District Hospital Direct Payment (net) for 2023
- $4.3M - HQAF program (net) for 2024
- $1.4M – Medi-Cal Supplemental OP (net) for CY 2023-24
- $2.3M – DHCS Medi-Cal Rate Range (net) for CY 2024-25
- **$17.4M – Total YTD**

Non Operating Income excludes Normalizing Items of:

- $6.3M - FEMA Grant funds (net) received YTD
- $12.9M - FEMA Grant funds received inception to date

SVHMC Revenue Highlights June 2025

Gross Revenues were 11.6% *favorable to budget*

- **IP Gross Revenues** were 1.2% ***unfavorable*** to budget
- **ED Gross Revenues** were 0.9% un***favorable*** to budget
- **OP Gross Revenues** were 33.4% ***favorable*** to budget in the following areas:
  - OP Infusion
  - OP Surgery
  - MRI Procedures

- **Commercial: 5%** *above* budget
- **Medicaid: 10%** *above* budget
- **Medicare: 15%** *above* budget

Payor Mix – Unfavorable

Total Net Patient Revenues were **$62.1M**, which was ***favorable*** to budget by **$10.8M** or 21.1%

Financial Summary – June 2025

ADC
Average daily census was 108, 8% below budget of 117

Admits
Total admissions were 3%, 29 admits above budget at 904

ER Visits
ER Outpatient visits were 6%, 252 cases, below budget

ER Admits
ER admissions were above budget 75 admits, 11%. ER admits as % of total admissions were 87.1% (Excluding OB ED)

IP Surgeries
Inpatient Surgeries were up 7%, 8 cases above budget at 137

OP Infusion
OP Infusion cases were up 16%, 156 cases above budget at 1,127

Cath Lab
Cath Lab procedures were up 21%, 63 cases above budget at 357

MRI/CT Procedures
MRI procedures were above budget by 55 cases, 23%. CT procedures were above budget by 255 cases, 14%

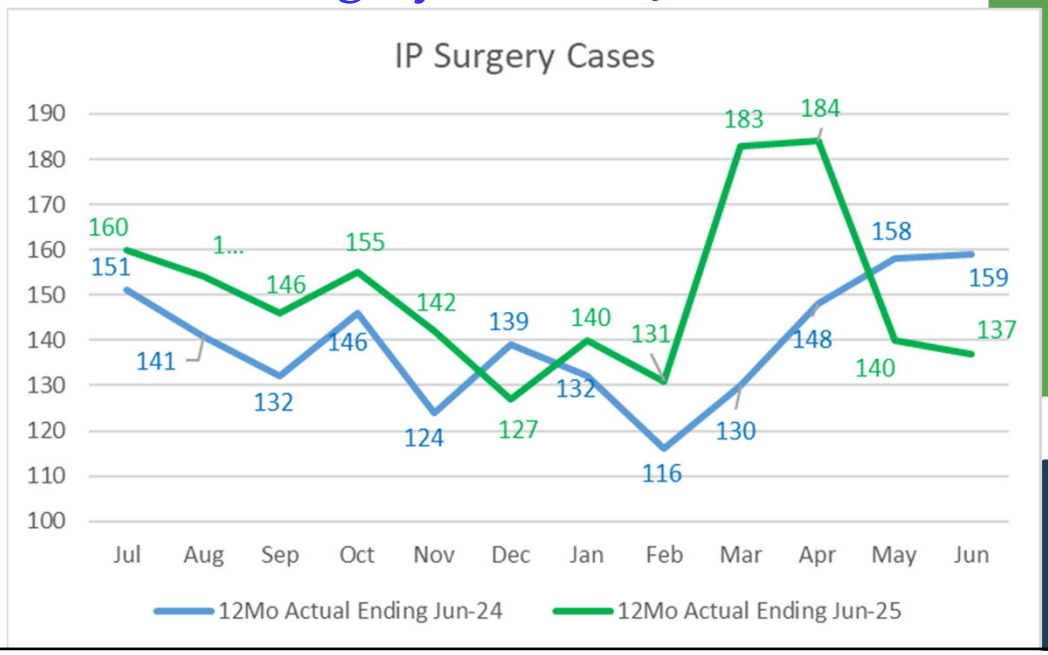
OP Surgeries
Outpatient Surgeries were above budget 22%, 58 cases, at 320

Deliveries
Deliveries were down 4%, 4 cases, below budget at 107

Observation Cases
OP Observations cases were over budget by 59%, or 79 cases at 212

Medicare ALOS
Medicare Traditional ALOS CMI adjusted was favorable to budget at 2.1 days with a Case Mix Index of 1.76

IP Surgery Cases - June 2025



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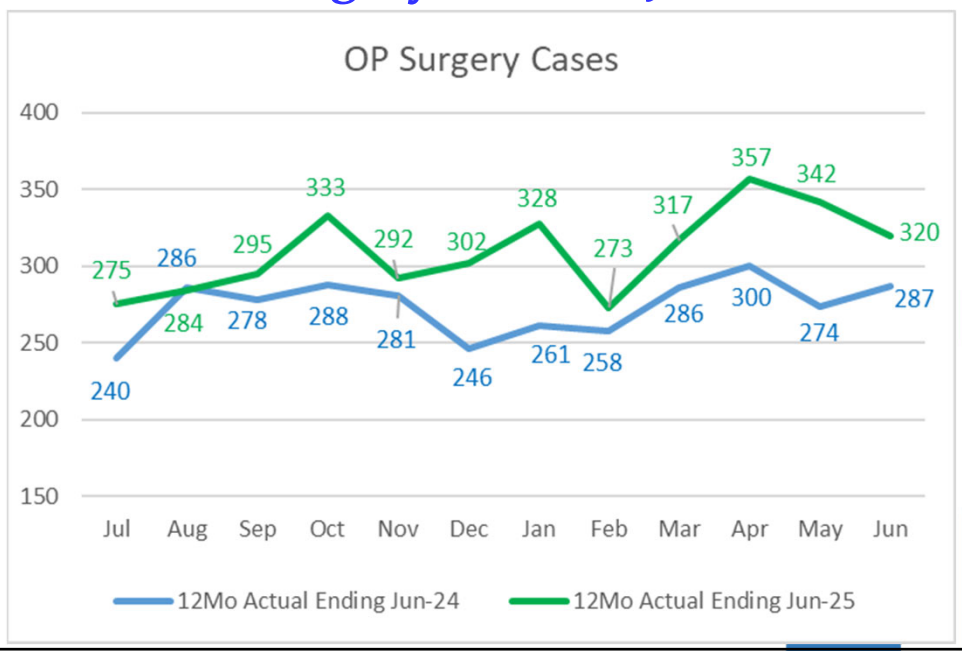
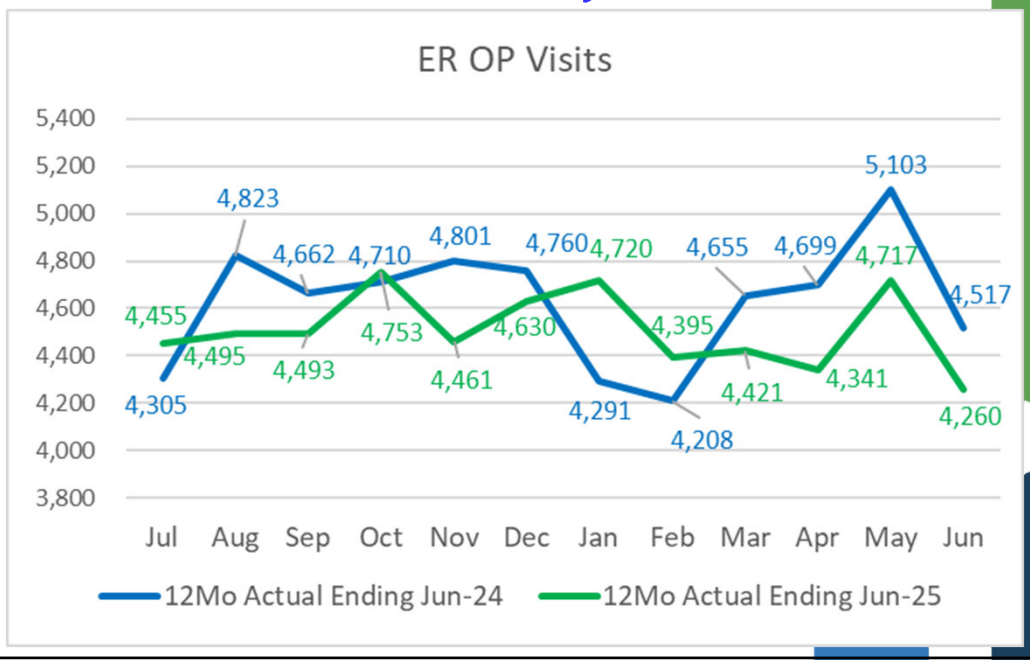
OP Surgery Cases - June 2025



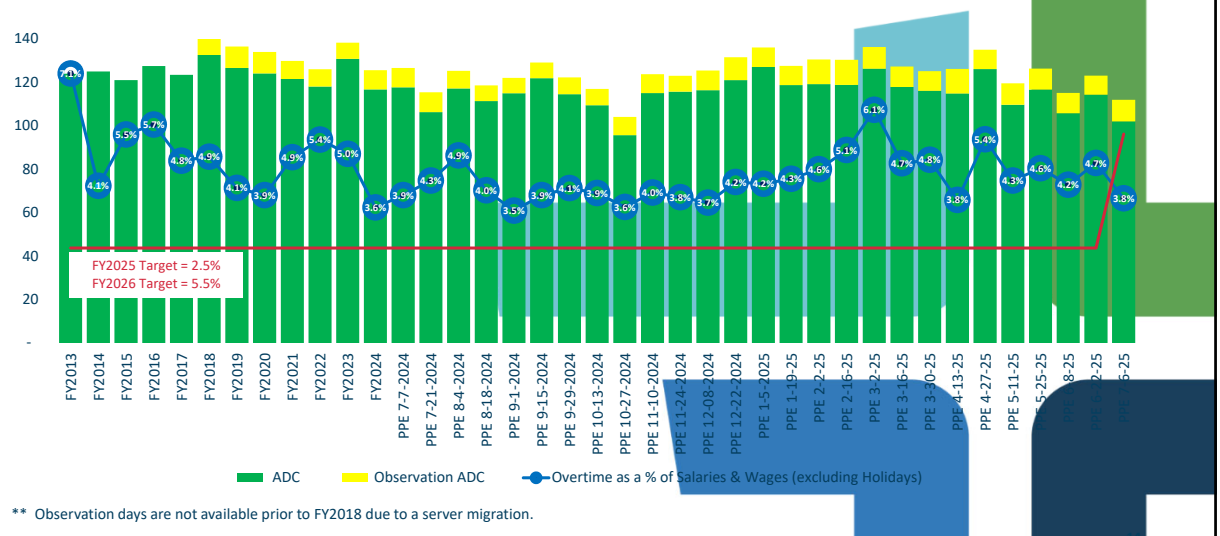
ER OP Visits- June 2025



Labor Productivity – June 2025

1. **Worked FTEs:** During the month of June, worked FTEs on a PAADC basis were 3% unfavorable at **6.8** with a target of **6.6.** *When reviewed on a unit-by-unit level, the variance was **56** FTEs negative (**$0.8M**). Lab was favorable 15.3 Worked FTEs. Excluding Lab, the variance was 71 FTEs negative ($1.0M).*
2. **Worked FTEs decreased** from 1,638 in May to 1,634 in June. Average daily census decreased by 3 compared to prior month at 108 (8% below budget).
3. **Paid FTEs:** On a PAADC basis, paid FTEs were **1%** unfavorable to budget at **8.0 actual vs. 7.9 budget.** Paid FTEs increased from 1,877 in May to 1,913 in June.

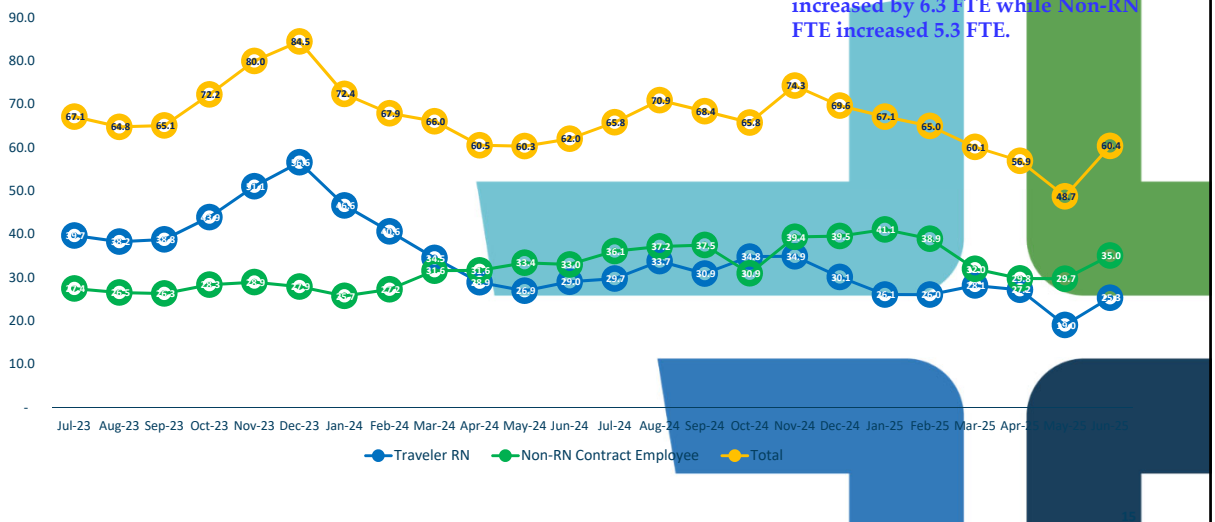
Overtime as a Percent of Total Salaries & Wages (excluding Holidays) Through the pay period ending July 6, 2025



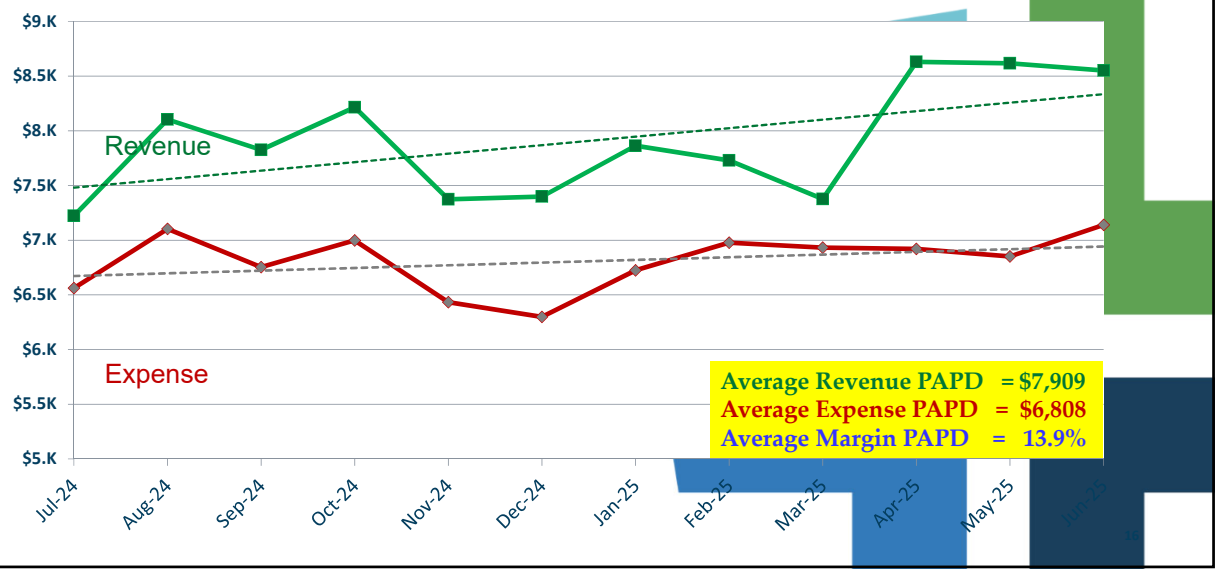
** Observation days are not available prior to FY2018 due to a server migration.

Contract Labor FTE by Month
July 2023 – June 2025

Contract labor increased by 11.6 FTE compared to May. RN travelers increased by 6.3 FTE while Non-RN FTE increased 5.3 FTE.

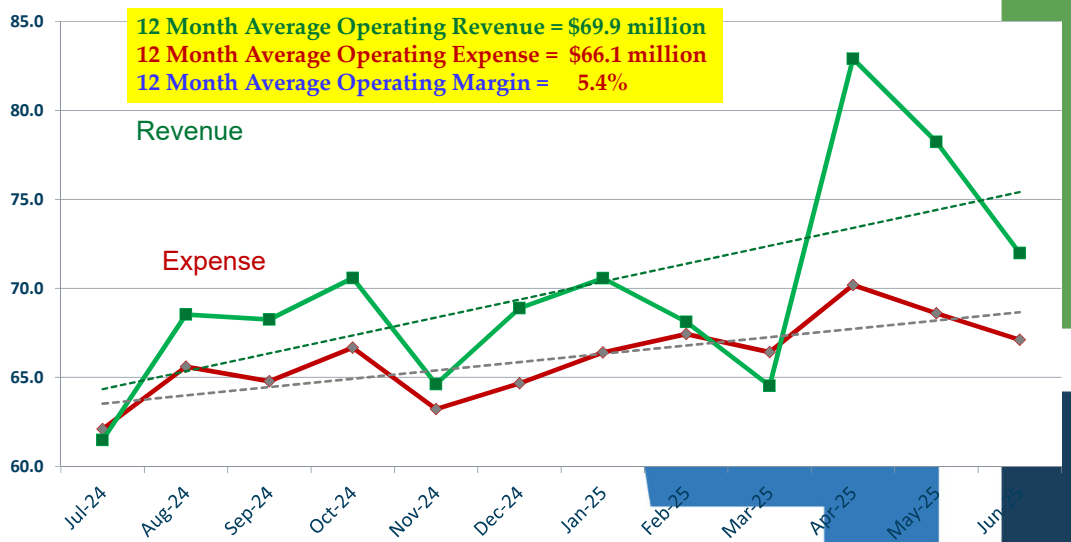


SVHMC Revenues & Expenses Per Adjusted Patient Day
Rolling 12 Months: Jul 24 to June 25



Average Revenue PAPD = $7,909
Average Expense PAPD = $6,808
Average Margin PAPD = 13.9%

SVH Consolidated Revenues & Expenses Rolling 12 Months: Jul 24 to June 25

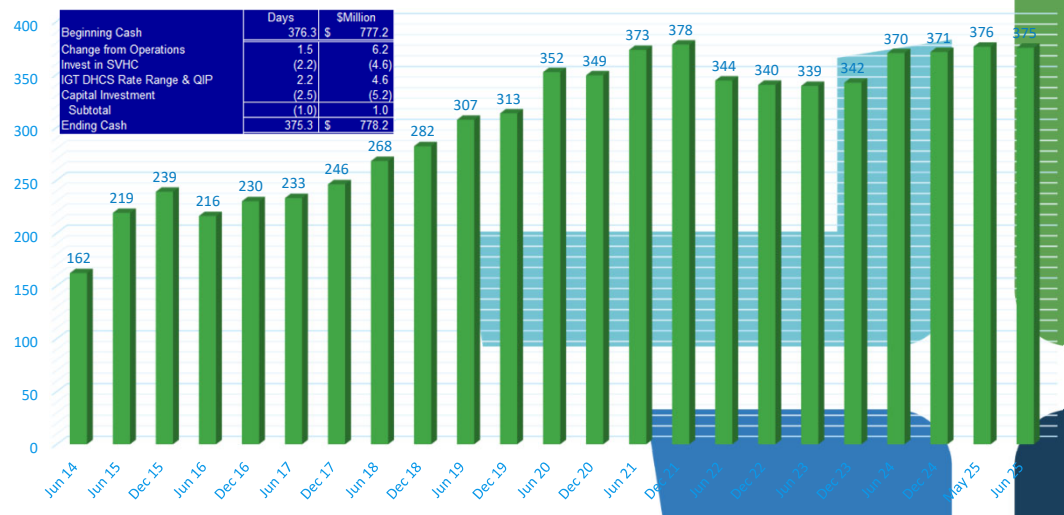


Salinas Valley Health Key Financial Indicators

Statistic	YTD 6/30/25	SVH Target	+/-	S&P A+ Rated Hospitals	+/-	YTD 6/30/24	+/-
Operating Margin*	6.6%	5.0%		4.0%		4.1%	
Total Margin*	11.5%	6.0%		6.6%		9.5%	
EBITDA Margin**	10.8%	7.4%		13.6%		8.7%	
Days of Cash*	375	305		249		370	
Days of Accounts Payable*	42	45		-		51	
Days of Net Accounts Receivable**	68	45		49		56	
Supply Expense as % NPR	14.9%	14.0%		-		14.0%	
SWB Expense as % NPR	50.6%	53.0%		53.7%		53.8%	
Operating Expense per APD*	6,760	6,739		-		6,743	

All metrics above are consolidated for SVH except Operating Expense per APD
*These metrics have **not** been adjusted for normalizing items
**Metric based on Operating Income (consistent with industry standard)
***Metric based on 365 days average net revenue (consistent with industry standard)

Salinas Valley Health
Days Cash on Hand = 375 Days ($778M) - June 2025



Routine Capital Expenditures
Through June 2025

Fiscal Month	FY 2025 Approved Budget *	Total Purchased Expenditures	Remaining	Project	Amount
July	1,916,667	712,780	1,203,887	Nurse Call System	333,949
August	1,916,667	1,382,572	1,737,981	Angio Equipment Replacement	66,226
September	1,916,667	729,309	2,925,338	Cath Lab 3 Equipment Replacement	27,863
October	1,916,667	1,191,148	3,650,857	Lab Air Handler	25,928
November	1,916,667	794,889	4,772,635	Miscellaneous	27,795
December	1,916,667	1,381,451	5,307,851	Total Improvements	481,761
January	1,916,667	1,565,871	5,658,646	IT Laptops, Electronic Signature pads, Software licenses	146,847
February	1,916,667	963,787	6,611,526	Cath Lab Sonosite LX Ultrasound System	42,484
March	1,916,667	815,462	7,712,730	Education Training Tables (20) & Instructor Tables (2)	35,436
April	1,916,667	1,449,571	8,179,826	Security Stryker Power-Load Cot Fastener	35,159
May	1,916,667	622,232	9,474,261	Miscellaneous	42,111
June	1,916,667	783,798	10,607,130	Total Equipment	302,037
YTD TOTAL	**23,000,000**	**12,392,870**	**10,607,130**	**Grand Total**	**783,798**


Questions/Comments
Salinas Valley HEALTH
21

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
June 30, 2025

	Month of June,		Twelve months ended June 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 62,063,203	$ 72,252,041	$ 699,625,337	$ 648,873,348
Other operating revenue	1,702,095	1,095,602	27,051,446	20,123,088
Total operating revenue	63,765,298	73,347,643	726,676,783	668,996,436
Total operating expenses	51,310,580	48,073,203	612,361,012	581,405,204
Total non-operating income	2,051,262	3,841,274	(18,021,995)	(13,268,375)
Operating and non-operating income	$ 14,505,980	$ 29,115,714	$ 96,293,776	$ 74,322,857

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
June 30, 2025

	Current year	Prior year
ASSETS:		
Current assets	$ 450,836,019	$ 401,143,649
Assets whose use is limited or restricted by board	176,240,532	166,413,835
Capital assets	268,321,713	250,296,507
Other assets	311,149,374	303,368,798
Deferred pension outflows	85,734,219	85,734,219
	$ 1,292,281,857	$ 1,206,957,009
LIABILITIES AND EQUITY:		
Current liabilities	94,827,909	99,632,993
Long term liabilities	18,364,449	20,640,668
Lease deferred inflows	(1,716,305)	2,171,322
Pension liability	90,863,576	90,863,576
Net assets	1,089,942,228	993,648,450
	$ 1,292,281,857	$ 1,206,957,009

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
June 30, 2025

	Month of June,		Twelve months ended June 30,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,667	1,829	21,063	21,385
Medi-Cal	980	1,032	12,517	12,532
Commercial insurance	496	577	6,562	6,913
Other patient	103	88	1,455	1,237
Total patient days	3,246	3,526	41,597	42,067
Gross revenue:				
Medicare	$ 137,030,426	$ 121,703,177	$ 1,575,690,497	$ 1,395,446,137
Medi-Cal	81,130,711	77,201,924	994,634,404	875,243,374
Commercial insurance	57,434,309	54,328,979	697,395,885	641,129,022
Other patient	11,463,917	10,052,648	132,919,228	110,305,478
Gross revenue	287,059,363	263,286,728	3,400,640,014	3,022,124,011
Deductions from revenue:				
Administrative adjustment	188,660	244,590	3,378,536	3,607,697
Charity care	627,130	349,225	7,704,358	7,410,211
Contractual adjustments:				
Medicare outpatient	48,047,958	39,430,344	532,607,105	442,800,772
Medicare inpatient	47,752,282	50,081,312	600,952,657	567,347,145
Medi-Cal traditional outpatient	1,484,722	1,796,203	20,853,421	28,467,619
Medi-Cal traditional inpatient	(318,269)	(2,249,601)	47,800,021	45,866,021
Medi-Cal managed care outpatient	40,514,157	36,327,715	483,306,408	395,375,929
Medi-Cal managed care inpatient	28,806,931	20,221,280	323,975,730	297,492,152
Commercial insurance outpatient	27,575,984	19,422,189	327,374,584	270,180,430
Commercial insurance inpatient	22,657,538	18,685,248	266,401,886	245,845,850
Uncollectible accounts expense	5,928,123	5,000,605	67,357,917	53,909,164
Other payors	1,730,944	1,725,577	19,302,054	14,947,674
Deductions from revenue	224,996,160	191,034,688	2,701,014,677	2,373,250,663
Net patient revenue	$ 62,063,203	$ 72,252,041	$ 699,625,337	$ 648,873,348
Gross billed charges by patient type:				
Inpatient	$ 129,577,794	$ 129,076,916	$ 1,586,964,880	$ 1,505,395,392
Outpatient	126,414,919	101,975,544	1,430,384,816	1,154,368,991
Emergency room	31,066,650	32,234,268	383,290,317	362,359,628
Total	$ 287,059,363	$ 263,286,728	$ 3,400,640,013	$ 3,022,124,011

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
June 30, 2025

	Month of June,		Twelve months ended June 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 62,063,203	$ 72,252,041	$ 699,625,337	$ 648,873,348
Other operating revenue	1,702,095	1,095,602	27,051,446	20,123,088
Total operating revenue	63,765,298	73,347,643	726,676,783	668,996,436
Operating expenses:				
Salaries and wages	18,775,863	16,966,515	216,616,602	201,270,627
Compensated absences	3,132,549	3,056,905	37,734,937	36,321,373
Employee benefits	5,423,685	5,637,351	93,951,047	98,607,037
Supplies, food, and linen	10,165,934	8,923,867	110,149,834	91,697,342
Purchased department functions	4,851,047	4,122,625	47,956,842	44,677,529
Medical fees	2,877,281	2,686,306	31,324,616	30,307,206
Other fees	1,571,037	1,794,818	21,727,326	26,902,570
Depreciation	2,621,236	2,771,479	31,114,605	29,727,931
All other expense	1,891,948	2,113,337	21,785,203	21,893,589
Total operating expenses	51,310,580	48,073,203	612,361,012	581,405,204
Income from operations	12,454,718	25,274,440	114,315,771	87,591,232
Non-operating income:				
Donations	3,412,102	1,058,525	9,026,633	3,752,618
Property taxes	1,140,377	2,013,568	6,384,235	5,680,235
Investment income	2,497,324	6,625,951	22,571,505	31,424,366
Taxes and licenses	0	0	0	0
Income from subsidiaries	(4,998,541)	(5,856,770)	(56,004,368)	(54,125,594)
Total non-operating income	2,051,262	3,841,274	(18,021,995)	(13,268,375)
Operating and non-operating income	14,505,980	29,115,714	96,293,776	74,322,857
Net assets to begin	1,075,436,249	964,532,736	993,648,451	919,325,593
Net assets to end	$ 1,089,942,228	$ 993,648,450	$ 1,089,942,228	$ 993,648,450
Net income excluding non-recurring items	$ 14,505,980	$ 29,115,714	$ 96,293,776	$ 74,322,857
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	$ 14,505,980	$ 29,115,714	$ 96,293,776	$ 74,322,857

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
June 30, 2025

	Month of June,		Twelve months ended June 30,	
	current year	prior year	current year	prior year
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	$ (187,542)	$ (203,510)	$ (2,407,711)	$ (2,401,179)
Neurological Clinic	(82,981)	(68,236)	(896,728)	(776,880)
Palliative Care Clinic	(97,777)	(132,842)	(1,167,170)	(1,112,902)
Surgery Clinic	(201,917)	(127,468)	(2,049,011)	(2,098,510)
Infectious Disease Clinic	(49,084)	(32,505)	(565,415)	(450,755)
Endocrinology Clinic	(210,342)	(173,339)	(2,682,757)	(2,646,171)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(609,430)	(400,909)	(7,186,280)	(6,623,279)
OB/GYN Clinic	(429,125)	(189,944)	(4,912,840)	(4,680,756)
PrimeCare Medical Group	(940,206)	(299,187)	(9,966,407)	(9,444,589)
Oncology Clinic	(402,508)	(409,691)	(4,946,946)	(4,246,439)
Cardiac Surgery	(367,872)	(469,067)	(4,161,475)	(3,994,589)
Sleep Center	(73,157)	(91,935)	(999,506)	(746,977)
Rheumatology	(69,148)	(56,170)	(869,731)	(861,353)
Precision Ortho MDs	(465,507)	(417,627)	(5,594,349)	(5,560,948)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(70,815)	(73,149)	(893,543)	(606,135)
Vaccine Clinic	0	(16)	0	0
Dermatology	(20,449)	(62,344)	(425,468)	(489,294)
Hospitalists	0	0	0	0
Behavioral Health	(32,944)	(56,067)	(444,548)	(605,904)
Pediatric Diabetes	(32,343)	(19,251)	(448,785)	(514,063)
Neurosurgery	(121,321)	(190,183)	(1,495,894)	(818,506)
Multi-Specialty-RR	9,475	52,135	171,948	91,961
Radiology	(197,528)	(489,878)	(3,735,772)	(3,211,138)
Salinas Family Practice	(33,131)	(49,104)	(1,234,953)	(1,432,249)
Urology	(189,632)	(149,153)	(2,016,234)	(1,974,315)
Total SVHC	(4,875,284)	(4,109,440)	(58,929,575)	(55,204,970)
Doctors on Duty	(340,957)	(166,745)	247,632	480,575
LPCH NICU JV	0	(1,811,458)	0	(1,811,458)
Central Coast Health Connect	29,720	(102,308)	29,720	(102,308)
Monterey Peninsula Surgery Center	85,934	205,940	1,752,283	1,710,349
Coastal	3,370	67,945	(41,688)	195,730
Apex	0	0	0	0
21st Century Oncology	32,311	(37,148)	288,188	30,926
Monterey Bay Endoscopy Center	66,365	96,445	649,071	575,563
Total	$ (4,998,541)	$ (5,856,770)	$ (56,004,368)	$ (54,125,594)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
June 30, 2025

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 298,732,436	$ 270,616,444
Patient accounts receivable, net of estimated uncollectibles of $65,015,741	130,877,702	111,333,643
Supplies inventory at cost	8,089,558	7,607,679
Current portion of lease receivable	169,584	1,732,185
Other current assets	12,966,739	9,853,698
Total current assets	450,836,019	401,143,649
Assets whose use is limited or restricted by board	176,240,532	166,413,835
Capital assets:		
Land and construction in process	60,799,063	43,340,180
Other capital assets, net of depreciation	207,522,650	206,956,327
Total capital assets	268,321,713	250,296,507
Other assets:		
Right of use assets, net of amortization	7,574,841	7,284,598
Long term lease receivable	(1,865,445)	467,297
Subscription assets, net of amortization	7,733,276	10,207,128
Investment in Securities	272,022,409	257,603,817
Investment in SVHC	764,540	14,375,278
Investment in Coastal	1,710,683	1,877,370
Investment in other affiliates	21,374,531	11,021,137
Net pension asset	1,834,539	532,173
Total other assets	311,149,374	303,368,798
Deferred pension outflows	85,734,219	85,734,219
	$ 1,292,281,857	$ 1,206,957,009
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	$ 64,806,399	$ 66,971,203
Due to third party payers	4,491,164	3,699,690
Current portion of self-insurance liability	20,078,895	22,085,361
Current subscription liability	2,555,609	4,227,920
Current portion of lease liability	2,895,842	2,648,818
Total current liabilities	94,827,909	99,632,993
Long term portion of workers comp liability	11,003,713	12,078,720
Long term portion of lease liability	4,702,091	5,101,119
Long term subscription liability	2,658,645	3,460,829
Total liabilities	113,192,358	120,273,661
Lease deferred inflows	(1,716,305)	2,171,322
Pension liability	90,863,576	90,863,576
Net assets:		
Invested in capital assets, net of related debt	268,321,713	250,296,507
Unrestricted	821,620,515	743,351,943
Total net assets	1,089,942,228	993,648,450
	$ 1,292,281,857	$ 1,206,957,009

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
June 30, 2025

	Month of June,			Twelve months ended June 30,			
	Actual	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:							
Gross billed charges	$ 287,059,363	$ 29,792,671	11.58%	$ 3,400,640,014	$ 3,082,128,594	318,511,420	10.33%
Dedutions from revenue	224,996,160	18,959,948	9.20%	2,701,014,677	2,469,184,467	231,830,210	9.39%
Net patient revenue	62,063,203	10,832,723	21.15%	699,625,337	612,944,127	86,681,210	14.14%
Other operating revenue	1,702,095	249,426	17.17%	27,051,446	17,432,028	9,619,418	55.18%
Total operating revenue	**63,765,298**	**11,082,149**	**21.04%**	**726,676,783**	**630,376,155**	**96,300,628**	**15.28%**
Operating expenses:							
Salaries and wages	18,775,863	1,371,054	7.88%	216,616,602	209,084,229	7,532,373	3.60%
Compensated absences	3,132,549	(206,182)	-6.18%	37,734,937	37,683,444	51,493	0.14%
Employee benefits	5,423,685	(2,724,829)	-33.44%	93,951,047	97,118,446	(3,167,399)	-3.26%
Supplies, food, and linen	10,165,934	3,095,615	43.78%	110,149,834	85,981,374	24,168,460	28.11%
Purchased department functions	4,851,047	1,025,765	26.82%	47,956,842	45,903,393	2,053,449	4.47%
Medical fees	2,877,281	391,644	15.76%	31,324,616	29,827,647	1,496,969	5.02%
Other fees	1,571,037	(151,330)	-8.79%	21,727,326	20,838,710	888,616	4.26%
Depreciation	2,621,236	56,481	2.20%	31,114,605	29,489,338	1,625,267	5.51%
All other expense	1,891,948	(55,169)	-2.83%	21,785,203	23,646,239	(1,861,036)	-7.87%
Total operating expenses	**51,310,580**	**2,803,048**	**5.78%**	**612,361,012**	**579,572,821**	**32,788,191**	**5.66%**
Income from operations	**12,454,718**	**8,279,101**	**198.27%**	**114,315,771**	**50,803,334**	**63,512,437**	**125.02%**
Non-operating income:							
Donations	3,412,102	3,203,769	1537.81%	9,026,633	2,500,000	6,526,633	261.07%
Property taxes	1,140,377	663,663	139.22%	6,384,235	5,720,572	663,663	11.60%
Investment income	2,497,324	606,150	32.05%	22,571,505	22,694,078	(122,573)	-0.54%
Income from subsidiaries	(4,998,541)	124,681	-2.43%	(56,004,368)	(61,478,665)	5,474,297	-8.90%
Total non-operating income	**2,051,262**	**4,598,263**	**-180.54%**	**(18,021,995)**	**(30,564,015)**	**12,542,020**	**-41.04%**
Operating and non-operating income	**$ 14,505,980**	**$ 12,877,364**	**790.69%**	**$ 96,293,776**	**$ 20,239,319**	**76,054,457**	**375.78%**

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

	Month of June		Twelve months to date		
	2024	2025	2023-24	2024-25	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	54	30	444	415	(29)
Other Admissions	70	77	906	984	78
Total Admissions	124	107	1,350	1,399	49
Medi-Cal Patient Days	54	49	643	752	109
Other Patient Days	147	112	1,541	1,488	(53)
Total Patient Days of Care	201	161	2,184	2,240	56
Average Daily Census	6.7	5.4	6.0	6.1	0.2
Medi-Cal Average Days	1.5	1.7	1.7	2.0	0.3
Other Average Days	0.8	1.6	1.7	1.6	(0.1)
Total Average Days Stay	1.7	1.6	1.7	1.7	0.0
ADULTS & PEDIATRICS					
Medicare Admissions	384	366	4,474	4,646	172
Medi-Cal Admissions	312	272	3,211	3,413	202
Other Admissions	409	303	3,668	3,729	61
Total Admissions	1,105	941	11,353	11,788	435
Medicare Patient Days	1,569	1,289	18,036	17,499	(537)
Medi-Cal Patient Days	1,080	1,069	12,951	13,191	240
Other Patient Days	926	676	11,213	8,893	(2,320)
Total Patient Days of Care	3,575	3,034	42,200	39,583	(2,617)
Average Daily Census	119.2	101.1	115.6	108.4	(7.2)
Medicare Average Length of Stay	4.2	3.4	4.0	3.8	(0.3)
Medi-Cal AverageLength of Stay	3.5	3.3	3.5	3.4	(0.1)
Other Average Length of Stay	2.3	1.9	2.5	1.9	(0.6)
Total Average Length of Stay	3.3	2.9	3.3	3.0	(0.3)
Deaths	15	30	310	317	7
Total Patient Days	3,776	3,195	44,384	41,823	(2,561)
Medi-Cal Administrative Days	0	0	398	0	(398)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	0	0	398	0	(398)
Percent Non-Acute	0.00%	0.00%	0.90%	0.00%	-0.90%

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

	Month of June		Twelve months to date		
	2024	2025	2023-24	2024-25	Variance
PATIENT DAYS BY LOCATION					
Level I	271	239	3,020	3,008	(12)
Heart Center	325	314	3,902	3,838	(64)
Monitored Beds	650	530	7,390	6,892	(498)
Single Room Maternity/Obstetrics	300	282	3,543	4,001	458
Med/Surg - Cardiovascular	864	762	10,077	10,389	312
Med/Surg - Oncology	180	269	3,234	3,201	(33)
Med/Surg - Rehab	499	451	5,541	5,604	63
Pediatrics	128	99	1,561	1,416	(145)
Nursery	201	161	2,184	2,240	56
Neonatal Intensive Care	44	88	1,205	1,234	29
PERCENTAGE OF OCCUPANCY					
Level I	69.49%	61.28%	63.47%	63.22%	
Heart Center	72.22%	69.78%	71.07%	69.91%	
Monitored Beds	80.25%	65.43%	74.78%	69.74%	
Single Room Maternity/Obstetrics	27.03%	25.41%	26.16%	29.55%	
Med/Surg - Cardiovascular	64.00%	56.44%	61.18%	63.08%	
Med/Surg - Oncology	46.15%	68.97%	67.97%	67.28%	
Med/Surg - Rehab	63.97%	57.82%	58.23%	58.89%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	23.70%	18.33%	23.69%	21.49%	
Nursery	40.61%	32.53%	18.08%	18.55%	
Neonatal Intensive Care	13.33%	26.67%	29.93%	30.65%	

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

	Month of June		Twelve months to date		
	2024	2025	2023-24	2024-25	Variance
DELIVERY ROOM					
Total deliveries	99	109	1,266	1,391	125
C-Section deliveries	29	31	382	444	62
Percent of C-section deliveries	29.29%	28.44%	30.17%	31.92%	1.75%
OPERATING ROOM					
In-Patient Operating Minutes	17,993	17,976	196,776	227,251	30,475
Out-Patient Operating Minutes	32,130	36,424	361,429	430,580	69,151
Total	50,123	54,400	558,205	657,831	99,626
Open Heart Surgeries	10	10	136	140	4
In-Patient Cases	126	115	1,380	1,477	97
Out-Patient Cases	320	342	3,581	4,040	459
EMERGENCY ROOM					
Immediate Life Saving	36	38	443	449	6
High Risk	856	941	9,470	10,558	1,088
More Than One Resource	2,758	2,565	33,671	33,283	(388)
One Resource	1,842	1,685	22,909	21,390	(1,519)
No Resources	81	60	1,052	826	(226)
Total	5,573	5,289	67,545	66,506	(1,039)

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

	Month of June		Twelve months to date		
	2024	2025	2023-24	2024-25	Variance
CENTRAL SUPPLY					
In-patient requisitions	12,716	10,926	154,567	147,044	-7,523
Out-patient requisitions	10,300	10,667	126,556	131,103	4,547
Emergency room requisitions	645	357	8,252	6,280	-1,972
Interdepartmental requisitions	6,892	6,460	79,697	82,251	2,554
Total requisitions	30,553	28,410	369,072	366,678	-2,394
LABORATORY					
In-patient procedures	36,157	35,773	433,828	430,760	-3,068
Out-patient procedures	41,060	47,646	377,306	547,508	170,202
Emergency room procedures	11,665	11,582	153,246	148,768	-4,478
Total patient procedures	88,882	95,001	964,380	1,127,036	162,656
BLOOD BANK					
Units processed	292	296	3,370	3,398	28
ELECTROCARDIOLOGY					
In-patient procedures	1,117	1,189	13,338	13,678	340
Out-patient procedures	388	615	4,742	5,641	899
Emergency room procedures	1,277	1,291	15,122	15,589	467
Total procedures	2,782	3,095	33,202	34,908	1,706
CATH LAB					
In-patient procedures	115	129	1,508	1,621	113
Out-patient procedures	155	165	1,520	1,544	24
Emergency room procedures	0	0	1	2	1
Total procedures	270	294	3,029	3,167	138
ECHO-CARDIOLOGY					
In-patient studies	403	370	4,618	4,757	139
Out-patient studies	260	305	3,370	4,016	646
Emergency room studies	4	2	17	21	4
Total studies	667	677	8,005	8,794	789
NEURODIAGNOSTIC					
In-patient procedures	141	127	1,538	1,642	104
Out-patient procedures	13	26	203	306	103
Emergency room procedures	0	1	0	2	2
Total procedures	154	154	1,741	1,950	209

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

	Month of June		Twelve months to date		
	2024	2025	2023-24	2024-25	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	1	1
Out-patient procedures	259	324	3,031	3,496	465
Emergency room procedures	0	0	0	0	0
Total procedures	259	324	3,031	3,497	466
RADIOLOGY					
In-patient procedures	1,267	1,240	15,651	15,510	-141
Out-patient procedures	456	506	4,953	5,441	488
Emergency room procedures	1,505	1,476	18,172	18,638	466
Total patient procedures	3,228	3,222	38,776	39,589	813
MAGNETIC RESONANCE IMAGING					
In-patient procedures	183	200	1,817	2,191	374
Out-patient procedures	98	124	1,299	1,456	157
Emergency room procedures	8	4	74	72	-2
Total procedures	289	328	3,190	3,719	529
MAMMOGRAPHY CENTER					
In-patient procedures	3,065	4,073	48,819	46,419	-2,400
Out-patient procedures	3,045	4,056	48,356	46,252	-2,104
Emergency room procedures	0	3	10	15	5
Total procedures	6,110	8,132	97,185	92,686	-4,499
NUCLEAR MEDICINE					
In-patient procedures	15	18	228	184	-44
Out-patient procedures	137	152	1,421	1,633	212
Emergency room procedures	0	0	3	3	0
Total procedures	152	170	1,652	1,820	168
PHARMACY					
In-patient prescriptions	80,980	76,368	999,487	959,666	-39,821
Out-patient prescriptions	15,898	18,492	191,292	207,588	16,296
Emergency room prescriptions	9,743	9,447	114,678	118,469	3,791
Total prescriptions	106,621	104,307	1,305,457	1,285,723	-19,734
RESPIRATORY THERAPY					
In-patient treatments	15,192	14,329	191,679	176,273	-15,406
Out-patient treatments	348	961	12,400	11,241	-1,159
Emergency room treatments	637	396	6,246	6,182	-64
Total patient treatments	16,177	15,686	210,325	193,696	-16,629
PHYSICAL THERAPY					
In-patient treatments	2,224	2,265	29,748	27,338	-2,410
Out-patient treatments	247	586	3,074	3,955	881
Emergency room treatments	0	0	0	0	0
Total treatments	2,471	2,851	32,822	31,293	-1,529

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

	Month of June		Twelve months to date		
	2024	2025	2023-24	2024-25	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,289	1,423	17,072	17,567	495
Out-patient procedures	245	362	2,761	3,097	336
Emergency room procedures	0	0	0	0	0
Total procedures	1,534	1,785	19,833	20,664	831
SPEECH THERAPY					
In-patient treatments	539	518	6,054	6,386	332
Out-patient treatments	36	47	447	483	36
Emergency room treatments	0	0	0	0	0
Total treatments	575	565	6,501	6,869	368
CARDIAC REHABILITATION					
In-patient treatments	0	0	12	9	-3
Out-patient treatments	535	641	6,641	7,503	862
Emergency room treatments	0	0	3	4	1
Total treatments	535	641	6,656	7,516	860
CRITICAL DECISION UNIT					
Observation hours	349	263	3,792	3,082	-710
ENDOSCOPY					
In-patient procedures	75	105	934	1,001	67
Out-patient procedures	72	70	708	697	-11
Emergency room procedures	0	0	0	4	4
Total procedures	147	175	1,642	1,702	60
C.T. SCAN					
In-patient procedures	778	772	8,692	9,182	490
Out-patient procedures	377	526	4,304	6,005	1,701
Emergency room procedures	655	722	8,749	8,649	-100
Total procedures	1,810	2,020	21,745	23,836	2,091
DIETARY					
Routine patient diets	11,891	16,896	191,757	194,030	2,273
Meals to personnel	31,578	29,738	358,577	422,654	64,077
Total diets and meals	43,469	46,634	550,334	616,684	66,350
LAUNDRY AND LINEN					
Total pounds laundered	94,389	104,106	1,164,513	1,201,720	37,207

Finance Committee Board Paper

Agenda Item: **Consider Recommendation for Board Approval of the Short Term Lease Agreement for Epic Inpatient Training Space at 928 East Blanco Road, Suite 121, Salinas Between Salinas Valley Health and Rancho Llano Development, LLC**

Executive Sponsors: Gary Ray, Chief Legal Officer
Brad McCoy, Vice President of Facilities, Construction & Real Estate

Date: July 15, 2025

Executive Summary

As part of the multi-year implementation plan for the Epic Inpatient System, SVH requires additional space for training purposes. Very recently, 1,914 square feet of office space became available at 928 East Blanco Road, Suite 121 in Salinas. This additional space is located in the same building as the SVH IT and Enterprise Informatics Offices and can be leased under a modified gross month-to-month lease. At this time, the plan is to lease the space for four to six months. If needed, there may be an opportunity to add this space on a longer term basis. The landlord is very flexible in working with SVH to meet its space needs.

Timeline

July 21, 2025 – Request SVH Finance Committee Recommendation for Board Approval
July 24, 2025 – SVH Board of Directors Meeting/Consider Recommendation for Approval
August 1, 2025 – Commencement Date of Month-to-Month Lease Agreement

Meeting our Mission, Vision, Goals—Strategic Plan Alignment

This transaction is aligned with strategic initiatives supporting the implementation of the Epic Inpatient system.

Pillar/Goal Alignment: ☐ Service ☐ People ☐ Quality ☑ Finance ☑ Growth ☐ Community

Financial/Quality/Safety/Regulatory Implications

The modified gross Lease Agreement is month-to-month for Suite 121 at 928 East Blanco Road, Salinas:

1. Lease Commencement Date	August 1, 2025
2. Term of Lease	Month-to Month
3. Option	Possible option for longer term lease if there is a need.
4. Payment Terms	Modified Gross Lease (utilities covered except for PG&E)
5. Initial Rent (per sq. ft.)	$2.15 per square foot
6. Rentable square feet	1,914 rentable square feet
7. Initial Rent	$4,115.70
8. Tenant Improvements	Clean carpet, paint, replace some ceiling tiles

Recommendation

Administration requests that the Finance Committee make a recommendation to the Board of Directors to approve the Short Term Lease Agreement for Epic Inpatient Training Space at 928 East Blanco Road, Suite 121 Salinas Between Salinas Valley Health and Rancho Llano Development, LLC

COMMERCIAL LEASE AGREEMENT
(C.A.R. Form CL, Revised 12/24)

Date (For reference only): *July 1, 2025*
Rancho Llano Development LLC, a California Limited Liability Company (Owner, Authorized Broker or Agent, or Property Manager, ("Landlord")) and *Salinas Valley Memorial Healthcare System, a California Local Health Care District dba Salinas Valley Health* ("Tenant") agree as follows:

1. **PROPERTY:** Landlord rents to Tenant and Tenant rents from Landlord, the real property and improvements described as *928 E. Blanco, Ste 121, Salinas, CA 93901 +/-1,914 rsf* ("Premises"), which comprise approximately *3.240* % of the total square footage of rentable space in the entire property. See exhibit *A* for a further description of the Premises.
2. **TERM:** The term begins on (date) *August 1, 2025* ("Commencement Date"), **(Check A or B):**
   - **A.** ☐ **Lease:** and shall terminate on (date) _____ at _____ ☐AM ☐ PM. Any holding after the term of this agreement expires, with Landlord's consent, shall create a month-to-month tenancy that either party may terminate as specified in **paragraph 2B**. Rent shall be at a rate equal to the rent for the immediately preceding month, payable in advance. All other terms and conditions of this agreement shall remain in full force and effect.
   - **B.** ☒ **Month-to-month:** and continues as a month-to-month tenancy. Either party may terminate the tenancy by giving written notice to the other at least 30 days prior to the intended termination date, subject to any applicable laws. Such notice may be given on any date.
   - **C. RENEWAL OR EXTENSION TERMS:** *None* OR ☐ See attached addendum.
3. **BASE RENT:**
   - **A.** Tenant agrees to pay Base Rent at the rate of (CHECK ONE ONLY):
     - ☒ (1) $*4,115.70* per month, for the term of the agreement.
     - ☐ (2) $_____ per month, for the first 12 months of the agreement. Commencing with the 13th month, and upon expiration of each 12 months thereafter, rent shall be adjusted according to any increase in the U.S. Consumer Price Index of the Bureau of Labor Statistics of the Department of Labor for All Urban Consumers ("CPI") for _____ (the city nearest the location of the Premises), based on the following formula: Base Rent will be multiplied by the most current CPI preceding the first calendar month during which the adjustment is to take effect, and divided by the most recent CPI preceding the Commencement Date. In no event shall any adjusted Base Rent be less than the Base Rent for the month immediately preceding the adjustment. If the CPI is no longer published, then the adjustment to Base Rent shall be based on an alternate index that most closely reflects the CPI.
     - ☐ (3) $_____ per month for the period commencing _____ and ending _____ and $_____ per month for the period commencing _____ and ending _____ and $_____ per month for the period commencing _____ and ending _____.
     - ☐ (4) In accordance with the attached rent schedule.
     - ☐ (5) Other: _____ .
   - **B.** Base Rent is payable in advance on the 1st (or ☐ _____) day of each calendar month, and is delinquent on the next day.
   - **C.** If the Commencement Date falls on any day other than the first day of the month, Base Rent for the first calendar month shall be prorated based on a 30-day period. If Tenant has paid one full month's Base Rent in advance of Commencement Date, Base Rent for the second calendar month shall be prorated based on a 30-day period.
4. **RENT:**
   - **A. Definition:** ("Rent") shall mean all monetary obligations of Tenant to Landlord under the terms of this agreement, except security deposit.
   - **B. Payment:** Rent shall be paid to (Name) *Rancho Llano Development, LLC* at (address) *c/o M.A. Wynne 27810 Mesa Del Toro Road, Salinas, CA 93908*, or at any other location specified by Landlord in writing to Tenant.
   - **C. Timing:** Base Rent shall be paid as specified in **paragraph 3**. All other Rent shall be paid within 30 days after Tenant is billed by Landlord.
5. **EARLY POSSESSION:** Tenant is entitled to possession of the Premises on *07/01/2025*. If Tenant is in possession prior to the Commencement Date, during this time **(i)** Tenant is not obligated to pay Base Rent, and **(ii)** Tenant ☐ is ☒ is not obligated to pay Rent other than Base Rent. Whether or not Tenant is obligated to pay Rent prior to Commencement Date, Tenant is obligated to comply with all other terms of this agreement.
6. **SECURITY DEPOSIT:**
   - **A.** Tenant agrees to pay Landlord $_____ as a security deposit. Tenant agrees not to hold Broker responsible for its return. (IF CHECKED:) ☐ If Base Rent increases during the term of this agreement, Tenant agrees to increase deposit by the same proportion as the increase in Base Rent.
   - **B.** All or any portion of the security deposit may be used, as reasonably necessary, to: **(i)** cure Tenant's default in payment of Rent, late charges, non-sufficient funds ("NSF") fees, or other sums due; **(ii)** repair damage, excluding ordinary wear and tear, caused by Tenant or by a guest or licensee of Tenant; **(iii)** broom clean the Premises, if necessary, upon termination of tenancy; and **(iv)** cover any other unfulfilled obligation of Tenant. **SECURITY DEPOSIT SHALL NOT BE USED BY TENANT IN LIEU OF PAYMENT OF LAST MONTH'S RENT.** If all or any portion of the security deposit is used during tenancy, Tenant agrees to reinstate the total security deposit within 5 days after written notice is delivered to Tenant. Within 30 days after Landlord receives possession of the Premises, Landlord shall: **(i)** furnish Tenant an itemized statement indicating the amount of any security deposit received and the basis for its disposition, and **(ii)** return any remaining portion of security deposit to Tenant. However, if the Landlord's only claim upon the security deposit is for unpaid Rent, then the remaining portion of the security deposit, after deduction of unpaid Rent, shall be returned within 14 days after the Landlord receives possession.
   - **C.** No interest will be paid on security deposit, unless required by local ordinance.

7. QUALIFIED COMMERCIAL TENANT

A. DEFINITION: A "Qualified Commercial Tenant" means a tenant of commercial real property that meets both of the following requirements:

- The tenant is a microenterprise, a restaurant with fewer than 10 employees, or a nonprofit organization with fewer than 20 employees ("microenterprise" as defined under Business and Professions code § 18000 means a sole proprietorship, partnership, limited liability company, or corporation that meets both of the following: **(i)** has 5 or fewer employees including the owner, and **(ii)** generally lacks sufficient access to loans, equity, or other financial capital); and
- **(i)** Subject to subclause (ii), the tenant has provided the landlord, within the previous 12 months, a written notice that the tenant is a qualified commercial tenant and a self-attestation regarding the number of employees, at such time the protections under this provision come into place.
  (ii) Unless the tenancy is from week to week, month to month, or other period less than a month, the tenant provided the notice of self-attestation described in subclause (i) before or upon execution of the lease, and annually thereafter, at such time the protections under this provision come into place.

B. MODIFICATIONS TO AGREEMENT: If Tenant is a Qualified Commercial Tenant, the following provisions apply:

(1) **NOTICE OF RIGHT TO RECEIVE FOREIGN LANGUAGE TRANSLATION OF LEASE/RENTAL AGREEMENTS:** California Civil Code requires a Landlord or property manager to provide a tenant with a foreign language translation copy of a lease or rental agreement if the agreement was negotiated primarily in Spanish, Chinese, Korean, Tagalog or Vietnamese. If applicable, every term of the lease/rental needs to be translated except for, among others, names, dollar amounts and dates written as numerals, and words with no generally accepted non-English translation. Even if Tenant negotiates through the Tenant's own interpreter, Landlord is not relieved on this obligation.

(2) **TERMINATION:** If Tenant has occupied the Premises for one year or more and is on a month to month tenancy, Landlord shall give notice at least 60 days prior to the propose date of termination.

(3) **NOTICE TO INCREASE RENT:** For any proposed rent increase greater than 10 percent of the rental amount charged to Tenant at any time during the 12 months before the effective date of the increase, the notice shall be delivered at least 90 days before the effective date of the increase, and subject to California Civil Code § 1013 if served by mail.

(4) **NOTICE AND DOCUMENTATION RELATED TO PROPERTY OPERATING EXPENSES:**

(A) **NOTICE PRIOR TO EXECUTION OF THE LEASE:** Tenant may inspect any supporting documentation of building operating costs upon written request. Within 30 days of a written request, Landlord shall provide supporting documentation of the previously incurred or reasonably expected building operating costs.

(B) **TIMING OF EXPENSES:** Operating expenses must have been incurred within the previous 18 months, or reasonably expected to be incurred within the next 12 months of any payment.

(C) **SUPPORTING DOCUMENTATION:** Landlord shall provide supporting documentation prior to any charge to recover any building operating costs from tenant under **paragraph 15**.

8. PAYMENTS:

		TOTAL DUE	PAYMENT RECEIVED	BALANCE DUE	DUE DATE
A.	**Rent:** From *08/01/2025* To *08/31/2025*	$ *4,115.70*	$	$ *4,115.70*	*08/01/2025*
B.	**Security Deposit**	$	$	$	
C.	**Other:** _____ Category	$	$	$	
D.	**Other:** _____ Category	$	$	$	
E.	**Total**:	$ *4,115.70*	$	$ *4,115.70*	

9. PARKING: Tenant is entitled to *Seven (7)* unreserved and _____ reserved vehicle parking spaces. The right to parking [X] is [ ] is not included in the Base Rent charged pursuant to **paragraph 3**. If not included in the Base Rent, the parking rental fee shall be an additional $_____ per month. Parking space(s) are to be used for parking operable motor vehicles, except for trailers, boats, campers, buses or trucks (other than pick-up trucks). Tenant shall park in assigned space(s) only. Parking space(s) are to be kept clean. Vehicles leaking oil, gas or other motor vehicle fluids shall not be parked in parking spaces or on the Premises. Mechanical work or storage of inoperable vehicles is not allowed in parking space(s) or elsewhere on the Premises. No overnight parking is permitted.

10. ADDITIONAL STORAGE: Storage is permitted as follows: _____. The right to additional storage space [ ] is [X] is not included in the Base Rent charged pursuant to **paragraph 3**. If not included in Base Rent, storage space shall be an additional $_____ per month. Tenant shall store only personal property that Tenant owns, and shall not store property that is claimed by another, or in which another has any right, title, or interest. Tenant shall not store any improperly packaged food or perishable goods, flammable materials, explosives, or other dangerous or hazardous material. Tenant shall pay for, and be responsible for, the clean-up of any contamination caused by Tenant's use of the storage area.

11. LATE CHARGE; INTEREST; NSF CHECKS: Tenant acknowledges that either late payment of Rent or issuance of a NSF check may cause Landlord to incur costs and expenses, the exact amount of which are extremely difficult and impractical to determine. These costs may include, but are not limited to, processing, enforcement and accounting expenses, and late charges imposed on Landlord. If any installment of Rent due from Tenant is not received by Landlord within 5 calendar days after date due, or if a check is returned NSF, Tenant shall pay to Landlord, respectively, $*411.57* as late charge, plus 10% interest per annum on the delinquent amount and $25.00 as a NSF fee, any of which shall be deemed additional Rent. Landlord and Tenant agree that these charges represent a fair and reasonable estimate of the costs Landlord may incur by reason of Tenant's late or NSF payment. Any late charge, delinquent interest, or NSF fee due shall be paid with the current installment of Rent. Landlord's acceptance of any late charge or NSF fee shall not constitute a waiver as to any default of Tenant. Landlord's right to collect a Late Charge or NSF fee shall not be deemed an extension of the date Rent is due under **paragraph 4,** or prevent Landlord from exercising any other rights and remedies under this agreement, and as provided by law.

12. CONDITION OF PREMISES: Tenant has examined the Premises and acknowledges that Premises is clean and in operative condition, with the following exceptions: *Tenant shall accept the Premises "as-is" subject to all electrical, plumbing and mechanical in good working order*. Items listed as exceptions shall be dealt with in the following manner: _____.

13. ZONING AND LAND USE: Tenant accepts the Premises subject to all local, state and federal laws, regulations and ordinances ("Laws"). Landlord makes no representation or warranty that Premises are now or in the future will be suitable for Tenant's use. Tenant has made its own investigation regarding all applicable Laws.

14. TENANT OPERATING EXPENSES: Tenant agrees to pay for all utilities and services directly billed to Tenant.

15. PROPERTY OPERATING EXPENSES:

A. Tenant agrees to pay its proportionate share of Landlord's estimated monthly property operating expenses, including but not limited to, common area maintenance, consolidated utility and service bills, insurance, and real property taxes, based on the ratio of the square footage of the Premises to the total square footage of the rentable space in the entire property.

B. [X] **(If checked) paragraph 15** does not apply.

16. USE: The Premises are for the sole use as _____. No other use is permitted without Landlord's prior written consent. If any use by Tenant causes an increase in the premium on Landlord's existing property insurance, Tenant shall pay for the increased cost. Tenant will comply with all Laws affecting its use of the Premises.

17. RULES/REGULATIONS: Tenant agrees to comply with all rules and regulations of Landlord (and, if applicable, Owner's Association) that are at any time posted on the Premises or delivered to Tenant. Tenant shall not, and shall ensure that guests and licensees of Tenant do not, disturb, annoy, endanger, or interfere with other tenants of the building or neighbors, or use of the Premises for any unlawful purposes, including, but not limited to, using, manufacturing, selling, storing, or transporting illicit drugs or other contraband, or violate any law or ordinance, or committing a waste or nuisance on or about the Premises.

18. MAINTENANCE:

A. Tenant **OR** [X] (**If checked**, Landlord) shall professionally maintain the Premises including heating, air conditioning, electrical, plumbing and water systems, if any.

B. Tenant **OR** [X] (**If checked**, Landlord) shall keep glass, windows and doors in operable and safe condition.

C. Landlord **OR** [ ] (**If checked**, Tenant) shall maintain the roof, foundation, exterior walls, common areas and _____ _____ _____.

D. Unless Landlord is indicated above, if Tenant fails to maintain the Premises, or keep it in operable and safe condition, as specified in **18A-C**, Landlord may contract for or perform such services to maintain the Premises, or keep it in operable and safe condition, as specified in **18A-C**, and charge Tenant for Landlord's cost.

19. ALTERATIONS: Tenant shall not make any alterations in or about the Premises, including installation of trade fixtures and signs, without Landlord's prior written consent, which shall not be unreasonably withheld. Any alterations to the Premises shall be done according to Law and with required permits. Tenant shall give Landlord advance notice of the commencement date of any planned alteration, so that Landlord, at its option, may post a Notice of Non-Responsibility to prevent potential liens against Landlord's interest in the Premises. Landlord may also require Tenant to provide Landlord with lien releases from any contractor performing work on the Premises.

20. GOVERNMENT IMPOSED ALTERATIONS: Any alterations required by Law as a result of Tenant's use shall be Tenant's responsibility. Landlord shall be responsible for any other alterations required by Law.

21. ENTRY: Tenant shall make Premises available to Landlord or Landlord's agent for the purpose of entering to make inspections, necessary or agreed repairs, alterations, or improvements, or to supply necessary or agreed services, or to show Premises to prospective or actual purchasers, tenants, mortgagees, lenders, appraisers, or contractors. Landlord and Tenant agree that 24 hours notice (oral or written) shall be reasonable and sufficient notice. In an emergency, Landlord or Landlord's representative may enter Premises at any time without prior notice.

22. SIGNS: Tenant authorizes Landlord to place a FOR SALE sign on the Premises at any time, and a FOR LEASE sign on the Premises within the **90 (or** [ ] _____ **) day** period preceding the termination of the agreement.

23. SUBLETTING/ASSIGNMENT: Tenant shall not sublet or encumber all or any part of Premises, or assign or transfer this agreement or any interest in it, without the prior written consent of Landlord, which shall not be unreasonably withheld. Unless such consent is obtained, any subletting, assignment, transfer, or encumbrance of the Premises, agreement, or tenancy, by voluntary act of Tenant, operation of law, or otherwise, shall be null and void, and, at the option of Landlord, terminate this agreement. Any proposed sublessee, assignee, or transferee shall submit to Landlord an application and credit information for Landlord's approval, and, if approved, sign a separate written agreement with Landlord and Tenant. Landlord's consent to any one sublease, assignment, or transfer, shall not be construed as consent to any subsequent sublease, assignment, or transfer, and does not release Tenant or Tenant's obligation under this agreement.

24. POSSESSION: If Landlord is unable to deliver possession of Premises on Commencement Date, such date shall be extended to the date on which possession is made available to Tenant. However, the expiration date shall remain the same as specified in **paragraph 2**. If Landlord is unable to deliver possession within **60 (or** [ ] ___**)** calendar days after the agreed Commencement Date, Tenant may terminate this agreement by giving written notice to Landlord, and shall be refunded all Rent and security deposit paid.

25. TENANT'S OBLIGATIONS UPON VACATING PREMISES: Upon termination of agreement, Tenant shall: **(i)** give Landlord all copies of all keys or opening devices to Premises, including any common areas; **(ii)** vacate Premises and surrender it to Landlord empty of all persons and personal property; **(iii)** vacate all parking and storage spaces; **(iv)** deliver Premises to Landlord in the same condition as referenced in **paragraph 12**; **(v)** clean Premises; **(vi)** give written notice to Landlord of Tenant's forwarding address; and **(vii)** ____ _____.

All improvements installed by Tenant, with or without Landlord's consent, become the property of Landlord upon termination. Landlord may nevertheless require Tenant to remove any such improvement that did not exist at the time possession was made available to Tenant.

26. BREACH OF CONTRACT/EARLY TERMINATION: In event Tenant, prior to expiration of this agreement, breaches any obligation in this agreement, abandons the premises, or gives notice of tenant's intent to terminate this tenancy prior to its expiration, in addition to any obligations established by **paragraph 25**, Tenant shall also be responsible for lost rent, rental commissions, advertising expenses, and painting costs necessary to ready Premises for re-rental. Landlord may also recover from Tenant: **(i)** the worth, at the time of award, of the unpaid Rent that would have been earned at the time of termination; **(ii)** the worth, at the time of award, of the amount by which the unpaid Rent that would have been earned after expiration until the time of award exceeds the amount of such rental loss the Tenant proves could have been reasonably avoided; and **(iii)** the worth, at the time of award, of the amount by which the unpaid Rent for the balance of the term after the time of award exceeds the amount of such rental loss that Tenant proves could be reasonably avoided. Landlord may elect to continue the tenancy in effect for so long as Landlord does not terminate Tenant's right to possession, by either written notice of termination of possession or by reletting the Premises to another who takes possession, and Landlord may enforce all Landlord's rights and remedies under this agreement, including the right to recover the Rent as it becomes due.

27. **DAMAGE TO PREMISES:** If, by no fault of Tenant, Premises are totally or partially damaged or destroyed by fire, earthquake, accident or other casualty, Landlord shall have the right to restore the Premises by repair or rebuilding. If Landlord elects to repair or rebuild, and is able to complete such restoration within 90 days from the date of damage, subject to the terms of this paragraph, this agreement shall remain in full force and effect. If Landlord is unable to restore the Premises within this time, or if Landlord elects not to restore, then either Landlord or Tenant may terminate this agreement by giving the other written notice. Rent shall be abated as of the date of damage. The abated amount shall be the current monthly Base Rent prorated on a 30-day basis. If this agreement is not terminated, and the damage is not repaired, then Rent shall be reduced based on the extent to which the damage interferes with Tenant's reasonable use of the Premises. If total or partial destruction or damage occurs as a result of an act of Tenant or Tenant's guest, **(i)** only Landlord shall have the right, at Landlord's sole discretion, within 30 days after such total or partial destruction or damage to treat the lease as terminated by Tenant, and **(ii)** Landlord shall have the right to recover damages from Tenant.
28. **HAZARDOUS MATERIALS:** Tenant shall not use, store, generate, release or dispose of any hazardous material on the Premises or the property of which the Premises are part. However, Tenant is permitted to make use of such materials that are required to be used in the normal course of Tenant's business provided that Tenant complies with all applicable Laws related to the hazardous materials. Tenant is responsible for the cost of removal and remediation, or any clean-up of any contamination caused by Tenant.
29. **CONDEMNATION:** If all or part of the Premises is condemned for public use, either party may terminate this agreement as of the date possession is given to the condemner. All condemnation proceeds, exclusive of those allocated by the condemner to Tenant's relocation costs and trade fixtures, belong to Landlord.
30. **INSURANCE:** Tenant's personal property, fixtures, equipment, inventory and vehicles are not insured by Landlord against loss or damage due to fire, theft, vandalism, rain, water, criminal or negligent acts of others, or any other cause. Tenant is to carry Tenant's own property insurance to protect Tenant from any such loss. In addition, Tenant shall carry (i) liability insurance in an amount of not less than $_____ and (ii) property insurance in an amount sufficient to cover the replacement cost of the property if Tenant is responsible for maintenance under **paragraph 18B**. Tenant's insurance shall name Landlord and Landlord's agent as additional insured. Tenant, upon Landlord's request, shall provide Landlord with a certificate of insurance establishing Tenant's compliance. Landlord shall maintain liability insurance insuring Landlord, but not Tenant, in an amount of at least $_____ , plus property insurance in an amount sufficient to cover the replacement cost of the property unless Tenant is responsible for maintenance pursuant to **paragraph 18B**. Tenant is advised to carry business interruption insurance in an amount at least sufficient to cover Tenant's complete rental obligation to Landlord. Landlord is advised to obtain a policy of rental loss insurance. Both Landlord and Tenant release each other, and waive their respective rights to subrogation against each other, for loss or damage covered by insurance.
31. **TENANCY STATEMENT (ESTOPPEL CERTIFICATE):** Tenant shall execute and return a tenancy statement (estoppel certificate), delivered to Tenant by Landlord or Landlord's agent, within 3 days after its receipt. The tenancy statement shall acknowledge that this agreement is unmodified and in full force, or in full force as modified, and state the modifications. Failure to comply with this requirement: **(i)** shall be deemed Tenant's acknowledgment that the tenancy statement is true and correct, and may be relied upon by a prospective lender or purchaser; and **(ii)** may be treated by Landlord as a material breach of this agreement. Tenant shall also prepare, execute, and deliver to Landlord any financial statement (which will be held in confidence) reasonably requested by a prospective lender or buyer.
32. **LANDLORD'S TRANSFER:** Tenant agrees that the transferee of Landlord's interest shall be substituted as Landlord under this agreement. Landlord will be released of any further obligation to Tenant regarding the security deposit, only if the security deposit is returned to Tenant upon such transfer, or if the security deposit is actually transferred to the transferee. For all other obligations under this agreement, Landlord is released of any further liability to Tenant, upon Landlord's transfer.
33. **SUBORDINATION:** This agreement shall be subordinate to all existing liens and, at Landlord's option, the lien of any first deed of trust or first mortgage subsequently placed upon the real property of which the Premises are a part, and to any advances made on the security of the Premises, and to all renewals, modifications, consolidations, replacements, and extensions. However, as to the lien of any deed of trust or mortgage entered into after execution of this agreement, Tenant's right to quiet possession of the Premises shall not be disturbed if Tenant is not in default and so long as Tenant pays the Rent and observes and performs all of the provisions of this agreement, unless this agreement is otherwise terminated pursuant to its terms. If any mortgagee, trustee, or ground lessor elects to have this agreement placed in a security position prior to the lien of a mortgage, deed of trust, or ground lease, and gives written notice to Tenant, this agreement shall be deemed prior to that mortgage, deed of trust, or ground lease, or the date of recording.
34. **TENANT REPRESENTATIONS; CREDIT:** Tenant warrants that all statements in Tenant's financial documents and rental application are accurate. Tenant authorizes Landlord and Broker(s) to obtain Tenant's credit report at time of application and periodically during tenancy in connection with approval, modification, or enforcement of this agreement. Landlord may cancel this agreement: **(i)** before occupancy begins, upon disapproval of credit report(s); or **(ii)** at any time, upon discovering that information in Tenant's application is false. A negative credit report reflecting on Tenant's record may be submitted to a credit reporting agency, if Tenant fails to pay Rent or comply with any other obligation under this agreement.
35. **CONSTRUCTION-RELATED ACCESSIBILITY STANDARDS:**
    A. Landlord states that the Premises ☐ have, or ☒ have not been inspected by a Certified Access Specialist (CASp).
    B. **If** the Premises have been inspected by a CASp,
        (1) Landlord states that the Premises ☐ have, or ☐ have not been determined to meet all applicable construction-related accessibility standards pursuant to Civil Code Section 55.53. Landlord shall provide Tenant a copy of the report prepared by the CASp (and, if applicable a copy of the disability access inspection certificate) as specified below.
        (2) ☐ **(i)** Tenant has received a copy of the report at least 48 hours before executing this lease. Tenant has no right to rescind the lease based upon information contained in the report.
        OR ☐ **(ii)** Tenant has received a copy of the report prior to, but no more than, 48 hours before, executing this lease. Based upon information contained in the report, Tenant has 72 hours after execution of this lease to rescind it.
        OR ☐ **(iii)** Tenant has not received a copy of the report prepared by the CASp prior to execution of this lease. Landlord shall provide a copy of the report prepared by the CASp (and, if applicable a copy of the disability access inspection certificate) within 7 days after execution of this lease. Tenant shall have up to 3 days thereafter to rescind the lease based upon information in the report.
    C. If the Premises have not been inspected by a CASp or a certificate was not issued by the CASp who conducted the inspection, "A Certified Access Specialist (CASp) can inspect the subject premises and determine whether the subject premises comply with all of the applicable construction-related accessibility standards under state law. Although state law does not require a CASp inspection of the subject premises, the commercial property owner or lessor may not prohibit the lessee or tenant from obtaining a CASp inspection of the subject premises for the occupancy or potential occupancy of the lessee or tenant, if requested by the lessee or tenant. The parties shall mutually agree on the arrangements for the time and manner of the CASp inspection, the payment of the fee for the CASp inspection, and the cost of making any repairs necessary to correct violations of construction-related accessibility standards within the premises."

D. Notwithstanding anything to the contrary in **paragraph 17, 18, 19** or elsewhere in the lease, any repairs or modifications necessary to correct violations of construction related accessibility standards to the Premises are the responsibility of the [X] Tenant, [ ] Landlord, [ ] Other _____ .

36. MEDIATION: Tenant and Landlord agree to mediate any dispute or claim arising between them out of this agreement, or any resulting transaction, before resorting to arbitration or court action, subject to **paragraph 36** below. **Paragraphs 37B** and **C** apply whether or not the arbitration provision is initialed. Mediation fees, if any, shall be divided equally among the parties involved. If for any dispute or claim to which this paragraph applies, any party commences an action without first attempting to resolve the matter through mediation, or refuses to mediate after a request has been made, then that party shall not be entitled to recover attorney fees, even if they would otherwise be available to that party in any such action. THIS MEDIATION PROVISION APPLIES WHETHER OR NOT THE ARBITRATION PROVISION IS INITIALED.

37. ARBITRATION OF DISPUTES:

A. Tenant and Landlord agree that any dispute or claim in Law or equity arising between them out of this agreement or any resulting transaction, which is not settled through mediation, shall be decided by neutral, binding arbitration, including and subject to paragraphs 37B and C below. The arbitrator shall be a retired judge or justice, or an attorney with at least 5 years of real estate transactional law experience, unless the parties mutually agree to a different arbitrator, who shall render an award in accordance with substantive California Law. In all other respects, the arbitration shall be conducted in accordance with Part III, Title 9 of the California Code of Civil Procedure. Judgment upon the award of the arbitrator(s) may be entered in any court having jurisdiction. The parties shall have the right to discovery in accordance with Code of Civil Procedure §1283.05.

B. EXCLUSIONS FROM MEDIATION AND ARBITRATION: The following matters are excluded from Mediation and Arbitration hereunder: (i) a judicial or non-judicial foreclosure or other action or proceeding to enforce a deed of trust, mortgage, or installment land sale contract as defined in Civil Code §2985; (ii) an unlawful detainer action; (iii) the filing or enforcement of a mechanic's lien; (iv) any matter that is within the jurisdiction of a probate, small claims, or bankruptcy court; and (v) and action for bodily injury or wrongful death, or for latent or patent defects to which Code of Civil Procedure §337.1 or §337.15 applies. The filing of a court action to enable the recording of a notice of pending action, for order of attachment, receivership, injunction, or other provisional remedies, shall not constitute a violation of the mediation and arbitration provisions.

C. BROKERS: Tenant and Landlord agree to mediate and arbitrate disputes or claims involving either or both Brokers, provided either or both Brokers shall have agreed to such mediation or arbitration, prior to, or within a reasonable time after the dispute or claim is presented to Brokers. Any election by either or both Brokers to participate in mediation or arbitration shall not result in Brokers being deemed parties to the agreement.

"NOTICE: BY INITIALING IN THE SPACE BELOW YOU ARE AGREEING TO HAVE ANY DISPUTE ARISING OUT OF THE MATTERS INCLUDED IN THE 'ARBITRATION OF DISPUTES' PROVISION DECIDED BY NEUTRAL ARBITRATION AS PROVIDED BY CALIFORNIA LAW AND YOU ARE GIVING UP ANY RIGHTS YOU MIGHT POSSESS TO HAVE THE DISPUTE LITIGATED IN A COURT OR JURY TRIAL. BY INITIALING IN THE SPACE BELOW YOU ARE GIVING UP YOUR JUDICIAL RIGHTS TO DISCOVERY AND APPEAL, UNLESS THOSE RIGHTS ARE SPECIFICALLY INCLUDED IN THE 'ARBITRATION OF DISPUTES' PROVISION. IF YOU REFUSE TO SUBMIT TO ARBITRATION AFTER AGREEING TO THIS PROVISION, YOU MAY BE COMPELLED TO ARBITRATE UNDER THE AUTHORITY OF THE CALIFORNIA CODE OF CIVIL PROCEDURE. YOUR AGREEMENT TO THIS ARBITRATION PROVISION IS VOLUNTARY."

"WE HAVE READ AND UNDERSTAND THE FOREGOING AND AGREE TO SUBMIT DISPUTES ARISING OUT OF THE MATTERS INCLUDED IN THE 'ARBITRATION OF DISPUTES' PROVISION TO NEUTRAL ARBITRATION."

Landlord's Initials _____ / _____ Tenant's Initials _____ / _____

38. JOINT AND INDIVIDUAL OBLIGATIONS: If there is more than one Tenant, each on shall be individually and completely responsible for the performance of all obligations of Tenant under this agreement, jointly with every other Tenant, and individually, whether or not in possession.

39. NOTICE: Notices may be served by mail, email, or courier at the contact information provided in the signature section for Landlord or Tenant, or at any other location subsequently designated and is deemed effective upon personal receipt by either party or their agent.

40. WAIVER: The waiver of any breach shall not be construed as a continuing waiver of the same breach or a waiver of any subsequent breach.

41. INDEMNIFICATION: Tenant shall indemnify, defend and hold Landlord harmless from all claims, disputes, litigation, judgments and attorney fees arising out of Tenant's use of the Premises.

42. OTHER TERMS AND CONDITIONS/SUPPLEMENTS: ***Landlord shall be allowed to show the space to prospective tenants with 24 hours written notice to Tenant. Landlord will use reasonable efforts to prevent disruption of Tenant's business during any showings.***

The following ATTACHED supplements/exhibits are incorporated in this agreement: [ ] Option Agreement (C.A.R. Form OA) _____

43. ATTORNEY FEES: In any action or proceeding arising out of this agreement, the prevailing party between Landlord and Tenant shall be entitled to reasonable attorney fees and costs from the non-prevailing Landlord or Tenant, except as provided in **paragraph 36**.

44. ENTIRE CONTRACT: Time is of the essence. All prior agreements between Landlord and Tenant are incorporated in this agreement, which constitutes the entire contract. It is intended as a final expression of the parties' agreement, and may not be contradicted by evidence of any prior agreement or contemporaneous oral agreement. The parties further intend that this agreement constitutes the complete and exclusive statement of its terms, and that no extrinsic evidence whatsoever may be introduced in any judicial or other proceeding, if any, involving this agreement. Any provision of this agreement that is held to be invalid shall not affect the validity or enforceability of any other provision in this agreement. This agreement shall be binding upon, and inure to the benefit of, the heirs, assignees and successors to the parties.

45. BROKERAGE: Landlord and Tenant shall each pay to Broker(s) the fee agreed to, if any, in a separate written agreement. Neither Tenant nor Landlord has utilized the services of, or for any other reason owes compensation to, a licensed real estate broker (individual or corporate), agent, finder, or other entity, other than as named in this agreement, in connection with any act relating to the Premises, including, but not limited to, inquiries, introductions, consultations, and negotiations leading to this agreement. Tenant and Landlord each agree to indemnify, defend and hold harmless the other, and the Brokers specified herein, and their agents, from and against any costs, expenses, or liability for compensation claimed inconsistent with the warranty and representation in this **paragraph 44**.

46. AGENCY CONFIRMATION: The following agency relationships are hereby confirmed for this transaction:

Listing Agent: _____ (Print Firm Name) is the agent of (check one):
☐ the Landlord exclusively; or ☐ both the Tenant and Landlord.

Selling Agent: ***N/A*** (Print Firm Name) (if not same as Listing Agent) is the agent of (check one):
☐ the Tenant exclusively; or ☐ the Landlord exclusively; or ☐ both the Tenant and Landlord.

Real Estate Brokers are not parties to the agreement between Tenant and Landlord.

Landlord and Tenant acknowledge and agree that Brokers: (i) do not guarantee the condition of the Premises; (ii) cannot verify representations made by other; (iii) will not verify zoning and land use restrictions; (iv) cannot provide legal or tax advice; (v) will not provide other advice or information that exceeds the knowledge, education or experience required to obtain a real estate license. Furthermore, if Brokers are not also acting as Landlord in this agreement, Brokers: (vi) do not decide what rental rate a Tenant should pay or Landlord should accept; and (vii) do not decide upon the length or other terms of tenancy. Landlord and Tenant agree that they will seek legal, tax, insurance, and other desired assistance from appropriate professionals.

47. LEGALLY AUTHORIZED SIGNER: Wherever the signature or initials of the Legally Authorized Signer identified in **paragraphs 48** or **49** appear on this Agreement or any related documents, it shall be deemed to be in a representative capacity for the entity described and not in an individual capacity, unless otherwise indicated. The Legally Authorized Signer **(i)** represents that the entity for which that person is acting already exists and is in good standing to do business in California and **(ii)** shall Deliver to the other Party, upon request, evidence of authority to act in that capacity (such as but not limited to: applicable portion of the trust or Certification Of Trust (Probate Code § 18100.5), letters testamentary, court order, power of attorney, corporate resolution, or formation documents of the business entity).

48. Tenant agrees to rent the Premises on the above terms and conditions.

A. ☒ ENTITY TENANT: (Note: If this paragraph is completed, a Representative Capacity Signature Disclosure (C.A.R. Form RCSD) is not required for the Legally Authorized Signers designated below.)

(1) **Non-Individual (entity) Tenants:** One or more Tenants is a trust, corporation, LLC, probate estate, partnership, holding a power of attorney or other entity.

(2) **Full entity name:** The following is the full name of the entity (if a trust, enter the complete trust name; if under probate, enter full name of the estate, including case #): ***Salinas Valley Memorial Healthcare System, a California Local Care Health District dba Salinas Valley Health***.

(3) **Contractual Identity of Tenant:** For purposes of this Agreement, when the name described below is used it shall be deemed to be the full entity name.

(A) If a trust: The trustee(s) of the trust or a simplified trust name (ex. John Doe, co-trustee, Jane Doe, co-trustee or Doe Revocable Family Trust);

(B) If Property is sold under the jurisdiction of a probate court: The name of the executor or administrator, or a simplified probate name (John Doe, executor, or Estate (or Conservatorship) of John Doe).

(4) **Legally Authorized Signer:**

(A) This Agreement is being Signed by a Legally Authorized Signer in a representative capacity and not in an individual capacity. See **paragraph 47** for additional terms.

(B) The name(s) of the Legally Authorized Signer(s) is/are: ***Allen Radner, MD***, _____.

B. TENANT SIGNATURE(S):

(Signature) By, _____ Date: _____
Printed name of Tenant: ***Salinas Valley Memorial Healthcare System a California Local Care Health District dba Salinas Valley Health***
☒ Printed Name of Legally Authorized Signer: ***Allen Radner, MD*** Title, if applicable, ***President/CEO***
Address ***450 E. Romie Lane*** City ***Salinas*** State ***Ca*** Zip ***93901***
Telephone _____ Text _____ E-mail _____

(Signature) By, _____ Date: _____
Printed name of Tenant: _____
☐ Printed Name of Legally Authorized Signer: _____ Title, if applicable, _____
Address _____ City _____ State ____ Zip _____
Telephone _____ Text _____ E-mail _____

☐ IF MORE THAN TWO SIGNERS, USE Additional Signature Addendum (C.A.R. Form ASA).

☐ **GUARANTEE:** In consideration of the execution of this Agreement by and between Landlord and Tenant and for valuable consideration, receipt of which is hereby acknowledged, the undersigned ("Guarantor") does hereby: **(i)** guarantee unconditionally Landlord and Landlord's agents, successors and assigns, the prompt payment of Rent or other sums that become due pursuant to this Agreement, including any and all court costs and attorney fees included in enforcing the Agreement; **(ii)** consent to any changes, modifications or alterations of any term in this Agreement agreed to by Landlord and Tenant; and **(iii)** waive any right to require Landlord and/or Landlord's agents to proceed against Tenant for any default occurring under this Agreement before seeking to enforce this Guarantee.

Guarantor (Print Name) _____
Guarantor _____ Date _____
Address _____ City _____ State _____ Zip _____
Telephone _____ E-mail _____

49. Landlord agrees to rent the Premises on the above terms and conditions:

A. ☒ **ENTITY LANDLORD: (Note: If this paragraph is completed, a Representative Capacity Signature Disclosure (C.A.R. Form RCSD) is not required for the Legally Authorized Signers designated below.)**

(1) **Non-Individual (entity) Landlords:** One or more Landlords is a trust, corporation, LLC, probate estate, partnership, holding a power of attorney or other entity.

(2) **Full entity name:** The following is the full name of the entity (if a trust, enter the complete trust name; if under probate, enter full name of the estate, including case #): ***Rancho Llano Development, LLC, a California Limited Liability Company*** .

(3) **Contractual Identity of Landlord:** For purposes of this Agreement, when the name described below is used it shall be deemed to be the full entity name.
(A) If a trust: The trustee(s) of the trust or a simplified trust name (ex. John Doe, co-trustee, Jane Doe, co-trustee or Doe Revocable Family Trust);
(B) If Property is sold under the jurisdiction of a probate court: The name of the executor or administrator, or a simplified probate name (John Doe, executor, or Estate (or Conservatorship) of John Doe).

(4) **Legally Authorized Signer:**
(A) This Agreement is being Signed by a Legally Authorized Signer in a representative capacity and not for him/herself as an individual. See **paragraph 47** for additional terms.
(B) The name(s) of the Legally Authorized Signer(s) is/are: ***Henry J. Franscioni, Jr.*** , _____ .

B. LANDLORD SIGNATURE(S):

(Signature) By, _____ Date: _____
Printed name of Landlord: ***Rancho Llano Development, LLC, a California Limited Liability Company***
☒ Printed Name of Legally Authorized Signer: ***Henry J. Franscioni, Jr.*** Title, if applicable, ***Managing Member***
Address ***27810 Mesa Del Toro Road*** City ***Salinas*** State ***Ca*** Zip ***93908***
Telephone _____ Text _____ E-mail _____

(Signature) By, _____ Date: _____
Printed name of Landlord: _____
☐ Printed Name of Legally Authorized Signer: _____ Title, if applicable, _____
Address _____ City _____ State ____ Zip _____
Telephone _____ Text _____ E-mail _____
☐ IF MORE THAN TWO SIGNERS, USE Additional Signature Addendum (C.A.R. Form ASA).

Agency relationships are confirmed as above. Real estate brokers who are not also Landlords in this agreement are not a party to the agreement between Landlord and Tenant.

Real Estate Broker (Tenant Brokerage Firm) ***N/A*** Lic. # _____
By (Agent) _____ Lic. # _____ Date _____

Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ E-mail _____

Real Estate Broker (Landlord Brokerage Firm) _____ Lic. # _____
By (Agent) _____ Lic. # _____ Date _____

Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ E-mail _____

Landlord's Initials _____/ _____ Tenant's Initials _____/ _____

EQUAL HOUSING OPPORTUNITY

TRANSFORMATION, STRATEGIC PLANNING AND GOVERNANCE COMMITTEE

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

(ROLANDO CABRERA, M.D.)

Medical Executive Committee Summary – July 10 2025

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Euter, Demetri, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Toor, Jiwan, DO	Family Medicine	Medicine	Hospitalist – Adult

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Abundis, Rebecca, DO	Internal Medicine	Medicine	Medicine – Active Community
Chan, Erica, MD	Ob/Gyn	Ob/Gyn	Obstetrics & Gynecology
Chaudhry, Haider, MD	Neurology	Medicine	Tele-Neurology
Dacus, James, MD	Internal Medicine	Medicine	Internal Medicine
DeFilippi, Vincent, MD	Cardiothoracic Surgery	Surgery	Cardiac Surgery Thoracic Surgery
Hulkower, Jonathan, MD	Psychiatry	Medicine	Tele-Psychiatry
Javaid, Mazhar, MD	Sleep Medicine	Medicine	Sleep Medicine
Lieberman, Marc, MD	Rheumatology	Medicine	Medicine – Active Community
Moreno II, Alvaro, MD	Psychiatry	Medicine	Tele-Psychiatry
Park, Shin Young, MD	General Surgery	Surgery	General Surgery Salinas Valley Health Wound Healing Center
Petrini, Joseph, MD	Family Medicine	Family Medicine	Family Medicine – Active Community
Rabbani, Omid, MD	Neurology	Medicine	Tele-Neurology
Rana, Naeem, MD	Sleep Medicine	Medicine	Sleep Medicine
Rashid, Samiya, DO	Neurology	Medicine	Tele-Neurology
Santiago Vergara, Diana, MD	Psychiatry	Medicine	Tele-Psychiatry
Shen, Jason, MD	Neurology	Medicine	Tele-Neurology.
Siqueiros, Rafael, MD	Family Medicine	Family Medicine	Family Medicine – Active Community

Privilege Modifications:

NAME	SPECIALTY	PRIVILEGE CHANGE

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Cammarano, Caitlin, DO	Anesthesiology	Leave of Absence effective 8/1/2025
Falkoff, Gary, MD	Radiology	Emeritus status effective 6/10/2025
Healy, Mark, MD	Surgical Oncology	Recommend advancement to Active Staff
Honegger, Judy, DO	Ob/Gyn	Resignation effective 8/4/2025

Other Items: ***(Attached)***

ITEM	RECOMMENDATION
Family Medicine Active Community – Clinical Privileges Delineation – Revision	Recommended approval of the revision removing Surgical Assisting Only as special procedure.

General Surgery, Oncology General Surgery and Colorectal Surgery – Clinical Privileges Delineation – Revision	Recommend approval of the revision removing Intermediate and Advanced Laparoscopic Surgery from special procedures and adding them to the core procedure list. Removing FAST Scan and Interstim Sacral Nerve Stimulation (SNS) from the special procedures list.
Urology – Clinical Privileges Delineation – Revision	Recommend approval of the revision to current competency requirements at initial appointment, moving Basic, Intermediate and Advanced Urologic Laparoscopic surgery and Interstim Sacral Nerve Stimulation (SNS) from special procedures to core procedures.

Interdisciplinary Practice Committee

Initial Appointment:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Bhatt, Harita, PA-C	Gastroenterology	Medicine	Jeffrey Fiorenza, MD Richard Hell, MD Michael Le, MD Daniel Luba, MD Michael Mendoza, MD

Reappointment:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Shipley, Lara, DNP	Nurse Practitioner	Medicine	Michael Le, MD Daniel Luba, MD

Other Items: ***(Attached)***

ITEM	RECOMMENDATION
Amniotomy Nursing Standardize Procedure	Recommend approval as presented

Policies and Plans: Care of the CRRT Patient

Informational Items:

I. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Medical Staff Excellence Committee
d. Quality and Safety Committee
    - Quality Reports:
        - Med/Surg Unit
        - Pediatrics
        - Inpatient Wound Care Program
        - Transitional Care
        - Laboratory
        - Sepsis Initiative
        - Emergency Department
        - Health Information Management
        - Critical Care Services
        - Supply Chair/Materials
        - Volunteer/Community Services
        - Diagnostic Imaging
        - Rehab Services
    - Healing at Home Program Update

II. Other Reports:

a. Epic Implementation Update
b. Emergency Medicine Department Annual Report
c. Summary of Executive Operations Committee Meetings
d. Summary of Medical Staff Department/Committee Meetings June 2025
e. Medical Staff Treasury Report June 5, 2025
f. Medical Staff Statistics Year to Date
g. Financial Update May 2025
h. HCAHPS Update July 1, 2025

Clinical Privileges Delineation
Family Medicine – Active Community

Applicant Name: _____

Qualifications:

ACTIVE COMMUNITY MEDICINE PRIVILEGES:
To be eligible to apply for Active Community privileges in Family Medicine, the applicant must meet the following qualifications:

> Successful completion of an accredited ACGME-or AOA-accredited post-graduate training program in family medicine.

These privileges are available only for those applicants who qualify and apply for Active Community Status membership.

ACTIVE COMMUNITY PRIVILEGES
Active Community privileges are reserved for physicians with office based practices who do not routinely provide care in the acute hospital setting.

Active Community Privilege: Applicant please check box next to privilege you are requesting.

☐ **Concurrent review of hospitalized patients – excludes documentation in the medical record, inpatient orders and any activity construed to direct patient care.**
(No volume associated proctoring or reappointment criteria associated with this privilege)

☐ **Ordering of outpatient diagnostic tests**
(No volume associated proctoring or reappointment criteria associated with this privilege)

Special Procedures/Privileges

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
				Surgical Assisting Only (*Designation as Co-Surgeon is not allowed*)	• Successful completion of an approved surgical or surgical associated residency training program **AND** • Applicant must be able to document that he or she has assisted in at least 12 surgical procedures as first assistant or primary surgeon within the past 24 months.	**1**	Applicant must provide reasonable evidence of current ability to perform requested privileges And document the performance of at least 6 surgical procedures as first assistant within the past 24 months

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

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

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

Applicant Signature Date

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

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

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

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

Department Chair Signature Date

Clinical Privileges Delineation
General Surgery, Oncology General Surgery
And
Colorectal Surgery

Robotic Assisted Surgery Privileges must be requested separately.

Applicant Name: _____

GENERAL SURGERY:

Qualifications:

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

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in general surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. For Board Eligible applicants, Board Certification as defined above must occur within 5 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board.

Ongoing Board Certification:
Once certified by a recognized Board, the Medical Staff Member must remain certified as a condition for Medical Staff privileges. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Applicants more than two years out of Residency training must provide documentation of the performance of at least 100 general surgical procedures during the past 12 months.

COLORECTAL SURGERY:

Qualifications:

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

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in colorectal surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. For Board Eligible applicants, Board Certification as defined above must occur within 5 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board.

Ongoing Board Certification:
Once certified by a recognized Board, the Medical Staff Member must remain certified as a condition for Medical Staff privileges. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Applicants more than two years out of Fellowship training must provide documentation of the performance of at least 50 colorectal surgical procedures during the past 24 months.

ONCOLOGIC GENERAL SURGERY:

Qualifications:

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

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in general surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. For Board Eligible applicants, Board Certification as defined above must occur within 5 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board AND Successful completion of an AMBS Complex General Surgical Oncology Fellowship.

Ongoing Board Certification:
Once certified by a recognized Board, the Medical Staff Member must remain certified as a condition for Medical Staff privileges. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Applicants more than two years out of Residency training must provide documentation of the performance of at least 100 general surgical procedures (50 of which must be oncologic general surgery procedures) during the past 12 months.

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.

SPECIAL REQUIREMENT:
Physicians involved in the evaluation and management of cancer patients must be either Board Certified, in the process of becoming board certified; or demonstrate ongoing cancer-related education by documenting 12 CME hours annually

New applicants will be required to provide documentation of the number and types of surgical 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 Surgery Core privileges**

Admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care, and perform surgical procedures, to patients of all ages to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Management of trauma and complete care of critically ill patients with underlying surgical conditions. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

☐ **Colorectal Surgery Core privileges**

Admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care, and perform surgical procedures, to patients of all ages admission, workup, diagnosis and performance of surgical procedures on patients presenting with illnesses related to the colon, rectum & anus; to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Management of trauma and complete care of critically ill patients. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

☐ Oncologic General Surgery Core privileges

Admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care, and perform surgical procedures, to patients of all ages to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Management of trauma and complete care of critically ill patients with underlying surgical conditions. The core privileges in this specialty include General Surgery core procedures, Colorectal Surgery core procedures as well as the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

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 cases per year in the hospital, and cannot provide documentation of current competence from another facility, will not qualify for reappointment.

AND

Be Board Certified. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Board certification/eligibility requirements are applicable to new privilege requests after the Board of Directors approval of these revisions on September 28, 2017.

Special Procedures/Privileges

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

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

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

(R)=Requested **(A)**=Recommended as Requested **(C)**=Recommended w/Conditions **(N)**=Not Recommended
Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	1	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases
				Insertion and management of pulmonary artery catheters	Successful completion of an accredited residency or fellowship in internal medicine, general surgery, cardiology, anesthesiology, pulmonary medicine, critical care, or family medicine; and performance of at least 10 PACs during this formal training, as primary operator **Required Previous Experience:** Active hospital practice in the chosen respective field; and performance (as the primary operator) of at least 10 PACs during the past 24 months.	1	Performance of at least four (4) PACs during the past 24 months.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				~~*Intermediate Laparoscopic Surgery~~	~~Must possess unrestricted privileges for open procedures~~ ~~**AND**~~ ~~Meet criteria for credentialing in basic laparoscopic general surgery~~ ~~**AND**~~ ~~Document completion of an accredited, hands-on course in laparoscopic general surgery for any one of the procedures herein defined as intermediate, or same in residency~~ ~~**AND**~~ ~~Document successful completion of at least four (4) procedures in the past 24 months~~	~~1~~ ~~by proctor with at minimum Intermediate Laparoscopic Surgery Privileges~~	~~Performance of at least four (4) cases during the past 24 months~~
				Percutaneous Endoscopic Gastrostomy (PEG).	Formal fellowship training in gastroenterology or a residency in general surgery **AND** Performance of at least five (5) cases during the past 24 months	1 Observation and 3 chart reviews	Performance of at least five (5) cases during the past 24 months
				Laparoscopic Sleeve Gastrectomy	Unrestricted privileges to perform advanced laparoscopic surgery (*restrictions do not include initial appointment proctoring)*	5 cases observed by a surgeon with unrestricted privileges for the procedure	Performance of at least 20 cases during the past 24 months.
				~~*Advanced Laparoscopic Surgery~~	~~Fulfillment of criteria initially for Basic Laparoscopic privileges~~ ~~**AND**~~ ~~Document evidence of completing an accredited, hands-on course in advanced laparoscopic general surgery in the procedure requested or in three of the other advanced laparoscopic procedures, OR document having completed training and experience for such residency~~ ~~**AND**~~ ~~Document successful completion of at least four (4) procedures in the past 24 months~~ ~~*General Surgeons who qualify for advanced laparoscopic privileges also qualify for intermediate laparoscopic privileges.~~	~~1~~ ~~by proctor with at minimum Intermediate Laparoscopic Surgery Privileges~~	~~Performance of at least four (4) cases during the past 24 moths~~

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Esophagogastroduodenoscopy EGD	Documentation of successful completion of 50 cases in the past 24 months	**1**	Performance of at least 25 cases during the past 24 months
				Esophageal resection and reconstruction, or esophagogastrectomy, or Transhiatal Esophagectomy	Documentation of successful completion of four (4) cases in the past 24 months	**1**	Performance of at least two (2) cases during the past 24 months
				Colonoscopy	Documentation of successful completion of 50 cases in the past 24 months	**1**	Performance of at least 25 cases during the past 24 months
				Hysterectomy as part of general surgical procedures	Documentation of successful completion of eight (8) cases in the past 24 months	**1**	Performance of at least four (4) cases during the past 24 months
				Salinas Valley Health Wound Healing Clinic (SVHWHC)	Applicants must meet initial appointment or reappointment criteria for General and Colorectal Surgery Privileges **AND** Be approved by the Medical Director of the SVHWHC or their designee	N/A	Applicants must meet initial appointment or reappointment criteria for General and Colorectal Surgery privileges.
				Percutaneous/Open Radiofrequency Ablation of Tumors	Successful completion of an ACGME/AOA accredited residency in general surgery, urology or otolaryngology **OR** Fellowship training in oncologic general surgery, vascular surgery or interventional radiology **AND** Documentation of successful completion of two (2) procedures in the past 24 months	**1**	Performance of at least two (2) cases during the past 24 months **AND** Documentation of CME directly related to radiofrequency ablation within the past 24 months

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Use of radiofrequency for interruption of veins	Successful completion of the equipment manufacturer's training course **AND** Current unrestricted privileges in non-radiofrequency assisted deep vein interruption procedures	**1**	Performance of at least two (2) cases during the past 24 months
				Radical regional lymph node dissections, including retroperitoneal, pelvic and inguinal	Documentation of successful completion of four (4) cases in the past 24 months	**1**	Performance of at least two (2) cases during the past 24 months
				Salpingooopherectomy	Documentation of successful completion of eight (8) cases in the past 24 months	**1**	Performance of at least four (4) cases during the past 24 months
				~~FAST Scan~~	~~Completion of an accredited Surgery Residency and documentation of a minimum of 12 hours of didactic training including physics of ultrasound, sonographic instrumentation, basic interpretation (including common pitfalls) and supervised use of instrumentation in normal patients~~ ~~**OR**~~ ~~Documentation of training and experience during residency.~~	~~Seven (7) FAST Scan cases must be performed and the hard copy reviewed by a radiologist. At least three (3) scans must demonstrate free fluid or blood. Initial FAST Scans will be followed by surgery or CT Scan which will provide "Gold Standard" documentation of free fluid status.~~	~~**N/A**~~
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification.	None	Current California Stat X-Ray S&O Fluoroscopy Certification

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				~~Interstim Sacral Nerve Stimulation (SNS)~~	~~The application must be able to demonstrate:~~ ~~Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)/AOA Accredited training program in FPMRS (Female Pelvic Medicine & Reconstructive Surery) that included training in SNS.~~ ~~**OR**~~ ~~Completion of ACGME or AOA accredited residency in Colorectal Surgery, OB/GYN or Urology and Completion of training course in InterStim Therapy.~~ ~~**AND**~~ ~~Demonstrate that they have performed at least six (6) Intertstim Therapy simulator tests and implant procedurs within the past 12 months.~~	~~1~~	~~Successful performance of six (6) procedures within the past 24 months.~~

***Core Procedure List*:** The following procedures are considered to be included in the core privileges for the specialty. 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

General Surgery

1. Amputations, above the knee, below knee, toe, transmetatarsal
2. Appendectomy
3. Biliary enteric anastomosis
4. Biliary tract resection/reconstruction
5. Breast: complete mastectomy with or without axillary lymph node dissection; excision of breast lesion, breast biopsy, incision and drainage of abscess. modified radical mastectomy, operation for gynecomastia, partial mastectomy with or without lymph node dissection, radical mastectomy, subcutaneous mastectomy including diagnosis and management of breast disorders
6. Colectomy, colotomy, colostomy
7. Proctectomy, including abdominoperineal approach
8. Correction of intestinal obstruction
9. Emergency thoracostomy
10. Enteric fistulae, management
11. Enterostomy (feeding or decompression)
12. Anal fistula and fissure procedures
13. Hemorrhoidectomy
14. Excision of thyroglossal duct cyst
15. Gastric operations for cancer (partial. or total gastrectomy)
16. Gastroduodenal surgery
17. Gastrostomy (feeding or decompression)
18. Hepatic lobectomy and insertion of infusion catheters, pumps
19. Incision and drainage of abscesses and cysts of the soft tissue
20. Biopsy of superficial lymph nodes, cutaneous and soft tissue lesions
21. Incision, excision, resection, and enterostomy of small intestine
22. Incision/drainage of perirectal abscess
23. Incision/excision of pilonidal cyst
24. Intraoral surgery, local excision
~~24.~~25. Laparoscopic General and Colorectal Surgery
~~25.~~26. Laparotomy for diagnostic or exploratory purposes or for management of intra-abdominal sepsis
~~26.~~27. Liver biopsy (intra-operative)
~~27.~~28. Management of burns
~~28.~~29. Management of intra-abdominal trauma, including injury, observation, paracentesis, lavage
~~29.~~30. Management of multiple trauma
~~30.~~31. Management of soft tissue tumors, inflammations, and infections and necrosis
~~31.~~32. Open operations on gallbladder, biliary tract, bile ducts, hepatic ducts, excluding biliary tract reconstruction
~~32.~~33. Pancreatic pseudoscyst drainage
~~33.~~34. Debridement of infected pancreatic tissue
~~34.~~35. Nephrectomy with Urology present
~~35.~~36. Debridement of decubitus and stasis ulcers of the skin
~~36.~~37. Removal of ganglion (palm or wrist; flexor sheath)
~~37.~~38. Removal of Peritoneal Dialysis Catheter
~~38.~~39. Repair of perforated viscus (gastric, small intestine, large intestine)
~~39.~~40. Sentinal lymph node biopsy
~~40.~~41. Vagotomy
~~41.~~42. Skin grafts (partial thickness, full thickness, split thickness)
~~42.~~43. Splenectomy (trauma, staging, therapeutic)

~~43.~~44. Surgery of the abdominal wall, including management of all forms of hernias, including diaphragmatic hernias, inguinal hernias, and orchiectomy in association with hernia repair
~~44.~~45. Thoracentesis
~~45.~~46. Thyroid and parathyroid surgery
~~46.~~47. Tracheostomy
~~47.~~48. Varicose vein injection, sclerotherapy, excision & ligation, interruption of deep perforator veins of the lower extremities
~~48.~~49. Insertion of central venous catheters: non-tunneled, tunneled, with or without subcutaneous ports
~~49.~~50. Arterial line placement and monitoring
~~50.~~51. Basic Laparoscopy – diagnostic, appendectomy, cholecystectomy, lysis of adhesions, Peritoneal Dialysis , feeding tubes and catheter positioning and Liver Biopsy

***Core Procedure List*:** The following procedures are considered to be included in the core privileges for the specialty. 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

Colorectal Surgery

1. Abdominal procedures related to diseases of the colon, rectum and anus
2. Anorectal procedures
3. Endoscopic procedures including anoscopy, rigid sigmoidoscopy, flexible sigmoidoscopy, & total colonoscopy
4. Endoscopic rectal ultrasound
5. History & Physical
6. Operative management and post-operative care of patients with pathologic conditions involving the intestinal tract, colon, rectum, anal canal and perianal area
7. Urogynecologic procedures related to diseases of the colon, rectum and anus
8. Use of Laser
9. Vascular access procedures
10. Laparoscopic Colon Surgery
11. Laparoscopic Hernia Repair

***Core Procedure List*:** The following procedures are considered to be included in the core privileges for the specialty. 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

Oncologic General Surgery

1. All core procedures for General Surgery and Colorectal Surgery
2. Hysterectomy and BSO as part of cytoreductive surgery
3. Intraoperative EGD
4. Intraoperative sigmoidoscopy

* DEFINITIONS

Intermediate laparoscopic general surgery

- Jejunostomy
- Gastrostomy
- Vagotomy
- Lymph node biopsy
- Closure perforated ulcer
- Oopherectomy and/or drainage of ovarian cyst in consultation with OB/GYN
- Hernia repair to include hiatal, umbilical, incisional and inguinal with or without graft

Advanced laparoscopic general surgery

- Bowel surgery to include resection, anastomosis, stoma, colectomy, hemicolectomy, and sigmoidectomy
- Common bile duct exploration
- Splenectomy
- Lymph node dissection
- Nephrectomy with Urologist present
- Adrenalectomy
- Gastrectomy

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

_____ _____

_____ _____

Applicant Signature: Date:

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

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

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

Applicant Signature _____ Date _____

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

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

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

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

Department Chair Signature _____ Date _____

Clinical Privileges Delineation
Urology

Applicant Name: _____

Qualifications:

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

Board certification/eligibility requirements are applicable to new privilege requests after the Board of Directors approval of these revisions on September 28, 2017.

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in urologic surgery by the American Board of Urology or the American Osteopathic Board of Urology. For Board Eligible applicants, Board Certification as defined above must occur within 6 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board.

Ongoing Board Certification:
Once certified by a recognized Board, the Medical Staff Member must remain certified as a condition for Medical Staff privileges. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Applicants more than two years out of Residency/Fellowship training must provide documentation of the performance of at least 75 varied urological procedures during the past 24 months.

Physicians involved in the evaluation and management of cancer patients must be either Board Certified, in the process of becoming Board certified; or demonstrated ongoing cancer-related education by documenting ~~earning~~ 12 CME hours annually

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 Privileges 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.

Urology core privileges
Admit, evaluate, diagnose, treat (surgically or medically) and provide consultation to patients, presenting with malignant medical and surgical disorders of the genitourinary system and the adrenal gland and including endoscopic, percutaneous, and open surgery of congenital and acquired conditions of the urinary and reproductive systems and their contiguous structures. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

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 perform fewer than 25 urological procedures per year in the hospital, and cannot provide documentation of current competence from another facility, will not qualify for reappointment.
AND
Be Board Certified. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Board certification/eligibility requirements are applicable to new privilege requests after the Board of Directors approval of these revisions on September 28, 2017.

Special Requirements:
Physicians involved in the evaluation and management of cancer patients must be either Board Certified, in the process of becoming Board certified; or demonstrated ongoing cancer-related education by documenting earning 12 CME hours annually.

Special Procedures/Privileges

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

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

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

(R)=Requested **(A)**=Recommended as Requested **(C)**=Recommended w/Conditions **(N)**=Not Recommended
Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	**1**	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases within the past 24 months
				~~Basic and Intermediate Urologic Laparoscopic Surgery~~	~~Unrestricted privileges in open procedures requested~~ ~~**AND**~~ ~~Evidence of completion of either didactic hands-on course of no less than 2 days length in basic and intermediate urologic laparoscopy, or evidence of satisfactory training and performance of basic laparoscopy in residency training~~ ~~**AND**~~ ~~Document successful completion of at least four (4) procedures within the past 24 months~~ ~~First six (6) cases must have assistant surgeon with either urologic or general surgical privileges.~~	~~**First 6** Cases~~	~~Successful performance of six (6) procedures within the past 24 months~~
				~~**Basic & Intermediate Procedures are:** Pelvic lymphadenectomy, Varix ligation, Intraperitoneal drainage of pelvic lymphocele, Bladder Suspension, Cystorrhaphy, Diagnostic Laparoscopy for cryptorchidism~~			

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				~~Advanced Urologic Laparoscopic Surgery~~ ~~(includes Basic & Intermediate Urologic Laparoscopic Surgery)~~	~~Meet criteria for credentialing in basic and intermediate urologic laparoscopy~~ ~~**AND**~~ ~~Evidence of attending an accredited, hands-on course in advanced urologic laparoscopy for any one of the advanced procedures herein defined or same in residency~~ ~~**AND**~~ ~~Unrestricted privileges for open procedure in the same advanced urologic laparoscopic procedure requested.~~ ~~**AND**~~ ~~Document successful completion of at least 4 procedures in the past 24 months~~ ~~*Urologists who qualify for advanced laparoscopic privileges also qualify for basic and intermediate laparoscopic privileges.~~	~~**First 3 cases**~~ ~~To be assisted and proctored by a urologist with privileges in advanced laparoscopic urologic surgery, arranged by the surgeon.~~	~~Successful performance of six (6) procedures within the past 24 months~~
				~~**Advanced Procedures are:** Nephrectomy, Cystectomy, Adrenalectomy, Ileal lop, continent urinary diversion, and Cryo Ablation of the Kidney, Radical prostatectomy~~			
				Epispadias	Documentation of successful performance of at least one (1) procedure in the previous four (4) years	**1**	Successful performance of at least one (1) procedure in the previous four (4) years
				~~Interstim Sacral Nerve Stimulation (SNS)~~	~~The applicant must be able to demonstrate~~ ~~1. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) / AOA Accredited training program in FPMRS (Female Pelvic Medicine & Reconstructive Surgery) that included training in SNS~~ ~~**OR**~~ ~~2. Completion of ACGME or AOA accredited residency in OB/GYN or urology and Completion of a training course in InterStim Therapy~~ ~~**AND**~~ ~~3.~~1. ~~Demonstrate that they have performed at least six (6) InterStim Therapy simulator tests and implant procedures within the past 12 months~~	~~**1**~~	~~Successful performance of six (6) procedures within the past 24 months~~
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	None	Current California State X-Ray S&O Fluoroscopy Certification

(*A qualified proctor is defined as (1) an expert outside of the SVH Medical Staff who has been approved by the appropriate department; or (2) a Medical Staff member with unrestricted robotic surgery platform privileges.)*

Salinas Valley Health Medical Center

Core Procedure List: The following procedures are considered to be included in the core privileges for this specialty. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Chief Medical Officer and/or the Chief of Staff

Urology

1. Adrenalectomy
2. All forms of prostate ablation and removal including needle biopsy
3. Anterior pelvic exenteration
4. Appendectomy as component of urologic procedure
5. Bladder instillation of anticarcinogenic agent
6. Bowel resection as component of urologic procedure
7. Circumcision
8. Cystolithotomy
9. Cystoscopy
10. Cystourethroscopy with subureteric injeciton of implant material
11. Endoscopic destruction of urethral valves, child
12. Enterostomy as component of urologic procedure
13. Excision of retroperitoneal cyst or tumor
14. Excision of urethral valves
15. Exploration of retroperitoneum
16. Extracorporeal shock wave lithotripsy
17. Ileal or intestinal conduit
18. Inguinal herniorrhaphy as related to urologic operation
19. Insertion of totally indwelling ureteral stent
~~19.~~20. Laparoscopic urologic surgery
~~20.~~21. Laparotomy for diagnostic or exploratory purposes (urologic related conditions)
~~21.~~22. Lymph node dissection - inguinal, retroperitoneal, or iliac
~~22.~~23. Male sphincter prosthesis
~~23.~~24. Management of congenital anomalies of the genitourinary tract, including hypospadias
~~24.~~25. Microscopic surgery - epididymovasostomy, vasovasotomy
~~25.~~26. Surgery upon the kidney, including removal, partial removal, reconstruction, for benign and malignant processes including cryo and thermal ablation techniques.
~~26.~~27. Open renal stone surgery (e.g., pyelolithotomy)
~~27.~~28. Open renal biopsy
~~28.~~29. Operation for Peyronie's disease, including grafting
~~29.~~30. Operation for ureterocele
~~30.~~31. Operation for urethral fistula
~~31.~~32. Other plastic and reconstructive procedures on external male genitalia
~~32.~~33. Pelvic and inguinal lymph node biopsy
~~33.~~34. Percutaneous nephrolithotripsy
~~34.~~35. Periurethral collagen or durasphere injections
~~35.~~36. Photo-Selective Vaporization of the Prostate
~~36.~~37. Plastic and reconstructive procedures on ureter, bladder, and urethra
~~37.~~38. Radical cystectomy and urinary diversion (continent reservoir/neobladder reservoir)
~~38.~~39. Radioactive Seed Implantation
~~39.~~40. Reconstructive procedures on external male genitalia requiring prosthetic implants or foreign materials
~~40.~~41. Renal endoscopy through established nephrostomy or pyelostomy
42. Sacral Nerve Stimulation
~~41.~~43. Surgery of the testicle, scrotum, epididymis and vas deferens including biopsy, excision and reduction of testicular torsion and orchiepexy
~~42.~~44. Surgery upon the adrenal gland
~~43.~~45. Surgery upon the kidney, including total or partial nephrectomy, for malignant or benign disease, including radical transthoracic nephrectomy
~~44.~~46. Surgery upon the penis

~~45.~~47. Surgery upon the prostate: suprapubic and radical prostatectomy
~~46.~~48. Surgery upon the ureter and renal pelvis
~~47.~~49. Surgery upon the urinary bladder for benign or malignant disease, including partial resection and removal of stones and foreign bodies
~~48.~~50. Testicular biopsy
~~49.~~51. Transurethral surgery, including resection of prostate and bladder tumors
~~50.~~52. Transvesical ureterolithotomy
~~51.~~53. Ureteral substitution
~~52.~~54. Uretero-calyceal anastomosis
~~53.~~55. Ureteroscopy
~~54.~~56. Urethral suspension procedures
~~55.~~57. Urethroscopy
~~56.~~58. Use of Laser
~~57.~~59. Ventral/flank herniorrhaphy as related to urologic operation
~~58.~~60. Visual urethrotomy

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

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

_____ _____

_____ _____

_____ _____

Applicant Signature: Date:

Acknowledgment of practitioner

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

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

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

Applicant Signature Date

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

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

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

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

Department Chair Signature Date

Status Pending PolicyStat ID 18055761

Origination	03/2022	Owner	Daniela Jago: Clinical Manager
Last Approved	N/A	Area	Nursing Standardized Procedures
Next Review	3 years after approval		

Amniotomy Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Amniotomy – artificial rupture of membranes.

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

C. RN – Registered Nurse employed by SVHMC

D. SP – Standardized Procedure

III. PROCEDURE

A. Function (s)

- To provide the registered nurse with guidance in determining the need to perform an urgent/emergent amniotomy and/or placement of internal fetal spiral electrode through intact membranes.

B. Circumstances

- Setting
  1. The registered nurse may apply a fetal scalp electrode APPLICATION OF FETAL SCALP ELECTRODE through intact membranes for the purpose of obtaining additional assessment data and continuing treatment under certain circumstances. Amniotomy should only be performed in a labor and delivery area equipped to handle an emergency situation.
- Supervision
  1. Telephone contact with physician.

- Patient Conditions
    1. Amniotomy should not routinely be used to place fetal scalp electrodes when membranes are intact, simply for the convenience of other health care providers. Patient condition situations may typically include when fetal well- being is in question based on evaluation of the characteristics of the external fetal monitor tracing, or when fetal well-being is in question and the tracing is unreadable.

C. Database

- Subjective
    1. Assessment and documentation of the fetal heart rate and characteristics; uterine activity; color, consistency, odor and amount of amniotic fluid.
- Objective
    1. Immediately prior to amniotomy, the nurse should assess the fetal heart rate and characteristics, and perform a vaginal exam to palpate for umbilical cord, determine fetal station and presentation.
    2. Document the indication for placement of fetal scalp electrode.
    3. Palpate for umbilical cord following completion of amniotomy via application of fetal scalp electrode.

D. Diagnosis

- Questionable fetal well-being in patients with intact membranes without a physician present

E. Plan

- Treatment
    1. Application of fetal scalp electrode for improved ability to assess fetal well-being evaluation.
- Patient conditions requiring consultation/reportable conditions
    1. Notify physician of fetal scalp electrode placement and amniotomy as well as assessment of fetal heart rate, uterine activity and characteristics of amniotic fluid.
- Education-Patient/Family
    1. Provide education to patient as to procedure that will be performed.
- Follow-up
    1. Monitor for appropriate fetal response.
- Documentation of Patient Treatment
    1. Indication for placement of fetal scalp electrode through intact membranes.
    2. Patient response to procedure.

3. Fetal heart rate characteristics.
4. Uterine activity.
5. Characteristics of amniotic fluid.
6. Vaginal exam findings.
7. Any conversations with the physician.

F. Record Keeping

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

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education

- In accordance with the SVHMC RN job description

B. Training

- Indications for use of fetal scalp electrode and placement.

C. Experience

- In accordance with the established SVHMC job description..
- Six months documented labor and delivery experience.

D. Evaluation

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

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Review Schedule

1. Every 3 years or when practice changes are made.

B. Approval

1. The electronic policy and procedure system maintains tracking of initiation, review

and approval of this SP including the Interdisciplinary Practice Committee, Medical Executive Committee and the Board of Directors.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

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

VII. REFERENCES

O'Brien-Abel, N. & Simpson, K. (2021). Fetal assessment during labor in Simpson,K., Creehan, P., O'Brien-Abel, B., Roth, C., & Rohan, A (Eds) *Perinatal Nursing* (5th ed. P. 420-422). Philadelphia:Wolters Kluwer.

Approval Signatures

Step Description	Approver	Date
IDPC	Katherine DeSalvo: Director Medical Staff Services	Pending
WCSL	Katherine DeSalvo: Director Medical Staff Services	06/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	Daniela Jago: Clinical Manager	05/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17826811**

Origination	07/2022	Owner	Amy Grimsley: Clinical Manager
Last Approved	N/A	Area	Patient Care
Next Review	3 years after approval		

Care of the CRRT Patient- Monitoring, Troubleshooting, and Termination of PrismaFlex

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide an ICU/CCU RN procedural guidelines with managing care of patient undergoing continuous renal replacement therapy

III. DEFINITIONS

A. SCUF – Slow Continuous Ultrafiltration – for fluid removal only. Poor emergent treatment of hyperkalemia and acidosis.

B. CRRT-Continuous Renal Replacement Therapy

C. CVVH – Continuous Veno-venous Hemofiltration – for convective solute clearance and patient fluid removal. Replacement solution is required.

D. CVVHD – Continuous Veno-Venous Hemodialysis – for diffusive solute clearance and patient fluid removal. Dialysate solution is required.

E. CVVHDF – Continuous Veno-Venous Hemodiafiltration – for convective and diffusive clearance and patient fluid removal. Blood pump, effluent pump, dialysate pump, and replacement pump are operational. Both replacement and dialysate solutions are required.

F. SLEDD - Sustained Low Efficiency Daily Dialysis - Time limited form of CRRT, usually 8-10 hours.

G. Temporary Dialysis Catheter – is a large bore, double lumen central venous catheter placed in the internal jugular vein, subclavian vein or femoral vein.

H. Dialysis – the process of diffusing blood across a semi-permeable membrane to remove toxic materials and to maintain fluid, electrolyte and acid-base balance in cases of impaired kidney function.

IV. GENERAL INFORMATION

A. The primary responsibility of managing the CRRT is assumed by the Nephrologists in collaboration with the Critical Care physician.

B. The Dialysis RN sets up the CRRT equipment, initiates therapy according to MD order, and changes hemofilter and blood lines every 72 hours or as needed.

C. A Critical Care RN who demonstrated competency in CRRT is responsible to monitor and care for the patient throughout the course of treatment.

D. The Dialysis RN is available on-call 24 hours a day as a nursing and technical resource.

E. If the patient needs to come off CRRT for a procedure or surgery, the Critical Care RN discontinues the therapy according to procedure and collaborates with the Dialysis RN when therapy is to be reinitiated.

F. The hemofilter is changed every 72 hours or prn using the prescribed hemofilter.

G. A PRISMAFLEX cart is ordered from SSP which will be used to store all CRRT fluids and supplies while patient is on CRRT therapy.

V. PROCEDURE

1. **Catheter Care Supplies for Heplock when not in use:**
    1. 1000 units/ml Heparin vials (use to Heplock dialysis catheter)
    2. (4) 10 mL syringes filled with 0.9% Sodium Chloride Solution
2. **PRISMAFlex Monitoring**
    1. **Status screen** displays information about the procedure during RUN mode.
    2. The first **self-test** will take place ten minutes after beginning of RUN, then every two hours thereafter. Do not make changes to circuit pressures during self-checks
    3. **Current Flow Rates** – located in upper left box. Displays the current flow rate settings.
        a. **Blood Flow Rate**– is always displayed. Stated as a physician order.
        b. **Replacement Solution Rate**- Stated as a physician order
        c. **Dialysate Rate-** Stated as a physician order
        d. **Patient set removal rate**– Net fluid removal set for the hour
        e. **Anticoagulation** Adjusted according to parameters when Heparin is use
    4. **Current Pressures-** Located in the upper right box. Gives continuous updates on pressures measured by the PRISMAFLEX system at each pressure pod location. Alarms occur if one or more pressures go out of range.
        a. ACCESS – The pressure measured as blood leaves the catheter and enters the extra-corporeal set. Since it is measured before the blood pump, it is always negative.
        b. FILTER– The pressure in the extracorporeal set immediately before entering the filter. Since it is measured after the blood pump, it is always positive.
        c. EFFLUENT – The pressure in the effluent line between the filter and the effluent

pump. It can be positive or negative depending on the therapy chosen and filter condition.

d. RETURN – The pressure measured as the blood leaves the extracorporeal set and goes back to the patient. It is always positive.

e. TMP – Transmembrane Pressure – reflects the pressure difference between the fluid and blood compartments of the filter.

f. FILTER PRESSURE (ΔP Filter) – determine pressure conditions in the hollow fibers of the filter.

5. **Input and Output Data** - Depending on the therapy chosen, the following cumulative totals are displayed.
    a. Effluent and actual patient fluid removal
    b. Elapsed Time
    c. Treatment Time– Total treatment time for patient
        1. Filter Time – Time elapsed on current disposable set
        2. Doses and Solutions (replacement and dialysate used)
        3. The length of the I/O period is set to 60 minutes. The data on the screen accumulates for the length of time set and then reverts to zero at the end of each I/O period., A chart reminder sound (BEEP) can occurs at the end of each I/O period.

6. **Next Intervention** – An advanced warning is displayed which includes the number of minutes before the next intervention is due and what the actual intervention is. The NEXT INTERVENTION warnings are:
    a. Effluent (YELLOW) bag full- Each time the effluent bag is emptied, a NEW STERILE effluent bag must be attached. Effluent output must be emptied into the proper receptacle (i.e. hopper).
    b. Pre-blood pump scale (WHITE)
    c. Dialysate (GREEN) bag empty**.**
    d. Replacement (PURPLE) bag empty.
    e. Time to change set**.**
    f. In addition to the advanced warning, a caution alarm occurs at the time the intervention is actually due. **DO NOT change any bags until prompted to do so.**
    g. **Syringe empty** – A caution alarm but not advance warning is also given for an empty anticoagulant syringe. **Alarm provides 5 minute warning**

7. **Treatment History Screen** – Press TREATMENT HISTORY Soft key which allows viewing of treatment history information. Vital machine conditions and operating data are stored and updated minute-by-minute in software memory. The memory stores up to 96 hours of treatment data but only the last 24 hours of data are viewable in the Treatment
    a. **History Screen**- If the machine is powered down (switched off) or a total power loss occurs during treatment, history data are retained in the Prismaflex software memory.
    History data includes:

a. Patient Fluid Removal including Unintended Patient Fluid
b. Loss/Gain volume
c. Doses and Solutions – delivered doses and the amount of solutions used.
d. Pressures
e. Events

b. **Treatment History Screen** can be accessed from:
    a. The *Status* screen during a treatment (Run mode)
    b. The *Treatment Complete* screen when ending a treatment (End mode)
    c. The *Choose Patient* screen (Setup mode)
    d. With the **left and right arrows** the operator can scroll among four 24-hour intervals. Circles between the arrows are displayed unfilled if there are data available for that specific period and a filled circle indicates the selected 24-hour period. The circle to the right indicates the current day.
    e. With the **up and down arrows** the operator can scroll within the selected 24-hour interval.

c. **Patient Fluid Removal table** has three columns:
    a. Time – shows chart time intervals. The date is displayed next to the time when a new calendar day has begun.
    b. Periodic – presents the accumulated volume for the chart time interval.
    c. Total – shows the accumulated value since the start of the selected 24-hour period.
    d. The **footer displays** values for unintended patient fluid loss or gain volume and limit (selected in Setup mode)

8. **Events**
    a. Certain events that may occur during setup and delivery of a treatment are stored and displayed on the three Events screens. The control unit stores the date, hour and minute that events occur, as well as the description of the event. Up to 2500 events can be stored.
    b. Pressing the EVENTS soft key on the History screens displays the Events screen and the events are displayed in chronological order, starting with the most recent. Arrow keys to the right on the Events screen allow the operator to scroll up or down in the chronological list. When the operator presses the ALL EVENTS soft key, all events are displayed. If desired, the operator can then view only alarm-related events by pressing the ALARM EVENTS soft key or treatment-related settings by pressing the SETTING EVENTS soft key.

9. **TMP or Transmembrane pressure**
    a. The pressure exerted on the filter membrane during operation of the Prismaflex

system. It reflects the pressure difference between the blood and fluid compartments of the filter.

b. During a patient treatment, permeability of the membrane decreases due to protein coating on the blood side of the membrane. This causes the TMP to increase.

c. During operation, the software sets the initial TMP value at the same time as the initial pressure operating points are established (shortly after entering Run Mode). Thereafter, the initial TMP value is reset:

    1. each time the blood flow,
    2. each time the patient fluid removal is changed
    3. each time the replacement solution rates are changed and
    4. also after self-test

10. **Filter Pressure Drop**

    a. A calculated value used to determine pressure conditions in the blood compartment of the filter.

    b. During patient treatment, clotting can occur in the blood compartment of the filter. Clotting adds resistance to the blood flow through the filter and causes the filter pressure to increase. In case of severe clotting, the set needs to be exchanged.

    c. During operation, the software sets the initial value for filter pressure drop at the same as the initial operating points are established.

    d. Monitor PRISMAFLEX System pressures continuously. Chart pressure readings every hour:

11. **Access Pressure** - The pressure measured as blood leaves the catheter and enters the extra-corporeal set

    a. Typical: -50 to –150 mmHg

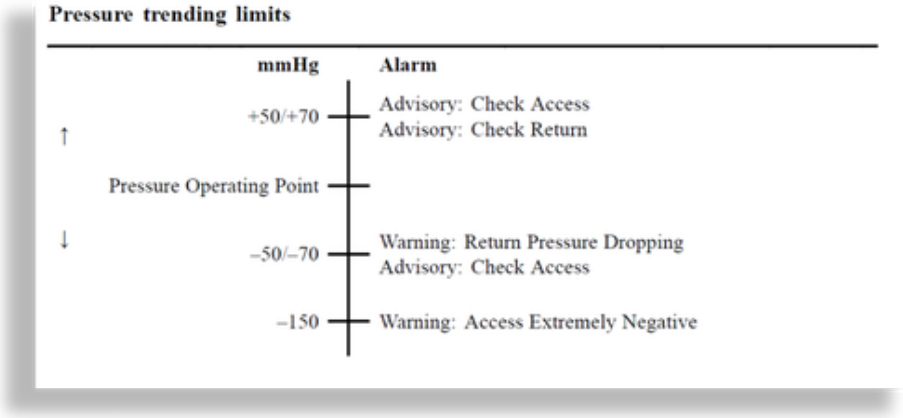
12. **Return Pressure**

13. **Filter Pressure -** The pressure in the extracorporeal set immediately before entering the filter. This is always positive and higher than return pressure.

14. **Effluent Pressure**- The pressure in the effluent line between the filter and the effluent pump. This can be positive or negative depending on the therapy chosen and the ultrafiltration rate.

15. **Pressure Trending Limits**

    a. If the access or return pressure changes 50 mmHg (or 70 mmHg if blood flow >200 ml/min) negative or positive from its established pressure operating point, the control unit notifies the operator by issuing an Advisory alarm or a Warning alarm.



16. STOP soft key – stops all pumps and navigates to the Stop screen. The Prismaflex goes into STANDBY Mode when this soft key is pressed. It allows for:
    a. RESUME – to restart pumps and resume treatment
    b. CHANGE SET – allows for the operator to remove the present set, with or without returning blood t the patient and load a new set. The control unit retains the following information on set up: patient ID, current weight and current hematocrit. This the soft key that the critical care nurse presses when returning the patient's blood.
    c. To change set – Temporarily disconnect patient or end treatment,
    d. RECIRCULATE – temporarily disconnect patient and recirculate saline or blood through the blood lines.
    e. END TREATMENT – terminates the present treatment, with or without returning blood to the patient
17. Setting Flow Rates:
    a. Blood flow can be set between 200-250 mL/min. as ordered. But it can be set specific to therapy/set from 10 to 450 mL/min.
    b. PATIENT FLUID REMOVAL can be set specific to therapy or hemofilter set. The flow rate can be set at 0 or 10-1000 ml/hr in CVVH, CVVHD, and CVVHDF mode. In SCUF mode the patient fluid removal can be set from 10-2000 ml/hr. as ordered.
    c. DIALYSATE flow in CVVHD and CVVHDF mode can be set can be set specific to therapy or hemofilter set. REPLACEMENT can be set specific to therapy or hemofilter set.
    d. Pre-blood pump (PBP) Flow Rate can be set specific to therapy/set. Maximum range: 0, 10 to 4000 mL/hr. as ordered.
    e. If using Heparin 20,000 units/ 20 mL Luer Lock syringe, adjust the Heparin dose per titration as ordered or (1) 20mL Luer-Lock syringe of sterile Normal Saline (if NOT using Heparin)
        1. Note: Heparin concentration is 20,000 units per 20 mL (1000 units/ 1 ml/ 100 units/ 0.1 ml); minimum heparin rate on machine is 0.5 mL/ hour. May use heparin IV systemically via IV pump instead of through

PRISMAFlex if MD orders.

2. Date/Time/Initial Heparin/NS syringe placed in machine

3. **Critical Care RN Monitoring/care**
    1. **Heparin use**
        a. Monitor aPTT and adjust Heparin rate as ordered. Heparin 20,000 units/20ml =1000 units/1 ml= 100 units/0.1ml
        b. If protocol requires a bolus, Heparin will be obtained and administered from the Pyxis. DO NOT BOLUS through the PRISMAFlex.
            i. High-alert medication independent double check co-signature is required for new syringe and bolus doses
        c. If CRRT/SLEDD treatment is stopped (ie. clotted filter/CT/procedure):
            i. Check PTT prior to restarting.
            ii. If PTT is less than or equal to 60, IV Bolus 1000 units of Heparin x1 and resume previous heparin rate. Recheck PTT in 6 hours.
            iii. If PTT 61-80, restart Heparin at previous rate and recheck PTT in 2 hours.
            iv. If PTT is greater than 80, hold the Heparin infusion, recheck PTT in 2 hours. Restart Heparin IV at previous rate once the PTT is less than 80.
        d. When CRRT is running and heparin is set at the lower rate (500 units/hour), and the protocol recommends a decrease in the dose, HOLD heparin and recheck PTT in 2 hours.
            i. Once PTT is less than 60, resume heparin at the lower rate (500 units/hour)

Post Filter aPTT Results	Bolus Dose and Heparin Infusion Changes	When to repeat post-filter aPTT:
	Initial Bolus 1000 units or as directed by Physician Start Heparin at ordered rate through CRRT machine.	2 hours
aPTT > 150	No bolus; Stop for 1 hour, then decrease by 200 units/hour	6 hours, if aPTT still > 150 seconds, notify Nephrology
aPTT > 100	No bolus; Stop for 1 hour, then decrease by 100 units/hour	6 hours and adjust per protocol
aPTT 81-100	No bolus; Decrease infusion by 200 units/hour	6 hours and adjust per protocol
aPTT 61-80	No bolus; No Change	6 hours and adjust per protocol
aPTT 51-60	No bolus; Increase infusion by 100 units/hour	2 hours and adjust per protocol

aPTT 41-50	1000 units IV Bolus; Increase infusion by 200 units/hour	2 hours and adjust per protocol
aPTT 30-40	2000 units IV Bolus; Increase infusion by 200 units/hour	2 hours and adjust per protocol
aPTT < 30	5000 units IV Bolus; Increase infusion by 300 units/hour	2 hours, if aPTT still < 30 seconds, notify Nephrology

2. **Citrate Use** - if citrate is ordered instead of heparin, the following will be implemented:
    a. Procedure
        i. Prime the CRRT circuit.
        ii. Place a 3-way stop cock to the "red access line" and the "blue return" ports of the CRRT circuit.
        iii. Attach the Citrate ACD(A) solution to a regular IV pump and then attach it to the "red" stop cock
            a. The initial Citrate rate will be 250 ml/hour and will be adjusted to the POST-FILTER ionized Calcium levels.
        iv. Attach the Calcium solution to a regular IV pump and then attach it to the "blue" stop cock. It may also be given via a central access line.
            a. The initial Calcium rate will be 60 ml/hour and will be adjusted to the SYSTEMIC ionized Calcium levels.
        v. Ionized Calcium levels:
            a. Post-filter are drawn from the CRRT circuit before the IV Calcium infusion is attached to the system.
            b. Systemic are drawn from the patient (venipuncture).
            c. Draw pre citrate initiation; 1 hour post, Q2h x2, then Q4h thereafter as timed below
                i. ** Recheck Ionized Calcium levels Q2H x2 with any titration change, then resume Q4h thereafter, if stable
        vi. Time 0 (Prior to initiating CRRT and the citrate/calcium infusions)
            a. Draw a baseline SYSTEMIC ionized Calcium level
            b. Start the CRRT, the citrate, and calcium infusions.
        vii. Time 60 (60 minutes after starting)
            a. Draw a POST FILTER and a SYSTEMIC ionized Calcium level.
            b. Titrate the rate of Citrate and/or Calcium infusion per chart below.
        viii. Time 180 (180 minutes after starting)
            a. Draw a POST FILTER and a SYSTEMIC ionized Calcium level.

b. Titrate the rate of Citrate and/or Calcium infusion per chart below.

ix. Time 300 (300 minutes after starting)

a. Draw a POST FILTER and a SYSTEMIC ionized Calcium level.

b. Titrate the rate of Citrate and/or Calcium infusion per chart below.

x. Time Q4H thereafter

a. Draw a POST FILTER and a SYSTEMIC ionized Calcium level.

b. Titrate the rate of Citrate and/or Calcium infusion per chart below.

c. ** Recheck Ionized Calcium levels Q2H x2 with any titration change, then resume Q4h thereafter if stable

xi. Use the following chart to titrate the Citrate:

Citrate-Dextrose (ACD) Solution Anticoagulation Protocol

Condition	Dose/Rate
Initial Rate	250 ml/h
Post Filter iCA2+ less than 1 mg/dl	Decrease by 20 ml/h
Post Filter iCA2+ 1 to 1.4 mg/dl	No change
Post Filter iCA2+ 1.41 to 1.56 mg/dl	Increase by 10 ml/h
Post Filter iCA2+ 1.57 to 2 mg/dl	Increase by 20 ml/h
Post Filter iCA2+ greater than 2 mg/dl	Increase by 30 ml/h
*Maximum flow of Citrate	1.5 x the Blood Flow Rate

xii. Use the following chart to titrate the Calcium Gluconate

Condition	Dose/Rate
Initial Rate	60 ml/h
Systemic iCA2+ less than 3.4 mg/dl	Increase by 40 ml/h
Systemic iCA2+ 3.4 to 3.6 mg/dl	Increase by 20 ml/h
Systemic iCA2+ 3.61 to 4.8 mg/dl	No change
Systemic iCA2+ greater than 4.8 mg/dl	Decrease by 20 ml/h

3. **Patient Monitoring**

a. Daily weights.

b. Vital signs – blood pressure, pulse, respirations, central venous pressure (CVP)

as indicated hourly and prn. If patient becomes hypotensive, see CRRT PRISMA TROUBLESHOOTING DURING PROCEDURE.

c. Check Blood Lines (Access Line and Return Line), Effluent Line, Replacement Line, and Dialysate Line (if applicable) for kinks. Kinking of the tubing can cause pressure alarms and interruption of the treatment.

d. Check catheter insertion site and tubing connections for bleeding and separation of lines.

e. Only use 21g, 22g or 25g needles in sample ports, no blunt needles

f. Monitor electrolytes, glucose, and albumin during treatment and initiate replacement/treatment per MD order

g. Monitor all connections are secure, no occlusion or kinks in blood lines and vascular access.

h. Assess hourly intake and output and adjust fluid removal rate accordingly.

i. Document the patient's intake and output, fluid removed from the machine, the level of blood/solution on the deaeration chamber, the PRISMAFLEX flow rates and pressures, hourly on the CRRT flowsheet

    1. CRRT flowsheet is a part of the patient's permanent medical record.
    2. Monitor flow rates continuously. Chart every hour:
    3. Blood Flow Rate – Typically 200 - 250 mL/min or as ordered by MD
    4. Patient Fluid Removal Rate – Calculation from CRRT flowsheet
    5. Replacement Fluid Solution – Typically 2000 ml/hr as ordered by MD
    6. Effluent Flow Rate – Dependent on calculated fluid removal rate, dialysate and replacement flow rates
    7. Dialysate Flow Rate – Typical 500-1000 ml/hr as ordered by MD
    8. Anticoagulation (Heparin) Infusion Rate – Variable dependent upon aPTT result.
    9. **Intake and Output standardize I/O calculation**:

        Intake – replacement fluids, and dialysate fluids are not included with the intake.

        a. Oral/OG/NG/Peg Intake
        b. All IV infusions – e.g. IVPB, TPN,
        c. Blood products

        Output

        a. Urine
        b. Nasogastric tube drains, chest tubes, etc. Note: Do not count effluent or ultrafiltrate, on output section of the calculation. This is determined by the PrismaFlex machine as fluid removed

a. Determine Patient Fluid Removal Rate
    1. Patient Net I + O = C= A – B
    2. A = Projected Hour Non-Prismaflex Intake (for current hour)
    3. B = Last hour's output
    4. C = Patient Net I/O
b. Determine "RN Set Fluid removal rate" = (F = C+ or –D + or - E)
    1. F = RN set removal rate
    2. C = Patients Net I /O
    3. D = Doctors order desired fluid loss
    4. E = Previous hour deficit

j. Connect new STERILE effluent bag when directed by the machine. Check ultrafiltrate color. Should be clear light yellow.
k. For CVVHD and CVVHDF monitor dialysate rate as ordered.
l. Change dialysate, replacement fluid and post filter solution when directed by the machine.
m. Notify physician for patient care problems. **Any deviations from the protocol requires a physician order.**
n. Monitor and troubleshoot alarms on PRISMAFLEX during therapy. If pressures exceed typical settings, See CRRT CONTINUOUS RENAL REPLACEMENT THERAPY PRISMAFLEX TROUBLESHOOTING DURING PROCEDURE
o. Notify on-call Dialysis RN for clotted hemofilter or equipment troubleshooting.
p. Discontinue and return blood if allowed. by pressing CHANGE SET and following the directions on the PRISMAFLEX MACHINE
q. Do not use germicidal wipes on the Prismaflex screen. Only alcohol wipes.

4. **TROUBLESHOOTING**
Troubleshooting shall be performed by the Dialysis RN on call in collaboration with the qualified Critical Care RN assigned to the patient.
    1. **ACUTE ALLERGIC REACTIONS**
        a. Patients receiving angiotensin converting enzyme inhibitors can develop, within the first few minutes of treatment, symptoms similar to acute allergic reactions, including bronchospasm, edema of airways or larynx, dyspnea, angioedema, urticaria, nausea and vomiting, diarrhea, respiratory arrest, abdominal cramping, hypotension, hypovolemic shock, and death.
        b. **STOP TREATMENT IMMEDIATELY.** Administration of antihistamines may not alleviate the symptoms. If symptoms of a severe reaction occur, stop treatment immediately and begin a more aggressive first-line therapy for anaphylactic reaction.

2. **ALARMS**
    a. Respond to alarms and correct alarm conditions immediately according to prompts on the Status/Alarm/Help screens and/or procedures in the Operator's Manual/Policy and Procedures in order to prevent clotting in the system.
3. **OVERRIDE** Soft Key –
    a. A new alarm cannot occur during the override period. Carefully observe the set and all operation during this period.
4. **POWER LOSS**
    a. If power is lost to the PRISMAFLEX Control Unit, the patient can be manually disconnected from the set.
    b. When performing a Manual Termination with Blood Return, visually check for air in the blood return line until the patient is disconnected.
    c. The Control Unit may not detect disconnections of the set from the patient's catheter. Carefully observe the set and all operation while using the PRISMAFLEX system.
5. **AIR REMOVAL**
    a. When the AIR IN BLOOD screen appears on the PRISMAFLEX system, the user will be given step-by-step instructions on how to remove air from the PRISMAFLEX set.
6. **PRISMAFLEX Pods**
    a. When pods are out of position, put the pods back into the correct position and re-test the machine by:
        1. Pressing SYSTEM TOOLS
        2. Press SELF-TEST soft key
7. **BLOOD LEAK ALARM- NOTE:** This procedure is used when the PRISMAFLEX gives a Blood Leak Alarm.
    a. Procedure
        1. Ensure that the effluent line is properly placed in the Blood Leak Detector (BLD).
        2. You are now at Test Effluent for presence or absence of blood.
        3. Draw sample according to directions on screen and send to lab. Mark Specimen as "Effluent Fluid", not urine
        4. If false positive:
            - Press CONTINUE.
            - Press Normalize BLD soft key
            - Return to STATUS SCREEN.
        5. If true positive, perform Termination of Therapy with Expected Re-initiation.

8. **PROBLEM SOLVING**
    a. Hypotension
        1. Decrease Pt. Net Loss to 0.
        2. Administer IV fluid (fluids, albumin, plasma, etc.) Peripherally to increase plasma volume as ordered by physician. (Do not count these fluids in the calculations for Pt. Net Loss for next hour.)
        3. Follow unit specific procedures for B/P maintenance.
        4. Notify physician.
    b. Cardiac Arrest
        1. Discontinue treatment and return blood to patient by pressing STOP.
        2. Press RECIRCULATION (if will be off machine only 3-5 minutes) and follow instructions displayed on the screen or
        3. Press END TREATMENT and follow the instructions displayed on the screen.
        4. **NOTE:** A 1000ml Normal Saline bag with a Y connect and a spike adapter must be available to connect to the patient's Access Line during the RETURN BLOOD mode. Flush both catheter lumens with 10ml NS, fill with 1000 units/ml of Heparin to fill volume as ordered. Label cath ports appropriately.
        5. Notify physician.
        6. Notify Dialysis nurse.
    c. Bleeding
        1. Bleeding From Access Catheter Site
            a. Apply direct pressure.
            b. Check anticoagulant rate, check PTT.
            c. Notify physician.
        2. Separation of Blood Tubing
            i. An Access Discontinuation Warning Alarm will occur (if access pressure is more positive than –10 and more negative than –10).
            ii. Reconnect if possible. Press OVERRIDE.
            iii. If contaminated:
                1. Push STOP.
                2. Do Not Return blood.
                3. Follow instructions displayed on screen.
                4. Notify Dialysis Nurse.
        3. Bleeding into Filtrate
            i. A Blood Leak Detect Warning alarm will occur.

ii. All pumps will stop to limit blood loss.

iii. Discontinue treatment.

iv. To return blood to the patient, press STOP from the Alarm screen, then press CHANGE SET from the Stop screen and follow the screen instructions.

v. Notify physician.

vi. Notify the Dialysis nurse.

d. Air in System

1. An Air in Blood Warning alarm will occur.
2. Remove the air via instructions on the Alarm screen or refer to Operator's manual.
3. Identify and remedy cause.
4. Press CONTINUE.
5. **NOTE:** If air is prevalent in entire set, change the set via Manual Termination without Blood Return.
6. Press both clips of cartridge carrier. Tug on cartridge assembly while manually turning each pump COUNTERCLOCKWISE.
7. When pump segments are free from pump raceways, remove set and discard using Standard Precautions.

e. Air in Blood

1. Verify all connections are secure.
2. Visualize for break in integrity of tubing/hemofilter.

f. Without Blood Return

1. Turn off power switch. Clamp access line (red) and return line (blue) and disconnect from patient. Flush both arterial and venous lumens of patient catheter with 10ml Normal Saline and fill with 1000 units/ml Heparin to fill volume as ordered, cap and label appropriately.

g. Access Pressure Alarm (Occurs if access pressure is more negative than the user settable "Access Pressure Extremely Negative" warning limit)

1. Check for adequate flow from catheter.
2. Verify secure connection to blood circuit tubing.
3. Is patient hypovolemic?
4. Consider vascular spasm.
5. Change patient position.
6. Access pressure maximum lower limit should not be less than –250.

h. Return Pressure Alarm (Occurs if return pressure is more positive than the user-settable "Return Pressure Extremely Positive" warning limit)

1. Is patient moving?

2. Possible kink in blood circuit line.
3. Clotting in the blood circuit line or catheter.
4. Check for adequate flow from catheter.
5. Return pressure upper limit should not exceed +350.

i. Poor Ultrafiltration Rates
   1. Check functioning of filter.
   2. Is hemoconcentration occurring?
   3. Possible clotting present?
   4. What is the patient's hematocrit?

j. Poor Blood Flow Rates
   1. Does the catheter provide adequate flow?
   2. Is the hemofilter clotted or clogged?
   3. Is the patient MAP **greater than** 60mmHg?
   4. What is the patient's hematocrit? Higher hematocrit values lead to sluggish blood flow through the hemofilter.

k. Blood Leaks
   1. Problems with the membrane possibly dropped during shipment and handling, blunt contact with other equipment in the patient's room, or manufacturing defect.
   2. Check ultrafiltrate for presence of blood. If positive, cease treatment and DO NOT return patient's blood. Discard entire blood circuit and follow facility protocol for reinitiating treatment.

l. Hypovolemia
   1. Check for secure connections to the blood circuit.
   2. Assess patient for cause of hypovolemia.
   3. Adjust ultrafiltration rate in accordance with assessment findings, and physician orders.

m. Electrolyte Imbalance
   1. Verify accurate ECG tracing.
   2. Monitor ECG tracing for changes in heart rhythm, QRS size, changes in the T waves, changes in PR interval, and changes in the ST segment.
   3. Assess laboratory values.
   4. Assess patient for changes in mentation, reflexes, seizure activity, skin turgor, muscle cramps, focal weakness, thready pulse, etc.
   5. Adjust dialysate and/or replacement solution per physician orders.

n. Calcium Imbalance

1. Assess laboratory values.
2. Monitor ECG tracings for changes in the QT interval.
3. Assess patient for changes in reflexes, complaints of bone and/or chest pain.
4. Adjust dialysate and/or replacement solutions per physician order.

o. Phosphorous Imbalance
   1. Assess laboratory values.
   2. Monitor ECG tracing for heart rate changes.
   3. Assess patient for changes in oxygenation, seizure activity, reflexes, tetany, or complaints of nausea or vomiting.
   4. Adjust dialysate and/or replacement solutions per physician orders.

p. Acid/Base Imbalance
   1. Renal failure patients tend to be acidotic related to the renal inability to excrete acid.

q. Infection Control
   1. Maintain strict aseptic technique at all times.
   2. Monitor patient's vital signs. Watch for trends in temperature changes.

r. Anticoagulation
   1. Deliver per facility protocol and physician orders.

5. **TERMINATION OF CRRT**
   The completion and termination of CRRT is determined by a nephrologist and performed by an ICU/CCU RN in collaboration with dialysis RN. The recommended maximum time for therapy for each hemofilter is 72 hours. Therapy will be discontinued and filter will be replaced by a dialysis RN.
   1. Equipment
      a. PRISMAFlex machine connected to patient in RUN mode. See *CRRT – Prisma Initiation of Treatment* or *CRRT – Prisma Monitoring During Therapy*.
      b. 1000ml bag Normal Saline
      c. 2 10ml syringes filled with Normal Saline
      d. Sterile piercer spike
      e. 2 - 3ml syringes
      f. 2 Sterile injection caps
      g. 3 vials Heparin 1000 units/ml
      h. 2 plastic blue clamps
   2. STOP-STANDBY mode is automatically entered when pressing the STOP key on the Status screen. By choosing one of the following options other than RESUME, END mode will automatically be entered.

a. RESUME – To restart pumps and resume treatment.
b. CHANGE SET – To change the set and then resume treatment.
c. RECIRCULATION- TO temporarily disconnect the patient
d. END TREATMENT – To terminate the treatment.

3. RECIRCULATION- TO temporarily disconnect patient, press RECIRCULATION key
    a. **Do Not** try to return blood if clotting is present in blood lines or filter.
    b. **Follow step-by-step instructions provided on screen.**
    c. Flush patient catheter with 5-10 ml Normal Saline per limb. Instill the amount of heparin (1000units/ml) as stated on each catheter port. Clamp the catheter lumen while applying positive pressure.
    d. If significant clotting is discovered, press UNLOAD and prepare a new PRISMAFlex set.
    e. If no clotting is seen, press PRIME key and follow the same priming procedure as for a new PRISMAFLEX set.
    f. Press CANCEL to cancel temporary disconnection and return to STOP screen.
4. END TREATMENT – To end treatment, choose one of the following options:
    a. RETURN BLOOD – To return blood to patient.
    b. DISCONNECT – To disconnect patient from machine without returning blood.
    c. CANCEL – To cancel END TREATMENT choice and return to the STOP screen.
5. RETURN BLOOD
    a. Ensure that there is at least 300 mL of 0.9% Sodium Chloride left in the bag to return blood.
    b. Clamp arterial port of dialysis catheter to and the access line on the CRRT circuit. Flush the arterial port of the dialysis catheter with 10 mL flush of 0.9% Sodium Chloride. Connect the access line to either of the limbs of the Y Connect. Unclamp the access line and the clamp on the Y Connect to allow normal saline to flow.
    c. Return blood by:
        1. Pressing AUTO RETURN. The machine will return a pre-programmed amount which is equal to the volume of the extracorporeal circuit. If more blood is desired to be returned, then press and hold the MANUAL RETURN soft key.
        2. Pressing and holding the MANUAL RETURN soft key to return the desired amount of blood.
        3. Clamp patient's venous catheter port and the return line. Disconnect the return line and flush the venous catheter port with 10 mL of 0.9% Sodium Chloride. Connect return line to the Y-Connect. Press CONTINUE
6. DISCONNECT
    a. Clamp all lines in the tubing set.

b. Disconnect access and return lines. Disconnect anticoagulant line from syringe.

c. Flush patient catheter with 10 ml of Normal Saline per limb. Instill Heparin 1000units/ml (see recommended amount printed on the catheter port) into each catheter port per protocol and place sterile caps on ends.

7. TREATMENT COMPLETE

    a. Disconnect lines from all bags, drain any fluid remaining in bags at appropriate waste site(s) according to policy. (All bags should be emptied before discarding.)

    b. Discard all tubing and empty bags into red hazardous waste receptacle.

    c. Press the TREATMENT HISTORY key to review the treatment data from the last 24 hours.

        1. The treatment data is stored in memory until the next New Patient procedure is selected on the CHOOSE PATIENT screen.
        2. Turn off machine. Place PRISMAFlex equipment in Dirty Utility Room.
        3. Wipe down outside of PRISMAFlex machine with hospital approved disinfectant (located on the CRRT cart).

6. **DOCUMENTATION**

    1. Document settings, fluids, and pressures every 60 minutes after initiation of CRRT. The Dialysis nurse documents the initiation and post 60 minutes post-initiation.
    2. Document ongoing monitoring of rates, pressures, and I&O at least hourly in the critical care flowsheet.
    3. Document any complications and interventions.
    4. Document discontinuation of CRRT therapy and patient tolerance of procedures.
    5. Document insertion site and any signs or symptoms of infection.
        a. Patient's response to CRRT and daily progress towards treatment goals.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Baxter (2023). *Renal acute therapy products.* Renal Acute Education Resources. https://usrenalacute.baxter.com/renal-acute- education-resources

B. Cooper, A. (2022, August). Pharmacological interventions to prevent clotting in extracorporeal circuit during continuous renal replacement therapy. *Critical Care Nurse, 42*(4), 84-85.

C. Heering, H., & Gruenwald, J. (2023, March 24). Performing continuous renal replacement therapy in adults. In *Dynamic Health*. https://www.dynahealth.com/nursing-skills/performing-continuous-renal-replacement-therapy-in-adults

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
P&T Committee	Genevieve delos Santos: Director Pharmacy	06/2025
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	06/2025
Critical Care Committee	Katherine DeSalvo: Director Medical Staff Services	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Critical Care Director	Lacey Cone: Director Critical Care Services	05/2025
Policy Owner	Amy Grimsley: Clinical Manager	03/2025

Standards

No standards are associated with this document

EXTENDED CLOSED SESSION

(if necessary)

(Report on Items to be

Discussed in Closed Session)

(Meeting Chair)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)

ADJOURNMENT